United States Government Accountability Office

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Report to the Chairman, Committee on Veterans' Affairs, House of Representatives

September 2006

HOMELESS VETERANS PROGRAMS

Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program

GAO-06-859

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-06-859, a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

About one-third of the nation's adult homeless population are veterans, according to the Department of Veterans Affairs (VA). Many of these veterans have experienced substance abuse, mental illness, or both. The VA's Homeless Providers Grant and Per Diem (GPD) program, which is up for reauthorization, provides transitional housing to help veterans prepare for permanent housing. As requested, GAO reviewed (1) VA homeless veterans estimates and the number of transitional housing beds, (2) the extent of collaboration involved in the provision of GPD and related services, and (3) VA's assessment of GPD program performance.

GAO analyzed VA data and methods used for the homeless estimates and performance assessment, and visited selected GPD providers in four states to observe the extent of collaboration.

What GAO Recommends

To further strengthen VA's ability to help homeless veterans, GAO is recommending that VA take steps to ensure policies are understood by providers and staff who implement them. GAO also recommends that VA explore feasible and cost-effective means of obtaining information on long-term outcomes for veterans who leave the GPD programs. VA generally agreed with our findings and recommendations.

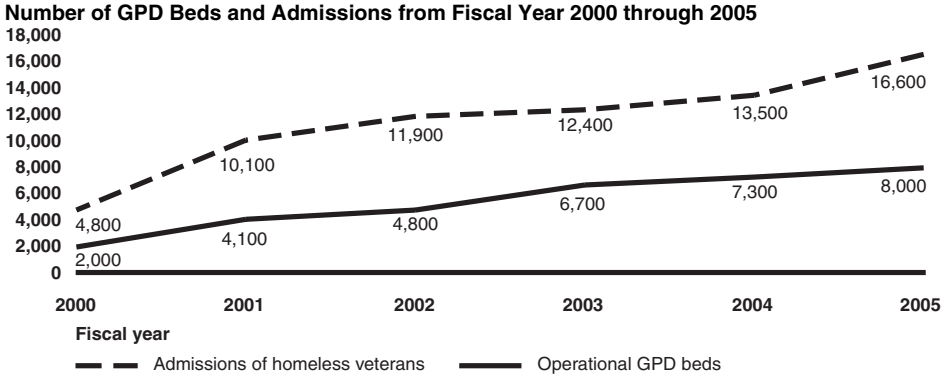
www.gao.gov/cgi-bin/getrpt?GAO-06-859.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cristina T. Chaplain at (202) 512-7215 or chaplainc@gao.gov.

What GAO Found

VA estimates that on a given night about 194,000 veterans were homeless in 2005. The estimate, generally lower than the numbers reported prior to 2004, is considered by VA officials to be the best available. VA officials believe that its new estimation process and use of better local data have improved the estimate. While VA has increased the capacity of the GPD program over the past several years, VA reports that an additional 9,600 transitional housing beds from various sources are needed to meet current demand. VA has plans to make 2,200 additional GPD beds available.

Number of GPD Beds and Admissions from Fiscal Year 2000 through 2005



Source: GAO analysis of VA data rounded to nearest 100th.

GPD providers collaborate with other agencies to help veterans regain their health and obtain housing, jobs, and various services to enable them to live independently. However, resource and communications gaps may stand in the way of VA and provider efforts to meet these goals. Limited availability of affordable permanent housing, for example, may make it difficult to move veterans out of homelessness, according to GPD providers. We also identified instances of misunderstandings of program policies related to eligibility and program stay limits that could prevent homeless veterans from being admitted into the GPD program.

VA assesses overall program performance by the success of veterans in attaining stable housing, income, and self-determination at the time they leave the program. VA data show that the percentage of veterans achieving these goals has generally increased or held steady over time. In 2006, VA also stepped up its assessment of the performance of GPD providers. While these assessments do not indicate how veterans fare after they leave the program, preliminary results of a onetime VA study indicate positive housing outcomes were maintained 1 year later. However, VA does not routinely collect follow-up data and may not be able to determine how veterans who were not included in the study are faring after they leave the program.

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Abbreviations

CHALENG	Community Homelessness Assessment, Local Education and Networking Group for Veterans
DOL	Department of Labor
GPD	Homeless Providers Grant and Per Diem
HCHV	Health Care for Homeless Veterans
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
NEPEC	Northeast Program Evaluation Center
OIG	Office of Inspector General
VA	Department of Veterans Affairs

GAO
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United States Government Accountability Office
Washington, DC 20548

September 11, 2006

The Honorable Steve Buyer
Chairman
Committee on Veterans' Affairs
House of Representatives

Dear Chairman Buyer:

On any given night in the United States, an estimated 700,000 people, including veterans, are homeless and sleep on the streets or in shelters. Veterans constitute about one-third of the adult homeless population, according to the Department of Veterans Affairs (VA). Many veterans who are not homeless may be at risk of homelessness as a result of poverty, lack of support from family and friends, or precarious living conditions in overcrowded or substandard housing.

To help address the needs of homeless veterans, VA operates several programs, the largest of which is the Homeless Providers Grant and Per Diem (GPD) program. Scheduled for reauthorization in 2007, this program provides a transitional setting to help veterans prepare for permanent housing. The program is not intended to serve all homeless veterans but is focused instead on serving those who are most in need, including veterans whose circumstances make them likely to remain homeless unless they receive assistance, such as those who have had problems with mental illness, substance abuse, or both. Through a network of local nonprofit or public agencies, the program provides beds to homeless veterans in settings free of drugs and alcohol that are supervised 24 hours a day, 7 days a week. Program rules generally allow veterans to stay with a single GPD provider for 2 years, but providers have the flexibility to set shorter time frames. In addition, veterans are generally limited to a total of three stays in the program over their lifetime. The program's goals are to help homeless veterans achieve residential stability, increase their skill levels or income, and attain greater self-determination.

As Congress considers the reauthorization of the GPD program, you asked us to review (1) VA estimates of the total number of homeless veterans and the number of transitional beds available, (2) the extent of collaboration involved in the provision of GPD and related services, and (3) VA's assessment of GPD program performance.

In examining VA's estimates of the number of homeless veterans, we reviewed relevant reports and interviewed outside experts as well as officials with the Bureau of the Census, the Department of Housing and Urban Development (HUD), and VA's Community Homelessness Assessment, Local Education and Networking Group for Veterans (CHALENG). To assess the extent of coordination among community partners serving homeless veterans, we visited 13 GPD providers located in California, Florida, Massachusetts, and Wisconsin, including some in rural areas as well as large cities. In addition, we analyzed data from a survey of GPD providers conducted by VA's Northeast Program Evaluation Center (NEPEC) and attended a meeting of VA's Advisory Committee on Homeless Veterans. We focused our review on those GPD providers serving homeless veterans in general rather than special subgroups, such as the chronically mentally ill. In each of these locations, we interviewed local VA officials, GPD staff, community partners, and, where possible, current and former program participants. To develop information on GPD performance, we interviewed officials and analyzed data from NEPEC and VA's national program office. Data obtained were considered sufficiently reliable for our purposes. We coordinated with VA's Office of Inspector General so that our review complemented but did not duplicate its recent review related to GPD financial management and oversight issues.[1] We conducted our work between August 2005 and July 2006 in accordance with generally accepted government auditing standards. For more information on our scope and methodology, see appendix I.

Results in Brief

VA reports that about 194,000 veterans were homeless nationwide on a given night in fiscal year 2005—an estimate that VA officials consider the best available. VA changed its estimation process in 2004 to provide a snapshot of the number of homeless veterans at a given point in time, as opposed to an aggregate total of veterans who were homeless over the course of the year. Earlier estimates combined these aggregate totals with the snapshot data. While VA officials consider the current estimate to be more reliable than those for earlier years, the agency believes the estimate to be on the low side because some veterans cannot be located at the time the counts are taken. To accommodate veterans ready and willing to assume the responsibilities involved in transitional housing, VA reports that a total of 45,000 transitional beds are needed. VA has identified 35,400

[1] VA's Office of Inspector General reviewed the GPD program and planned to issue a report in September 2006 titled *Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program* that will be available on the Internet.

beds that are available from various sources, including the GPD program, resulting in a shortfall of about 9,600 beds. In fiscal year 2005, the GPD program had about 8,000 beds available for homeless veterans. Because veterans only stayed in GPD beds on average about 4 months, the GPD program was able to admit over 16,000 veterans over this same period. VA officials told us that they have plans to expand the GPD program by 2,200 beds in the near future. As the GPD program continues to grow, VA also recognizes that it will have to accommodate the needs of the changing homeless veteran population, including increasing numbers of women and veterans with dependents.

The GPD providers that we visited often collaborated with public and nonprofit agencies in helping veterans to recover from substance abuse or mental illness and obtain permanent housing, employment, financial stability, and services needed to enhance their ability to live independently. While GPD providers were generally able to build successful partnerships, most of them identified resource and communications gaps that presented challenges to delivering certain services. For example, providers reported difficulties in locating affordable permanent housing for veterans ready to leave the program because of shortages in their communities. In addition we found that those responsible for program implementation did not always understand the policies. Some GPD providers believed that homeless veterans were eligible for the GPD program only if they were eligible for VA health care. This assumption was incorrect and may have had the effect of erroneously turning away veterans seeking to enter the GPD program. There were also instances in which GPD providers did not understand that veterans may be able to exceed the 3-stay lifetime limit under certain conditions. This assumption, also incorrect, could keep veterans from obtaining needed care.

VA assesses performance in two ways—the veterans' circumstances at the time they leave the program and the ability of individual GPD providers to meet their own objectives—but VA generally does not know how veterans are faring months or years later. When veterans leave the program for any reason, VA collects information on their immediate success in obtaining housing, income, and greater self-determination—the primary measures of overall GPD program performance. VA reports that of all veterans leaving the program in fiscal year 2005, half had successfully arranged independent housing, one-third had jobs, over one-third were receiving public benefits, and 57 to 69 percent showed progress with substance abuse, mental health or medical problems or demonstrated greater self-determination in other ways. In addition, in 2006 VA took steps to ensure

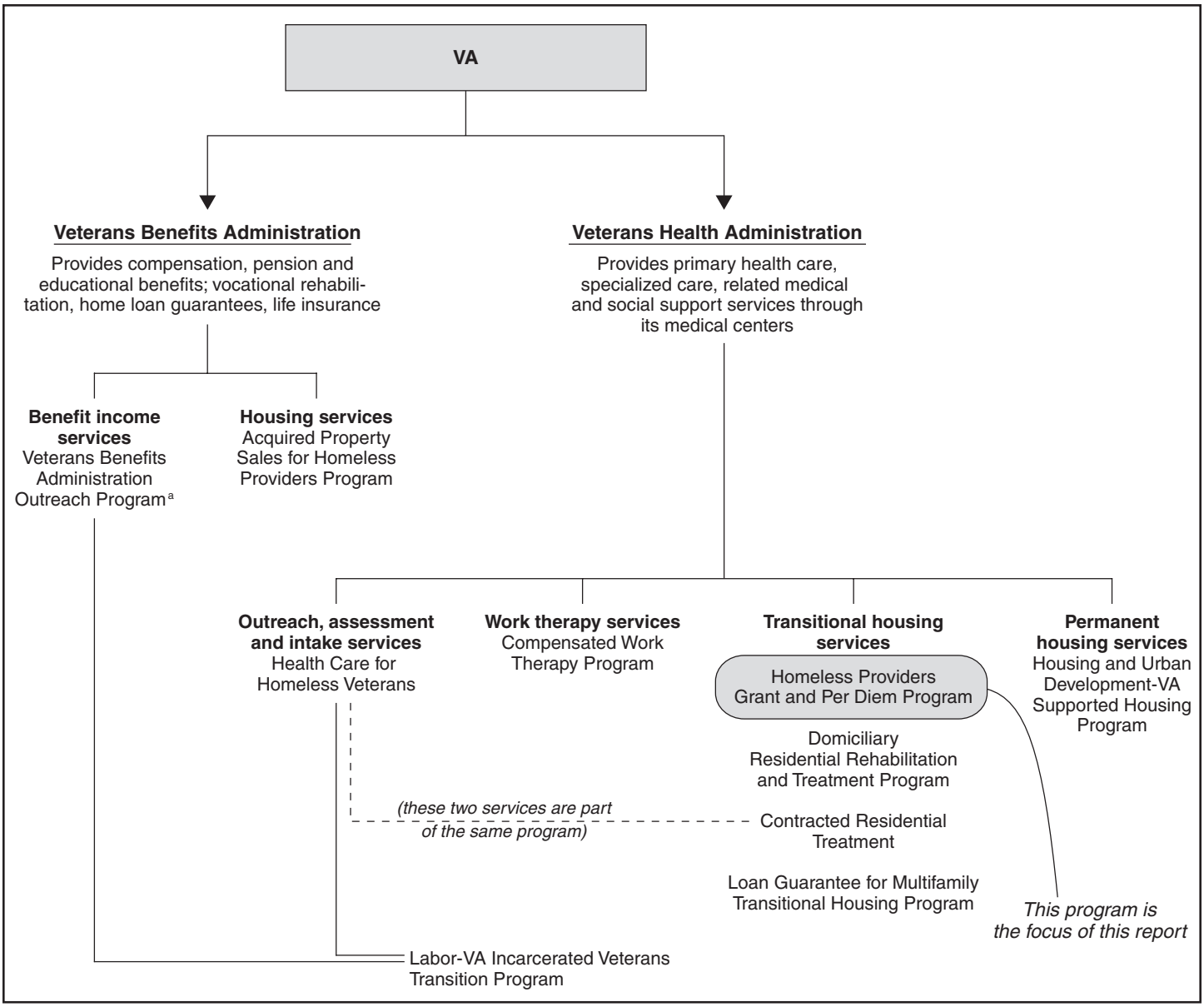
that its local staff conduct annual reviews to determine if the GPD providers are meeting their objectives. VA does not require providers to collect data from veterans months or years after they leave the program, although many providers attempt to maintain contact with former participants. Some indication of how veterans are faring after they leave the program should be available from VA's recent follow-up study of 520 program participants. Preliminary results of this study indicate that veterans maintained positive housing outcomes 1 year after leaving the GPD program.

To further strengthen VA's ability to help homeless veterans, we are recommending that VA take steps to ensure that GPD policies and procedures are consistently understood and to explore feasible means of obtaining information about the circumstances of veterans after they leave the GPD program. In its comments on a draft of this report, VA concurred with our recommendations and described several initiatives planned or under way to address some issues raised in our report as well as other challenges the GPD program faces.

Background

The GPD program is one of nine VA programs that specialize in serving homeless veterans. Six of these programs fall under the responsibility of the Veterans Health Administration, which obligated about $224 million in fiscal year 2006 for these programs as well as $1.2 billion for outreach and treatment of homeless veterans. Outreach is considered particularly important to locate and serve veterans living on the street and in temporary shelters who otherwise would not seek assistance. Treatment involves primary and specialty medical care, mental health care, and alcohol and drug abuse services for eligible homeless veterans. Three of the nine programs are run jointly or solely by the Veterans Benefits Administration that also serves homeless veterans as part of its broader mission to provide disability compensation and pensions to eligible veterans. Figure 1 illustrates some of the key programs and services for homeless veterans—including the GPD program that is the focus of this report—provided by VA. (App. II provides a general description of the eight programs not otherwise covered in this report.)

Figure 1: VA Services and Programs for Homeless Veterans



Source: GAO analysis of VA data.

[a]This program is a joint initiative with VHA.

[b]HUD provides the housing subsidy; VA provides case management services.

GPD Transitional Housing Program for Homeless Veterans

The GPD program—-VA's major transitional housing program for homeless veterans—-spent about $67 million in fiscal year 2005. It became VA's largest program for homeless veterans after fiscal year 2002, when VA began to increase GPD program capacity and phase out national funding for the more costly contracted residential treatment—another of VA's transitional housing programs.[2] To operate the GPD program at the local level, nonprofit and public agencies compete for grants. The program provides two basic types of grants—capital grants to pay for the buildings that house homeless veterans and per diem grants for the day-to-day operational expenses.

- Capital grants cover up to 65 percent of housing acquisition, construction, or renovation costs and require that agencies receiving the grants cover the remaining costs through other funding sources. Generally, agencies that have received capital grants are considered for subsequent per diem grants, so that the VA investment can be realized and the buildings can provide operational beds.

- Per diem grants support the operations of about 300 GPD providers[3] nationwide. The per diem grants pay a fixed dollar amount for each day an authorized bed is occupied by an eligible veteran up to the maximum number of beds allowed by the grant. Generally under this grant, VA does not pay for empty beds. VA makes payments after an agency has housed the veteran, on a cost reimbursement basis, and the agency may use the payments to offset operating costs, such as staff salaries and utilities. By law, the per diem reimbursement cannot exceed a fixed rate, which was $29.31 per person per day in 2006. Reimbursement may be lower for providers receiving funds for the same purpose from other sources.

On a limited basis, special needs grants are available to cover the additional costs of serving women, frail elderly, terminally ill, or chronically mentally ill veterans. Although the primary focus of the GPD

[2] Some medical centers continue to fund contracted residential treatment from their own budgets. For more on earlier VA programs serving homeless veterans, see GAO, *Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness Is Unclear*, GAO/HEHS-99-53 (Washington, D.C.: Apr. 1, 1999).

[3] Throughout this report, we use the term "GPD provider" to refer to a locally run program. In some cases a single organization may have several GPD grants for housing at different locations, and we generally report this as multiple providers.

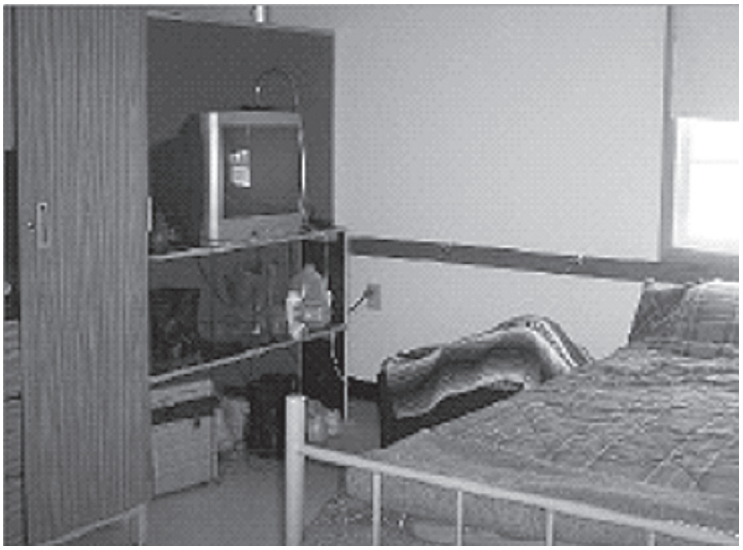
program is housing, grants may also be used for transport or to operate daytime service centers that do not provide overnight accommodations. According to VA, in fiscal year 2005, GPD grants supported about 75 vans that were used to conduct outreach and transport homeless veterans to medical and other appointments. Also, 23 service centers were operating with GPD support.

Most GPD providers have 50 or fewer beds available for homeless veterans, with the majority of providers having 25 or fewer. Accommodations vary and may range from rooms in multistory buildings in the inner city to rooms in detached homes in suburban residential neighborhoods. Veterans may sleep in barracks-style bunk beds in a room shared by several other participants or may have their own rooms. Figure 2 shows the exteriors and interiors of selected GPD buildings we visited.

Figure 2: Interiors and Exteriors of Selected GPD Buildings That GAO Toured

Source: Maryland Center for Veterans Education and Training.

Source: Veterans Hospice Homestead, Inc.



Source: GAO.

Source: GAO.

Generally housing is either male only or has separate sleeping areas for males and females. Multipurpose rooms may be available for television, games, and conversation, as well as communal kitchen facilities where meals can be purchased or made by the participants themselves. Not all GPD providers supply food. Some may assist the participants in obtaining items from community food banks. GPD providers may require veterans to pay rent, but the rent cannot exceed 30 percent of a veteran's income, after deducting the costs of medical, child care, and court-ordered payments. In addition, veterans may be charged fees for other services not

supported by the GPD grant, such as cable television. According to VA rules, veterans may stay with a single GPD provider for 24 months or longer under certain conditions.[4] GPD providers may specify shorter limits such as 3, 6, or 12 months. In fiscal year 2005, the average stay for veterans was about 4 months with a single GPD provider.

Veteran Eligibility for the GPD Program

To meet VA's minimum eligibility requirements for the program, individuals must be veterans and must be homeless. A veteran is defined as an individual who has been discharged or released from active military service and includes members of the Reserves and National Guard with active federal service. Although the GPD program definition excludes individuals who have received a dishonorable discharge, it is less restrictive in terms of length of service requirements. As a result, some homeless veterans may be eligible for the GPD program and not eligible for VA health care.[5] VA does not pay for spouses and children of veterans who are not themselves veterans, but they may be served by GPD providers using other funds.[6] Consistent with the definition used in many other federal programs, VA defines a homeless individual as a person who lacks a fixed, regular, adequate nighttime residence and instead stays at night in a shelter, institution, or public or private place not designed for regular sleeping accommodations.[7] Prison inmates are not deemed homeless, but may be at risk of homelessness and may be eligible for the program upon their release. GPD providers determine if potential participants are homeless, but VA officials determine if potential participants meet the program's definition of veteran. VA officials are also responsible for determining whether veterans have exceeded their lifetime limit of three stays in a GPD program and for issuing a waiver to that rule when appropriate.

[4] VA granted extensions to about 1 percent of the veterans who left the program in fiscal year 2005. The rules allow extensions when permanent housing for the veteran has not been located or the veteran requires additional time to prepare for independent living.

[5] In contrast to the GPD program, veterans must meet the minimum length of service requirements of in 38 U.S.C. §5303A in order to be eligible for VA health care. In certain cases veterans with dishonorable discharges may obtain an upgrade to their discharge status and thus become eligible for the GPD program or for VA medical care.

[6] Veterans must constitute at least 75 percent of participants in facilities that have received GPD capital grants.

[7] The definitions appear at 42 U.S.C. § 11302 and 38 C.F.R. § 61.1.

Prospective GPD providers may identify additional eligibility requirements in their grant documents. Because the providers are responsible for providing a clean and sober environment that is free of illicit drugs, about two-thirds of providers require that veterans entering the program be sober and free from alcohol and drug use for a given length of time. The time frames set by many providers range from 1 to 30 days of sobriety. Many providers also conduct drug tests of veterans after they enter the program to ensure their continued sobriety. Most providers will not accept veterans considered to be a danger to themselves or others, in need of detoxification, or under the influence of drugs or alcohol. About one-fifth of providers also exclude veterans who are considered seriously mentally ill, because the providers may not be able to provide adequate care.

Characteristics of Veterans Eligible for the GPD Program

The GPD program is focused primarily on helping those most in need—veterans who might remain homeless for long periods of time if no intervention occurs—and is not intended to serve all homeless veterans. About two-thirds of homeless veterans in the program in fiscal year 2005 had struggled with alcohol, drug, medical, or mental health problems. About 40 percent of homeless veterans seen by VA had served during the Vietnam era, and most of the remaining homeless veterans served after that war, including over 2,500 who served in military operations in the Persian Gulf, Afghanistan, and Iraq. Almost all homeless veterans seen by VA are males; about half are between 45 and 54 years old, one-quarter are older, and one-quarter are younger. African-Americans are disproportionately represented, constituting the largest racial group at 47 percent; whites are the next largest group at 45 percent. About 75 percent of veterans are either divorced or never married.

Roles of Various Agencies Serving Homeless Veterans

The complex problems faced by homeless veterans require a system of comprehensive, integrated services that often involves multiple organizations. Key federal agencies with programs specifically targeted to the homeless, including veterans, are HUD, the Department of Health and Human Services (HHS), and the Department of Labor (DOL). HUD makes funds available to bring together community organizations to plan and coordinate service delivery through local or regional networks designated as the “Continuums of Care.” In their planning role, the Continuums arrange for counts of the homeless in their area, and since 2003, are required to report the number for a given point in time and to do so at

least every 2 years.[8] Further, as part of their coordination role, the Continuums review agency applications for certain HUD grants. HUD also funds emergency shelters that are open seasonally or year-round for temporary, overnight accommodations. In addition, HUD is the only federal agency that is authorized to provide permanent subsidized housing for the homeless. HHS specializes in funding health care and researching the needs of homeless with substance abuse and mental health issues. DOL, like VA, has programs targeted specifically to veterans within the homeless population, with DOL's emphasis on helping veterans obtain employment. Charities, businesses, and state and local governments are also involved in meeting the needs of homeless veterans and, in some cases, providing funding to GPD providers.

At the federal level, VA works with these and other federal agencies through two key committees. VA's Advisory Committee on Homeless Veterans is responsible for assessing the needs of homeless veterans and determining if VA and others are meeting these needs. The committee comprises homeless veterans, experts and advocates, community-based service providers, state and federal government officials, and representatives of veterans' service organizations. The committee has made several recommendations on improvements to homeless veterans' programs, including the GPD program, some of which have been implemented. In 2004 the committee urged VA to fund GPD providers serving veterans with special needs, especially female veterans; in fiscal year 2005 there were 29 programs of this kind, including 8 for female veterans.[9]

VA is also a participant on the Interagency Council on Homelessness, which coordinates the federal response to homelessness and works with state and local governments to develop plans for ending chronic homelessness among individuals, including veterans, in 10 years.[10] Although the chronic homeless represent only 10 to 20 percent of all

[8]To assist Continuums in conducting counts of the homeless, HUD issued *A Guide to Counting Unsheltered Homeless People*, which is available on the Internet.

[9]For the committee's recommendations and VA's responses, see Department of Veterans Affairs, *2005 Annual Report of the Advisory Committee on Homeless Veterans: Reaching Out to Homeless Veterans* (Washington, D.C.: July 2005).

[10]The chronic homeless are unaccompanied individuals with disabling conditions who have either been continuously homeless for a year or have had at least four episodes of homelessness in the past 3 years. An estimated 63,000 veterans were considered chronically homeless in 2005.

homeless adults, they take up roughly half of all shelter beds and also use a disproportionate share of resources for the homeless.

At the local level, VA works with various agencies through the Community Homelessness Assessment, Local Education and Networking Groups for Veterans, referred to as Project CHALENG. An arrangement of this kind is needed, according to VA, because no single agency can provide the full range of services required to help homeless veterans become more productive members of society. Through CHALENG, a designated VA official in each medical center, usually VA's homeless coordinator, reaches out to community agencies that provide services to the homeless to raise awareness of homeless veterans' particular needs and to plan to meet those needs. Specific needs to be addressed include outreach, counseling, health care, education and training, employment, and housing. Every year these VA officials prepare estimates of the total number of homeless veterans in their area, based on input from various sources. In addition, the officials meet with community representatives to complete a survey of available resources, additional resources needed, priorities for service, and an action plan.[11]

VA Estimates about 194,000 Veterans Are Homeless and Has Increased Its Capacity to Provide Transitional Housing

VA estimates that on a given night in fiscal year 2005 about 194,000 veterans were homeless.[12] The estimate, generally lower than the numbers reported prior to 2004, is considered by VA officials to be the best estimate available. VA officials believe that a new methodology and use of local HUD data has improved the estimate, although some homeless veterans may not have been included because they could not be found when the estimate was developed. While VA has increased its capacity to provide transitional housing for homeless veterans in recent years, its program planning efforts indicate that an additional 9,600 transitional housing beds from various sources are needed to meet current demand. VA officials report that they are working to operationalize an additional 2,200 beds for the GPD program.

[11]For the fiscal year 2005 report, see VA, *Community Homelessness Assessment, Local Education and Networking Group (CHALENG) for Veterans: The Twelfth Annual Progress Report on Public Law105-114, Services for Homeless Veterans Assessment and Coordination*, (Washington, D.C.: Apr. 15, 2006).

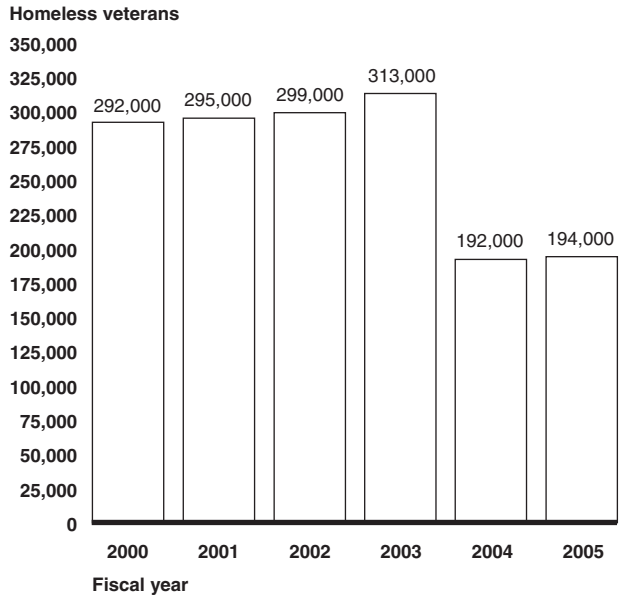
[12] The estimate of homeless veterans is derived from the CHALENG survey of designated local VA officials who are asked to provide the highest number of homeless veterans estimated in their service area on one day of the official's choosing in fiscal year 2005.

VA Considers Its Homeless Veterans Estimate to Be the Best Available

VA bases its national estimate of homeless veterans on the summation of local estimates developed by VA officials for the areas served by VA medical facilities. This process is part of the annual CHALENG planning effort, which involved 135 local VA officials in 2005. Local VA officials are not responsible for conducting their own counts of homeless veterans, but are expected to rely on data from other groups that have collected these data. More than 75 percent of VA officials use multiple data sources, in part because the areas covered by VA medical facilities often comprise several cities, counties, or even states, while local data sources may cover one or more of these jurisdictions, but rarely cover the full area served by the medical facility. Most often, local VA officials rely on data collected by the HUD-funded Continuums of Care, local governments, university researchers, or other groups along with information from local homeless providers. The estimates reported by local VA officials are compared to the previous year's and if they have significantly changed, the local VA officials are asked to explain the differences before their estimates are incorporated into the national figure.

Prior to 2004, local VA officials used a methodology to develop their estimates that was the equivalent of mixing apples with oranges and, as a result, yielded less consistent, reliable counts of the homeless veteran population. This mixed methodology combined cumulative numbers such as the total who were homeless over the course of a year with point-in-time numbers involving the number homeless on any given day or night. The numbers were not comparable because over the course of a year some individuals who were not homeless when the counts were conducted later became homeless. Generally, the number of veterans who are homeless sometime over the course of a year is larger than the number who are homeless on any given night. Since 2004, local VA officials have been directed to use point-in-time data exclusively in developing their estimates to reflect the number of homeless veterans on any given day of the year. VA reports that this standardized method yields more reliable estimates than were developed for earlier years, although there may be some veterans who cannot be located. Figure 3 shows VA's estimates of the homeless veteran population from fiscal years 2000-2005.

Figure 3: VA Estimates of Homeless Veterans Nationwide, Fiscal Years 2000 through 2005



Source: GAO analysis of VA data from CHALENG reports.

Recent estimates are also likely to be more reliable, according to VA, because local VA officials increasingly use homeless data from counts funded by HUD's Continuum of Care, which are believed to be more accurate. In 2005, more than twice as many local VA officials used HUD counts as was the case in 2003. HUD-funded counts in many communities are gradually improving as the census takers increasingly seek out the "hidden" homeless who do not contact service providers as well as the homeless who congregate at soup kitchens and shelters. In both Atlanta and Los Angeles, homeless individuals were hired in 2005 to assist the census takers in locating areas where homeless individuals could be found. As a result, the local counts that were conducted in these two communities were more accurate than the counts conducted in earlier years, according to VA officials.

Although VA officials believe that the number is likely an underestimate, VA officials consider their 2005 year estimate of 194,000 homeless veterans on any given night to be the best available. Counting the homeless is a challenge for several reasons, as VA and other agencies have

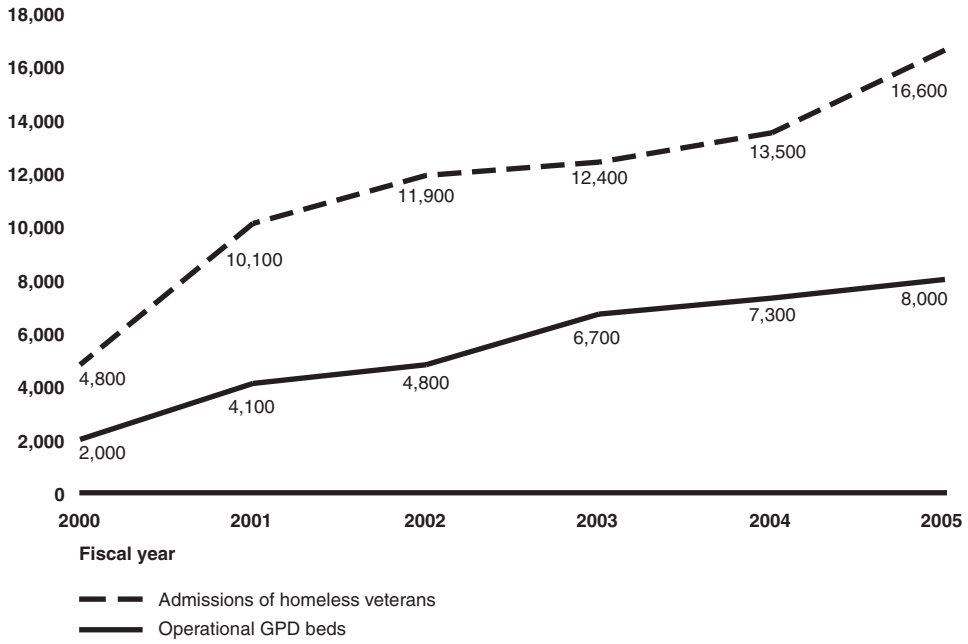
acknowledged,[13] since the homeless are hard to locate and some may not be included in the current estimate. Also, the number may change in relation to social and economic factors, such as job layoffs or a tighter housing market. In addition, veterans who are doubled up and sharing crowded living quarters with others are considered at risk of becoming homeless but are not included in the counts because they do not meet VA's definition of homeless.

VA Expanded GPD Program Capacity and Plans Further Expansion to Help Meet Homeless Veterans' Needs

Since fiscal year 2000, VA has almost quadrupled the number of available beds and the number of admissions of homeless veterans to the GPD program in order to address some of the needs identified through the CHALENG survey. In fiscal year 2005, VA had the capacity to house about 8,000 veterans on any given night. However, over the course of the year, because some veterans completed the program in a matter of months and others left before completion, VA was able to admit about 16,600 veterans into the program. Figure 4 illustrates the growth in GPD program capacity from fiscal years 2000 through 2005.

[13]The Bureau of the Census has had difficulty enumerating the overall homeless population, as we reported in GAO, *Decennial Census: Methods for Collecting and Reporting Data on the Homeless and Others without Conventional Housing Need Refinement*, GAO-03-227 (Washington, D.C.: Jan. 17, 2003). A Census official we interviewed cautioned that the 2010 Census may not enumerate homeless veterans.

Figure 4: Number of GPD Beds Compared to Admissions of Homeless Veterans, Fiscal Years 2000 through 2005

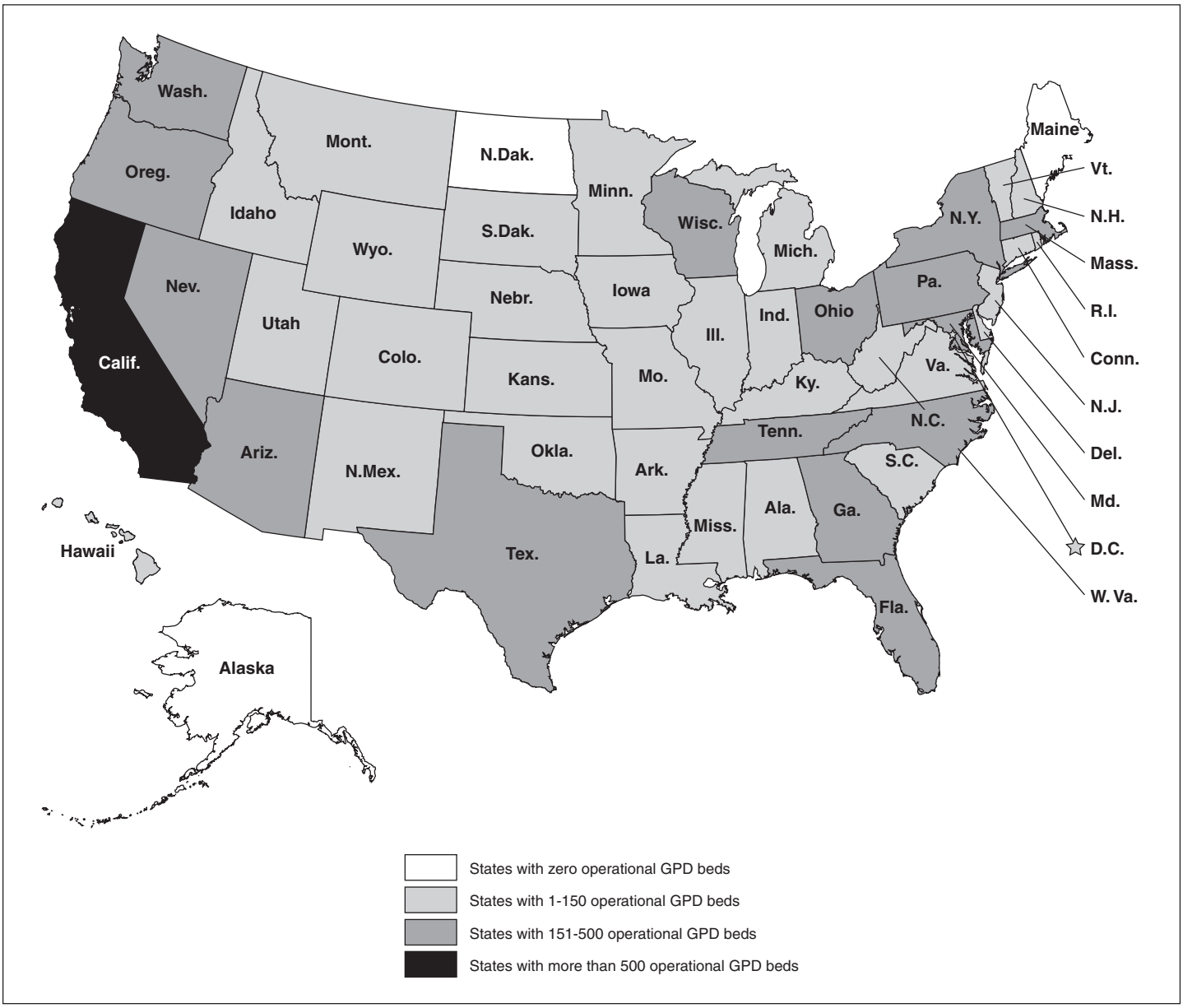


Source: GAO analysis of VA data rounded to nearest 100th.

Note: Not all beds shown were in operation for the full year; for example, only 7,800 beds were in operation at the end of fiscal year 2005.

VA has pursued a policy of making GPD beds available in all states and the District of Columbia, in line with the recommendation made by the VA Advisory Committee on Homeless Veterans. As shown in figure 5, all but three states had beds available in May 2006, and VA officials told us that they were working with potential providers to develop the capacity in these states. The greatest number of beds is in California (1,867 beds); Florida and Massachusetts (430 and 378 beds, respectively); and New York, Ohio and Pennsylvania (274, 261, and 332 beds respectively).

Figure 5: Distribution of the Beds Available under the GPD Program in May 2006



Source: GAO analysis of VA data.

Note: VA reports that grants have been awarded to providers in Alaska, Maine, and North Dakota to develop 20, 18 and 48 beds respectively in those states.

VA's CHALENG report found that about 45,000 transitional housing beds were needed in fiscal year 2005 to help homeless veterans become more socially and economically independent. As shown in table 1, the report identified over 35,000 transitional housing beds that were available through various sources for this purpose—including the GPD beds, another 2,400 beds funded by VA through its other specialized homeless programs, and additional beds funded by other sources. Still needed were about 9,600 more transitional housing beds nationwide beyond the number currently available to meet the demand in fiscal year 2005. To begin to address the demand, VA officials told us that, as of May 2006, they have negotiated an additional 2,200 beds for the GPD program that are expected to be available in the near future.

Table 1: Available and Needed Transitional Beds for Homeless Veterans, Fiscal Year 2005

Transitional beds needed		**45,000**
VA transitional beds available		10,400
• GPD program	(8,000)	
• Non-GPD programs[a]	(2,400)	
Other transitional beds available		25,100
Total transitional beds available[b]		**35,400**
Additional beds still needed[b]		**9,600**

Source: GAO analysis of VA data.

[a]Beds for VA's contracted residential treatment are not included, but VA officials estimate about 304 beds are available.

[b]Numbers are CHALENG estimates rounded to nearest 100; subtotals included in these numbers may not add to numbers shown due to rounding.

Although VA reports the need for transitional housing beds is greater than the capacity, the demand varies throughout the year and by location. Some GPD programs we visited had vacancies and others had waiting lists at the time of our visit. GPD providers and VA officials identified several reasons that beds may go unfilled at any given time. Some beds are held for veterans who are receiving medical treatment, while others may be unfilled as a result of the normal transition when one veteran has left the program and another veteran will soon be entering the program.

VA officials and GPD providers also told us they expect a change in the demographics of homeless veterans that may require them to reconsider the type of housing and services that they are providing with GPD funds. Specifically, VA officials expect to see more homeless women veterans

and more veterans with dependents who are in need of transitional housing. GPD providers told us that women veterans have sought transitional housing; some recent admissions had dependents; and a few of their beds were occupied by the children of veterans, for whom VA could not provide reimbursement. To meet the needs of homeless women veterans, VA has provided additional funding in the form of special needs grants to a few GPD programs.

GPD Providers Collaborate to Offer a Range of Services but Still Face Challenges in Helping Veterans

GPD providers often worked with public and nonprofit agencies to offer a spectrum of services that may help veterans meet individual and GPD program goals. While GPD providers were generally able to build successful partnerships, most of them identified resource gaps that presented challenges to helping veterans, particularly affordable permanent housing. We also found that communication issues related to program policies could prevent veterans from being offered care. Providers did not always understand eligibility requirements such as which veterans may be eligible for the program and the allowable number and length of program stays. Further, providers were not always aware of policy changes.

GPD Providers Create Partnerships to Help Veterans Meet Program Goals, but Resource Gaps Remain

GPD providers generally created partnerships to help prepare veterans to obtain permanent housing and, ultimately, to live independently. VA's grant process encourages such collaboration by awarding points to GPD program applicants that demonstrate they have relationships with other organizations. GPD providers are to identify how they will provide services to meet the program's goals—residential stability, increased skill level or income, and greater self-determination. For example, providers may identify services such as substance abuse and mental health treatment, financial counseling, employment assistance and training, transportation to appointments and job interviews, and related services. We found variation in the agencies that provided these services. According to a VA survey, most GPD providers used their own on-site staff to offer services like case management and transportation assistance. In contrast, mental health assessments were mostly handled indirectly, with 79 percent of the GPD providers using the staff of other agencies, often the VA. (More information from the survey can be found in app. III.)

The GPD providers that we visited established partnerships with state and local government agencies, other federal agencies, and local community organizations. Further, several of the providers that we visited participated in the local Continuum of Care funded by HUD or in other community coalitions, taking advantage of community networks that serve homeless individuals. While most providers offered a range of services, not all veterans received each service. To identify the specific services a veteran may need, providers typically worked with veterans to develop individual treatment plans that identified the veteran's needs on entering the program. Table 2 lists examples of services and partners of GPD providers we visited.

Table 2: Examples of Services and Partners That Worked with GPD Providers We Visited

Veterans' needs	Select services	Partners that provided services[a]
Case management and individual treatment plan		• VA liaison with GPD provider
Health Care	Mental health treatment	• VA • Local area hospitals • Local organizations
	Substance abuse treatment	• VA • Local area hospitals • Local organizations
	Counseling (family, nutritional, etc.)	• VA • Local organizations
	Medical services	• VA • Local area hospitals
Employment and Income	Financial counseling	• Local organizations

	Employment assistance and training	• Department of Labor
		  • Disabled Veterans' Outreach Program[b]
		  • Homeless Veterans Reintegration Program[c]
		• VA
		  • Compensative Work Therapy
		  • Incentive Therapy[d]
		• State and local training programs
		• Local organizations and colleges

	Assistance with getting benefits	• VA • Social Security Administration representative • State/county benefits counselors • Veterans service organizations
After leaving GPD program	Stable housing	• State and local programs • HUD
	Follow-up care and supportive services[e]	• VA • Local organizations
Other needs	Legal assistance	• Local organizations and law offices • Local colleges • Outreach to local jails
	Transportation	• VA GPD van grants • Relationship with local transit authority

Source: GAO analysis of GPD provider partnerships.

[a]GPD provider staff also may have been directly involved in providing services in any of these partnership examples.

[b]Program provides funding through state employment security agencies to support dedicated staff positions to develop and provide employment and job training opportunities for disabled and other qualified veterans.

[c]Program provides services to assist in reintegrating homeless veterans into meaningful employment within the labor force.

[d]Program helps veterans regain work habits and skills by participating in various work situations within VA as part of their treatment or rehabilitative programs.

[e]Supportive services for veterans who leave the GPD program may include health care services rendered during a veteran's GPD program stay, as well as other services to help veterans maintain housing.

GPD programs often collaborated with VA and others to provide health care-related services—such as mental health and substance abuse treatment, and family and nutritional counseling—to help veterans become more self-sufficient in their day-to-day activities. Several programs hosted Alcoholics Anonymous meetings and other counseling services, while some GPD programs expected veterans to attend regular meetings elsewhere in the community. At least two GPD providers we visited provided their own substance abuse treatment and did not rely on community partners to provide such services. At least two other providers that referred veterans to VA for substance abuse treatment expressed concerns about waiting lists for that service, making it hard for veterans to access care immediately. Typically, a VA local medical center provided veterans with primary and specialized health care. However, GPD providers sometimes expressed concerns about difficulties obtaining dental care.[14] To meet the needs of veterans who were not eligible for VA health care, GPD providers made other arrangements. For example, a program in the Boston area partnered with the local hospital which provided free health care to homeless veterans who were in the GPD program but were ineligible for VA health care. We also found that many providers either used their own staff or used partners' staff to provide mental health services and family and nutritional counseling services.

All providers we visited tried to help veterans obtain financial benefits or employment. Some had staff who assessed a veteran's potential eligibility for public benefits such as food stamps, Supplemental Security Income, or Social Security Disability Insurance. Other providers relied on relationships with local or state officials to provide this assessment. For example, a Wisconsin GPD provider worked with a county veterans' service officer who reviewed veterans' eligibility for state and federal benefits. The provider also had a relationship with a county employment representative who came to the GPD facility to discuss job searches, training, and other employment issues with veterans. Several providers were receiving DOL grants to provide employment training services, worked with local colleges, or relied on other local programs to help

[14] VA issued a directive for a onetime dental care opportunity for homeless veterans (VHA Directive 2002-080) in line with 38 U.S.C. § 101 note. VA officials told us that funding was provided in 2006 to implement this directive.

veterans to increase skills.[15] However, a lack of available jobs in an area may sometimes pose problems to finding employment for veterans.

Most of the GPD providers in the areas that we visited worked with community partners to obtain permanent housing for veterans ready to leave the GPD program, but indicated this was sometimes difficult because of limited affordable permanent housing. Some providers had established extensive partnerships with organizations that provide or find affordable permanent housing. For instance, several of the providers worked with the local HUD-funded Continuum of Care network to identify permanent housing resources. Some providers had or were applying for HUD funds to build single room occupancy housing units that could serve as a transition to more permanent long-term housing.[16] As at least one provider mentioned, veterans sometimes become resourceful and agree to share apartments. In some instances, providers have asked for an extension to allow veterans to stay until housing becomes available.

GPD providers and VA staff coordinated with community resources to help address other issues that they identified that might also present obstacles for transitioning veterans out of homelessness. For example, staff in some locations indicated that such legal issues as criminal records or credit problems may preclude veterans from obtaining employment and housing. To help overcome these issues, some GPD providers worked with lawyers who provided services at no cost or other volunteer organizations. Staff in some of the locations also reported that transportation issues made it difficult for veterans to get to medical appointments or employment-related activities. To help address potential transportation difficulties, some providers received GPD grants to purchase vans. One provider that we visited partnered with the local transit company that provided subsidies to homeless veterans. This option is not always available, however, and transportation remained an issue in areas not near a medical center.

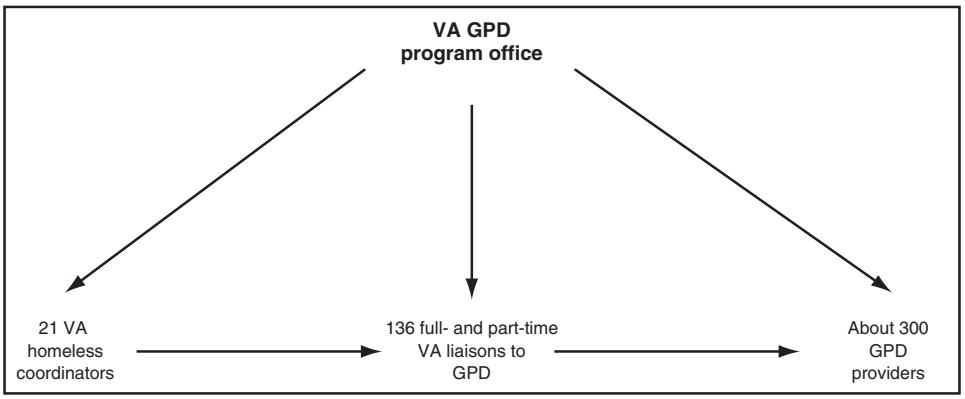
[15] For more information on DOL programs, see GAO, *Homeless Veterans: Job Retention Goal Under Development for DOL's Homeless Veterans' Reintegration Program*, GAO-05-654T (Washington, D.C.: May 4, 2005).

[16] Through the Continuum of Care, HUD contracts with public housing agencies for the rehabilitation of residential properties that provide multiple single room dwelling units. These agencies make Section 8 rental assistance payments generally covering the difference between a portion of the tenant's income (normally 30 percent) and the unit's rent to participating owners (i.e., landlords) on behalf of homeless individuals who rent the rehabilitated dwellings.

Communication of Program Polices May Affect Providers' Ability to Serve Veterans

VA has five staff in the national program office who administer the GPD program through a network of 21 regional homeless coordinators and 136 local VA liaisons. While program policies are developed at the national level by the GPD program staff, the local VA liaisons designated by VA medical centers have primary responsibility for communicating with GPD providers in their area. Figure 6 depicts the flow of information about the GPD program.

Figure 6: Flow of Policy and Program Information from VA to GPD Providers



Source: GAO analysis of VA data.

The VA liaisons may serve in a full-time or part-time capacity, in part depending on the number of GPD beds in the area served by the VA medical centers and the number of admissions per year. In fiscal year 2006, there were 60 full-time liaisons and another 76 individuals serving as part-time liaisons in addition to their other VA duties. Liaisons sometimes found it hard to readily assist providers, according to some staff we met, because of the liaisons' large caseloads and multiple GPD responsibilities—including eligibility determination, verification of intake and discharge information, case management, fiscal oversight, monitoring program compliance and inspections of GPD facilities, among other duties. To help address this issue, VA has set aside additional funding for more full-time liaisons.[17]

[17] According to VA, in fiscal years 2005 and 2006 it had allocated funding for a total of 97 full-time liaisons. As of the time of our review, some sites were still going through the recruitment and hiring processes to fill these positions.

The program office communicates with GPD providers and VA liaisons through written guidance and teleconferences. VA provides liaisons with a guidebook about their responsibilities and the program rules as well as a manual prepared by NEPEC on the forms to be completed for all program participants. To stay up-to-date on GPD program policies, liaisons participated in monthly conference calls and also had the opportunity to attend a conference conducted by the GPD program office in 2004. The program office recently held a training seminar for new liaisons and also offers training via phone. VA also gives GPD providers program handbooks and holds monthly conference calls to discuss program rules. In addition, some of the VA medical centers we visited held meetings with local GPD program providers in their areas to share information.

Despite VA's efforts, we found that some providers did not understand all of the GPD program policies. Some misunderstandings could affect a veteran's ability to get—and a GPD provider's ability to offer—care. For instance, two providers said that VA staff told them that veterans eligible to participate in the GPD program were also required to be eligible for VA health care, but this is not the case. Similarly, in another location, the local VA liaison and a provider both told us that they had received information from the GPD program office indicating that the total lifetime length of stay was 2 years, but the GPD program officials told us this interpretation of the information that they provided is incorrect. Elsewhere several providers understood the lifetime limit of three GPD stays but may not have known or believed that waivers to this rule could be granted. They argued that the limit could hinder a veteran's ability to participate in the GPD program if participation involved phased care offered by separate GPD providers, each specializing in certain phases of treatment, such as detoxification or job preparation. Since each phase of treatment is counted as one GPD stay, veterans may exhaust their 3-stay limit before they have received services vital to their improved functioning. Although VA has the authority to waive the 3-stay limit in such cases, these providers did not seem to understand that this option was available to them.[18] In addition, providers were not always aware of changes in the GPD program in a timely fashion; sometimes not at all. For example, not all GPD providers knew in 2006 that their program's inspections would

[18] VA may waive the episode requirement if the services offered are different from those previously provided and may lead to a successful outcome. The VA liaisons must review and approve or deny the waiver based on their best clinical assessment of the individual case.

include a review of whether they were meeting the objectives described in their GPD grant documents.

VA recognizes that communication to providers and liaisons needs to be improved. In its fiscal year 2005 report, the VA Advisory Committee on Homeless Veterans recommended that VA hold an annual conference and that each GPD provider have an opportunity to attend at least one such conference. The purpose of the conference would be to improve communications, program compliance, and treatment strategies. In the spring of 2006 when the committee reconvened, VA had not yet accepted the committee's recommendation.

VA Data Show That the GPD Program Helps Veterans Get Housing and Income, but Data Are Limited on Veterans' Circumstances after They Leave the Program

VA data show that in fiscal years 2000-2005 a steady or increasing percentage of veterans had stable housing, income, and greater self-determination at the time they left the GPD program. These national performance results are derived from standard forms filled out by VA staff or by provider staff with VA's review and sign-off for every veteran who leaves the program for any reason. While the veterans' success is VA's primary measure of program performance, in 2006 VA took steps to ensure that the performance of individual GPD providers would also be reviewed, in line with a recommendation of VA's Office of Inspector General (OIG). Some GPD providers we visited had stated in their grant documents that a certain percentage of veterans they served would have permanent housing or employment a year after they left the program. Also, VA recently completed a onetime study looking at longer-term outcomes for homeless veterans, including 520 who participated in the GPD program, and preliminary results show that positive housing outcomes were maintained 1 year after veterans left the GPD program. However, VA does not routinely collect follow-up information to determine the status of participants at specified times after they leave the program and may not be able to rely on the results of its study to determine the success of future program participants.

Many Veterans Attain Stable Housing, Income, and Greater Self-Determination Immediately upon Leaving the Program, According to VA Data

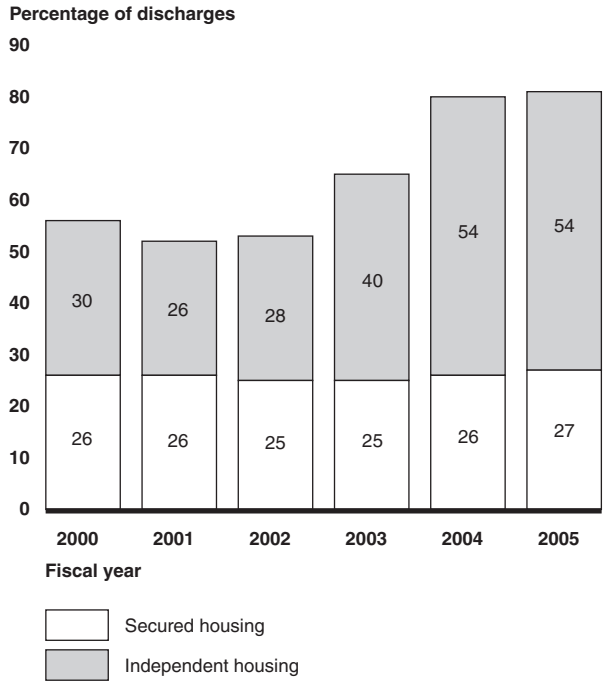
The following sections compare VA's GPD performance data from fiscal year 2005 with data from fiscal years 2000 through 2004.

Stability in Independent and Secured Housing

VA reports that about 81 percent of veterans had arranged some form of housing at the time they left the GPD program in fiscal year 2005, a significant improvement over the 56 percent with housing in fiscal year 2000. VA considers the program successful if veterans have obtained either independent or secured housing.[19] Independent housing comprises apartments, rooms, or houses, while secured housing includes transitional housing programs, halfway houses, hospitals, nursing homes, or similar facilities. Most of the improvement in housing outcomes has occurred in independent housing. While independent housing may be a more desirable outcome, for some veterans, including those with severe disabilities, secured housing may be more appropriate. Figure 7 shows the percentages of veterans who had arranged housing when they left the GPD program in fiscal years 2000 through 2005.

[19]Since fiscal year 2002, VA's strategic plan has included a performance target to capture the housing status of veterans discharged from three of its transitional housing programs, including the GPD program. VA has gradually increased its target from 65 percent in fiscal year 2002 to 79 percent in fiscal year 2005. VA estimates that it exceeded this target in fiscal year 2005.

Figure 7: Percentage of Veterans with Independent or Secured Housing upon Leaving GPD Program, Fiscal Years 2000 through 2005



Source: GAO analysis of NEPEC data.

In its annual reports, VA compares the housing arrangements of veterans who successfully met provider requirements with those who did not. As might be expected, proportionately more veterans who met requirements had obtained independent housing in fiscal year 2005—-nearly 70 percent—compared to the 40 percent with independent housing who had not met provider requirements. In terms of numbers, about half of the 15,000 veterans who left the program in fiscal year 2005 were considered by the GPD providers to have met program requirements, an improvement over earlier years. Of the approximately 7,500 veterans remaining, about half dropped out and the other half violated program rules, such as rules on maintaining sobriety, or they left for other reasons. VA derives this information from discharge forms completed by VA or GPD staff for all veterans at the time they leave the program. VA's evaluation center NEPEC aggregates this data and prepares annual reports on overall GPD program performance. For more on this process, see appendix IV.

Income from Employment or Financial Benefits

The program goal of increased income can be achieved through maintaining or obtaining employment or financial benefits such as VA disability compensation or pensions, Supplemental Security Income, or food stamps. From fiscal years 2000 to 2005, about one-third of veterans had jobs, mostly on a full-time basis, when they left the GPD program. The number of veterans with jobs more than tripled over the period, with about 4,900 employed in fiscal year 2005 at the time they left the program. The number of veterans receiving VA benefits when they left the GPD program was about 3,800, while another 2,200 veterans had applied or planned to apply for VA benefits. Table 3 shows the percentages and numbers of those employed or receiving benefits for fiscal years 2000 through 2005, but VA did not have data on receipt of benefits until 2003.

Table 3: Numbers and Percentages of Veterans Leaving the GPD Program with Employment or Benefit Income, Fiscal Years 2000 through 2005

Number and percentage of discharges from GPD program with	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002	Fiscal year 2003	Fiscal year 2004	Fiscal year 2005
• Total full- and part-time employment	1,404 (37%)	2,803 (33%)	3,579 (33%)	3,735 (33%)	4,108 (34%)	4,920 (33%)
• full-time	1,163 (30%)	2,178 (26%)	2,852 (26%)	2,995 (26%)	3,311 (27%)	3,927 (26%)
• part-time	241 (6%)	625 (7%)	727 (7%)	740 (7%)	797 (7%)	993 (7%)
• Total with any benefits				3,594 (31%)	4,400 (36%)	5,840 (38%)
• VA benefits only	NA	NA	NA	1,530 (13%)	2,091 (17%)	2,924 (19%)
• other benefits only	NA	NA	NA	1,494 (13%)	1,699 (14%)	2,089 (14%)
• both VA and other benefits	NA	NA	NA	570 (5%)	610 (5%)	827 (5%)

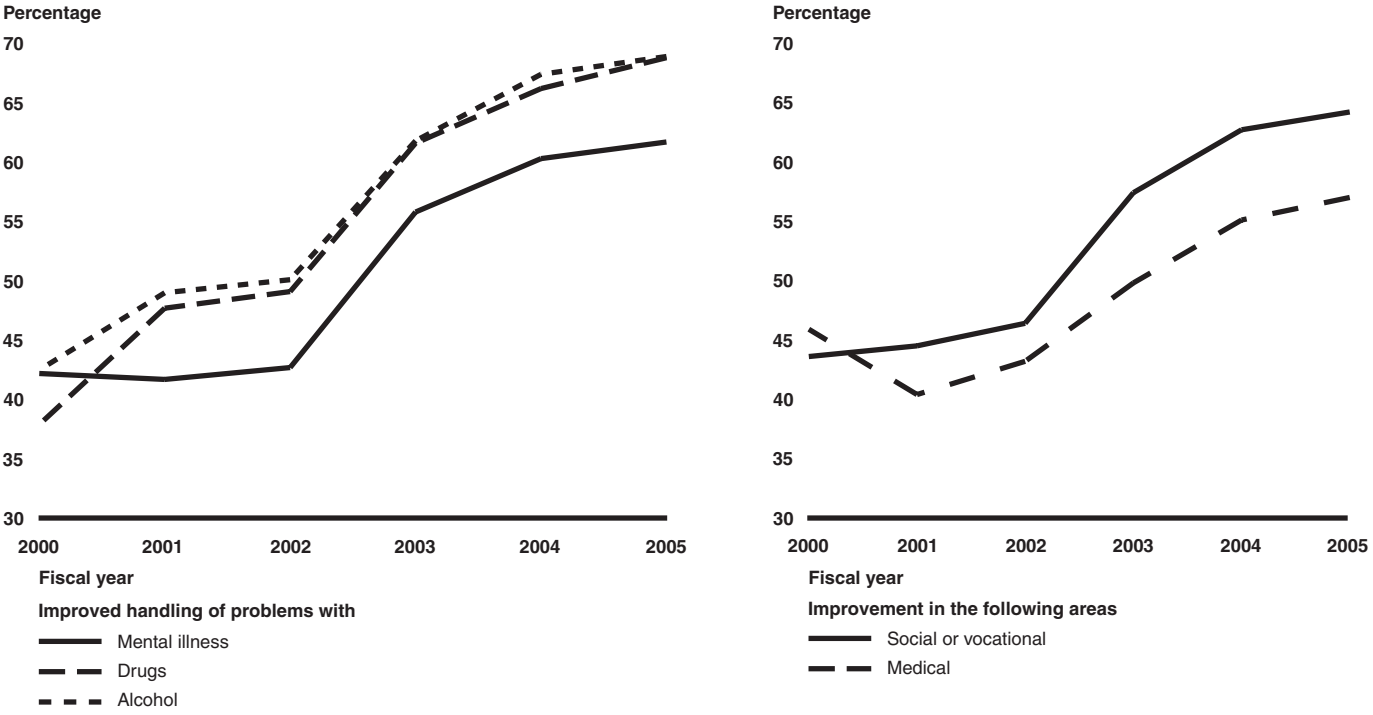
Source: GAO analysis of VA data.

Notes: Percentages may not add up to total shown due to rounding.
NA = Data on receipt of VA and other benefits were not available for fiscal years 2000 through 2002.

Greater Self-Determination in Terms of Improved Functioning in Several Areas

To track greater self-determination, VA examines such goals as veterans' progress in handling of alcohol, drug, mental health, and medical problems and overcoming deficits in social or vocational skills.[20] A greater proportion of veterans leaving the program each year have met these goals, with 57 to 69 percent showing improved functioning in fiscal year 2005, as shown in figure 8.

Figure 8: Percentage of Veterans Leaving the GPD Program with Greater Self-Determination, Fiscal Years 2000 through 2005



Source: GAO analysis of VA data.

Note: The percentage calculations are based on the number of veterans who showed the problem at admission.

These improvements have occurred while the proportion of veterans who entered the GPD program with a history of such problems remained constant or increased. Specifically, the proportion entering with substance

[20] VA also asks participants for their evaluations after they have been in the program for 1 month. Nearly half of the participants completed the surveys in fiscal year 2005. Most reported satisfaction with the GPD, rating it at 3.2 on a scale where 4 is the highest possible score, and with their VA case managers, rating them at 4.6 on a scale where 6 is the highest possible score.

abuse problems who left the program in fiscal years 2000 through 2005 remained relatively constant, while the proportion of veterans with a history of mental or medical illness more than doubled, according to VA data. See table 4.

Table 4: Number of Veterans Leaving GPD Program and Percentage with Specific Problems at Entry, Fiscal Years 2000 and 2005

Number of discharges from GPD program	Fiscal year 2000	Fiscal year 2005
	4,020	15,403
Number of discharges for whom data are available	3,826	15,048
Problems that discharged veterans showed on entering the program:		
• Alcohol	2,789 (73%)	11,180 (74%)
• Drugs	2,579 (67%)	10,307 (68%)
• Mental illness	1,205 (32%)	9,736 (65%)
• Medical illness	1,255 (33%)	10,488 (70%)
• Social or vocational	2,276 (60%)	10,864 (72%)

Source: GAO analysis of data from NEPEC annual reports.

In 2006 VA Took Steps to Help Ensure That VA Liaisons Conduct Required Reviews of GPD Provider Performance

In addition to assessing the program through the success of its veterans, VA policy calls for all VA liaisons to review the performance of individual GPD providers in meeting objectives that are identified in their grant documents. Providers are required to establish specific measurable objectives for each of the three program goals. To reach the housing goal, for example, some providers we visited established savings objectives, requiring veterans to set aside a portion of any income they receive so that they can accumulate sufficient cash reserves to cover costs of renting a room or apartment when they leave the program. Most providers we visited also set outcome objectives for the percentage of veterans expected to obtain independent housing when they left the program. For the income goal, some providers set objectives requiring that a certain percentage of veterans be offered or enrolled in vocational training, develop résumés, interview for jobs, or apply for entitlement benefits. Most providers also set objectives that a certain percentage of veterans would find work. For the self-determination goal, some providers required that a certain percentage of veterans maintain sobriety or attend weekly Alcoholics or Narcotics Anonymous meetings.

In its 2006 examination of the GPD program, VA's OIG found, however, that many providers had not tracked their performance in achieving these

objectives and some VA liaisons had not reviewed the providers' performance. The OIG recommended that VA liaisons ensure that the providers' performance be monitored. The GPD program office has since moved to enforce the requirement that VA liaisons review GPD providers' performance when the VA team comes on-site each year to inspect the GPD facility.[21] The VA liaison will have the flexibility to determine the method for reviewing and recording the providers' performance, so long as the results are documented. GPD providers who do not meet performance objectives will be required to work with their local VA staff to create a corrective action plan or resubmit their applications with new objectives.

VA Does Not Routinely Collect Data on Veterans' Long-Term Success, but Recent Study May Provide Insights on How Veterans Fare a Year after Leaving the Program

VA does not require that veterans be contacted for purposes of program evaluation after they leave the GPD program. With a view to the long-term health of veterans, however, VA attempts to have its clinicians provide GPD participants with a substance abuse or mental health assessment within 2 months of leaving the program. In addition, the forms completed when veterans leave the GPD program identify any follow-up that may have been arranged to help them continue to cope with problems that they have experienced. While follow-up is not required, about 80 percent of GPD providers reported that they conduct some sort of follow-up with veterans after they leave the GPD program. Providers may call veterans who have left, obtain data on those who return for additional support services, or arrange reunions or other gatherings. Some grant documents also indicate that the providers planned to measure their performance, in part by following up with veterans from 3 to 12 months after they left the program. Some providers follow up to meet the requirements of non-VA funding they receive. Several providers we interviewed had DOL grants requiring them to report the employment status of veterans 3 and 6 months after they left the DOL program. These providers were able to report results for the veterans deemed employable who participated in both the GPD and DOL programs. However, GPD participants who were deemed unemployable because of their disabilities may not have been included in the DOL program. While many providers attempt to follow up with veterans, several told us that it is sometimes difficult to maintain contact, especially with veterans lacking telephones or reliable mailing addresses and with veterans who have moved away from the area.

[21] This effort has been possible, according to VA, in part because increased funds have made it possible for more liaisons to work with the GPD program on a full-time rather than a part-time basis.

While VA considers it important for veterans to achieve immediate success on leaving the GPD program, homeless veterans may experience setbacks later on that may negatively affect their housing arrangements, employment and financial benefits, and self-determination. Furthermore, veterans who were not immediately successful on leaving the program nevertheless may have benefited from participating and may be able to achieve success at a later time. To explore the long-term outcomes of program participants, VA funded a onetime follow-up study in May 2001 to examine the outcomes for a randomly selected sample of about 1,300 veterans spread across five geographic locations who were participating in the GPD program and two other VA-sponsored homeless programs. According to a VA official, the cost of the study was about $1.5 million.[22] Included in the sample were 520 veterans housed with 19 GPD providers. Proportionately more veterans in the GPD programs were chronically homeless, while veterans in one of the other programs had higher levels of serious medical and psychiatric problems and greater impairments. At the time of selection, the veterans had various lengths of stays in these programs.

For the study, university and RAND Corporation researchers interviewed veterans to determine their status at 1, 3, 6, and 12 months after they left the programs, with the last interviews conducted in October 2005. About 360 of the former GPD participants responded to the last interviews. VA officials do not expect to release final results of the study until 2007, but preliminary results show that just over 80 percent of the GPD participants had housing 12 months after they left the program. Other outcomes that are expected to be included in the report are the number of days that the veterans have either been housed or homeless, their income and employment situation, their use of drugs and alcohol, their physical and mental health status, and quality of life.

[22]VA has also conducted other follow-up studies designed to test innovative approaches to serving homeless veterans, including ways to improve employment outcomes, ensure the safety and serve the needs of female veterans, and intervene on behalf of veterans dually diagnosed with both mental health and substance abuse problems.

Conclusions

Addressing homelessness is a daunting challenge, given the difficulties associated with identifying those who need help and the broad spectrum of services that need to be successfully tailored, coordinated, and delivered in order to enable individuals and even families to secure permanent housing and to live more independently. Limited resources—particularly the availability of affordable permanent housing—make this job even more difficult. Moreover, the physical and emotional conditions including substance abuse, and mental illness, prevalent in the homeless veteran population further increase the difficulty.

VA has taken a number of steps to tackle this challenge by enhancing its ability to estimate how many veterans need assistance, increasing the number of GPD beds, instituting measures that help gauge the program's effectiveness, and through the GPD program, working proactively with local and federal government agencies and nonprofits to provide the assistance needed. However, more could be done to optimize VA's investment, particularly with respect to ensuring policies and criteria are clearly understood and consistently applied and assessing longer-term outcomes. In enhancing communications, VA will need to identify effective ways of sharing information with the more than 100 agency liaisons in addition to the 300 local GPD program providers—each with a potentially different means of operating. In assessing longer-term outcomes, VA will need to weigh the costs, benefits, and feasibility of implementing a variety of analytical approaches. Clearly, these endeavors will not be easy, but they are critical to better equipping VA to help homeless veterans.

Recommendations for Executive Action

We recommend that the Secretary of Veterans Affairs take the following two steps to improve and evaluate the GPD program:

1. To aid GPD providers in better understanding the GPD policies and procedures, we recommend that VA take steps to ensure that its policies are understood by the staff and providers who are to implement them. For example, VA could make more information, such as issues discussed during conference calls, available in writing or online, hold an annual conference, or provide training that may also include local VA staff.

2. To better understand the circumstances of veterans after they leave the GPD program, we recommend that VA explore feasible and cost-effective ways to obtain such information, where possible using data from GPD providers and other VA sources. For example, VA could review ways to use the data from its own follow-up health assessments

and from GPD providers who collect follow-up information on the circumstances of veterans whom they have served.

Agency Comments and Our Evaluation

We provided a draft of this report to VA for review and comment. VA agreed with our findings and concurred with our recommendations and provided information on initiatives it has under way or planned that will address issues raised in our report as well as other challenges the GPD program faces.

VA concurred that there is an apparent lack of consistency in GPD program implementation and stressed its commitment to further enhance communications with VA liaisons and GPD providers, including providers whose operations are still in the developmental stage. For example, VA plans to develop a comprehensive GPD implementation plan that will address several operational issues, including training and certification requirements. As well, for the first time, the VA's Veterans Health Administration plans to host a conference or series of regional conferences for GPD providers and VA liaisons to review program requirements and expectations. VA estimates these conferences will take place in spring 2007.

VA also concurred with the need to better understand the circumstances of veterans after they leave the GPD program and stated that it has plans in place to address optional approaches for long-term study in this area after it completes an analysis of its longitudinal outcome studies of VA's homeless program. In the interim, VA said it would continue to explore options for using existing data to evaluate program effectiveness.

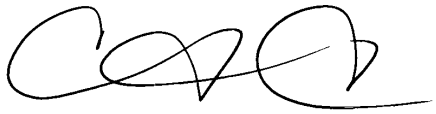
However, the agency disagreed with the statement in our draft report that VA officials attribute the decrease in the estimates of homeless veterans to VA's estimation process and better local data. VA believes that the recent decrease in the estimates is a direct result of its progress in treating these veterans through the GPD program.

Several factors may have contributed to the decrease in the estimates of homeless veterans. We did not intend to imply that the decrease was solely attributable to changes in VA's estimation process and better local data, nor did we intend to downplay VA's program successes. We have revised the language in this report accordingly.

VA's written comments appear in appendix V. VA also provided technical comments, which have been incorporated into the report as appropriate.

We are sending copies of this report to the Secretary of Veterans Affairs. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov. If you or your staff have any questions about this report, please contact me at (202) 512-7215 or chaplainc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.

Sincerely yours,



Cristina T. Chaplain
Acting Director
Education, Workforce, and Income Security Issues

Appendix I: Scope and Methodology

The objectives of this report were to review (1) Department of Veterans Affairs (VA) estimates of the total number of homeless veterans and the number of transitional beds available, (2) the extent of collaboration involved in the provision of Homeless Providers Grant and Per Diem (GPD) program and related services, and (3) VA's assessment of GPD program performance.

In conducting our review, we focused on the GPD providers that serve the general homeless veteran population rather than those serving veterans with special needs, although we visited some special needs grantees. We interviewed officials at VA headquarters, the GPD program office, the regional Veterans Integrated Service Networks, VA's Northeast Program Evaluation Center (NEPEC), and organizations knowledgeable about homeless veterans' issues, including the National Coalition for Homeless Veterans. To gain an initial understanding of the GPD program in operation, we spoke with staff and toured GPD facilities in Baltimore, Maryland; Denver, Colorado; and Washington, D.C. To develop greater in-depth material for this report, we made more extensive visits to 13 GPD providers that fall under the responsibility of VA's medical centers in Boston, Massachusetts; Los Angeles, California; Tampa, Florida; and Tomah and Madison, Wisconsin. We selected these GPD providers to obtain a range of geographic locations, size of programs, and proximity to VA medical centers. (See table 5 for a listing of sites we visited and their characteristics.) During our visits, we toured GPD facilities, interviewed GPD providers, medical center staff, community agencies that partner with the GPD providers, and current and former GPD program participants. Additionally, we interviewed staff but did not tour facilities of 16 other GPD providers in the areas we visited. We also met with GPD and other service providers at conferences sponsored by the Departments of Labor and Health and Human Services.

Table 5: Features of GPD Programs That GAO Visited

	Number of GPD beds	Fiscal Year '05 Admits	Fiscal Year '05 Discharges	Location Type[a]
Massachusetts—Boston, Fitchburg, Leominster				**Veterans Integrated Service Network 1**
New England Shelter for Homeless Veterans, Post-Detox Program (Boston)	30	149	137	urban
Veteran Hospice Homestead (Fitchburg)	12	19	21	rural
The Armistice Homestead[b] (Leominster)	15	NA	NA	rural
Florida—Tampa, Melbourne, Cocoa				**Veterans Integrated Service Network 8**
Agency for Community Treatment Services, (Tampa)	60	64	53	urban
Vietnam Veterans of Brevard (Melbourne)	19	70	53	urban
Volunteers of America—Florida (Cocoa)[c]	80	100	100	urban
Wisconsin—Tomah, Madison, Fort McCoy				**Veterans Integrated Service Network 12**
Veterans Assistance Foundation (Tomah)[d]	60	162	167	rural
Veterans Assistance Foundation, Step Up Program (Madison)	7	9	10	urban
Wisconsin Department of Veterans Affairs (Fort McCoy)	14	23	18	rural
California—Los Angeles				**Veterans Integrated Service Network 22**
P.A.T.H.[c]	10	28	23	urban
The Salvation Army, The Haven[d]	95	193	200	urban
Volunteers of America—LA[c]	102	106	98	urban
Weingart Center Association	100	107	113	urban

Source: GAO review of VA data.

[a]VA does not classify grantees as rural; however, we included this type of information for site selection purposes.

[b]The Armistice Homestead is part of a collaborative grant under Massachusetts Veterans Inc. The entire grant funds 43 beds, 15 of which are located at the Armistice. Specific admission and discharge data were not available for the Armistice program.

[c]Program also has funding for a service center.

[d]Program is located on VA medical center grounds.

Throughout our review, we worked with the VA's Office of Inspector General (OIG) to ensure that we complemented but did not duplicate a review it was conducting on GPD program management. The OIG's review was designed to determine if records demonstrate that (1) homeless veterans receive appropriate assessment and treatment, (2) GPD provider performance is evaluated and actions are taken to improve conditions, (3) GPD providers achieve their stated goals, (4) VA's guidelines for the inspection of GPD facilities are followed, (5) GPD operations are properly monitored by VA, and (6) fiscal controls are adequate. Although the OIG's report was not available at the time we prepared our report, we were

briefed on results that were relevant to our work and incorporated the information as appropriate. In addition, we discussed with the OIG's team our selection of sites to visit and chose sites that were not included in the team's review.

In reviewing VA estimates of the number of homeless veterans, we reviewed the literature, read relevant reports, and interviewed VA officials, particularly those involved in the federally mandated Community Homelessness Assessment, Local Education and Networking Group for Veterans (CHALENG). We interviewed experts in the subject area and officials with the Bureau of the Census and the Department of Housing and Urban Development (HUD). We used information from our site visits to supplement our discussion on how local entities conduct counts of homeless individuals. We did not review the validity of VA's estimates. To identify GPD program capacity, location, and number of admissions, we analyzed data from a series of annual reports prepared by NEPEC, updated where appropriate by information from the GPD program office in May 2006.

To assess the overall extent to which GPD providers collaborated with other agencies to offer services to homeless veterans, we analyzed NEPEC survey data. The survey included responses from all GPD providers in 2003, when NEPEC first conducted the survey, and all programs that became operational or were funded in subsequent years through November 2005. For more information on the survey data, see appendix III. We performed basic reasonableness tests on the survey data and contacted NEPEC for any clarifications or discrepancies. We determined these data to be sufficiently reliable for the purposes of this report. To get an understanding of how collaboration was actually occurring at the local level, we conducted site visits. During these visits we gathered information on the types of services GPD providers offer, how providers partnered with local agencies (including VA) to offer services, and how these partnerships were working. To review how VA coordinates with other federal agencies, we attended a meeting of VA's Advisory Committee on Homeless Veterans, talked with a representative from the Interagency Council on Homelessness, and contacted other prominent federal partners.

To identify how VA assesses the performance of the GPD program, we reviewed GPD program goals, interviewed VA officials, including a team with the OIG, and analyzed data obtained from VA's national program office and NEPEC. We reviewed the *Grant and Per Diem Program Evaluation Procedures Manual* that NEPEC sends to each VA liaison that

describes the responsibilities of liaisons and GPD providers in completing, reviewing, and submitting intake and discharge forms on individual participants. We extracted data on outcomes from tables included in NEPEC's series of annual reports on the program and discussed the reliability of these data with NEPEC officials. This information is briefly summarized in appendix IV along with relevant findings from the OIG's review. We did not independently verify the NEPEC data. We reviewed how VA collects and analyzes outcome data and found these data to be sufficiently reliable for our purposes. Additionally, we reviewed grant documents for the sites we visited to identify the specific objectives they set to meet program goals and asked VA officials and providers about various aspects of performance measurement during our site visits. We did not conduct our own review of outcomes for homeless veterans served by the GPD providers we visited.

At the time we conducted our analysis, VA's follow-up study had not been released; therefore, our discussion of the study is based on our review of preliminary results that identified the numbers and characteristics of the participants, the timetable and roles of the universities and researchers involved, and the housing outcomes at the end of the year. Conducted from 2001 through 2005, the study followed a total of 1,294 participants, with approximately 260 participants from each of five medical center areas serving California, the District of Columbia, Florida, Maryland, Ohio, Pennsylvania, and West Virginia. Veterans were randomly selected from lists of active participants that included recent admissions as well as participants with longer stays in the program. Participants were drawn from programs operated by 6 domiciliary care providers, 16 contracted residential treatment providers, and 19 GPD providers. The study had an overall response rate of 72 percent for all participants in the three transitional housing programs, with a response rate of 69 percent for the GPD participants, for the interviews conducted a year after they left the program. Of the 520 GPD participants studied, 359 were interviewed a year after leaving the program. Of those interviewed, 60 percent were in their own independent housing, 23 percent were sharing with friends or family, and 15 percent were in temporary housing, including shelters or in an institution other than a jail.

We conducted our work between August 2005 and July 2006 in accordance with generally accepted government auditing standards.

Appendix II: VA's Programs for Homeless Veterans Other than the GPD Program

Veterans Health Administration Programs for Homeless Veterans

Health Care for Homeless Veterans (HCHV) including Contracted Residential Treatment

Under the HCHV umbrella program, VA provides outreach, health and mental health assessments, treatment, and referrals for homeless veterans with mental health and substance abuse problems. Veterans with limited length of service or with other than a dishonorable discharge are eligible for the HCHV program but may not necessarily be eligible for VA health care, where the criteria are more restrictive. A veteran needing transitional housing while undergoing treatment may be placed in one of the approximately 300 contracted residential treatment beds that are funded from the budgets of individual medical centers. In fiscal year 2005, there were about 1,700 admissions for an average stay of 2 months at $36 per day; the recommended maximum stay is 6 months. Where contracted residential treatment is not available, veterans in need of transitional housing may be referred to the more widely available GPD program or domiciliary care. In fiscal year 2005, VA's HCHV program provided outreach, treatment, and referral services to about 61,000 homeless veterans, with obligations of about $40 million.

Homeless Domiciliary Residential Rehabilitation and Treatment Program

This transitional housing program is designed for homeless veterans who do not need hospital or nursing home services while their clinical status is being stabilized. In this program, veterans receive various services, including medical and mental health evaluations, treatment, and community support. Domiciliary programs are generally located on the grounds of VA medical centers, and unlike the GPD programs, they are usually managed and staffed by the local VA medical center. In fiscal year 2005 about 5,000 homeless veterans stayed an average of 4 months in this program. About 1,800 beds were available exclusively for homeless veterans, with obligations of about $58 million. Additional funding was awarded in 2005 to increase the number of beds available to about 2,200 in fiscal year 2007, bringing total obligations up to a projected $73 million.

Homeless Compensated Work Therapy/Transitional Residence

This work therapy program provides veterans with job skills and income. Through the program veterans produce items for sale or provide services such as temporary staffing to a company. While participating in this program, veterans may receive individual or group therapy and follow-up medical care on an outpatient basis. At some locations, program participants can stay in one of the about 500 beds available in transitional, community-based group homes. Veterans participating in this program are required to use a portion of their income from the work program to pay for rent, utilities, and food. Obligations for this program in fiscal year 2005 were about $10 million.

Loan Guarantee for Multifamily Transitional Housing

This transitional housing program provides guaranteed loans to nonprofit organizations to construct or rehabilitate multifamily transitional housing for homeless veterans, including single room occupancy units. Supportive services and counseling, including job counseling, must be provided with the goal of encouraging self-determination among participating veterans. Veterans must maintain sobriety, seek and maintain employment, and pay a fee in order to live in these transitional units. Not more than 15 loans with an aggregate total of $100 million may be guaranteed under this program. In fiscal year 2005, the Vietnam Veterans of San Diego housing project was under construction. Other programs have been conditionally selected and are expected to be approved in fiscal years 2006 and 2007. For information on the challenges encountered in implementing this initiative, see Related GAO Products for GAO's report on this program.

Housing and Urban Development-VA Supported Housing

This permanent, subsidized housing program provides HUD rental assistance (Section 8) vouchers for use by homeless veterans with chronic mental health or substance abuse disorders. Veterans are required to pay a portion of their income for rent; those without income receive fully subsidized housing. In general, veterans who do not exceed the maximum allowable income can remain in the housing permanently, but must agree to intensive case management services from VA staff and make a long-term commitment to treatment and rehabilitation. Local housing authorities control access to the vouchers. Many of the 1,780 vouchers allocated by HUD remain in use but no new vouchers have been made available. As a result, in fiscal year 2005, only 142 veterans were admitted to the program. VA's obligations in support of this program in fiscal year 2005 were about $3 million.

Veterans Benefits Administration Programs for Homeless Veterans

Veterans Benefits Administration Outreach

According to VA, in 20 of its 57 regional offices VA has designated full-time homeless veterans coordinators who work with HCHV and other VA staff to conduct joint outreach, provide counseling, and offer other services to homeless veterans, such as helping them apply for veterans benefits. In the remaining regions, staff may be assigned collateral responsibility to work with homeless veterans. One of the goals of this program is to expedite the processing of benefit claims made by homeless veterans. According to VA, in fiscal year 2005, VA received approximately 4,400 claims from homeless veterans. Of these claims, 56 percent were for disability compensation and 44 percent were for pensions. Of the compensation claims, 26 percent were granted, 33 percent denied, and 41 percent pending an average of about 4 months. Of the pension claims, 62 percent were granted, 18 percent denied, and 21 percent pending an average of about 3 months.

Acquired Property Sales for Homeless Providers

VA properties that are obtained through foreclosures on VA-insured mortgages are available for sale at below fair market value to nonprofit and public agencies that use the properties to shelter or house homeless veterans. Since the inception of this program, more than 200 properties have been sold or leased.

Labor-VA Incarcerated Veterans' Transition Program

Under this demonstration program, the Department of Labor (DOL) funds community agencies to provide training and support services, and VA contributes its services, to help veterans who are incarcerated and at risk of homelessness make a successful transition back into the workforce. According to DOL, services provided include career counseling, employment training, job-search and job-placement assistance, life-skills development, and follow-up. Local staff from both VA's Health Administration and Benefits Administration provide information about available VA benefits and services. Grantees must report the number of veterans who are still employed 6 months after job placement, whether they are in the same or similar jobs, and the reasons why veterans who were placed are no longer employed. DOL provided $2 million to seven community agencies in 2006 for this purpose.

Appendix III: Range of Services Offered by GPD Programs Nationwide

We analyzed NEPEC's Facility Survey data to identify the types of services that programs provide and how they are provided. NEPEC conducted the survey to capture information on the types of GPD programs funded. According to NEPEC officials, the survey was used to capture information such as program location, admissions criteria, services available, and licensing. Because the survey was not intended to be used as a tool to review how programs were performing, NEPEC does not conduct rigorous internal reviews of the data collected. We conducted basic reasonableness tests and contacted NEPEC for any clarifications or discrepancies. We found the survey data sufficiently reliable for the purposes of this report.

The survey was first deployed in 2003 to all agencies that were receiving funding that year. In subsequent years, NEPEC had newly funded agencies complete this onetime survey. A total of 281 transitional housing facilities were included in the survey data we analyzed—148 of the facilities were surveyed in 2003, 94 in 2004, and 39 in 2005. According to NEPEC, this represents all operational programs as of November 2005. While there were about 300 agencies with GPD grants, some of the agencies have multiple grants for one facility, resulting in one survey being completed for that facility. The surveys were completed by the VA liaisons in consultation with GPD provider staff. NEPEC officials were confident they have achieved a 100 percent response rate. While we did not independently verify the response rate for the survey, we concluded that it would be at least 90 percent.

Table 6 shows the percentage of facilities that reportedly provide the selected services and how the services were provided. Survey respondents were asked to identify how, if at all, services were provided and were directed to choose only one method. It may be the case, however, that as in some locations we visited, services were provided by more than one method. As can be seen, the majority of GPD programs provided a spectrum of services for veterans. However, these programs varied in how services were provided, with some services more likely to be provided through partnerships and others more likely to be provided in-house directly by staff. Some of the services that were more likely to be provided through partnerships include those that require counseling or medical-related treatment. Services primarily provided directly by GPD providers tended to be more related to case management type activities.

Table 6: Percentage of GPD Facilities Reporting They Provided Selected Services by Method

	How services were provided by programs			
Services (ordered by prevalence of service being offered)	**Indirectly through linkages[a]**	**Indirectly by staff[b]**	**Directly by staff[c]**	**Total percentage of facilities providing service**
Vocational/educational counseling	48.0	11.5	39.8	99.3
Discharge planning	8.2	2.5	88.6	99.3
Assistance with obtaining social services (e.g., Medicaid, Supplemental Security Income, Social Security Disability Insurance)	25.7	5.4	67.5	98.6
Case management services	10.0	3.2	85.4	98.6
Housing assistance	20.8	4.3	73.1	98.2
Assistance with spending money, banking or other financial matters	18.6	8.2	70.0	96.8
Transportation or assistance using public transportation	20.0	7.1	69.3	96.4
Relapse prevention groups	48.8	5.4	41.9	96.1
Comprehensive mental health assessment/diagnosis	70.4	8.6	16.8	95.7
Individual therapy	47.9	5.4	42.5	95.7
Referral to other transitional services	13.9	3.2	78.2	95.4
Comprehensive substance abuse assessment/diagnosis	47.7	8.6	38.7	95.0
Group therapy, not including relapse prevention	38.6	5.7	47.1	91.4
Aftercare counseling	48.2	5.4	37.5	91.1
AIDS screening and counseling	75.0	7.5	6.8	89.3
Nutritional counseling	54.6	11.4	23.2	89.3
Legal advice or counseling	76.1	3.9	5.7	85.7
Outcome follow-up (post discharge)	18.6	6.1	56.3	81.0
Family counseling	44.3	7.1	28.6	80.0
Religious or spiritual counseling	51.1	8.2	17.5	76.8
Domestic violence—family/partner violence services	63.2	4.3	8.2	75.7
Representative payee services[d]	51.4	3.6	8.6	63.6
Child care	17.1	3.2	1.8	22.1

Source: GAO analysis of NEPEC GPD program facility survey.

Note: Percentages were calculated for facilities that completed the survey question, either 279 or 280 facilities depending on the question.

[a]Indirectly through linkages means treatment is provided indirectly through links with other agencies, including VA.

[b]Indirectly by staff means treatment is provided indirectly by other staff of the organization.

[c]Directly by staff means treatment is provided directly by staff at this program.

[d]Representative payees handle an individual's benefits if the individual is unable to. The benefits must be used to meet the needs of the beneficiary.

Appendix IV: Participant Outcomes for the Grant and Per Diem Program

Outcomes are reported on a standard Northeast Program Evaluation Center discharge form that must be filled out by VA staff or by GPD staff with VA's review and sign-off when the participant leaves the program. The form also captures information on the length and cost of stay in the GPD, reasons the participant left the program, and any plans for follow-up treatment for substance abuse or other problems. NEPEC officials told us that they do not verify the data submitted to them, but they do perform tests for completeness and internal consistency. VA's Office of Inspector General (OIG) found that not all outcomes shown on the discharge forms were supported by additional information in the sample of case records that the OIG reviewed. For example, 76 percent of records included information supporting the veterans' outcomes indicated on the form, but about 24 percent of records lacked such support.

Outcomes for housing and income are shown as a percentage of all participants who left the program for any reason. However, outcomes for self-determination in terms of improved functioning are shown as a percentage of those veterans who had an identified problem when they entered the program. The determination that a participant has or has not improved may be considered somewhat subjective. The problems are described by participants themselves to VA staff in response to a series of questions on a standard NEPEC intake form that also includes a section for the VA clinical staff to record their observations of the substance abuse or mental health problems that the participants face. The intake form also captures other characteristics of the participants, such as their military, financial and living circumstances. VA staff are expected to complete these forms when they first contact homeless veterans but no later than the veterans' third day with a GPD provider and to forward the forms to NEPEC. NEPEC reports that it does not receive intake forms for about 10 percent of participants in the GPD program each year.

Table 7: Number Served by VA's Health Care for Homeless Veterans and Grant and Per Diem Program and Veterans' Outcomes, Fiscal years 2000 through 2005

Participants served and outcomes	Federal fiscal year (October through September of year shown)					
	2000	2001	2002	2003	2004	2005
Number of						
• veterans treated by VA's Health Care for Homeless Veterans' (HCHV) staff	43,082	57,854	61,123	60,970	63,283	61,261
• intake assessments of homeless veterans by HCHV staff[a]	34,206	46,862	44,296	42,380	42,485	41,111
• admissions of veterans to GPDs	4,841	10,137	11,913	12,396	13,509	16,597
• discharges from GPDs	4,020	8,706	11,098	11,467	12,454	15,403
Days a veteran stays at a GPD, on average	91	85	93	110	126	127
Housing stability outcomes:						
Number of discharges from GPDs with						
• independent housing	1,163	2,187	3,073	4,590	6,597	8,186
• placement in halfway house or institution such as hospital. nursing home, or domiciliary	991	2,162	2,731	2,882	3,127	4,003
Increased income or skills outcomes:						
Number of discharges from GPDs with						
• full-time or part-time employment	1,404	2,803	3,579	3,735	4,108	4,920
• VA benefits[b]	NA	NA	NA	2,100	2,701	3,751
• Other public benefits[b]	NA	NA	NA	2,064	2,309	2,916
Greater self-determination outcomes:						
Percentage of discharges from GPDs with						
• improved alcohol, drug, mental health[c]	38-42	42-49	43-50	56-62	60-67	62-69
• improved medical, social/vocational condition[c]	43-46	40-44	43-46	50-57	55-63	57-64
• success in program	30	32	38	43	49	50

Source: VA data.

[a]Intake assessments are completed by HCHV staff when they first encounter a homeless veteran, unless the contact is casual and no services are offered or referrals made. After a year, new assessments are required if VA care or services are provided and VA staff have not been working with the veteran.

[b]Numbers shown here include veterans who receive both types of benefits as well as those who receive only the designated benefits. For this reason, they differ from the numbers shown in table 3.

[c]Percentages are ranges showing the highest and lowest of each of two or three outcome measures.

Appendix V: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

August 25, 2006

Commemorating 75 Years of Service

Ms. Cristina Chaplain
Acting Director
Education, Workforce, and
Income Security Team
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Chaplain:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***HOMELESS VETERANS PROGRAMS: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program*** (GAO-06-859) and agrees with the findings and concurs with the recommendations. However, we disagree with the comment attributed to VA officials that VA's new estimation process and better local data are the reasons we are experiencing a decrease in the number of homeless veterans. VA believes the decrease is a direct result of our progress in treating these veterans through an effective needs-focused GPD health care program.

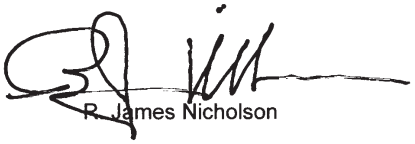
The Department is proud of the wide array of services that its GPD program provides to homeless veterans through our partnership with many community provider organizations. GAO's findings favorably highlight the accomplishments of this rapidly expanding program. Nevertheless, we recognize opportunities for improvement exist. The Veterans Health Administration (VHA) is pursuing initiatives that actually reach well beyond issues GAO raises. As GAO reports, VA has almost quadrupled the number of beds and admissions to the GPD program since fiscal 2000. Such explosive growth has resulted in significant challenges. Although program oversight by VA field facilities is crucial in ensuring program effectiveness at the local level, it is also apparent that there is a lack of consistency in implementation of the program, as well as in national oversight. These have contributed to program gaps that VA is currently addressing. The Acting Under Secretary for Health has directed the Deputy Chief Patient Care Services Officer for Mental Health to convene a special field advisory group to develop a comprehensive GPD implementation plan that will address such issues as functional responsibilities at all organizational levels, staff roles and responsibilities, training/certification requirements, data collection, and standardization of reporting and oversight, including uniform management controls. Because planning for this advisory group is still in the early

developmental stages, I am unable to provide established timeframes; however, we look forward to sharing progress with GAO in the coming months.

In addition, VHA is finalizing a statement of work for solicitation of an expert consultant to evaluate the current GPD program/process—especially as it relates to financial oversight. The solicitation will include a requirement for the development of alternative options for program management.

The enclosure details actions the Department has taken and has planned to implement GAO's recommendations. Technical corrections were passed separately. I appreciate the opportunity to comment on your draft report.

Sincerely yours,



R. James Nicholson

Enclosure

Enclosure

Department of Veterans Affairs (VA)
Comments on
Government Accountability Office (GAO) Draft Report,
HOMELESS VETERANS PROGRAMS: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program
(GAO-06-859)

To improve and evaluate the Grant Per Diem (GPD) program, GAO recommends that the Secretary of Veterans Affairs take the following two steps:

1. **to help ensure that GPD providers' understand the GPD policies and procedures, GAO recommends that VA take steps to help ensure its policies are understood by the staff and providers who are to implement them. For example, VA could make more information, such as issues discussed during conference calls, available in writing or online, hold an annual conference, or provide training that may also include local VA staff.**

Concur - During the past 9 months, the Veterans Health Administration's (VHA) GPD program office has conducted regional face-to-face training sessions for all newly hired and current liaison staff. These training sessions will continue to be scheduled for all new staff as they come onboard. The GPD program office has worked in close coordination with VA's Employee Education Service (EES) to design the training sessions, as well as an informative web-based training package that is widely accessed by both VA staff and GPD providers. The EES has also established a feedback mechanism whereby the liaison staff is contacted to determine the extent to which training tools are actually being implemented in practice.

Avenues of communication with GPD liaisons and providers will be enhanced further. A recently-appointed national clinical manager serves as a resource expert on issues regarding veteran care and program design, as well as technical determinations involving eligibility, length of stay, episodes of care, etc. This individual also facilitates the regularly scheduled monthly conference calls for GPD liaisons, network homeless coordinators, and providers and will be available for consultative site visits as required. In addition, the new clinical manager will conduct an annual assessment of problematic areas and initiate follow-up corrective actions as indicated.

All relevant policies and procedures related to the GPD program, including issues identified by GAO, are consolidated in the recently published VHA GPD Handbook (1162.01, March 2006). This easily accessed document is available

Enclosure

Department of Veterans Affairs (VA)
Comments on
Government Accountability Office (GAO) Draft Report,
HOMELESS VETERANS PROGRAMS: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program
(GAO-06-859)
(Continued)

on the GPD Intranet Web site. In addition, the GPD program office will soon provide a personal copy to each GPD liaison.

The GPD national program office is also actively pursuing more open lines of communication with operational grantees and with those grantees whose programs are still in the developmental stage. As noted, the new national clinical manager will serve as a liaison for these organizations. Monthly conference calls with the grantees are already routinely scheduled, and minutes of these meetings are distributed to the attendees as well as posted on the Intranet Web site. For the first time, VHA is also planning to host a post-award conference or series of regional conferences, possibly in the spring of 2007 for all FY 2006 grant awardees and their respective GPD liaisons. These face-to-face meetings will provide an opportunity to review program requirements and expectations and to gain valuable feedback from the providers about the status of project initiatives.

2. **To better understand the circumstances of veterans after they leave the GPD program, GAO recommends that VA explore feasible and cost-effective ways to obtain such information, where possible using data from GPD providers and other VA sources. For example, VA could review ways to use the data from its own follow-up health assessments and from GPD providers who collect follow-up information on the circumstances of veterans whom they have served.**

Concur - Plans are in place to address optional approaches for long-term study in this area. VA's first priority is to complete an analysis of the data already generated from the nine longitudinal outcome studies of VA's homeless programs that the Northeast Program Evaluation Center (NEPEC) has conducted. We anticipate having the initial analyses by the end of December 2006 from the four completed projects. At that time, more information will be available to make evidence-based decisions about future directions. In the interim, VA will continue to explore the feasibility, limits, and utility of using existing health care performance measures and quality indicators to evaluate program effectiveness.

2

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Cristina T. Chaplain, Acting Director, (202) 512-7215, chaplainc@gao.gov

Acknowledgments

Shelia Drake, Assistant Director; Patricia L. Elston; David Forgosh; and Nyree M. Ryder made significant contributions to this report. In addition, Roger Thomas provided legal assistance; Walter Vance and Lynn Milan analyzed and assessed the reliability of data; Lily Chin, Jonathan McMurray, and Charles Willson assisted in report development; and Amy Sheller supported the team during its Los Angeles site visit.

Related GAO Products

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