



DEPARTMENT OF VETERANS AFFAIRS  
Washington, DC 20420

November 15, 2013

The Honorable Carolyn N. Lerner  
Special Counsel  
U.S. Office of Special Counsel  
1730 M Street, NW, Suite 300  
Washington, DC 20036

RE: OSC File No. DI-13-1275

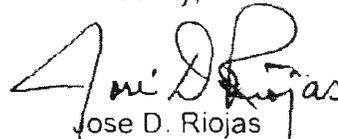
Dear Ms. Lerner:

I am responding to your letter regarding alleged violations at the John D. Dingell Department of Veterans Affairs (VA) Medical Center (hereafter, the Medical Center) in Detroit, Michigan. The whistleblower alleged that myriad violations of VA rules governing the mission, management, and goals of the Housing and Urban Development/VA Supportive Housing (HUD/VASH) program resulted in a failure to provide fundamental services to the homeless Veteran population, possibly constituting a violation of law, rule, or regulation, and gross mismanagement. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Secretary asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under the above code. He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI partially substantiated the whistleblower's primary allegation, substantiated four of five supporting allegations, and did not substantiate the fifth supporting allegation. OMI made five recommendations to the Medical Center to improve its HUD/VASH program and one for the Veterans Health Administration (VHA) to guarantee the Medical Center is in compliance with VHA Handbook 1162.05, which governs national implementation of the HUD/VASH program. Findings from the investigation are contained in the enclosed report, which I am submitting for your review.

Thank you for the opportunity to respond to this issue.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

**OFFICE OF THE MEDICAL INSPECTOR**

**Report to the  
Office of Special Counsel  
File Number DI-13-1275**

**Department of Veterans Affairs (VA)  
John D. Dingell VA Medical Center  
Detroit, Michigan**



**Veterans Health Administration  
Washington, DC**

**Report Date: September 16, 2013**

**OMI TRIM # 2013-D-959**

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act (HIPAA) of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

## **Executive Summary**

### **Summary of Allegations**

The Under Secretary for Health requested the Office of the Medical Inspector (OMI) investigate a complaint filed with the Office of Special Counsel (OSC) by (b)(6) (hereafter, the whistleblower), a former case manager (CM) at the John D. Dingell Department of Veterans Affairs (VA) Medical Center, in Detroit, Michigan (hereafter, the Medical Center). The whistleblower's primary allegation was that myriad violations of VA rules governing the mission, management, and goals of the Housing and Urban Development/VA Supported Housing (HUD/VASH) program resulted in a failure to provide fundamental services to Detroit's homeless Veteran population. She also provided five supporting allegations of violations of HUD/VASH operations, which covered such areas as management support and provision of resources, training, candidate screening and assessments, Veteran needs and recovery goals, and hiring practices. OMI conducted a site visit to the Medical Center on August 14-16, 2013. Based on its investigation, OMI makes the following conclusions and recommendations.

### **Conclusions**

OMI partially substantiates the whistleblower's primary allegation that myriad violations of VA rules governing the mission, management, and goals of the HUD/VASH program resulted in a failure to provide fundamental services to Detroit's homeless Veteran population. While the Medical Center has satisfactorily accomplished VA's three national performance measures for HUD/VASH, ensuring that homeless Veterans are being placed in permanent housing, there is evidence that the program is noncompliant with VHA Handbook 1162.05, Housing and Urban Development (HUD)-Department of Veterans Affairs Supported Housing (VASH) Program, governing nationwide implementation, and there are concerns about management and oversight, which have resulted in a very high turnover rate among the CMs. OMI is especially concerned about employee safety issues, such as the lack of cell phones and the absence of a process to track and locate employees when they are working in potentially dangerous environments.

Other conclusions follow:

- OMI substantiated the whistleblower's allegation that management failed to provide necessary support and resources (VHA Handbook 1162.05, Paragraph 9 (c)). As HUD/VASH grew, Medical Center leadership has failed to provide the support items and collateral resources needed for the staff to function. The CMs were not given sufficient tools needed to do their jobs, such as laptop computers, locked cabinets, cell phones, and vehicles, nor were they given a reasonable amount of space in which to work.
- The lack of a private space in which to interview Veterans, the lack of a process that provides information on the whereabouts of each CM while in the community, and the practice of allowing newly-assigned CMs to enter the community without cell

phones and laptops, are extremely concerning. These shortcomings, which undermine CMs' efforts to follow HIPAA rules and protect patient privacy, may expose them to personal harm if, in an emergency, they are unable to contact anyone at the Medical Center or the police.

- Some CMs are reluctant to complain about their unpleasant and potentially unsafe working conditions, expressing fear of retaliation.
- Morale among the CMs was extremely low because they felt neglected by leadership, due to the lack of an acceptable working environment and resources required for their jobs. Consequently, the turnover rate in CM positions has been very high.
- OMI substantiated the allegation that management failed to provide training in accordance with VHA Handbook 1162.05, Paragraph 10 (c). OMI found that CM training was inadequate, inconsistent, and untimely. There was no systematic effort made to provide training to CMs. The stipulation that required training was to occur within 90 days of hire was not met, and the CMs were given the message to disregard national policy as "not the Detroit way."
- HUD/VASH leadership did not provide clear-cut policies, procedures, or guidelines to properly direct HUD/VASH CMs.
- HUD/VASH leadership did not provide an effective process for orienting newly-hired CMs. The buddy program (a preceptor program where newly-hired CMs shadow more experienced CMs) did not work because of the demands of the job and the stress CMs were under due to poor working conditions. Consequently, CMs were placed in the field without proper orientation and appropriate training.
- OMI substantiated the allegation that management failed to require CMs to conduct candidate assessments (VHA Handbook 1162.05, Paragraph 12 (c)). CMs are required to use referrals from other programs in place of their own independent assessments. At the same time, we could not find evidence to substantiate (a) that persons who were not qualified Veterans, and not homeless, were brought into HUD/VASH and given vouchers; (b) that staff members completing the referral forms were not trained in assessing the Veteran's physical and mental status; or (c) that CMs were not ensuring the proper identification of the chronically homeless, and were not educating them about the availability of housing.
- OMI substantiated the allegation that management failed to require CMs to assess Veterans' needs and recovery goals (VHA Handbook 1162.05, Paragraph 12 (d)). We were unable to find adequate psychosocial assessments written by HUD/VASH CMs and could not find the overall assessments at the introduction of services, which would be expected of professional social workers.
- OMI did not substantiate the allegation that management failed to hire staff in a timely manner. HUD/VASH leadership showed evidence that they had a staffing plan, that they executed this plan, and as a result, they filled 100 percent of CM positions, including numerous vacancies to replace departing CMs.

## **Recommendations**

The Medical Center should:

1. As a matter of safety, ensure that all CMs have a functioning cell phone before being sent into the community.
2. As a matter of safety, implement a system to know the whereabouts of CMs when they are working in the community.
3. Ensure Veterans' privacy by providing CMs appropriate office space for interviews, counseling, and protected computer displays.
4. Comply with national HUD/VASH guidelines contained in VHA Handbook 1162.05, with particular emphasis on providing CMs the resources – space, information technology support, equipment, vehicles, and other services – they need to do their jobs.
5. As specified in VHA Handbook 1162.05 paragraph 10 (c), ensure that newly-hired CMs receive required training within 90 days; implement a plan for existing CMs to receive this training at the earliest possible time; and develop an effective orientation process for new CMs.

VHA should:

6. Task the Homeless Program Office, in collaboration with Veterans Integrated Service Network 11, to conduct a comprehensive review of the Medical Center's HUD/VASH program to ensure compliance with VHA Handbook 1162.05, identifying strategies and tools available for improving resource use, expanding training opportunities, and effectively screening, assessing, and following up on Veteran clients, providing technical assistance as necessary.

## **Summary Statement**

OMI's investigation and review of its findings did not reveal any violation or apparent violation of statutory laws, or mandatory rules or regulations set forth in the Code of Federal Regulations. OMI did find that the Medical Center's HUD/VASH program failed to comply with VHA policy, contained in Handbook 1162.05.

## **I. Introduction**

The Under Secretary for Health requested OMI investigate a complaint filed with OSC by (b)(6) (hereafter, the whistleblower), a former CM at the John D. Dingell VA Medical Center, in Detroit, Michigan (hereafter, the Medical Center). The whistleblower's primary allegation was that myriad violations of VA rules governing the mission, management, and goals of the HUD/VASH program resulted in a failure to provide fundamental services to Detroit's homeless Veteran population. She provided five supporting allegations of violations in HUD/VASH operations. These areas are: management support and provision of resources, training, candidate screening and assessments, Veteran needs and recovery goals, and hiring practices. OMI conducted a site visit to the Medical Center on August 14-16, 2013.

## **II. Facility Profile**

The Medical Center, part of Veterans Integrated Service Network (VISN) 11, is a 267-bed, full-service facility that provides primary, secondary, and tertiary care, including the operation of 108 acute care beds and an onsite 109-bed nursing home/palliative care unit. The Medical Center provides acute medical, surgical, psychiatric, neurological, and dermatological inpatient care, as well as primary care, medical and surgical specialties, and mental health clinical services, such as substance abuse treatment, a compensated work therapy program, and a community-based psychiatric program.

As part of its Mental Health Service, the Medical Center has a Homeless Program to assess the needs of homeless Veterans, to link them with VA and community resources, and to find them suitable transitional or permanent housing. Within this setting, HUD/VASH provides the Veteran with permanent supportive housing, along with supportive case management services.

The Medical Center has four Veteran Outreach Centers located in Dearborn, Detroit, Clinton Township (Macomb County), and Pontiac, as well as two community based outpatient clinics located in Yale and Pontiac, Michigan. It is affiliated with Wayne State University School of Medicine and supports over 75 physician resident positions. Other major training programs at the Medical Center include audiology and speech pathology, dietetics, nursing, psychology, rehabilitation medicine, social work, surgical auxiliaries, and a compensated work therapy program.

## **III. Background**

The Medical Center's Homeless Program, organizationally aligned under the Mental Health Service, is the umbrella for many component programs. The Healthcare for Homeless Veterans program includes a Veterans Community Resource and Referral Center (VCRRC), a one-stop service center for Veterans experiencing homelessness, or those who are at risk of homelessness. The VCRRC is a 12-hour per day, 7-day per week, walk-in clinic, and a center where homeless Veterans can receive a variety of

services, such as care referral, substance abuse treatment, peer counseling, and food and clothing. The Emergency Contract Residential Program provides Veterans with short-term transitional housing and case management assistance for up to 6 months; it is in the process of developing a 15-bed Safe Haven Contract for low demand housing. The Homeless Veteran Supportive Employment Program delivers employment assistance to Veterans, by Veteran peers who have been at risk for homelessness, have been homeless in the past, or who were homeless at the time they were hired. The Homeless Providers Grant and Per Diem program furnishes transitional housing to homeless Veterans for up to 24 months. The Veterans Justice Outreach Program has developed eight Veteran Courts to assist Veterans with re-entry into the community and to provide access to VA services.

The Homeless Program also has a co-ed, 50-bed, Domiciliary Residential Rehabilitation Treatment Program (DRRTP) that serves as a transitional residential treatment facility for Veterans in need of structured treatment to prepare them for a move into permanent housing.

HUD/VASH is a joint effort between HUD and VA to move Veterans and their families out of homelessness and into permanent housing. HUD provides housing assistance through its Housing Choice Voucher (HCV), allowing homeless Veterans to rent privately-owned housing. VA offers these same Veterans case management and supportive services through its medical centers. These case management services are provided by licensed masters-level social workers.

Since 2008, the Medical Center's HUD/VASH program has targeted the most vulnerable Veterans in the Detroit metropolitan area in an effort to get them into subsidized housing with supportive services. To date, this program has allocated a total of 585 HCVs, providing 65 percent of these vouchers to those Veterans who meet the chronically homeless criteria (Veterans who have had 1 full year of homelessness or four episodes of homelessness in the past 3 years). The program has been growing rapidly; it began in 2008 with one staff member; today, it has 15 CMs.

VA has established national performance measures for HUD/VASH. The Medical Center has met all three: 65 percent of all vouchers are assigned to the chronically homeless; 88 percent of all vouchers allocated are issued to Veterans by the end of the year; and 60 percent of HUD/VASH Veterans have been referred from other VA programs.

#### **IV. Conduct of Investigation**

An OMI team consisting of (b)(6) Medical Inspector; (b)(6) RN, Clinical Program Manager; (b)(6) (b)(6)A, Executive Assistant; and (b)(6) (b)(6) VISN 19 Network Homeless Coordinator, conducted the site visit and reviewed reports, organization charts, education/training folders, memoranda, the HUD/VASH Handbook, and other relevant documents. A full list of these documents is in Attachment A.

OMI held an entrance briefing with Medical Center leadership, including: (b)(6) (b)(6) , Medical Center Director; (b)(6) Deputy Chief of Staff; (b)(6) (b)(6) Associate Director for Patient Care Services; (b)(6) Associate Chief of Staff for Mental Health Services; (b)(6) , Director of the Homeless Program; (b)(6) , Supervisor/Coordinator, HUD/VASH; (b)(6) (b)(6) Acting Associate Director; (b)(6) Administrative Officer to the Chief of Staff; (b)(6) , Administrative Officer for Mental Health Service; and (b)(6) (b)(6) Administrative Officer to the VISN 11 Network Director. (b)(6) and (b)(6) presented an overview of the Medical Center's Homeless Program including HUD/VASH.

OMI toured the HUD/VASH program's second floor office spaces, the library that some CMs use for office space, and the newly-renovated Mental Health Service offices located on the seventh floor.

OMI interviewed the whistleblower by phone prior to the site visit, and in person, on the first day of the visit. During the second meeting, she gave OMI additional documents to review. OMI held individual interviews with the following Medical Center staff during the site visit: the Medical Center Director, the Associate Chief of Staff for Mental Health, the Director of the Homeless Program, and the Supervisor/Coordinator of HUD/VASH. In addition, we interviewed (b)(6) , Social Worker, Mental Health Clinic; (b)(6) (b)(6) Chief, VCRRC; and, (b)(6) , Program Support Assistant, HUD/VASH. The following HUD/VASH CMs were interviewed: (b)(6)

(b)(6)  
(b)(6) , VISN 11 Network Homeless Coordinator, and (b)(6)  
(b)(6) , a HUD/VASH CM, were interviewed by phone.

OMI held an exit briefing with the Medical Center Director, the Chief of Staff, and the Associate Director for Patient Care Services. Attending by phone were: (b)(6) (b)(6) Acting Chief Medical Officer, VISN 11; (b)(6) , Deputy ADUSH for Clinical Operations, VA Central Office; (b)(6) , Deputy Network Director, VISN 11; and (b)(6) , Acting Quality Management Officer, VISN 11.

The Office of General Counsel reviewed OMI's findings to determine whether there was any violation of law, rule, or regulation.

OMI substantiated allegations when the facts and findings supported the alleged events or actions took place. OMI did not substantiate allegations when the facts showed the allegations were unfounded. OMI could not substantiate allegations when there was no conclusive evidence to either sustain or refute the allegations.

## **V. Allegations**

The whistleblower made one primary allegation and five supporting allegations. The primary allegation is:

"Myriad violations of VA rules governing the mission, management, and goals of the Housing and Urban Development-Veterans Affairs Supported Housing (HUD/VASH) program resulted in a failure to provide fundamental services to Detroit's homeless Veteran population."

The supporting allegations are that management failed to:

1. Provide necessary support and resources;
2. Provide required training;
3. Require CMs to conduct candidate assessments;
4. Require CMs to assess Veterans' needs and recovery goals; and
5. Hire staff in a timely manner.

### **Allegation 1: Management's Failure to Provide Necessary Support and Resources**

The whistleblower stated that VA Handbook 1162.05, Paragraph 9 (c), requires the Facility Director to provide appropriate administrative support and resources to ensure HUD/VASH is able to accomplish its stated mission, goals, and objectives, including office space, information technology (IT), equipment, and car allocations. She claimed that 13 CMs shared four single-person offices and were told they did not need individual offices, since they were to spend 80 percent of their workdays visiting Veterans and their families. Many times, CMs worked without desks, balancing case files on their laps. Veterans were interviewed in rooms occupied by other CMs, and sometimes other Veterans, potentially violating confidentiality and HIPAA. There were two or three phones in each office that CMs shared; most did not have their own telephones to conduct interviews and had to wait until one became available.

The whistleblower also claimed that these CMs shared nine operable vehicles, making it difficult to meet the local goal of spending 80 percent of the workday away from the office, meeting with Veterans and their families in the community. She estimated that only 50 percent of her time was spent outside of the office because of car shortages. Vehicles were frequently unavailable and needed to be reserved up to a month in advance.

The whistleblower further alleged that there were no file cabinets in which to store Veteran's files, that these files, containing confidential Veteran medical and financial information, were stored in unsecured cardboard boxes, and that some files were stored in unlocked closets within the HUD/VASH office. Although the office with the HUD/VASH files could be locked at night, the main door into the office was frequently left ajar, allowing members of the public to enter without an employee escort. Since CMs shared only three operable computers, they were unable to keep electronic

records of Veterans' information. As a result, handwritten notes were placed in files, which were then stored in unsecured boxes in the HUD/VASH office.

## Findings

VHA Handbook 1162.05, Paragraph 9 (c), states that the Facility Director is responsible for providing appropriate administrative support and resources, including office space, IT equipment, and car allocations.

At the time of OMI's site visit, there were 15 CMs assigned to HUD/VASH, plus 1 HUD/VASH Supervisor (1 CM was out of the office on extended sick leave). From 2008 to 2013, the staff has grown from 1 to 15 CMs, despite experiencing a very high turnover rate, with 13 CMs leaving the program during this time period. We interviewed the HUD/VASH Supervisor and 8 of the 15 CMs. Initially, several of the CMs were hesitant to speak with OMI and asked whether their names would be used, since they were still in their probationary period of employment. They expressed concern about losing their jobs if they spoke with us; one CM – the whistleblower – had recently been terminated.

When OMI toured the second floor space designated for the CMs, we observed three offices and space in the former library. Each of the offices had three to four desks with a computer and phone on each. The desks were approximately 2-3 feet apart, and the computers on top of them were displayed so anyone could see them; thus the office space and proximity of desks to one another afforded no privacy for Veteran interviews, or for securing data.

We also observed two sets of lockable file cabinets in one of the offices. The HUD/VASH Supervisor informed us that these cabinets had been purchased the week before our visit. On the floor, under two of the tables, we observed two cardboard boxes filled with patient documents. We also noticed that the front door leading to the HUD/VASH offices had been propped open but were unable to determine whether this also occurred after hours, when no staff members are present.

OMI also toured the newly renovated Mental Health Service space on the seventh floor. We observed that each employee had his or her own office space. Some HUD/VASH CMs later told us that they felt slighted by the new offices occupied by the Mental Health Service employees on the seventh floor.

All CMs interviewed expressed dissatisfaction with the way the HUD/VASH program was being managed. They complained about the lack of privacy, telling OMI that when other CMs were in the office, to ensure patient confidentiality, they would interview Veterans in the corridor outside of the office, or try to find a vacant office or break room. Because CMs were not assigned a specific desk or work space, they used whatever desk was available. They never knew if a desk would be available when they reported for work, and none of them were given keys to the offices or the rest rooms. One CM

reported not being assigned an office space for 6 months after being hired and having, on occasion, to use space in the break room for an office.

CMs also told us that, until the locked file cabinets arrived, they had been working out of cardboard boxes the entire time they had been in the program. One CM said he carried his paperwork and files to and from work in a briefcase, because he had not been assigned work space or a place to lock his files.

CMs indicated that they were supposed to be issued a laptop computer, but that it took approximately 2 months to obtain one. Once they received it, they often could not get it to work. Many said that it took 30 to 60 minutes to boot up; one CM estimated that 85 percent of the laptops malfunctioned.

The HUD/VASH Supervisor gave us a list of 10 operable cars that CMs used to visit Veterans and their families. The CMs reported that obtaining cars had always been a problem, and that they sometimes had to wait up to 6 months for a vehicle, because some of their coworkers would sign them out for months at a time. They indicated that recently the process had improved as one car was now assigned to a team of two workers. Now all they had to do was coordinate their schedule with their teammate assigned to the vehicle.

In addition to the above, OMI learned that some of the newly-assigned CMs had to wait from 1 to 3 months before obtaining a Government-issued cell phone, and that some were sent into the community, even high crime areas, without a Government-issued cell phone or laptop. Many CMs who did have cell phones reported that their phones had poor reception, and that they frequently did not work inside the Medical Center.

Our interviews also revealed that when CMs were in the field, there was no system in place to know where individual CMs were at any given time. As a result, there was no way to know a CM's whereabouts, and a CM without a cell phone had no way of contacting the program or the police when faced with a potentially dangerous situation or in the event of an emergency.

## **Conclusions**

- OMI substantiated the whistleblower's allegation that management failed to provide necessary administrative support and resources (VHA Handbook 1162.05, Paragraph 9 (c)). As HUD/VASH grew, Medical Center's leadership failed to provide the support items and collateral resources needed for staff to function. CMs were not given sufficient tools needed to do their jobs, such as laptop computers, locked cabinets, cell phones, and vehicles, nor were they given a reasonable amount of space in which to work.
- The lack of a private space in which to interview Veterans, the lack of a process that provides information on the whereabouts of each CM while in the community, and the practice of allowing newly-assigned CMs to enter the community without cell

phones and laptops are extremely concerning. These shortcomings, which undermine CMs' efforts to follow HIPAA rules and protect patient privacy may expose them to personal harm if, in an emergency, they are unable to contact anyone at the Medical Center or the police.

- Some CMs are reluctant to complain about their unpleasant and potentially unsafe working conditions, expressing fear of retaliation.
- Morale among CMs was extremely low because they felt neglected by leadership, due to the lack of an acceptable working environment and resources required for their jobs. Consequently, the turnover rate in CM positions has been very high.

### **Allegation 2: Management's Failure to Provide Required Training**

According to VHA Handbook 1162.05, Paragraph 10 (c), the HUD/VASH program team is responsible for ensuring that training for new CMs is conducted within 90 days of an initial start date. All CMs and Substance Use Disorder (SUD) Specialists are to have training in Critical Time Intervention (CTI), Assertive Community Treatment (ACT), Motivational Interviewing (MI), Housing First, Low-Demand Model of Care, and other clinical processes relevant to the homeless population. The whistleblower alleges that CMs and SUD Specialists do not receive training within 90 days of their initial start, and that only 3 of the 13 CMs she worked with received training in CTI. She indicates that CMs receive some training in Housing First, but that they receive no training in ACT, MI, Low-Demand Model of Care, or other relevant clinical processes.

### **Findings**

The HUD/VASH Supervisor reported that training in CTI had been offered for several years, but that few CMs had actually taken it, due to demands of the job and high turnover. She explained that CTI training was offered via VA's internet-based Talent Management System, but CMs were not required to take it. In a discussion with the VISN 11 Network Homeless Coordinator, we were told that he provided an 8-week, online course for seven HUD/VASH CMs and the former HUD/VASH Supervisor. Three of the eight remain in the program. He also told us that the VISN holds a call once a month with directors and supervisors of each component of the Homeless Program. He also assists the HUD/VASH team with online screening and training in the case management models. He indicated that a homeless summit was held once a year, and boot camps periodically, to bring stakeholders together in an effort to decrease the homeless population. In addition, as a Project Improvement Effort, VISN 11 established the goal of placing homeless Veterans into HUD/VASH housing within 75 days or less. While the Medical Center has met its national performance measures, it has not met this VISN goal; the Medical Center places homeless Veterans, on average, in 120 days. The Network Homeless Director states, "Detroit was a unique situation," due to its economy and the number of chronically homeless Veterans.

CMs we interviewed told us that they had not received all of the training mandated in VHA Handbook 1162.05, Paragraph 10 (c). Most CMs interviewed had received training in Housing First; four had attended a local MI workshop, but two of those four had left the program, and the remaining two were not allowed to practice the training techniques they learned. Many stated that when they asked about the different training techniques listed in the Handbook, they were told, "That is not the Detroit way."

In addition to lacking the required training, OMI found that there was no standard orientation process to HUD/VASH for newly-hired CMs. None of the CMs had received a formal orientation to the HUD/VASH program, although they had participated in new employee orientation to the Medical Center. Their orientation to HUD/VASH was limited to receiving a checklist without measurable action items or goals, after which they were assigned to shadow a "buddy," one of the other CMs. They further stated that they received no policies or standard operating procedures to provide direction about the program. CMs to whom they were assigned were also newly-assigned and ill-prepared to orient them. One CM admitted to not having had the time to orient a new employee because he was new himself, and at the time, too busy trying to obtain a car and other resources to get his work done. Some CMs said that newly-assigned CMs were being set up for failure, given the inadequate resources, the lack of training, and the heavy caseloads.

### **Conclusions**

- OMI substantiated the allegation that management failed to provide training in accordance with VHA Handbook 1162.05, Paragraph 10 (c). OMI found that CM training was inadequate, inconsistent, and untimely. There was no systematic effort made to provide training to the CMs. The stipulation that required training was to occur within 90 days of hire was not met, and the CMs were given the message to disregard national policy as "Not the Detroit way."
- HUD/VASH leadership did not provide clear-cut policies, procedures, or guidelines to properly direct HUD/VASH CMs.
- HUD/VASH leadership did not provide an effective process for orienting newly hired CMs. The buddy program did not work because of the demands of the job, and the stress CMs were under due to poor working conditions. Consequently, CMs were placed in the field without proper orientation and appropriate training.

### **Allegation 3: Management's Failure to Require Case Managers to Conduct Candidate Assessments**

According to VHA Handbook 1162.05, Paragraph 12 (c), CMs are supposed to conduct screenings and assessments required to ensure the appropriateness of a Veteran's placement into HUD/VASH. The whistleblower alleges that CMs are instructed to rely on forms provided by other VA programs in assessing candidates for HUD/VASH, and that there is no way to determine whether CMs from these programs are trained in assessing the homeless Veteran's physical and mental status. She claims that the CM's role in assessing the candidate is limited to contacting the Veteran by telephone,

when housing vouchers become available to inquire whether he or she is still interested in placement. This results in most CMs failing to ensure that Veterans who are offered vouchers are qualified for the program. She also states that CMs are not ensuring that the chronically homeless, the highest priority, are identified and properly educated about the availability of housing.

### **Findings**

CMs interviewed confirmed that they were not allowed to conduct screenings and assessments required to ensure the appropriateness of a Veteran's placement into HUD/VASH. They reported that HUD/VASH leadership requires them to use a screening referral form provided by other VA programs and does not emphasize assessments. They often received completed referrals from other clinicians in the DRRTTP and VCRRRC programs, on which they had to rely for admission of Veterans into HUD/VASH. If they disagreed with the assessment, they had to go back to the DRRTTP or VCRRRC staff person to ask them to change it. CMs told us that they have brought this issue up with the HUD/VASH Supervisor, requesting that they complete the assessments, only to be told that there was no need and to focus on working with Veterans once vouchers became available. Many voiced frustration at not being able to provide their clinical input into the assessment process.

### **Conclusions**

- OMI substantiated the allegation that management failed to require CMs to conduct candidate assessments (VHA Handbook 1162.05, Paragraph 12 (c)). CMs are required to use referrals from other programs in place of their own independent assessments.
- OMI could not find evidence to substantiate: (a) that persons who were not qualified Veterans, and not homeless, were brought into HUD/VASH and given vouchers; (b) that staff members completing the referral forms were not trained in assessing the Veteran's physical and mental status; or (c) that CMs were not ensuring the proper identification of the chronically homeless and were not educating them about the availability of housing.

### **Allegation 4: Management's Failure to Require CMs to Assess Veterans' Needs and Recovery Goals**

The whistleblower alleges that CMs were not required to assess Veterans through comprehensive psychosocial evaluations to determine case management needs and recovery goals as required by VHA Handbook 1162.05, Paragraph 12 (d), and that they relied solely on the medical history forwarded by a referring agency screener rather than on an independent assessment, as required by the Handbook. She further alleges that CMs were not required to support the Veteran once he or she was placed in housing.

## **Findings**

VHA Handbook 1162.05 Paragraph 12 Section (d) states: "The case manager is responsible for assessing Veterans through comprehensive psychosocial evaluations to determine case management needs and recovery goals." OMI reviewed the electronic health records of several Veterans in HUD/VASH and found that no comprehensive psychosocial evaluations had been completed by CMs. OMI also learned that no steps had been taken, by either the HUD/VASH CMs or other professional staff members in the Medical Center's Homeless Program, to document the initial outreach for securing and maintaining housing for the Veterans. CMs reported that they had been instructed by management to "cut and paste" the assessment information from the program evaluation system known as Homeless Operations and Management System; this is a data collection tool and not a replacement for a comprehensive psychosocial evaluation. In addition, several CMs said that whenever they asked why they were not allowed to perform psychosocial assessments or why they did not follow the VHA guidelines, they were told that "they were not that type of social worker," and that Detroit did things differently from other VA medical centers. Although OMI could not find evidence of a systematic approach to assessing Veterans and setting recovery goals, or a requirement on the part of management to do this, CMs indicated that they were supporting Veterans needs and recovery goals.

## **Conclusions**

- OMI substantiated the allegation that management failed to require CMs to assess Veterans' needs and recovery goals (VHA Handbook 1162.05, Paragraph 12 (d)).
- OMI could not find adequate psychosocial assessments written by HUD/VASH CMs and could not find overall assessments at the introduction of services, which would be expected of professional social workers.

## **Allegation 5: Management's Failure to Hire Staff in a Timely Manner**

The whistleblower alleges that the Medical Center Director violated HUD/VASH provisions regarding the timely hiring of staff, set forth in VHA Handbook 1162.05, Paragraph 9 (a). She specifically alleges that Medical Center leadership failed to replace HUD/VASH departing CMs in a timely manner, that they did not employ either a SUD Specialist or a dedicated Peer Support Specialist as required by Handbook Paragraphs 13 and 14, and that because of staffing shortages, they failed to meet the VISN 11 goal of providing housing to homeless Veterans within 75 days.

## **Findings**

As previously stated, HUD-VASH has grown rapidly from one CM in 2008 to the current complement of 15. OMI reviewed the Medical Center's staffing plan, which showed that the hiring and replacement of CMs was timely, and also that the SUD Specialist had been hired but had left, and they were in the process of recruiting for the position. There is a dedicated Peer Support Specialist. The VISN 11 Homeless Coordinator explained that

the program's failure to meet the VISN's goal of providing housing to homeless Veterans within 75 days was due to factors such as the vast number of chronically homeless Veterans in the area and the depressed state of the economy.

### **Conclusion**

OMI did not substantiate the allegation that management failed to hire staff in a timely manner. HUD/VASH leadership showed evidence that they had a staffing plan, that they executed this plan, and as a result, filled 100 percent of CM positions, including numerous vacancies to replace departing CMs.

### **Primary Conclusion**

OMI partially substantiates the whistleblower's primary allegation that myriad violations of VA rules governing the mission, management, and goals of the HUD/VASH program resulted in a failure to provide fundamental services to Detroit's homeless Veteran population. While the Medical Center has satisfactorily accomplished VA's three national performance measures for HUD/VASH, ensuring that homeless Veterans are being placed in permanent housing, there is evidence that the program is non-compliant with the VA Handbook governing HUD/VASH, and there are concerns about management and oversight, which have resulted in a very high turnover rate among CMs. OMI is especially concerned about employee safety issues, such as the lack of cell phones and the absence of a process to track and locate employees when they are working in potentially dangerous environments.

### **Recommendations**

The Medical Center should:

1. As a matter of safety, ensure that all CMs have a functioning cell phone before being sent into the community.
2. As a matter of safety, implement a system to know the whereabouts of CMs when they are working in the community.
3. Ensure Veterans' privacy by providing CMs appropriate office space for interviews, counseling, and secure computer displays.
4. Comply with national HUD/VASH guidelines contained in VHA Handbook 1162.05, with particular emphasis on providing CMs the resources—office space, IT equipment, vehicles, and other services they need to do their jobs.
5. As specified in VHA Handbook 1162.05 paragraph 10 (c), ensure that newly-hired CMs receive required training within 90 days; implement a plan for existing CMs to receive this training at the earliest possible time; and develop an effective orientation process for new CMs.

VHA should:

6. Task the Homeless Program Office, in collaboration with VISN 11, to conduct a comprehensive review of the Medical Center's HUD/VASH program to ensure compliance with VHA Handbook 1162.05, identifying strategies and tools available for improving resource use, expanding training opportunities, and effectively screening, assessing, and following up on Veteran clients, providing technical assistance as necessary.

**Summary Statement**

OMI's investigation and review of its findings did not reveal any violation or apparent violation of statutory laws or mandatory rules or regulations set forth in the Code of Federal Regulations. OMI did find that the Medical Center's HUD/VASH program failed to comply with VHA policy, contained in Handbook 1162.05.

## **Attachment A**

### **Documents Reviewed by OMI:**

1. VHA Handbook 1162.05, Housing and Urban Development (HUD)/Department of Veterans Affairs Supported Housing (VASH) Program, September 14, 2011
2. HUD/VASH Resource Guide for Permanent Housing and Clinical Care, August 6, 2012
3. Detroit VA Healthcare System, Homeless Program for Veterans Pamphlet, May 2013
4. John D. Dingell VA Medical Center, Homeless Veterans Program Operational Plan, August 2013
5. John D. Dingell VA Medical Center, Homeless Program Continuum of Care with a Special Focus on HUD/VASH. – Presentation to OMI August 14, 2013
6. Education and training folders of all HUD/VASH Case Managers
7. Medical Center Healthcare for Homeless Veterans Accessibility Plan FY 2012
8. Healthcare for Homeless Veterans Assessment Tool
9. Organization Charts of the Medical Center Homeless Program and the HUD-VASH Program
10. HUD/VASH Referral Form
11. HUD/VASH Monthly Status Report
12. HUD/VASH Housing Progress Form