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Linda Zander Altus's Response to OMI Investigation and Report

BACKGROUND INFORMATION

OMI wrote: "VA has established national performance measures for HUDVASH. 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 HUDVASH Veterans have been referred from other VA programs."

RESPONSE TO BACKGROUND INFORMATION

1. This writer questions the accuracy of the statements that the Detroit VA is meeting all of the national performance measures and suspects that this is based upon comments made by administration to the OMI investigators.

2. The number of chronically homeless Veterans who were assigned vouchers. This writer agrees that the national performance measure is 65%. This is based upon a memo dated 10/17/12 authored by Keith W. Harris, PhD (National Director of Clinical Operations) with a subject titled "FW: Chronically Homeless % by VAMC". This memo stated the following: "The national target for CH (chronically homeless) Veterans continues to be 65%."

However, this writer believes that the number of chronically homeless Veterans in Detroit receiving vouchers is far less than what was reported for several reasons. First, there is no indication when the Detroit VAMC started targeting the chronically homeless. A memo dated 10/18/12 from Phillip Thomas (VISN 11 Network Homeless Coordinator) with a subject titled: "RE: Housing First Education", stated the following: "Another central piece will be targeting chronic homeless. The performance measure is 65%. Our baseline was 53% and in 30% for our major urban areas (Indy and Detroit)."

Second, when this writer was present at the VA (7/2/12 to 11/23/12) approximately 75 % of the Veterans who had received vouchers were only homeless and not chronically homeless. Other co-workers indicated the same was true with their caseloads. This occurred since the majority of our referrals came from our residential programs, which included the DOM, Grant Per Diem, and Contract Residential, in which Veterans had been in placement for a number of months and even up to two years. However, according to VA Handbook 1162.05, the regulation concerning Referrals #18 states the following:

"NOTE: It is acceptable to evaluate a Veteran for participation in a HUD-VASH Program if the Veteran is a current participant in one of VA's homeless residential programs, such as MHR RTP, CWT-TR, or GPD. Veterans from these programs must meet the definition of homeless with priority for vouchers being given to those Veterans who are chronically homeless and most vulnerable. According to the HEARTH Act, individuals are no longer considered "chronically homeless" when the length of stay exceeds 90 days, however, this does not preclude admission to the HUD-VASH program if clinically indicated and substantiated. In such cases, a discussion must occur between the referring program and HUD-VASH staff."

Third, the correct percentage of Veterans who could be classified as chronically homeless is unknown since two federal regulations listed in VHA Handbook 1162.05 that would provide this information (Screenings and assessments plus comprehensive psychosocial assessments) were not being followed. Later in this report the following was indicated:

(a) OMI substantiated the allegation that management failed to require case managers to conduct candidate assessments to ensure the appropriateness of a Veteran's placement in HUD-VASH, as required in VHA Handbook 1162.05 Paragraph 12(c) (screenings and assessments).

(b). OMI also substantiated the allegation that management failed to require CMs to assess Veteran's needs and recover goals as required in VHA Handbook 1162.05 Paragraph 12(d) (psychosocial assessments)

Fourth, a memo from Stacy J. Knipscheer, dated 10/17/12, with a subject listed: FW: Chronically Homeless % by VAMC. The most relevant statements were: "As you all know, there continues to be considerable emphasis on the percentage of CH Veterans in HUD-VASH. In fact, among the many priorities associated with HUD-VASH, this focus on targeting CH Veterans in HUD-VASH should be considered the top one this year, more critical to the program's long term success than process times or utilization rates. **The current efforts related to Housing First are also consistent with this prioritization, as that model targets the CH Veterans.**" However, this VAMC had not implemented Housing First and the majority of HUD-VASH CMs had not participated in CTI training.

3. The number of Veterans who were referred from other VA programs. This writer does not believe there is any national performance measure regarding the percentage of Veterans referred from other VA programs, for three reasons: First, Detroit VA administration did not present to the OMI investigators any documentation to support their claims.

Second, this writer's personal work experience, consultation with other HUD-VASH workers, and research concerning this subject, did not reveal the existence of any national performance measure regarding the percentage of Veterans referred from other programs.

Third, federal regulations (#18 and #17) listed in the VA Handbook 1162.05 seem to indicate that HUD-VASH program accepts and encourages referrals from multiple sources, The most relevant sections of the regulations concerning this issue are:

#18 Referral: Referral sources may include any of the following:

- (a) The local CoC, community partners or other community-based stakeholders,
- (b) VA's National Homeless Call Center (1-877-4AID VET or 1-877-424-3838
- (c) Veteran self-referral
- (d) Other VA Homeless programs, and
- (e) Other VA or community medical facilities and programs including CBOCs and Vet Centers.

#17 Outreach and Education: "Outreach and education about HUD-VASH to all internal and external stakeholders is a critical component of this program and must be part of a strategic plan implementation. To effectively accomplish this, HUD-VASH Case Managers and Outreach staff must: (b) Actively network with community programs and organizations to encourage referrals and to secure alternative resources that assist in meeting the psychosocial needs of the homeless. To accomplish this, establishing close working relationships with the homeless CoC is critical."

ALLEGATION #1

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

VA Handbook 1162.05, Paragraph 9 (c) regarding the Responsibilities of the Facility Director states: "Each Facility Director is responsible for: Providing appropriate administrative support and resources. This includes office space, Information Technology (IT) equipment, and car allocations

RESPONSE TO ALLEGATION #1

1. Retaliation- OMI wrote in their report the following comment concerning the CMs they interviewed: "They expressed concern about losing their jobs if they spoke with us; one CM – the whistleblower – had recently been terminated." In the conclusion section OMI wrote: "Some CMs are reluctant to complain about their unpleasant and potentially unsafe working conditions, expressing fear of retaliation.

The CM they were referring to was this writer who was terminated less than one month, after she requested clarification regarding the Stratification Model that Lori Baumgart (HUD-VASH coordinator/supervisor) was wanting to implement and a memo she had presented at a staff meeting on 10/10/12, titled: "Concerns Regarding the Direction Our Program was Going".

10/1/12 Staff meeting in which Lori Baumgart indicated that she wanted to reassign cases based upon geographic area and her "own levels" and then handed out a memo titled: "Service Delivery That Emphasizes Community-Based, Client Driven Services". In this memo Lori Baumgart listed and described her level of care guidelines, which was as follows:

"Level One - Veterans present with 3 or more primary diagnosis/conditions and chronic homelessness. Common primary diagnosis include: diabetes, high blood pressure, heart disease, heart failure, COPD, bi-polar disorder, schizophrenia, major depressive disorder, and alcohol and substance abuse disorders.

Level Two - Veterans present with 2 primary diagnosis/conditions and chronic homelessness. Commonly these veterans who have dual disorders who lack income or benefits that support permanent housing. These veterans lack the skills needed to engage in supportive services and access resources on their own.

Level Three - Veterans present with a primary diagnosis/condition that is stable. The veteran presents as homeless or precariously housed, has stable income, social skills, and pro social behaviors that assist the veteran to easily navigate the myriad of systems and new relationships while transitioning from homelessness to domestic autonomy.

Lori Baumgart then indicated that she had divided the veterans according to 4 geographic areas and planned on assigning each worker only one level of care cases, which was listed as follows: "Level One = 20 cases/vets; Level Two = 45-55 cases/vets; Level three = 60 -80 cases/vets. In addition one person would be the Housing Navigator 10-15 (plus) Level 3 when housed."

We also learned that as veterans transitioned from one level of care to the next, they would end up having a total of four different case managers. This writer along with a couple of staff members voiced their concerns and questioned what guidelines Lori Baumgart was utilizing to establish her Levels of Care and the number of cases each worker would be assigned.

10/10/12, Staff meeting, in which this worker then summarized and presented a memo she had written titled “**Concerns Regarding the Direction Our Program was Going**”. This social

worker stressed the importance of our program following the VHA Handbook 1162.05 Transmittal Sheet, September 14, 2011, and then directly quoted what the guidelines were and consequences of not following them; provided definitions of Housing First, CTI, etc.; information concerning the three levels of case management that were related to the CTI model; incorporation of the CTI Model into the assessment and management of caseloads.”

This memo also included statements concerning “veterans are grouped by the acuity of their needs and the intensity of the interventions required which are broken down into three distinct phases, each of which last 3 months” and “all clinicians need to have a mix of Veterans in the low, medium and high intensity phases of their caseloads.” This writer also directly quoted the guidelines for screening, evaluating, and admissions into the HUD-VASH program based upon the same VHA Handbook and that “screening and evaluations must occur within 3 business days of receiving the referral” and that “admission need to occur within 24 hours of a completed assessment”. In addition, the writer also quoted the statements listed in the recently published HUD-VASH Resource Guide for Permanent Housing and Clinical Care concerning caseload size (25 to 35 Veterans) and the Veteran’s view of the case manager as “confident, ally, and an advocate”.

Lori Baumgart then decided to postpone implementing her Stratification Model and stated she would consult with management. (She later told this writer that she had sent a memo to Nancy Campbell and was waiting on a response.) After the Housing First presentation, it became apparent that the Stratification Model Lori Baumgart wanted to implement, contradicted the Housing First Model.

2. Low morale and high turnover. According to OMI’s report, “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.” However, this does not appear to be the only contributing factor.

This writer was terminated shortly after she expressed her concerns regarding the direction our HUD/VASH program was going. It seems that management terminated this writer because they wanted to make sure that no one else questioned the validity of their Stratification Model, etc. As a result, current worker concerns are realistic. This could also be another reason why morale is extremely low and turnover rate is very high. However, there are additional factors that are contributing to this issue and they will be addressed in subsequent sections of this report

3. Inadequate office space and lack of privacy. OMI indicated in their report that they had toured the second floor where the HUD/VASH CMs were located. Some of the most critical comments include the following: “Office space and proximity of desk to one another afforded no privacy for Veteran interviews or for securing data”; “cardboard boxes filled with patient data”; CMs had to find another location outside the office to interview Veterans when other people were present; CMs “never knew if a desk would be available when they reported to work”; plus “All CMs interviewed expressed dissatisfaction with the way the HUD/VASH program was being managed.”

Comment - Professional social workers should not have to conduct business with the Veterans they serve under these poor conditions. Every CM should have their own individual fully furnished office like their colleagues do in the Mental Health Service. This could easily be accomplished by allowing the CMs to move into the offices on the first floor which were left

vacant when the previous occupants moved up to the newly renovated 7th floor that had been converted into offices. This writer also suspects that CMs comment of feeling “slighted by the new offices occupied by the Mental Health Services Employees on seventh floor” is an understatement.

4. Lack of appropriate equipment and resources. OMI wrote in their report that “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.” According to the HUD-VASH weekly monitor report, during the time frame of 4/16/12 to 8/27/12, the “number of functional lap tops ranged between 0 and 3.” In other words, the maximum number of laptops available for a staff of fifteen was only 3 and on a number of occasions none of them worked.

This report also documented that “OMI learned that some of the newly-assigned CMs had to wait from 1 to 3 months before obtaining a Government-issued cell phone.” Plus, “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.”

In addition, “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.”

Comment: Every CM should receive their laptop and cell phone in a timely manner that is fully functional and reliable. Since it appears that the laptops and cell phones frequently malfunction, all of them need to be replaced with new ones. Training should also be provided by an expert in the area and available for future consultation. Replacements need to be provided when equipment needs to be repaired rather than leaving a CM with nothing to use for several weeks.

Being out in the community is a critical component of this program and all CMs should have access to a car on a daily basis. This writer understands that HUD-VASH workers located in other areas have not had any difficulty accessing cars. In addition, money was previously allocated to obtain cars and therefor needs to be used for the purpose it was designated for.

5. OMI concluded in their report: “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, cellphones, and vehicles, nor were they given a reasonable amount of space in which to work.”

They also wrote: “**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.

6. By not providing office space, equipment, and sending CMs out into high crime areas without cell phones and laptops also violates other federal regulations listed in the VA Handbook 1162.05 regarding confidentiality, safety, and productivity. This includes:

#34 Internal Administration: (a) Confidentiality. “VA may disclose relevant health care information to health and welfare agencies, housing resources, and utility companies, possibly to be combined with disclosures to other agencies.”

17 Outreach and Education: (e) (2) “Staff independence may necessitate medical facilities to recognize **additional considerations for program safety, employee security, and job effectiveness** (available vehicles for outreach and case management activities, cellular phones, laptop connectivity, additional security services, etc.).”

7. By not making the appropriate resources and equipment available the Director of the Detroit VAMC has made it very difficult for HUD/VASH CMs to provide the level of clinical services Veterans deserve and as a result is violating another one of her duties.

#9 Responsibilities of the Facility Director: “Each Facility Director is responsible for: (c) Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures.”

ALLEGATION #2

Allegation 2: Management's Failure to Provide Required Training

VA Handbook 1162.05, Paragraph 10 (c) regarding the Responsibilities of the HUD-VASH Team states: “Staff Training. Training for the new case manager must be conducted within 90 days of initial start date. For assistance in obtaining this orientation, the NHC, or their local designee, need to be contacted. All case managers 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.

RESPONSE TO ALLEGATION # 2

1. Statements made by Lori Baumgart regarding CTI training appear to be misleading and incorrect.

First Statement: 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.

Comment: CTI training has only been offered on two occasions, 2010 and 2012. Only 3 of the current staff of 15 were employed by the VA when the CTI training was offered the first time. Lori Baumgart never informed staff that it was available again in 2012. This can be verified by reviewing the memo submitted by Phillip Thomas (VISN 11 Homeless Coordinator) who wrote the following on 11/15/12. The subject matter was VISN 11 CTI Training a consultation status update, in which it was reported: **“Detroit is the only VAMC site out of 7 that has not scheduled let alone completed any consultation calls.** This is directly related to converting all HUD-VASH into Housing First and is a wonderful resource. This is a time-limited contract however.”

Second statement: “CTI training was offered via the VA’s internet based Talent Management System, but CMs were not required to take it.”

Comment: CTI training has never been offered via the VA’s internet TMS. This writer even tried to participate in this training when informed, but the link to it had expired. CMs are definitely required to take the CTI training according to the VA Handbook 1162.05

2. VISN 11 Network Homeless Coordinator statements regarding CTI training: “He provided

an eight week online course for seven HUDVASH CMs and the former HUDVASH supervisor”. Three of the eight remain in the program”

Comment: It appears that the training that Phillip Thomas made reference to was one that occurred in 2010. According to one of the former participants, that training was not completed and discontinued by the trainer since Detroit’s HUD-VASH program was too disorganized and this issue needed to be addressed first.

3. In the Conclusion section of this report it was stated: 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 has not met and the CMs were given the message to disregard national policy as "Not the Detroit way."

Several additional federal regulations listed in the VA Handbook 1162.05, were violated by not providing the mandated training (CTI, MI, ACT, etc.) which includes the following:

#11 Coordinators Responsibilities: “The HUD-VASH Program Coordinator is responsible for: (d.) Managing and ensuring even distribution of caseloads with consideration to the CTI model”.

#29 Case Management: “(b) There are three levels of case management which are related to the CTI Model, but modified to meet the unique needs of the HUD-VASH Program. The Active level is the most intensive, the Stabilization level is moderately intensive and the Maintenance level is the least intensive. The Veterans progress may not be linear. In fact, it is more likely that progress will vacillate between these levels.”

#33 Workload, Documentation, and Credit: “(a) The HUD-VASH Program intends to incorporate the CTI Model into the assignment and management of caseloads.”

#12 Case Manager Responsibilities: “The Case Manager is responsible for: (c.) Employing Motivational Interviewing approaches to promote Veteran follow through with referral for preventive care and treatment of medical conditions, substance use and dependence, other mental health conditions, and problematic health behaviors (e.g., problematic substance use, tobacco use, unsafe sexual practices).”

4. OMI wrote in the Conclusion section of this report: “HUD/VASH leadership did not provide clear-cut policies, procedures, or guidelines to properly direct HUD/VASH CMs.” As a result, a couple of federal regulations listed in VA Handbook 1162.05 were violated which includes:

#11 HUD-VASH Coordinator Responsibilities: “The HUD-VASH Program Coordinator is responsible for: (a) Establishing a process for referral, evaluation, and admission to the HUD-VASH Program.”

9 Responsibilities of the Facility Director: “Each Facility Director is responsible for: (c) Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures.”

The OMI investigators listed the HUD/VASH Resource Guide for Permanent Housing and Clinical Care in the appendix of their report. This book is an excellent reference that provides

extensive information regarding how the HUD-VASH program should be run by providing information regarding policy, procedures, guidelines, etc. This writer and other HUD-VASH workers have requested that this information be utilized, but management ignored this advice.

5. OMI wrote in the Conclusion section of this report: “HUD/VASH leadership did not provide an effective process for orienting newly hired CMs” They also stated: “Consequently, CMs were placed in the field without proper orientation or appropriate training.”

Comment: Sending CMs out into the field without proper orientation, the required training, or information regarding policies, procedures, or guidelines concerning the HUD-VASH program, puts HUD/VASH CMs at risk for harm and is a safety issue. As a result, this violates another regulation listed in the VA Handbook 1162.05

#17 Education and Outreach: “(e) (2) Staff independence may necessitate medical facilities to recognize additional considerations for program safety, employee security, and job effectiveness (available vehicles for outreach and case management activities, cellular phones, laptop connectivity, additional security services, etc.)”.

6. OMI wrote the following regarding Project Improvement Effort. “VISN 11 established a goal of placing homeless Veterans into HUDVASH housing within 75 days or less. While the Medical Center has met the national performance measure, it has not met the VISN goal; the Medical Center Veterans on an average, in 120 days.” The Network Homeless Director stated: “Detroit was a unique situation” due to its economy and the number of chronically homeless Veterans”

However, this statement appears to be contradicted by a memo submitted by Stacy J. Knipscheer, dated 10/17/12, with the subject listed as Homelessness Data. In this memo she wrote: “Please take a look the attached re our HUD/VASH improvement project.”

This memo also included an attachment she had received from: Sampath-Kumar, Arun-Deepak, dated 10/16/12. This attachment listed the number of cases and the average number of days it took to house Veterans in each VAMC of VISN 11, plus comments were made. This is as follows:

“Good News for the Homelessness team as a group. We are just below our aim of 75 days.”

Ann Arbor	# of cases = 81	average days = 69.68
Battle Creek	# of cases = 118	average days = 51.75
Danville	# of cases = 51	average days = 58.94
Detroit	# of cases = 135	average days = 102.8
Indianapolis	# of cases = 40	average days = 105.82
Northern Indiana	# of cases = 92	average days = 66.91
Saginaw	# of cases = 32	average days = 56.12
Northern Tier	# of cases = 366	average days = 74.93
Southern Tier	# of cases = 183	average days = 73.2
VISN	# of cases = 549	average days = 74.35

“Few things to be noted:

- **Battle Creek has done a wonderful job with second highest Case load with best time.**
- Ann Arbor, Battle Creek, Danville, Northern Indiana & Saginaw have met our aim.
- **Detroit & Indianapolis are the facilities went beyond the aim statement. Detroit has the**

highest case load and their shortage staff explains the reason for not meeting the target.

- Indianapolis with second lowest case load and the higher *average* time among VISN.
- Both Northern & Southern Tier and VISN have met the aim.
- Northern Tier had twice the case load of southern tier.”

Comment: This memo seems to be indicating that one of the Detroit was unable to meet the VISN goal was due to staff shortage. The second reason listed was Detroit had the highest caseload (135). However, Battle Creek had the second highest caseload (118) and the best time of housing Veterans in the entire VISN (51.75). Detroit had one of the highest number of days listed (102.8). **This document does not indicate that a large number of Veterans were the chronically homeless, nor is there any reference to the economy being a factor in Detroit being unable to meet the VISN goal of 75 days**

A memo from Phillip Thomas, dated 11/15/12, seems to provide the answer as to why Detroit is unable to meet the VISN goal of housing Veterans in 75 days or less. The subject matter was VISN 11 CTI Training a consultation status update, in which it was reported: **“Detroit is the only VAMC site out of 7 that has not scheduled let alone completed any consultation calls. This is directly related to converting all HUD-VASH into Housing First and is a wonderful resource. This is a time-limited contract however.”**

One will notice that the 5 VAMCs that were able to meet the VISN goal of housing Veterans in less than 75 days had participated in CTI training. The two VAMC that were unable to meet the VISN goal had not been involved in any CTI training, which was Indianapolis and Detroit. The former though had a new supervisor but a least made plans to correct this deficiency by scheduling a consultation and subsequent training. Detroit though ignored the issue.

7. Preparation prior to the Implementation of Housing First as VA National Policy. It appears that information regarding Housing First and its ACT component was withheld from HUD/VASH CMs. It also seems that Detroit VAMC administration did not tell the truth to higher level VA officials. This is illustrated by the following memos:

10/12/12 Memo from Phillip Thomas (VISN 11 Network Homeless Coordinator) which stated the following: “HCHV Coordinators, Action: In preparation for Mr. Finegan’s meeting with VACO regarding implementation of the Housing First approach into the HUD-VASH programs, we are asking for your assessment of how well it is going at your medical center and what the barriers are. Format: To assist you with your assessment, attached is the VA Housing First Checklist (Pathways Housing First Fidelity Ingredients VA 11-8-11). Please indicate if each criterion is being implemented, and if not indicate what the barrier(s) are to implementation. Due: by COB Monday 10-15-12.”

10/12/12 Pat Wolschon correspondence in response to Phillip Thomas’s memo, in which the following was written: “Are you asking these questions just regarding the Housing First Teams or are you asking for this information on all of our HUD/VASH Programming? We do use a housing first approach with all of our HUD/VASH proگرامing but the intensive team approach is only used with our 50 Housing First specific vouchers.”

Later on this same date, Pat Wolschon sent a memo to supervisors Beth Baker and Lori Baumgart, in which the following was written: “Hi Beth and Lori. Can the two of you work on this together with input from Ken and Mary? (Housing First ACT team members) This is due by

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Monday. **Let me know if you need my assistance with this.** I have asked for clarification on whether we also need to answer the questions for all of our HUD/VASH programming or just the Housing First team. For all of HUD/VASH we would need to have Lori gather the information from the rest of the HUD/VASH staff (Housing First ICM team members). Lori Baumgart will integrate all of our data gathered from staff into one report from Detroit. Thanks!"

Comment: Beth Baker is the Chief of the VCRRC. When this correspondence was written, none of the people on the HUD/VASH ICM team knew we had "Housing First Teams" nor had they been informed about the "housing first approach". It is not known what the people on the ACT team had been told. (They are located in a separate building, the VCRRC and are only seen once a week at an hourly staff meeting.)

10/15/12 On this date, Lori Baumgart, asked people at a staff meeting to review and indicate our responses to the VA Housing Checklist (Pathways Housing First Fidelity Ingredients). **Only ICM team members were present when this form was completed. No one had been informed about Housing First or that 2 people out of a staff of 15 had designated as the ACT team, while the rest were considered to be the ICM team. Staff had previously been told that the VA had received 50 SMI vouchers for Veterans who met the criteria.**

It was only after the Housing First presentation on 11/5/12, was staff eventually able to figure out that the two people who were handling the SMI vouchers were actually the ACT team. One of the slides stated the following: **Housing First Pilot . "Target is new chronically homeless veterans. 50 vouchers per site (Detroit) Using ACT services (when clinically indicated) to promote and sustain engagement with housing and services. Low barrier model."**

10/15/12 memo by Deesha Brown, on behalf of William Schoenhard (SES) regarding the conversion of all HUD/VASH programs to a Housing First Model. The most relevant statements are as follows:

First paragraph "As a follow up to the VISN briefings with the Secretary, I am requesting that each VISN Director to work with your local medical center leadership and homeless teams to implement Housing First as the official policy for the HUD-VASH program."

Last paragraph: "It is expected that each medical center will have a final plan to implement the Housing First model by December 1, 2012 and capacity to fully implement Housing First Model by the end of the fiscal year. Housing First will also be a focus of future VISN and Medical Center Director's calls."

10/18/12 memo from Phillip Thomas, with the following statement written: "This is what I sent to Mr. Finnegan based on what I got back from the sites. I think this is a good start to assessing our needs." Attached to the memo was a draft copy of the VISN 11 Housing First Assessments. This report indicated the responses from Ann Arbor, Battle Creek, Danville, Detroit, Indianapolis, NICHS, and Saginaw, concerning a number of different categories.

Comment: This is the results of the VA Housing Checklist that Lori Baumgart asked staff (ICM team) to complete together on 10/15/12. According to the prior memo from Phillip Thomas on 10/12/12, the reason for completing this form was for each VAMC to provide their: "assessment of how well it is going at your medical center and what the barriers are" regarding Housing First and to "indicate if each criterion is being implemented, and if not indicate what the barrier(s) are to implementation." **When this document was reviewed, it appeared that**

responses from the ICM team were ignored and several of them are incorrect. The most relevant are as follows:

Ex.# 1. “ Service Philosophy - Motivational Interviewing (page 5). Program staff are very familiar with principles of motivational interviewing and it is used consistently in daily practice.”

Comment: We responded yes to this question, when in fact no one on staff has ever received any training.

Ex.#2. “Service Philosophy - Assertive Engagement (page 6). Program systematically uses a12 variety of individualized assertive engagement strategies and systematically identifies and evaluates the need for various strategies. These strategies include (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of these techniques, and modifying approach when necessary.”

Comment: We responded yes to this question, but should have said no, since no one had been trained in Motivational Interviewing or Assertive engagement, which are primary components.

Ex. 4. “Service Array (pages 8, 9,10, & 11) regarding Psychiatric Services; Integrated, Stag-wise Substance Use Treatment; Supportive Employment Services; & Nursing Services”. All of them have separate areas for people to respond regarding ACT Program & ICM Programs.

Comment: When this form was completed, requests for clarification regarding the two programs (ACT and ICM) were ignored.

Conclusion: In this writer’s opinion, VA officials wanted to know if the VAMCs were advising staff about Housing First, beginning to implement some of its key concepts, and if they were having any difficulty. It seems that Detroit was the only VAMC awarded special grant money for a Housing First Pilot to demonstrate how ACT teams (SMI vouchers) was needed in addition to the ICM team of Housing First.

In other words, Detroit should have been the first VAMC to implement Housing First in the entire HUD-VASH program and developing both teams, not just ACT. It appears that the responses that were submitted were an attempt on the part of management to make it appear that the entire HUD-VASH program was implementing Housing First when in fact they were not. How much information the ACT team was provided about Housing First is even questionable, since they never had the opportunity to participate in CTI training either. CTI training is a critical component of the Housing First Model.

10/25/12 A memo was sent from Benjamin Deady, on behalf of William Gunnar, regarding Implementation of Housing First “As a follow up to the prior Outlook communication dated Monday October 15, 2012 regarding Housing First Implementation please note that each VISN must submit a certification letter of the completeness too the Homeless Program Office by COB December 3, 2012. Certification letters should be directed to Nancy Campbell at Nancy.Campbell@va.gov. **The certification must note the following:**

(1.) All Medical Centers have participated in an orientation to Housing First and are implementing principles of Housing First within HUD-VASH.

(2.) The HUD-VASH program at each participating medical center has conducted a self-assessment utilizing the fidelity tool that will be discussed on next national HUD VASH monthly call (details are at the end of this message). This assessment will determine the program's adherence to principles of Housing First and the staffing needed to fully meet client level needs through use of the Housing First model.

(3.) Medical Center leadership have processes in place to review HUD-VASH and Housing First on at least a monthly basis and to brief Network leadership at least quarterly on their progress.

(4.) Medical Centers are committed to evaluating the need and resources required to develop more of a team approach to managing homeless Veterans in the HUD-VASH program that includes reviewing existing capacity within other Mental Health and homeless programs. New staffing requests will be based on the findings of the staffing/client needs assessment and in consultation with the national program office and must be consistent with principles of Housing First.

(5.) Medical Center Directors along with the HUD-VASH coordinators have contacted participating Public Housing Authority (PHA) and discussed strategies for targeting the chronically homeless, retention, expediting the leasing process and addressing any other identified challenges.

(6) Medical Center leadership and program staff are committed to participating in site visits and teleconference calls to assist with fidelity and sustainment of the Housing First approach with in the HUD-VASH program."

"To facilitate compliance with requirement #1, there will be a special HUD-VASH national call on November 5, 2012 at 2:00 pm EST.....There will be 400 lines, so there should be a broad inclusion of not only HUD-VASH program staff, but leadership from mental health, primary care, and other program areas that will be impacted."

"During this call there will be a brief presentation regarding Housing First, and an introduction to the fidelity tool that staff will utilize to evaluate their current adaptation of Housing First which is a requirement #2.

11/1/12_ Memo from Nancy P. Campbell, (National Director, HUD-VASH Program). The following statements were written: " Hopefully most of you have seen the 2 emails (attached) that went out on October 15 and October 25 from VACO Leadership to your VISN Leadership stating that Housing First is to be implemented within all HUD-VASH Programs. We are dedicating our entire call on Monday to further explain this initiative and next steps. This is a critically important call for all of you to be on. It will occur Monday, November 5th at 2:00 pm EST"

11/5/12 This writer participated in the above mentioned Special National HUD-VASH and received a hard copy of the PowerPoint slides for the presentation. The most relevant information is as follows:

The slide concerning, “Why Housing First?” (Page 5) “Housing First ends homelessness; Housing First eliminates the need for costly shelter care, transitional and short term treatment services aimed at preparing Veterans to be housing ready; Studies demonstrate that Housing First reduces ER visits, unscheduled mental health visits and medical hospitalization; and Housing First decreases the frequency and duration of homelessness.”

Comment: Could these be the reasons why it appears that Detroit has been reluctant to implemented Housing First and withheld information concerning it, since this would decrease funding for their more expensive programs, Grant per Diem, DOM, Contract Residential, DOM, and to a lesser extent the ER, hospital, and mental health department

The slide concerning, “Housing First as Policy” (page 7) “Secretary announced Housing First is VA’s policy for accessing permanent housing September 15, 2011; Hearth Act: promotes “housing first” principles: rapid rehousing followed by community-based services; Shift away from shelter-based supportive services and transitional housing; Applied to families and transitionally homeless adults; A Prevention- centered approach is emergent: Housing First as official policy.”

Comment: This slide seems to be indicating that eventually that shelter-based and transitional housing would eventually be discontinued. In addition, SSVF is a program designed to prevent Veterans from becoming homeless to begin with and a number of Veterans being placed into transitional housing, by providing temporary rental assistance, etc. It appears that by withholding information concerning this component, management choose to ignore the prevention aspect of Housing First. (Additional information will be provided in the next section.)

On 11/5/12, a memo was received from Meghan Park, on behalf of William Gunnar, concerning the Implementation of Housing First. This correspondence indicated the following: “Please find below a message from VHA Homeless Programs. To meet the 6 requirements necessary to facilitate the broader implementation of Housing First within the HUD-VASH program as outlined in the email below, attached are the following:

“The Housing First PowerPoint utilized on the November 5th national HUD-VASH call to provide orientation to the field in this initiative (Requirement #1). The Housing First Fidelity/Readiness Scale to be completed by each Medical Center’s HUD-VASH Program (Requirement #2).

The template to be completed and returned by each Medical Center that documents the discussions with their respective Public Housing Authorities about strategies developed to address targeting the chronically homeless, retention, expediting the leasing process and dealing with any other challenges unique to their community (Requirement #5).

The certification memo to be signed by each Medical Center Director verifying that all 6 requirements pertaining to the implementation of the Housing First model have been met.”

8. Comment: Various memos and the presentation on 11/5/12 all indicate that Housing First is the VA National Policy. Dr. Reeves, is the Detroit VAMC’s facility director and signed a certification memo “verifying that all 6 requirements pertaining to the implementation of the Housing First model have been met”. By signing this certification memo, she claimed that this particular VAMC had a plan and were in the process of implementing the principles of Housing First within the entire HUD-VASH program, when in fact they were not. This is evidenced by a

failure to provide the necessary resources, mandated training, withholding of critical information, not making any changes to implement a Housing First team approach, etc. As a result, it seems Dr. Reeves is neglecting her duties and therefore violating one of the regulations listed in the VA Handbook 1162.05, which is:

9: Responsibilities of the Facility Director: “Each Facility Director is responsible for: (c) Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures”.

9. Sending HUD/VASH CMs out into the field, without the mandated training/ appropriate orientation, nor guidance regarding policy and procedures, plus withholding information concerning Housing First, appear to be additional reasons why staff morale is extremely low and turnover is very high.

ALLEGATION #3

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

VA Handbook 1162.05, Paragraph 12 (c) regarding Case Manager Responsibilities states: “The Case Manager is responsible for: Screenings and brief assessment to ensure appropriateness of placement into the program.”.

RESPONSE TO ALLEGATION #3

1. In the Conclusion section of this report it was written: “OMI substantiated the allegation that management failed to require CMs to conduct candidate assessments”.

This was supported in the Findings section, where it was written: “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.”

“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”

2. OMI also concluded: “CMs are required to use referrals from other programs in place of their own independent assessments.”

This was supported by comments in the Findings section which included the following statements: “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 DRRTP and VCRRC programs, in 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 DRRTP or VCRRC staff person to ask them to change it”

“Many voiced frustration at not being able to provide their clinical input into the assessment process.”

3. In other words, it appears that CMs wanted to conduct screenings and assessments, but management refused to allow rather than require them to complete them. It also seems that by not permitting CMs to conduct Screening and Assessments plus making them substitute their own clinical assessment in favor of the referral source, Detroit VAMC management violated two federal regulation listed in the VA Handbook 1162.05, which includes:

#19 Program Participant Targeting: “(a) Veteran participants in the HUD-VASH Program must be homeless and meet VA health care eligibility as defined by law and regulation.

(b). The target population for HUD-VASH needs to **include the chronically homeless** Veteran who is the most vulnerable and often has severe mental or physical health problems and/or SUD, with frequent emergency room visits, multiple treatment failures, and limited access to other social supports. However, other Veterans who are homeless with **diminished functional capacity** and **resultant need for case management** are also eligible for the program.

(c.) The HUD-VASH Case Manager is **to assess each case on an individual basis**. Based on **clinical judgment** and resource availability, it must be **demonstrated that the homeless veteran has an identified need for case management to obtain and sustain housing**.

(d). *NOTE:* The HUD-VASH Program need to be reserved for homeless Veterans *who have few resources and require long-term case management to either obtain or maintain permanent supportive housing.*”

Comment: The above regulation requires the HUD-VASH CM to **individually assess each Veteran and then make a clinical decision**. Since it appears that HUD-VASH CMs were **not allowed to conduct screenings it is impossible to confirm that Veterans are actually homeless, let alone met the criteria of being chronically homeless** especially since the majority of referrals are coming from transitional housing. The Hearth Act indicates that if a Veteran has been in placement (transitional housing) in excess of 90 days they are no longer considered chronically homeless only homeless.

Plus, the regulations indicates the target population must be the chronically homeless and that the homeless can only be admitted if they have diminished functional capacity and an identified need for case management. By not doing any type of evaluation or assessment, one cannot verify that the Veteran’s functional capacity is diminished or that they are in need of long term case management to obtain and maintain housing.

It also appears that none of the referral sources (Grant per Diem, DOM, Contract Residential, HCHV, VCRRC, or community agencies), have participated in any of the Housing First presentations or training. It should be noted that all of these referral sources (except the last) are supervised by Pat Wolschon (Director of Homeless Program). Dr. Bella Schanzer is the ACOS of Mental Health Services, which includes HUD-VASH.

#20 Screening and Evaluation: “(a) The screening process **determines a Veteran’s appropriateness and need for HUD-VASH**. As the target population for this program may be difficult to engage, a low-barrier, housing- focused approach is indicated.

(b) **Screening must be done by a HUD-VASH clinical team member** for all Veterans referred.

(c) Screening and evaluation must **occur within 3 business days of receiving the referral.**”

(e) **Is in need of, and is willing and able to, engage in clinical case management.**

Otherwise eligible homeless Veterans receiving HUD Homeless Prevention Rapid Re-

Housing Program (HPRP) or VA SSVF funds to move temporarily into housing while waiting to get into a HUD- VASH unit, retain eligibility for the HUD-VASH Program. HPRP is a temporary form of assistance and expressly touted in the HPRP notice as an eligible resource for HUD-VASH.”

First Comment: This regulation **requires that the screening must be done a HUD-VASH CM** in order for a decision to be made if a particular Veteran is **appropriate and in need of the program and the clinical case management** being offered. The regulation **does not indicate that is okay to substitute the referring programs assessment.**

This program has been using a wait list, for many years. Veterans are only contacted when a voucher becomes available. As a result, many have been left waiting up to one year and even longer, following the submission of their referral, not knowing if they even meet program guidelines. Nor is any information provided about the HUD/VASH program.

Second Comment: It appears that **information regarding SSVF & HPRP (programs whose primary objective is to prevent homelessness) was withheld from staff (HUD/VASH and most likely other VA Homeless Programs.)**

The staff meeting notes from 6/4/12, indicate:”Teena also asked about security deposits. Pat Wolschon informed her that SSVF will be at the table at the Wednesday meetings as well.” Staff then learned that when Ms. Wolcshon mentioned SSVF she was actually referring to an agency named Southwest Solutions (SWS).

Much later, an article posted on SWS website, dated July 28, 2011, was discovered which stated the following: “The U.S. Department of Veteran Affairs has awarded Southwest Solutions a nearly \$ 1 million grant to help low-income veterans and their families stabilize their housing situation and connect to other services and resources they need.” It then stated: “The grant issues from a new VA prevention program called Supportive Services For Veteran Families (SSVF), which the VA regards as a critical component in its efforts to prevent and end homelessness among veterans.” Another paragraph states: “With this funding, Southwest Solutions will outreach veterans at risk of becoming homeless and then provide short-term financial assistance to pay rent, rental arrearages, security deposits, utility bills, moving costs, other housing related costs, and childcare.”

Further research revealed that Veterans who had received a HUD-VASH voucher could only access the security deposit and payment of past utility bills, from SSVF. Even more important though, **is that had all staff at the John D. Dingell VAMC been informed about this valuable resource, it could have been used to prevent some veterans who ended up in our program or one of our transitional programs (Grant Per Diem, Contract Residential, or the DOM) from becoming homeless to begin with.**

4. By not allowing HUD/VASH staff to conduct screenings and assessments, Detroit VAMC is also violating an additional federal regulation listed in the VA Handbook 1162.05:

#9 Responsibilities of the Facility Director: “Each Facility Director is responsible for: (c) **Providing and maintaining program oversight** to ensure quality clinical services and compliance with VHA policy and procedures/”

5. Since Detroit VAMC management does not allow HUD/VASH staff to complete screenings/ assessments nor permit them to provide their own clinical input, it appears that these are

additional contributing factors why staff morale is extremely low and turnover rate is very high.

6. This writer disagrees with OMI's Conclusion that they could not find evidence to substantiate: "(a) that persons who were not qualified Veterans, and not homeless, were brought into HUDNASH and given vouchers; (b) that staff members complete 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 already documented that HUD-VASH CMs were not allowed to do screenings and evaluations or provide their own clinical input into the assessment process. In other words, they were being forced to accept the referral source's information without question. In addition, regulations concerning the screening process mandate only HUD-VASH CM have the credentials to make this type of determination.

In the next section, it was written: "OMI reviewed the electronic health records of several Veterans in HUD/VASH and found that no comprehensive psychosocial assessments had been completed by CM." When this writer and her co-workers received referrals, from Grant per Diem, Contract Residential, HCHV, VCRRC, it was observed that none of these CMs ever completed a psychosocial assessment. Psychosocial assessments provide very valuable information and involve assessing a Veterans functioning in number of areas including: educational background, family-work history, activities of daily living, in addition to their physical and mental status. All of these are important when it comes to accurately determining a Veterans level of functioning and services.

The definition of the chronically homeless involves working with individuals who have severe impairments in mental health, substance dependence, and/or major physical disabilities. In order to effectively work with this population, CMs need to be trained and have extensive experience in a mental health field. Working as a probation officer is quite different from being employed as a clinical therapist.

By not allowing HUD-VASH CMs to conduct screenings nor require/permit CMs to perform psychosocial assessments, one cannot verify Veterans were provided vouchers who were not qualified for the HUD-VASH program or met the criteria for being homeless.

It is this writer's professional opinion, that screenings and a brief assessment do not provide enough information concerning a Veteran. A comprehensive psychosocial would help to confirm or deny whether the referring CM had accurately assessed a Veteran's physical - mental status and met the criteria of being chronically homeless. Since none were completed, one cannot determine if the referring source was appropriately trained in assessing Veteran physical and mental status. (See Response to Background Information for additional comments.)

ALLEGATION #4

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

VA Handbook 1162.05 Paragraph 12 Section (d) regarding Case Manager Responsibilities states: "Assessing Veterans through comprehensive psychosocial evaluations to determine case management needs and recovery goals."

RESPONSE TO ALLEGATION #4

1. In the Conclusions section: “OMI substantiated the allegation that management failed to require CMs to assess Veterans' needs and recovery goals.”

This was supported by a statement in the Finding section where it was written: “OMI reviewed the electronic health records of several Veterans in HUD/VASH and found no comprehensive psychosocial evaluations had been completed by CMs.

In the same section, it was documented that: “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.”

2. In other words, it appears that psychosocial assessments were not done because management refused to allow CMs to conduct them rather than require them. It also seems that CMs were told it was not necessary for them to follow VHA guidelines and that this particular VAMC was exempt from these regulations. As a result, by engaging in this type of practice, management violated several federal regulations listed in VHA Handbook 1162.05, which includes the following:

#19 Program Participant Targeting: “(a) Veteran participants in the HUD-VASH Program must be homeless and meet VA health care eligibility as defined by law and regulation.

(b) The target population for HUD-VASH needs to include the chronically homeless Veteran who is the most vulnerable and often has severe mental or physical health problems and/or SUD, with frequent emergency room visits, multiple treatment failures, and limited access to other social supports. However, other Veterans who are homeless with diminished functional capacity and resultant need for case management are also eligible for the program.

(c) The HUD-VASH Case Manager is to assess each case on an individual basis. Based on clinical judgment and resource availability, it must be demonstrated that the homeless veteran has an identified need for case management to obtain and sustain housing.

(d.) NOTE: The HUD-VASH Program need to be reserved for homeless Veterans *who have few resources and require long-term case management to either obtain or maintain permanent supportive housing.*”

Comment: The above regulation requires the HUD-VASH CM to individually assess each Veteran and then make a clinical decision. Since HUD-VASH CMs are not allowed to conduct psychosocial assessments, it is impossible to confirm that Veterans who receive vouchers were actually homeless, let alone meets the criteria of being chronically homeless, especially since the majority of referrals are coming from transitional housing. The Hearth Act indicates that if a Veteran has been in placement (transitional housing) in excess of 90 days they are no longer considered chronically homeless only homeless.

Plus, the regulations indicates the target population must be the chronically homeless and that the homeless can only be admitted if they have diminished functional capacity and an identified need for case management. By not doing a psychosocial assessment, one cannot verify that the Veteran’s functional capacity is diminished or that they are in need of long term case management to obtain and maintain housing.

#21 Admission: “(a) Admission is by clinical decision of HUD-VASH staff, or, if indicated, a mutual decision with appropriate consultation in more complex situations. Veterans are considered admitted into the HUD-VASH Program when accepted for case management. **Admission decisions need to occur within 24 hours of a completed assessment.**

Comment: This HUD-VASH program has a history of admitting Veterans into HUD-VASH, only after they have received a voucher without any type of assessment (clinical decision) being completed.

#22 Assessment: “(1) Newly-accepted Veterans are assigned to a HUD-VASH case manager. (2) The HUD-VASH case manager must ensure that there is a homeless initial assessment completed on each new Veteran through HOMES.”

Comment: An accurate HOMES assessment cannot be done when neither the referring agency nor the HUD-VASH CMs have done a psychosocial assessment.

#23 Housing Plan: “Veterans are encouraged to work with their case manager to develop a housing plan with specific, individualized goals that focus the direction of case management.

Comment: Developing a housing plan (treatment plan) cannot and should be not done without first doing a comprehensive psychosocial assessment.

3. OMI documented in the Findings section that they: “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. They also wrote: “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 Programs, to document the initial outreach for securing and maintaining housing for the Veterans.

By not documenting the initial outreach or doing a psychosocial assessment, it appears that Detroit VAMC is violating additional regulations listed in the VA Handbook 1162.05 which includes:

#19 Program Participant Targeting: “(f) If there are no available case management openings or vouchers, the Veteran needs to be placed on an “interested in HUD-VASH” list. The Veteran needs to be provided with information about HUD-VASH, and when appropriate, the HUD-VASH case manager needs to invite the Veteran to participate in any existing HUD-VASH pre-groups. The HUD-VASH program staff **must document the referral** and note that the reason for denial was a lack of an available voucher.

#34 Internal Administrations: “(b) Medical Records. **Medical record documentation must comply with applicable TJC and CARF requirements,** as well as local medical facility policy and procedure. **Documentation** must reflect planning with the Veteran that is individualized, developed with the input of the Veteran and **information from an assessment.** Plans are to be reviewed for relevance, and modified as needed. Documentation is to note progress towards achievement of goals and objectives in the plan, significant events in the person’s life, the delivery of services and specific interventions, referrals, and discharges or transitions to other levels of care.”

Comment: CARF International web site in their Provider Profile section listed the John D. Dingell VA Medical Center/Homeless Programs as an “**Accredited Program in Community**

PSA

Services Coordination”. This was a “Three Year Accreditation”, which would have to be renewed at some point. Has CARF been informed that this facility’s HUD-VASH program has been under investigation and advised of OMI findings and conclusions?

#9 Responsibilities of the Facility Director: “Each Facility Director is responsible for: (c) Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures.”

5. Since Detroit VAMC management does not allow HUD/VASH staff to complete psychosocial assessments, it appears that this is an additional contributing factor why staff morale is low and turnover rate is high.

ALLEGATION #5

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

VA Handbook 1162.05 Paragraph 9 Section (a) Responsibilities of the Facility Director: Each Facility Director is responsible for: “(a) Timely hiring or contracting of staff. If an internal candidate is chosen for open HUD- VASH positions, staff must be released from the previous position as soon as possible.

RESPONSE TO ALLEGATION #5

1. In the Conclusion section it was written: “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.

This conclusion was supported by statements in the Finding section where it was written: “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 as 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.”

2. This writer does not concur with OMI’s Conclusion that this VAMC hired staff in a timely manner for the following reasons: (a) The regulation in VA Handbook 1162.05 states: #9 Responsibilities of the Facility Director: Each Facility Director is responsible for: “(a) Timely hiring or contracting of staff. If an internal candidate is chosen for open HUD- VASH positions, staff must be released from the previous position as soon as possible.

(b) During the year of 2012 year, 3 people were allowed to do lateral transfers to positions in the PTSD department, at the beginning of July. Two of their replacements were not due to start until mid-December 2012 and one of them at the beginning of January 2013. (At the end of November, 2012, another case manager indicated that she was transferring to another position

within the John D. Dingell VAMC. Management did not even indicate when they would be posting her position so that a replacement could be secured.)

The above mentioned transfers and their replacements can be confirmed by reviewing weekly staff meeting notes covering these time frames. This writer and other staff members can also verify the when the 3 CMs workers left and when their replacements were hired

It should be noted that these transfers occurred just after our HUD-VASH program started to process Veteran's applications for vouchers, via weekly One Stop Shop (OSS) meetings that began the week of June 13th and continued until the week of August 20th. That left the remaining people responsible for running the OSS and then assisting Veterans in locating suitable housing, which according to the Housing First Intensity (Acuity) Levels would be classified as "high intensity". (This is a complex process that can take up to 4 months helping a Veteran find suitable housing.)

In other words, **when an internal candidate from HUD-VASH is chosen for an open position in another department (PTSD) they are released from their position as soon as possible. This is done without any consideration that the remaining HUD-VASH CMs caseload is increased dramatically** and this situation lasts for several months.

(b) Previously allocated SUD (substance abuse disorder specialist) positions for the HUD-VASH program were allowed to remain vacant for a number of months during each of the past two years (2011 and 2012). For example, the staff meeting notes, indicate that Kirk Grohsman was last listed as being invited to attend on 6/4/12. By the end of November 2012, there was no indication that administration had any plans to fill this position. However according to our program guidelines SUD specialists are supposed to be working closely with HUD-VASH case managers and it appears that these positions were funded with money from our program. When this writer was present at the VAMC, she did not even know that there was any SUD specialist designated for the HUD-VASH program and had to consult with other SUD specialist in other programs. HUD-VASH CMS can also verify the absence of this program's SUD specialist for extended periods of time.

(c) This writer strongly suspects that administration's "staffing plan" did not indicate on what date a particular person left their position or on what date their replacement started which would have indicated how long positions were left vacant. Plus administration did not provide any documentation regarding different SUD specialists had been assigned to the HUD-VASH program.

(d) The comment made by VISN 11 Homeless Coordinator (Phillip Thomas) to OMI is contradicted by VISN 11 Deputy Director (Stacy Knipscheer).

The VISN 11 Homeless Coordinator claimed: "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.**

A memo from Stacy Knipscheer, dated 10/17/12, regarding the goal of housing veteran's in 75 days, stated: "Detroit has the highest case load and **their shortage of staff explains the reason for not meeting the target.**"

(e) This writer submitted an application for employment when one position was posted in **November 2011** and then another one when four more positions were listed in **December 2011.**

An interview was not scheduled until the end of January, 2012 and then had to wait a couple of more months before a tentative job offer was made. The VA Clinical Standards Board approved this worker's credentials on 5/2/12, but the director Dr. Pamela Reeves did not sign off on it her approval until 6/16/12. Another week passed before an "official job offer" was made and then was told to report on 7/2/12 for 3 days of general orientation to the VA Hospital.

3. HUD-VASH Case Manager's prior experience at the Detroit VAMC is ignored and everyone starts at the first step of GS 11 (Initially a couple of people were allowed to start at the 3rd step of grade 11.) These positions though were funded at GS level 12; however the director at each VAMC has discretion as to what level they want to bring people in at. When this writer checked the USA Job web site, it was noticed that these same HUD-VASH positions in Florida, Pennsylvania, North Carolina, and Georgia were offering to pay workers at the GS level 12.

When this writer recently reviewed USA Jobs website, it was noted that this VAMC was now advertising HUD-VASH positions between the GS 9 to GS 11 level. GS 9 level social workers are people who have less than two years post masters experience and as a result are not even licensed as independent practitioners by the state of Michigan and therefor need to be supervised. In addition, there is no shortage of independent licensed practitioner's in the Detroit Metro area.

4 Two questions need to be asked. First, why is this VAMC not paying HUD-VASH CMs at the rate their positions were funded, especially when other VAMC are doing so. Second, why did this VAMC, recently lowered their standards so they can hire these same workers at a GS 9 level. **Not properly compensating HUD-VASH workers and leaving positions vacant for many months (which increase their workload) could very well be contributing factors as to why morale is extremely low and turnover rate is very high.**

5. The two HUD/VASH CMs who were designated as the ACT team have access to a peer support specialist. The remaining 13 HUD/VASH CMs, who were designated as the ICM team, do not have access to a peer support specialist. However, the Veterans the ICM team serves are very similar to the Veterans served by the ACT team and deserve equal opportunity to access a peer support specialist if they need one.

6. At one point a Housing Specialist was hired, but was assigned other duties by her supervisor, which was Pat Wolschon, Director of Homeless Programming. (One of those duties involved developing a list of housing that Veterans could share. This was of no benefit to Veterans in HUD-VASH since rules prevented Veterans who received vouchers from living in the same residence.)

In the VA Handbook 1162.05, the following description was written regarding this regulation: "#16 Housing Specialist Responsibilities. "The Housing Specialist is responsible for: (a) Educating landlords about HUD-VASH; (b) Establishing lists of landlords interested in HUD/VASH Veterans as potential tenants; (c) Developing property lists of safe, decent, and stable housing units; (d) Obtaining pre-inspections and other inspections; (e) Showing Veteran families available housing units; (f) Assisting with PHA and landlord paperwork (lease).

HUD-VASH CMs and the Veterans they served could have used a Housing Specialist, who performed the above listed duties. The Housing Specialist could have also help in reducing the time frame it took for Veterans to secure permanent housing by helping them locate a suitable residence, assist them complete numerous forms that HUD/landlords required, and expedited the lengthy inspection process (The number of PHAs had been reduced from 5 to 1 to who only had

one inspector.) This would have also reduced the heavy burden HUD-VASH CMs were placed under when 3 of the CMs were allowed to transfer in early July 2012 and their positions were left vacant for about 6 months.

SUMMARY, CONCLUSION, & RECOMMENDATION

1. OMI confirmed that the Detroit VAMC violated the following four major federal regulations listed in VA Handbook 1162.05:

“#9 Responsibilities of the Facility Director: Each Facility Director is responsible for (b) Providing appropriate administrative support and resources to ensure the HUD-VASH Program is able to accomplish its stated mission, goals, and objectives. This includes office space, Information Technology (IT) equipment, and car allocations.

#10 Responsibilities of the HUD-VASH Program Team: (c) Staff Trainings. Training for the new case manager must be conducted within 90 days of initial start date. For assistance in obtaining this orientation, the NHC, or their local designee, need to be contacted. All case managers and SUD Specialists are to have training in Critical Time Intervention, Assertive Community Treatment, Motivational Interviewing, Housing First, Low-Demand Model of Care, and other clinical approaches relevant to the population.

#12 Case Manager Responsibilities: The Case Manager is responsible for: (c) Screening and a brief assessment to ensure appropriateness of placement into the program.

#12 Case Manager Responsibilities: The Case Manager is responsible for: (d) Assessing Veterans through comprehensive psychosocial evaluations to determine case management needs and recovery goals.”

2. OMI Investigators also expressed concerns regarding the following issues: Retaliation; Confidentiality; Extremely Low Morale; Very High Turnover; Safety; Documentation; Orientation; Evaluation; plus Leadership Did Not Provide Clear-Cut Policies, Procedures, or Guidelines to Direct CMs. These concerns are as follows:

(a) Retaliation- OMI wrote in their report the following comment concerning the CMs they interviewed: “They expressed concern about losing their jobs if they spoke with us; one CM – the whistleblower – had recently been terminated.” In conclusion section OMI wrote: “Some CMs are reluctant to complain about their unpleasant and potentially unsafe working conditions, expressing fear of retaliation.

(b) Confidentiality - Lack of private space in which to interview Veterans, and file cabinets to secure confidential information,

(c) Low morale and high turnover - Morale among CMs was extremely low because they felt neglected by leadership due to lack of acceptable work environment and resources required for their jobs. Consequently, the turnover rate in CM positions has been very high..

(d) Safety- Allowing newly assigned CMs to enter the community without cell phones and laptops Plus the majority of this equipment was dysfunctional.

(e) Documentation - No steps had been taken, for securing by either 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 Veterans.

(f) Orientation - HUD/VASH leadership did not provide an effective process for orienting newly hired CMs"

(g) Evaluation - CMs are required to use referrals from other programs in place of their own independent assessment.

(h) HUD/VASH leadership did not provide clear-cut policies, procedures, or guidelines to properly direct HUD/VASH CMs."

3. The four violations that OMI confirmed plus the above mentioned issues has resulted in additional federal regulations listed in the VA Handbook 1162.05 being violated. This includes the following:

" #34 Internal Administration: (a) Confidentiality. " VA may disclose relevant health care information to health and welfare agencies, housing resources, and utility companies, possibly to be combined with disclosures to other agencies.

Violates # 17 Outreach and Education: (e) (2) Staff independence may necessitate medical facilities to recognize additional considerations for program safety, employee security, and job effectiveness (available vehicles for outreach and case management activities, cellular phones, laptop connectivity, additional security services, etc.).

#9 Responsibilities of the Facility Director: Each Facility Director is responsible for: (c) Providing and maintaining program oversight to ensure quality clinical services and compliance with VHA policy and procedures.

#11 Coordinators Responsibilities: The HUD-VASH Program Coordinator is responsible for: (d) Managing and ensuring even distribution of caseloads with consideration to the CTI model.

#29. Case Management: (b) There are three levels of case management which are related to the CTI Model, but modified to meet the unique needs of the HUD-VASH Program. The Active level is the most intensive, the Stabilization level is moderately intensive and the Maintenance level is the least intensive. The Veterans progress may not be linear. In fact, it is more likely that progress will vacillate between these levels.

#33. Workload, Documentation, and Credit: (a) The HUD-VASH Program intends to incorporate the CTI Model into the assignment and management of caseloads.

#12 Case Manager Responsibilities: The Case Manager is responsible for: (c.) Employing Motivational Interviewing approaches to promote Veteran follow through with referral for preventive care and treatment of medical conditions, substance use and dependence, other mental health conditions, and problematic health behaviors (e.g., problematic substance use, tobacco use, unsafe sexual practices).

#11 HUD-VASH Coordinator Responsibilities: The HUD-VASH Program Coordinator is

responsible for: (a) Establishing a process for referral, evaluation, and admission to the HUD-VASH Program.

#19 Program Participant Targeting: (a) “Veteran participants in the HUD-VASH Program must be homeless and meet VA health care eligibility as defined by law and regulation.

(b) The target population for HUD-VASH needs to include the chronically homeless Veteran who is the most vulnerable and often has severe mental or physical health problems and/or SUD, with frequent emergency room visits, multiple treatment failures, and limited access to other social supports. However, other Veterans who are homeless with diminished functional capacity and resultant need for case management are also eligible for the program.

(c) The HUD-VASH Case Manager is to assess each case on an individual basis. Based on clinical judgment and resource availability, it must be demonstrated that the homeless veteran has an identified need for case management to obtain and sustain housing.

(d) *NOTE: The HUD-VASH Program need to be reserved for homeless Veterans who have few resources and require long-term case management to either obtain or maintain permanent supportive housing.*”

#20 Screening and Evaluation: (a) The screening process determines a Veteran’s appropriateness and need for HUD-VASH. As the target population for this program may be difficult to engage, a low-barrier, housing- focused approach is indicated.

b. Screening must be done by a HUD-VASH clinical team member for all Veterans referred.

c. Screening and evaluation must occur within 3 business days of receiving the referral.

e. Is in need of, and is willing and able to, engage in clinical case management. Otherwise eligible homeless Veterans receiving HUD Homeless Prevention Rapid Re-Housing Program (HPRP) or VA SSVF funds to move temporarily into housing while waiting to get into a HUD-VASH unit, retain eligibility for the HUD-VASH Program. HPRP is a temporary form of assistance and expressly touted in the HPRP notice as an eligible resource for HUD-VASH.

#19 Program Participant Targeting: (f) If there are no available case management openings or vouchers, the Veteran needs to be placed on an “interested in HUD-VASH” list. The Veteran needs to be provided with information about HUD-VASH, and when appropriate, the HUD-VASH case manager needs to invite the Veteran to participate in any existing HUD-VASH pre-groups. The HUD-VASH program staff must document the referral and note that the reason for denial was a lack of an available voucher

#34 Internal Administration (b) Medical Records: Medical record documentation must comply with applicable TJC and CARF requirements, as well as local medical facility policy and procedure. Documentation must reflect planning with the Veteran that is individualized, developed with the input of the Veteran and information from an assessment. Plans are to be reviewed for relevance, and modified as needed. Documentation is to note progress towards achievement of goals and objectives in the plan, significant events in the person’s life, the delivery of services and specific interventions, referrals, and discharges or transitions to other levels of care.

#21 Admission: (a) Admission is by clinical decision of HUD-VASH staff, or, if indicated, a mutual decision with appropriate consultation in more complex situations. Veterans are considered admitted into the HUD-VASH Program when accepted for case management. Admission decisions need to occur within 24 hours of a completed assessment.

#22 Assessment: (1) Newly-accepted Veterans are assigned to a HUD-VASH case manager.
(2) The HUD-VASH case manager must ensure that there is a homeless initial assessment completed on each new Veteran through HOMES

#23 Housing Plan: Veterans are encouraged to work with their case manager to develop a housing plan with specific, individualized goals that focus the direction of case management.”

Comment: There are far too many serious violations for any programs but especially one that is directly related to President Obama’s mission to end homelessness amongst Veterans.

4. OMI’s report did not indicate who was responsible for the gross mismanagement of the HUD-VASH program. Nor did they indicate a specific corrective action plan to remedy the multiple major violations and the number of concerns that they raised. Plus there is no deadline as to when these violations will be corrected or by whom. As a result, this writer will address these issues, which is as follows:

(a) This is the only VAMC in the entire United States that has a Director of Homeless Programming (GS level 13). Why was this expensive position created, especially when these duties were already provided for by positions already in existence? This unnecessary expensive position needs to be eliminated and its funding used to appropriately compensate HUD-VASH CMs at the GS level (12) they were originally designated, rather than a GS Level 11, first step. Homeless Veterans deserve highly qualified experienced clinicians. The Program Support Assistant position also needs to be upgraded to the GS Level they are performing at and deserve. In addition a Housing Specialist needs to be designated for the duties listed in the VA Handbook 1162.05. ICM team members should have access to a Peer Support Specialist like the ACT team members do.

(b) As Director of Homeless Programming, Patricia Wolschon, has been “supervising” HCHV Coordinator, HUD-VASH Coordinator, and the VCRRC Chief. In other words, she has a major influence on how CMs are allowed to perform their duties and the information they receive. The CMs this writer is referring to include those who work in Grant Per Diem, Contract Residential, DOM, HCHV, VCRRC, ICM &ACT team members in HUD-VASH, Peer Support Specialist, Housing Specialist, plus the Program Support Assistant. It should be noted that VA Handbook 1162.05 does not list a Director of Homeless Programming and what their responsibilities would be.

It appears that Ms. Wolschon is one of the people responsible for the Gross Mismanagement of the HUD-VASH program. For example it appears that this was done by withholding information concerning SSVF funding as illustrated in the staff meeting note on 6/4/12. This valuable resource should have been used to prevent Veterans from becoming homeless to begin with and then placed into expensive transitional housing. It seems that information concerning Housing First Was withheld. Plus it appears the same was done about the Housing First Pilot grant (50 SMI vouchers) that Detroit received to demonstrate why the ICM team needed to be supplemented with an ACT team.

Various high level VA memos and the presentation on 11/5/12 all indicate that Housing First is the VA’s National Policy for Veterans accessing permanent housing beginning 9/15/11. These memos also indicated that VAMC Directors had to sign a Certification letter “verifying that

all six requirements pertaining to the Housing First model have been met.” Plus this implementation should be completed by the end of the fiscal year 2013. (9/30/12).

The results of the OMI investigation that was conducted in August 2013 seem to clearly demonstrate that this VAMC had not even begun to implement Housing First across the board. This is also illustrated by Phillip Thomas’s memo dated 11/15/12, concerning CTI training, in which it was written: “Detroit is the only VAMC out of 7 that has not scheduled let alone completed any consultation calls. This is directly related to converting all HUD-VASH into Housing First and is a wonderful resource.” (Even Detroit’s ACT team had not participated in this training.) Stacy Knipscheer memo dated 10/17/12 seems to indicate that this lack of CTI training hindered this VAMC from meeting VISN 11 goal of housing Veterans in 75 or less, while other sites were able to do so in half the time it took Detroit.

It also seems that Pat Wolschon was not truthful with higher level VA officials, as documented in the correspondence with VISN 11 Network Homeless Coordinator, Phillip Thomas on 10/12/12, and the VA Housing Checklist that was completed on 10/15/12 and subsequently submitted and released on 10/18/12. It appears that the correspondence with Mr. Thomas and the responses that were entered on the VA Housing Checklist was an attempt on the part of management to make it appear that the entire HUD-VASH program was implementing Housing First when in fact they were not.

In addition, it appears that Pat Wolschon is responsible for not allowing HUD-VASH CMs to conduct screenings as mandated and to substitute the “assessment” from the referral source without question. Nor did Ms. Wolschon require the referral source to complete a psychosocial assessment and refused to allow HUD-VASH workers to do so, as mandated. “Messages” were also conveyed to HUD-VASH CMs to disregard VA policy and regulations.

One of Ms. Wolschon’s “duties” has involved working in conjunction with the PHA, who is responsible for the HUD component of the HUD-VASH vouchers. There were five PHAs working with the VA, but for some unknown reason has decreased down to only one. Veterans and CMs have repeatedly expressed concerns regarding how documents were processed and the lengthy time it took to get the unit inspected, but to no avail. (Inspections have been delayed since the PHA only has one housing inspector that covers a major metropolitan area that covers 4 counties.)

(c) It seems that the second person responsible for the Gross Mismanagement of the HUD-VASH program is the ACOS of Mental Health Services, Dr. Bella Schanzer. This is the individual that Patricia Wolschon reports to since all Homeless Programs, are under the Mental Health Department.

It appears that Dr. Schanzer withheld important information concerning Housing First, its prevention aspect (SSVF), and implementation of VA National Policy in the HUD-VASH program. . In addition it seems she was well aware of the heavy caseload workers had, the lack of appropriate equipment/resources and its functional status. This can be confirmed by a memo from Shufreda Jones (HUD-VASH Program Support Assistant) dated 8/6/12, in which the following was written to advise staff what needed to be done, when she off from work for a week. The most relevant sections are as follows: “Every Wednesday by 11 a.m. the **PIT report is due to Dr. Schanzer.** This is a report that Sheila (former HUD-VASH coordinator/supervisor) forewords to her. Every Friday the **weekly monitor** is due as well, I would say at least by 12 noon

(concerning CM average caseload, the number of functioning laptops, and cars available). Next Friday is the 3rd Friday of the month and the **Housing First Pilot report** (50 SMI vouchers handled by the Housing First ACT team members) is due to Pat (Wolschon) before COB. All of this needs to be covered in my absence.” This memo was sent to the entire HUD-VASH staff, Dr. Bella Schanzer, and Pat Wolschon.

It would seem that that an ACOS of Mental Health Services would want to make sure that CMs were performing their job duties as mandated and require that screenings and psychosocial assessments were being completed rather than prohibited. This would then result in an accurate HOMES being completed and a viable Housing Plan being developed.

This writer wonders why Dr. Schanzer would not want HUD-VASH CMs to have access to mandated training (CTI, MI, ACT, etc.) and be able to utilize such excellent resources such as the HUD-VASH Resource Guide on Permanent Housing and Clinical Care. This would allow workers to provide top quality clinical care to Veterans.

HUD-VASH needs to be removed from the Mental Health Department (control) since this arrangement seems to have not been beneficial to HUD-VASH and in fact has had a negative impact. Considering how the HUD-VASH program has been run, it is not surprising that staff morale is extremely low and turnover extremely high. This is not fair to the workers employed in the program and in particular the Veterans they serve.

CMs should not have to work in an atmosphere of disrespect in which their clinical expertise is ignored and staff is fearful that if they express their opinions, like this writer did, they will face retaliation including termination. Nor should they be subjected to a poor work environment that lacks adequate space to protect Veteran privacy, and reliable vital equipment is not made available. All of this contributes to putting CMs at risk for harm and hindering worker productivity.

(d) It seems that both Pat Wolschon and Bella Schanzer report to Dr. Bella Reeves, who is the JDD VAMC facility director. It appears that Dr. Reeves has neglected her duties as facility director and violated 3 major provisions listed in #9 Responsibilities of Facility Director concerning resources/equipment; program oversight/monitoring of policy and procedures; and timely hiring of staff.

(e) This writer strongly suspects that financial consideration may very well be at the root of the problem. Two of the slides at the Housing First presentation on 11/5/12, appear to answer this question. **The slide concerning, “Why Housing First?”** (Page 5) “Housing First ends homelessness; **Housing First eliminates the need for costly shelter care, transitional and short term treatment services** aimed at preparing Veterans to be housing ready; Studies demonstrate that **Housing First reduces ER visits, unscheduled mental health visits and medical hospitalization;** and Housing First decreases the frequency and duration of homelessness.”

The slide concerning, “Housing First as Policy” (page 7) “Secretary announced **Housing First is VA’s policy for accessing permanent housing September 15, 2011;** **Hearth Act: promotes “housing first” principles: rapid rehousing followed by community-based services; Shift away from shelter-based supportive services and transitional housing;** Applied to families and transitionally homeless adults; **A Prevention- centered approach is emergent: Housing First as official policy.”**

Comment: These two slides could be the reasons why it appears that Detroit management has been very resistant to implemented Housing First, withheld information concerning it, and did not tell the truth, since this would decrease funding for their more expensive programs, such as Grant per Diem, DOM, Contract Residential, and to a lesser extent the ER, hospital, and the mental health department. It also seems that shelter-based and transitional housing would eventually be discontinued. The prevention component of SSVF would also contribute to a decrease in funding.

In other words, the funding for Pat Wolschon's position and the departments she "supervises" will be decrease and eventually discontinued. It seems that management believed this lack of funding would adversely affect the Mental Health Services "supervised" by Dr. Bella Schanzer and a corresponding negative impact would be seen in other departments at the JDD VAMC.

Recommendation: First: The Director of Homeless Programing needs to be eliminated for the reasons already cited.

Second: HUD-VASH needs to be removed from under the auspices of the Mental Health Department, for the reasons already outlined and which is what a number of HUD-VASH programs have done.

Third: The Homeless Coordinator position needs to be reinstated as seen in other HUD-VASH programs. The HCHV Coordinator position is not necessary, and their duties can be placed back under the Homeless Coordinator like they use to be. The HUD-VASH Coordinator is no longer necessary either. Since the number of HUD-VASH positions has been expanded plus the Housing First model implemented with teams, their leaders can assume supervisory functions. These leaders can then report directly to the Homeless Coordinator, like it is in other programs and compensated at the GS level 12 but at a higher step (5th) than the rest of the CMs on their team.

Whoever is chosen to be Homeless Coordinator needs to be an individual who has the following qualifications: High ethics; Has a history of treating their co-workers and the Veterans they serve with dignity and respect; Welcomes and encourages the opinions of other people who work directly in and in conjunction with other departments/organization; Have the clinical expertise, knowledge and experience with the Housing First Model and be willing to implement it in the HUD-VASH program; Have a plan to make sure the resources, equipment, and training be provided. There are a couple of internal candidates in HUD-VASH who have these qualities.

Fourth: Mandate JDD VAMC management to allow HUD-VASH CMs to conduct screenings and psychosocial assessments, plus other federal regulations listed in the VA Handbook 1162.05

Fifth: Compensate HUD-VASH CMs at the level they were originally funded at, GS Level 12, 1st Step. Plus, hire only experienced independently licensed Master level Social Workers. Upgrade the HUD-VASH Program Support Assistant to the Level they are performing at and deserve. Designate a Housing Specialist to perform the duties listed in the VA Handbook 1162.05. Make available to the ICM team a Peer Support Specialist like the ACT members have.

Sixth: Provide HUD-VASH ICM team members their own office furnished in the same manner as those on the 7th floor. Provide with the reliable equipment (cell phones, laptops,

cars) and the mandated training (CTI, Motivation Interviewing, ACT, Housing First) within the next two months.

Fifth: Increase the number of PHAs within three months. Address promptly the concerns expressed by Veterans and CMs, especially the length of time concerning inspections.

Seventh: Implement a plan within two months to educate referral sources to the HUD-VASH program (Grant per Diem, Contract Residential, DOM, HCHV, VCRRRC, and other Departments located within the VAMC) about the entire Housing First model.

Eighth: Develop a plan within three months for Veterans who are in transitional housing and ineligible for HUD-VASH since they are not in need of long term case management, etc., a way to access permanent housing.

Ninth: Conduct an audit in order to determine how were the funds that were designated for the HUD-VASH program utilized, which might answer such questions as to why money was not made available to provide mandated training, appropriate equipment and resources, adequate office space, appropriately compensate HUD-VASH workers, etc. Especially since this VAMC was able to completely remodel the seventh floor and convert it into luxurious individual offices for occupants on the first floor.

Tenth: Jose D. Rojas (Chief of Staff), wrote in his letter dated 11/15/13: "The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code Section 1213(d)(5). This writer looked up this Statute and noticed that one of the actions that could be "taken or planned as a result of the investigation" includes: "the restoration of any aggrieved employee". This writer would like to respectfully request that she be reinstated back in the HUD-VASH program and would considerate it an honor and privilege to once again serve this country's courageous Veterans.

These recommendations could help restore CMs faith in the system that they can perform their job in the manner mandated, express their opinions freely without fear of retaliation, increase morale and reduce the very high turn-over rate.

I would like to thank in advance OMI and OSC taking the time to read this document,

Linda Zander Altus, LMSW

Linda Zander Altus, LMSW