US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Facility Leaders' Oversight of Care Coordination Services Within Homeless Programs at the VA Portland Health Care System in Oregon

Healthcare Inspection | **25-04102-182** | **August 6, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection to evaluate allegations that a lack of leadership oversight contributed to staff not conducting care coordination services, as required, for veterans within select homeless programs at the VA Portland Health Care System (facility) in Oregon. Additionally, the complainant provided names of veterans enrolled in homeless programs with limited case management contacts, including two veterans who died. The OIG initiated the inspection on September 29, 2025, conducted a virtual site visit November 18–24, 2025, and reviewed documentation through April 2026.

Veterans Health Administration (VHA) homeless programs are the largest network of housing and rehabilitation services in the country.[1] At the facility, VHA homeless programs are aligned under Community Reintegration Services (CRS) and include Health Care for Homeless Veterans (HCHV), Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), and Grant and Per Diem (GPD) programs.[2] The facility's CRS director is responsible for the management and oversight of these programs and supervises CRS leaders, including the HCHV program coordinator and HUD-VASH supervisors, as well as GPD liaisons.

Health Care for Homeless Veterans

The HCHV program is often the first point of contact for veterans experiencing homelessness to access VA services.[3] According to the facility's *HCHV Case Management Workflow Guide,* HCHV case managers are responsible for contacting veterans in the program at least once per month.[4]

The OIG substantiated the HCHV program coordinator did not ensure that HCHV case managers contacted veterans once a month. After conducting an audit that revealed case managers had the capacity to increase contacts, the CRS director instructed the HCHV program coordinator to ensure the frequency of veteran contacts increased. The HCHV program coordinator reported instructing HCHV case managers to increase engagement but did not verify improvement.

The OIG reviewed the electronic health record (EHR) of a veteran (Veteran A) who died by suicide while enrolled in HCHV case management. The HCHV case manager did not contact Veteran A monthly as required; however, the OIG was unable to determine whether more

[1] VHA Directive 1501, *VHA Homeless Programs,* October 21, 2016.

[2] VA Portland Health Care System, Standard Operating Procedure 17, "CRS Walk-in Procedures," June 3, 2024.

[3] VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[4] Community Reintegration Services Workload Documentation, *Attachment A: HCHV Case Management Workflow Guide*, January 31, 2023.

frequent case management contacts would have changed Veteran A's outcome. During the OIG team's inspection, the facility's quality management team initiated a review of Veteran A's care.

During the inspection, the OIG identified a concern related to HCHV case managers not discharging veterans from the HCHV program once admitted into another CRS housing program in accordance with facility policy. This practice contributes to case managers carrying higher than necessary caseloads, which limits the time and resources for veterans in need of HCHV case management services. According to the facility's *HCHV Case Management Workflow Guide,* HCHV case managers must discharge veterans from case management when a veteran is admitted into another CRS housing program.[5]

Housing and Urban Development-Veterans Affairs Supportive Housing

The HUD-VASH program is a partnership between the US Department of Housing and Urban Development (HUD) and VA in which HUD provides rental assistance vouchers and VA provides case management services to veterans.[6] HUD-VASH case managers are required to assess the clinical needs of veterans at admission to the program, assign a case management stage based upon those needs, and conduct visits accordingly. Case management stages range from *intensive* (requiring a minimum of weekly home visits) to *preparation for discharge* (requiring contact every 90 days).[7]

The OIG did not substantiate that the CRS director and HUD-VASH supervisors' lack of oversight contributed to case managers not conducting veteran home visits or contacts at the required frequency. The CRS director explained that staffing shortages, leading to a group of veterans being admitted without an assigned case manager, contributed to a lack of case management visits. The OIG found that overall compliance improved from November 2024 through November 2025, following increased staffing levels and efforts by the CRS director to ensure case manager assignment earlier in the admissions process.

The OIG reviewed the EHR of a veteran (Veteran B) who was permanently housed through the HUD-VASH program in early spring 2025 and died in police custody in early summer 2025. Despite observing and being informed of Veteran B's deteriorating mental health, the HUD-VASH case manager missed opportunities to intervene. After the OIG initiated the inspection,

[5] Community Reintegration Services Workload Documentation, *Attachment A: HCHV Case Management Workflow Guide*.

[6] VHA Directive 1162.05(2), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program*, June 29, 2017, amended June 24, 2024; Department of Housing and Urban Development, 24 C.F.R. § 982 and 983 (2021).

[7] VHA Directive 1162.05(2).

the facility's patient safety and risk manager reported that a review of Veteran B's care was being conducted.

Grant and Per Diem

Through the GPD program, community-based organizations receive grants (grantee) to provide supportive services and transitional housing to veterans experiencing homelessness who want to transition to permanent housing.[8] VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program,* requires GPD liaisons to meet with veterans within 7 calendar days of admission and at least once every 90 days thereafter to confirm that the grantee is supporting veterans' permanent housing goals.[9]

The OIG substantiated the CRS director did not ensure GPD liaisons met with veterans as required by VHA policy.[10] The CRS director, who supervises GPD liaisons, reported being overburdened with administrative tasks and not having the capacity to provide sufficient oversight of GPD liaisons.

The OIG made five recommendations to the Facility Director related to improving compliance with requirements for contacting and discharging veterans, addressing findings from quality management reviews of care, and evaluating the CRS program reporting structure.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A and B). Based on information provided, the OIG considers recommendations 3 and 4 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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[8] VHA, "US Department of Veterans Affairs (VA) Grant and Per Diem (GPD) Program" (fact sheet), July 2022.
[9] VHA Directive 1162.01, VA Homeless Providers Grant and Per Diem Program, November 17, 2020.
[10] The complainant did not provide any examples of adverse outcomes for veterans in the GPD program.

Contents

Abbreviations

AI	artificial intelligence
CRS	Community Reintegration Services
EHR	electronic health record
GPD	Grant and Per Diem
HCHV	Health Care for Homeless Veterans
HUD	US Department of Housing and Urban Development
HUD-VASH	Housing and Urban Development-Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations related to leaders' oversight of care coordination services for veterans within select homeless programs at the VA Portland Health Care System (facility) in Oregon. The OIG initiated the inspection on September 29, 2025, conducted a virtual site visit November 18–24, 2025, and reviewed documentation through April 2026.

Background

The facility, part of Veterans Integrated Service Network (VISN) 20, includes the Portland VA Medical Center in Oregon and the Vancouver VA Medical Center in Washington, and 10 community-based outpatient clinics in surrounding locations.[1] The Veterans Health Administration (VHA) classifies the facility as a 1a, highest complexity facility.[2] The facility provides a range of healthcare services, including emergency care, mental health care, specialty medicine, and homeless services. According to a facility mental health data analyst, from October 1, 2024, to September 30, 2025, the facility's homeless programs served 4,376 unique veterans.

VHA Homeless Programs

VHA homeless programs are the largest network of housing and rehabilitation services in the country.[3] These programs seek to ensure that veterans who are experiencing homelessness or are at-risk of homelessness have access to care and services that support their ability to obtain and maintain permanent housing.[4] VHA homeless programs provide services such as case management, employment resources, housing assistance, and medical and mental health care.[5]

At the facility, VHA homeless programs are aligned under Community Reintegration Services (CRS) and include, but are not limited to, Health Care for Homeless Veterans (HCHV), Housing

[1] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[2] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions VHA Facility Complexity Model," October 1, 2023. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, administrative complexity, and education and research. The model rates facilities as 1a, 1b, 1c, 2, or 3, with facilities rated as 1a being the most complex and those rated as 3 the least complex.

[3] VHA Directive 1501, *VHA Homeless Programs,* October 21, 2016.

[4] VHA Directive 1501.

[5] VHA Directive 1501.

and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), and Grant and Per Diem (GPD) programs.[6] The CRS director is responsible for the management and oversight of these programs.

Allegations and Concern

In July 2025, the OIG received allegations that CRS leaders' lack of effective oversight of Health Care for Homeless Veterans (HCHV), Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), and Grant and Per Diem (GPD) programs contributed to staff not contacting or visiting veterans in accordance with policy. The complainant provided the names of 69 veterans enrolled in CRS programs with limited case management contacts, including two veterans who died. The OIG initiated this healthcare inspection to evaluate the allegations and review the case management services provided to the two veterans who died.

During the inspection, the OIG identified an additional concern related to HCHV case managers not discharging veterans from the HCHV program in accordance with facility policy.[7]

Scope and Methodology

The OIG initiated the inspection on September 29, began virtual interviews on October 2, and conducted a virtual site visit November 18–24, 2025. The OIG interviewed the VISN 20 Network Homeless Coordinator; the Facility Director and Chief of Staff, facility mental health and quality management service chiefs, a quality management staff member, CRS leaders, and CRS front-line case managers. The OIG reviewed relevant VHA and facility policies and procedures, quality management reviews, patient safety reports, an issue brief, a mortality review, organizational charts, veteran electronic health records (EHRs), facility homeless data, and facility communications.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[8] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, and physical observations. After using this artificial intelligence (AI) tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The OHI

[6] VA Portland Health Care System, Standard Operating Procedure 17, "CRS Walk-In Procedures," June 3, 2024.

[7] Community Reintegration Services Workload Documentation, *Attachment A: HCHV Case Management Workflow Guide*, January 31, 2023.

[8] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "*Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*"[9]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence shows it is more likely than not that the event or action occurred. Conversely, the OIG does not substantiate an allegation when the available evidence shows it is more likely than not that the event or action did not occur. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

1. Health Care for Homeless Veterans

The Health Care for Homeless Veterans (HCHV) program is often the first point of contact for veterans experiencing homelessness to access VA services.[10] HCHV staff conduct outreach to veterans not receiving VA services and initiate case management services for those who are eligible.[11] Effective case management involves regular engagement between the case manager and the veteran.[12] HCHV case management involves assisting the veteran with securing appropriate housing while ensuring needs are met.[13] Additionally, HCHV staff may refer

[9] Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-21-21: § 4(a), April 3, 2025.

[10] VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[11] VHA Directive 1162.08.

[12] National Association of Social Workers, *NASW Standards for Social Work Case Management*, 2013.

[13] VHA Directive 1162.08.

veterans to community resources or other VA housing programs, including Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) and Grant and Per Diem (GPD).[14]

VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services,* states the HCHV program coordinator is responsible for providing oversight of the program and of case management services.[15] According to the facility's functional statement, the Community Reintegration Services (CRS) director is responsible for the direct supervision of the HCHV program coordinator.

Case Management Contacts

The OIG substantiated the HCHV program coordinator did not ensure that HCHV case managers complied with facility policy related to contacting veterans once a month.

According to the facility's *HCHV Case Management Workflow Guide,* HCHV case managers are responsible for contacting veterans in the program a minimum of once per month "to assess application readiness, continued interest in subsidized housing programs, and support other client-centered treatment goals."[16] The facility's functional statement requires the HCHV program coordinator to monitor the frequency of contacts to ensure "Veterans are not lost to care nor presented with barriers to accessing housing resources."

The OIG reviewed the EHRs of 15 veterans enrolled in the HCHV program who were identified by the complainant and found that, during fiscal year 2025, none were consistently contacted monthly by the designated HCHV case manager as required; periods without documented contacts ranged from 2 to 12 months.[17]

During OIG interviews, the CRS director and HCHV program coordinator identified several factors contributing to HCHV case managers not meeting contact requirements. HCHV case managers are responsible for providing case management to all veterans referred for, and awaiting, HUD-VASH admission. According to the CRS director, staffing shortages within the HUD-VASH program delayed veteran admissions, which increased HCHV caseloads and limited HCHV case managers' ability to complete all required contacts.

Additionally, the HCHV program coordinator noted that homeless veterans are often difficult to reach due to limited access to telephones or other communication methods. Because of these

[14] VA Portland Health Care System, Standard Operating Procedure 17, "CRS Walk-in Procedures."

[15] VHA Directive 1162.08.

[16] Community Reintegration Services Workload Documentation, *Attachment A: HCHV Case Management Workflow Guide.*

[17] Fiscal years for federal agencies include an annual period of October 1 of one calendar year through September 30 of the following year. "Common Budgetary Terms Explained," Congressional Budget Office, December 2021, accessed February 17, 2026, https://www.cbo.gov/publication/57660.

challenges, the HCHV program coordinator reported permitting HCHV case managers to count contacts made by community partners (third-party contacts) as meeting the monthly contact requirement, which deviated from facility policy contact requirements. The HCHV program coordinator told the OIG of expecting that HCHV case managers document the veteran's engagement with third-party contacts in the EHR; however, the OIG found that HCHV case managers did not document these interactions and thus could not verify the involvement of third-party contacts.

In an interview with the OIG, the CRS director reported awareness of HCHV case managers using third-party contacts and voiced concerns that HCHV case managers were not documenting the third-party contacts as expected. The CRS director reportedly met with the HCHV program manager to discuss documentation concerns and the need to take action. The CRS Director stated documentation concerns continued but noted there had been "some improvement."

In June 2025, the CRS director emailed the HCHV program coordinator noting that an audit revealed HCHV case managers had the capacity to increase the frequency of contacts and requested the HCHV program coordinator ensure this occurred. The CRS director sent a follow-up email in August, which noted that veteran contacts had not improved and reiterated the need for increasing the frequency of contacts.

When asked what actions were taken to address the CRS director's requests, the HCHV program coordinator reported asking HCHV case managers to review their caseloads for veterans in need of additional contact and increase engagement. The OIG reviewed a document that showed in August, the HCHV program coordinator informed the CRS Director that HCHV case managers reported increasing contacts; however, the HCHV program coordinator did not verify improvement was made.

The OIG concluded that the HCHV program coordinator did not ensure HCHV case managers completed monthly contacts with veterans as required, which may limit veterans' achievement of housing and treatment goals.

Veteran Care Summary

Veteran A, in their 50s with depression and severe alcohol dependence, was admitted to HCHV case management in early 2024. During intake, the assigned HCHV case manager referred Veteran A to the GPD and HUD-VASH programs to address Veteran A's goal of securing permanent housing. In early spring 2024, the assigned HCHV case manager made one attempted contact and one successful contact with Veteran A. During that contact, the HCHV case manager completed a referral to a CRS mental health provider, and Veteran A engaged in mental health services that same month. The next month, Veteran A declined admission to the GPD program and chose to reside at a community shelter where Veteran A remained for the duration of enrollment in HCHV case management.

> *In mid-summer 2024, Veteran A presented to the emergency department for suicidal ideation, which resulted in an inpatient hospitalization. Following this hospitalization, Veteran A continued receiving ongoing mental health services, which included psychotherapy, medication management, substance use disorder treatment, and vocational rehabilitation. In early 2025, Veteran A presented to the emergency department with suicidal ideation and alcohol intoxication. After an evaluation, Veteran A was assessed to be at low acute risk for suicide and discharged without inpatient hospitalization. In mid-spring 2025, Veteran A met with a CRS mental health nurse practitioner and was assessed to be at low acute risk of suicide. Less than a week later, Veteran A died by suicide.*

The OIG learned that although Veteran A was enrolled in HCHV case management, the HCHV case manager did not attempt to contact Veteran A from mid-spring 2024 to mid-spring 2025, which included periods in which Veteran A experienced suicidal ideation. According to VHA Directive 1501, *VHA Homeless Programs*, case management includes "ongoing support and monitoring due to complex … mental health, or psychosocial factors …" with continuous planning and coordination of care to meet treatment goals.[18]

When asked about the frequency of contacts, the HCHV case manager stated that when caseloads increased significantly, the HCHV program coordinator allowed case managers to contact a veteran less frequently if the veteran was engaged with other CRS staff or community partners. The HCHV case manager described Veteran A as "very resourceful," and reported completing chart reviews that indicated progress toward treatment goals. The HCHV case manager acknowledged, however, that Veteran A's hospitalization and suicidal ideation should have prompted increased case management contact but noted Veteran A was meeting regularly with mental health staff and described case management as a collaborative effort across CRS programs and staff. When asked by the OIG to review Veteran A's EHR, the Chief of Staff, mental health clinical director, CRS director, and HCHV program coordinator voiced concerns regarding the lack of HCHV case management contacts and documentation.

As Veteran A was engaged in ongoing mental health services while enrolled in the HCHV program, the OIG was unable to determine whether more frequent contact from the HCHV case manager would have altered Veteran A's outcome. However, the lack of HCHV case management contacts represented missed opportunities to provide additional support, address other psychosocial needs, and advance progress toward permanent housing goals. Following the OIG team's site visit, the quality management team initiated a second quality management review to assess Veteran A's care.

[18] VHA Directive 1501.

Program Discharge

The OIG determined the HCHV program coordinator did not provide the necessary oversight to ensure HCHV case managers complied with facility policy related to discharging veterans who were admitted into other CRS housing programs.

The facility's *HCHV Case Management Workflow Guide* indicates that HCHV case managers must discharge veterans from HCHV case management when a veteran is admitted into another CRS housing program.[19]

The OIG learned through the CRS director's email correspondence that HCHV case managers did not consistently discharge veterans enrolled in other CRS programs (dual enrollment). This practice contributes to staff carrying higher than necessary caseloads, which limits case managers' time and resources for veterans in need of HCHV case management services.

During an OIG interview, the CRS director expressed concern that not discharging veterans in accordance with policy could lead to inflated HCHV caseloads. The CRS director reported having multiple discussions with the HCHV program coordinator about the need to discharge dually enrolled veterans from the HCHV program and instructed the HCHV program coordinator to "monitor and manage this expectation." Email correspondence reviewed by the OIG showed that in June and August 2025, the CRS director informed the HCHV program coordinator of the expectation to regularly review HCHV caseloads and discharge veterans according to facility policy.

The HCHV program coordinator told the OIG of reinforcing the need for staff to discharge veterans who were dually enrolled in other CRS programs.[20] The HCHV program coordinator did not verify compliance and did not know whether adherence improved. In February 2026, the CRS director reported that HCHV case managers' compliance with facility discharge requirements had not sufficiently improved.

2. Housing and Urban Development-Veterans Affairs Supportive Housing

The Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program is a partnership between the US Department of Housing and Urban Development (HUD) and VA in which HUD provides rental assistance vouchers and VA provides case management services to veterans.[21] Veterans who qualify must be experiencing homelessness

[19] Housing programs include HUD-VASH, GPD, or HCHV permanent housing. Community Reintegration Services Workload Documentation, *Attachment A: HCHV Case Management Workflow Guide*.

[20] The HCHV program coordinator was unable to recall specific incidents or dates of becoming aware.

[21] VHA Directive 1162.05(2), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program,* June 29, 2017, amended June 24, 2024; Department of Housing and Urban Development, 24 C.F.R. § 982 and 983 (2021).

and need case management services to support their ability to obtain and maintain housing. Veterans with substance use disorders, severe mental illness, or chronic medical illness are targeted for program admission.[22]

Case Management Visits

The OIG did not substantiate that the Community Reintegration Services (CRS) director and HUD-VASH supervisors' lack of oversight contributed to case managers not conducting veteran home visits or contacts (visits) at the required frequency. The CRS director explained the extenuating circumstances that contributed to a lack of case management visits. The OIG found the CRS director implemented actions that improved overall compliance.

VHA Directive 1162.05(2), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program*, notes that HUD-VASH program coordinators (HUD-VASH supervisors) are responsible for program oversight activities, including monitoring the frequency of clinical contacts.[23] HUD-VASH case managers assist veterans in navigating the process to apply for and obtain a rental assistance voucher and search for and secure housing. HUD-VASH case managers are required to assess the clinical needs of veterans at admission, assign a case management stage based upon those needs, and conduct visits at the frequency required by the designated stage. The four stages of case management are *intensive* (requiring weekly home visits), *stabilization* (requiring bi-weekly home visits), *maintenance* (requiring monthly home visits), and *preparation for discharge* (requiring contact every 90 days in the veteran's home, community, or at the facility).[24]

VHA developed a tool, the HUD-VASH Case Management Report (case management report), that provides data related to the fidelity of care received by veterans enrolled in the program. This report allows facilities to track compliance with various care elements, including the percentage of veterans who, based on their designated case management stage, are overdue for a visit. The OIG reviewed the November 2024 case management report provided by the facility and found that 46 percent of enrolled veterans were overdue for a visit; comparatively, the national average was 30 percent. Additionally, the OIG conducted EHR reviews and found that 11 of the 12 veterans enrolled in the HUD-VASH program (identified by the complainant) were not visited by their HUD-VASH case manager at the required frequency during fiscal year 2025.

The CRS director attributed a high percentage of the overdue visits to a group of veterans referred to the HUD-VASH program after they became at-risk for homelessness when funding for these veterans' community resource-supported housing was coming to an end. Due to HUD-VASH staffing shortages and a high number of available housing vouchers, the CRS director

[22] VHA Directive 1162.05(2).
[23] VHA Directive 1162.05(2).
[24] VHA Directive 1162.05(2).

allowed veterans to be admitted to the program without an assigned HUD-VASH case manager, with community resource staff providing supportive services in the interim. As HUD-VASH staffing levels improved, these veterans were assigned case managers but were reportedly reluctant to engage; the CRS director and HUD-VASH supervisors attributed the veterans' hesitancy to limited program orientation at admission and delayed case management assignment. Further, the CRS director explained that some of the veterans had limited case management needs.

In response to these challenges, the CRS director reported ensuring that veterans referred by community resource staff are assigned HUD-VASH case managers earlier to better inform the veterans of program requirements, including the provision of case management. Additionally, the CRS director reported ensuring veterans meet program criteria, including needing the support of case management to obtain and maintain housing, prior to admission.

Through email correspondence with the OIG, HUD-VASH supervisors reported monitoring staff's compliance by regularly reviewing case management reports, conducting chart audits, and addressing concerns with staff when identifying noncompliance. The OIG reviewed the facility's case management reports provided from November 2024 through November 2025 and noted an overall increase in compliance through 2025. As of November 2025, the facility's percentage of veterans overdue for a visit had decreased from 46 percent to 28 percent, which was within 4 percent of the national average of 24 percent.[25]

Although the CRS director allowed veterans to be admitted without an assigned HUD-VASH case manager, the OIG recognized that the alternative may have resulted in these veterans becoming homeless. The OIG concluded that when staffing levels improved, the CRS director and HUD-VASH supervisors took a series of actions that improved HUD-VASH case managers' compliance with completing visits.

Veteran Care Summary

Veteran B was a veteran in their 50s with a history of schizophrenia and polysubstance use and was ineligible for VA care aside from HUD-VASH.[26] Prior

[25] The OIG also noted that by the end of fiscal year 2025, the facility led the VISN with the highest percentage of veterans permanently housed through the HUD-VASH program.

[26] Merck & Co., *MSD Manual Professional Version,* "Schizophrenia," accessed January 27, 2026, https://www.msdmanuals.com/professional/psychiatric-disorders/schizophrenia-and-related-disorders/schizophrenia?query=schizophrenia. The MSD manual describes individuals with schizophrenia as being out of touch with reality, experiencing hallucinations, delusions, disorganized speech, and motor function. Disorganized characteristics of schizophrenia refers to disorganized thought patterns resulting in rambling, non-sensical speech that may be mildly difficult to understand to unintelligible as well as improper behavior and self-care; Cleveland Clinic, "polysubstance use disorder," accessed January 27, 2026, https://my.clevelandclinic.org/health/diseases/polysubstance-abuse. Cleveland Clinic defines polysubstance use disorder as taking multiple drugs or substances at the same time or within a short window of time and becoming dependent on the drugs or substances in a manner that disrupts one's quality of life and functioning.

to obtaining housing through HUD-VASH, Veteran B was enrolled in HCHV case management, and the HCHV social worker coordinated a community mental health appointment that included medication management. Following this appointment, the HCHV social worker noted that Veteran B had improved speech and thought content.

After a HUD-VASH treatment team meeting, a HUD-VASH supervisor documented that Veteran B's plan of care included receiving intensive case management (weekly visits) and being supported in accessing health care in the community. In early spring 2025 (week one), Veteran B secured permanent housing and began receiving HUD-VASH case management services. Over the next eight weeks, the assigned HUD-VASH case manager made seven attempted home visits, completing one visit in week three. The case manager assessed Veteran B as having incomprehensible speech and disorganized behavior consistent with schizophrenia and psychosis, left contact information for the community mobile mental health unit with Veteran B, and decreased the stage of case management from intensive (weekly visits) to stabilization (bi-weekly visits).

The case manager documented that during two subsequent attempted home visits in weeks five and eight, Veteran B appeared to be home, did not respond, and in one instance was heard through the door to be mumbling "disorganized speech with incoherent, illogical word combinations." A few days later, property management staff informed the case manager that Veteran B was exhibiting bizarre behavior, experiencing visual hallucinations, and had concerns that the veteran was struggling with mental health or substance abuse. The case manager recommended that property management staff contact emergency response services if Veteran B's behavior escalated. Approximately two weeks later , in early summer 2025, property management staff called the police due to Veteran B's concerning behavior. Veteran B later died in police custody from cardiac arrest after being restrained face down, with methamphetamine intoxication as a contributing factor.

The OIG found the HUD-VASH case manager missed opportunities to address Veteran B's deteriorating mental health status, despite observing and receiving reports of concerning behavior from property management staff. Additionally, the OIG found that the case manager erroneously lowered Veteran B's designated stage of case management and missed opportunities to coordinate care. According to VHA Directive 1162.05(2), the HUD-VASH case management team is responsible for addressing physical and mental health concerns that may interfere with

maintaining housing stability and facilitating access to treatment with VA and non-VA providers.[27]

The case manager told the OIG that services provided were limited due to Veteran B's lack of engagement and that addressing Veteran B's mental health was a top priority when Veteran B engaged. However, the OIG found that during the home visit completed in week 3, the case manager missed an opportunity to coordinate services with Veteran B's community mental health provider, despite signs of active psychosis. When asked why the case manager did not consider options such as contacting the mobile mental health crisis unit to address Veteran B's concerning mental health status, the case manager stated, "… maybe that was the wrong judgment call at that time." Further, the case manager acknowledged that Veteran B's stage of case management should have remained as *intensive* and attributed changing the designated stage of case management from *intensive* to *stabilization* to a documentation error.

When asked by the OIG to review Veteran B's EHR, the Chief of Staff noted that the case manager should have contacted the mobile mental health crisis unit and attempted to coordinate care with Veteran B's community mental health provider. Additionally, the CRS director indicated that the case manager also missed an opportunity to work collaboratively with the prior HCHV case manager, who reportedly had an established relationship with Veteran B.

Following the patient's death, the facility generated an issue brief, which included a plan to "debrief the clinical interventions leading up to the crisis."[28] According to the CRS director, the purpose of the debrief was to identify missed opportunities and areas for improvement. During an interview with the OIG, the HUD-VASH case manager's supervisor reported reviewing the care provided to Veteran B, identifying opportunities for improvement, and providing feedback to the HUD-VASH case manager. After the OIG's site visit, the facility's patient safety and risk manager reported that a quality management review of Veteran B's care to identify opportunities for improvement was being conducted.

3. Grant and Per Diem

The OIG substantiated the Community Reintegration Services (CRS) director did not provide the necessary oversight to ensure GPD liaisons complied with VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program,* related to meeting with veterans (contacts).[29]

[27] VHA Directive 1162.05(2).

[28] Issue briefs are "reports created within VHA that are used to document situations, events, and/or problems that may impact VHA's ability to provide high quality care and services to Veterans." "Guide to VHA Issue Briefs," VHA Enterprise Issue Reporting System, accessed March 2, 2026, https://vssc.med.va.gov/EIRS/Documents/GuideToIssueBriefs.pdf. (This site is not publicly accessible.)

[29] VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, November 17, 2020. The complainant did not provide any examples of adverse outcomes for veterans in the GPD program.

Through the GPD program, community-based organizations are awarded grants to provide supportive services and transitional housing to veterans experiencing homelessness who desire to transition to permanent housing upon exiting the program.[30] The community organization in receipt of GPD funding (grantee) is responsible for the care and providing supportive services to the veteran. The facility's GPD liaison provides clinical oversight of veterans' care to ensure continuity of services and facilitate referrals and case management when necessary.[31]

VHA Directive 1162.01 requires GPD liaisons to meet with veterans within 7 calendar days of admission and at least once every 90 days thereafter to confirm that the grantee is supporting veterans' permanent housing goals.[32] According to the CRS director's functional statement, the CRS director is responsible for monitoring "staff compliance with practices, standards, and guidelines." Additionally, the CRS director is responsible for the direct supervision of GPD liaisons.

The OIG reviewed the EHRs of 42 veterans enrolled in the GPD program who were identified by the complainant and found that, during fiscal year 2025, 38 veterans were not regularly contacted at 90-day intervals by their designated GPD liaison as required; periods without documented contacts ranged from over 3 months to 12 months. Additionally, 32 of 33 veterans admitted during fiscal year 2025 had no documented contact with their designated GPD liaison within 7 calendar days after admission.

Through interviews and email correspondence with the OIG, the GPD liaisons provided reasons for noncompliance with veteran contacts, including a lack of awareness of visit requirements, competing workload demands, and conflicting liaison and veteran work schedules.

During an OIG interview, the CRS director reported trusting that GPD liaisons were meeting with veterans as required, conducting chart audits twice a year, and providing feedback to the GPD liaison if noncompliance was identified. The CRS director told the OIG that completing audits twice per year was not sufficient and acknowledged the need to monitor GPD liaisons more closely.[33] The CRS director reported being overburdened with other administrative tasks, not having the capacity to conduct chart audits more frequently, and needing more resources, such as additional CRS managers. In addition to supervising the CRS leadership team, which consists of 9 supervisors over four programs, the CRS director also directly supervises

[30] VHA, "US Department of Veterans Affairs (VA) Grant and Per Diem (GPD) Program" (fact sheet), July 2022.

[31] VHA Directive 1162.01. The directive further states "when necessary" refers to on a case-by-case basis, when there is a gap in services, as requested by the veteran or the grantee, and when deemed necessary by the GPD liaison during the admission screening. Supportive services include food, health care, mental health and substance abuse treatment, and assistance with obtaining permanent housing; 38 C.F.R. § pt. 61 (2026)

[32] VHA Directive 1162.01. The grantee is a community organization in receipt of GPD funding.

[33] After the OIG interview, the CRS director emailed the GPD liaisons in December 2025 with guidance reiterating the required frequency of contacts and reportedly provided a tool for GPD liaisons to track contacts with their assigned veterans.

10 additional staff and two additional programs.[34] The CRS director reported escalating workload concerns resulting from the current CRS reporting structure to the mental health clinical director. When interviewed, the mental health clinical director expressed an understanding of the workload challenges and acknowledged that the CRS director could benefit from having fewer direct reports.

The OIG concluded that competing workload demands contributed to the CRS director not ensuring GPD liaisons completed the required contacts. Lack of contact prevents GPD liaisons from verifying grantees are meeting the needs of the veteran and assisting the veteran with the goal of obtaining permanent housing.

Conclusion

The Health Care for Homeless Veterans (HCHV) program coordinator did not provide the necessary oversight to ensure HCHV case managers complied with facility policy related to contacting veterans once a month. HCHV case managers not complying with the monthly contact requirement may limit veterans' achievement of housing and treatment goals. The OIG reviewed the electronic health record (EHR) of a veteran (Veteran A) who died while enrolled in HCHV case management and determined that Veteran A was not contacted monthly by the assigned HCHV case manager as required; however, the OIG was unable to determine whether more frequent contacts from the HCHV case manager would have changed Veteran A's outcome. The lack of contacts represented missed opportunities to provide additional support, address other psychosocial needs, and advance progress toward permanent housing goals.

The HCHV program coordinator also did not provide the necessary oversight to ensure HCHV case managers complied with facility policy related to discharging veterans who were admitted into other Community Reintegration Services (CRS) housing programs. Not adhering to discharge criteria contributes to staff carrying higher than necessary caseloads, limiting the time and resources for veterans in need of HCHV case management services.

The CRS director explained extenuating circumstances that contributed to the lack of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) case management visits. The OIG found the CRS director and supervisors implemented actions that improved overall compliance. The OIG reviewed the EHR of a veteran (Veteran B) who died while enrolled in the HUD-VASH program and determined that the HUD-VASH case manager missed opportunities to address Veteran B's deteriorating mental health status, erroneously lowered Veteran B's designated stage of case management, and missed opportunities to coordinate care.

[34] The CRS director's oversight includes the HCHV, HUD-VASH, and GPD programs. Additionally, the CRS director provides direct supervision to the HCHV program coordinator, HUD-VASH supervisors, and GPD liaisons.

The facility's quality management team initiated quality management reviews to assess the care provided to Veteran A and Veteran B and identify opportunities for improvement.

The CRS director did not provide the necessary oversight to ensure Grant and Per Diem (GPD) liaisons complied with VHA policy related to meeting with veterans. Lack of contact prevents GPD liaisons from verifying grantees are meeting the needs of the veteran and assisting the veteran with the goal of obtaining permanent housing.

The OIG made five recommendations to the Facility Director. The Facility Director concurred with the recommendations and shared plans and actions taken to improve compliance with requirements for contacting and discharging veterans, review Veteran A's and Veteran B's care, and evaluate the CRS program reporting structure.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–5

1. The VA Portland Health Care System Director ensures the Community Reintegration Services director and Health Care for Homeless Veterans program coordinator establish a process to monitor and verify case managers comply with monthly veteran contacts as required by the facility's *HCHV Case Management Workflow Guide*, and takes action as warranted.

2. The VA Portland Health Care System Director ensures Health Care for Homeless Veterans staff discharge veterans from the Health Care for Homeless Veterans program in accordance with the facility's *HCHV Case Management Workflow Guide*.

3. The VA Portland Health Care System Director reviews the quality management evaluations, once completed, for Veteran A's and Veteran B's care, and takes action as warranted.

4. The VA Portland Health Care System Director evaluates the Community Reintegration Services reporting structure and resources to determine if the current structure allows for effective oversight of essential homeless programs, and makes modifications if needed.

5. The VA Portland Health Care System Director ensures the Community Reintegration Services director monitors and verifies Grant and Per Diem liaisons' compliance with Veterans Health Administration Directive 1162.01 requirements related to conducting veteran contacts.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 2, 2026

From: Director, Department of Veterans Affairs (VA) Northwest Health Network (10N20)

Subj: VA Office of Inspector General (OIG) Report, Review of Facility Leaders' Oversight of Care Coordination Services Within Homeless Programs at the VA Portland Health Care System in Oregon (VIEWS # 14858828)

To: Director, Office of Healthcare Inspections (54HL03)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.

2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)
Teresa D. Boyd, DO

[OIG comment: The OIG received the above memorandum from VHA on July 9, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 2, 2026

From: Director, Department of Veterans Affairs (VA) Portland Health Care System (648)

Subj: VA Office of Inspector General (OIG) Report, Review of Facility Leaders' Oversight of Care Coordination Services Within Homeless Programs at the VA Portland Health Care System in Oregon (VIEWS # 14858828)

To: Director, VA Northwest Health Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Healthcare Inspection - Review of Facility Leaders' Oversight of Care Coordination Services Within Homeless Programs at the VA Portland Health Care System in Oregon.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)
Karla M. Azcuy

[OIG comment: The OIG received the above memorandum from VHA on July 9, 2026.]

Facility Director Response

Recommendation 1

The VA Portland Health Care System Director ensures the Community Reintegration Services director and Health Care for Homeless Veterans program coordinator establish a process to monitor and verify case managers comply with monthly veteran contacts as required by the facility's *HCHV Case Management Workflow Guide*, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: October 2026

Director Comments

The VA Portland Health Care System has implemented the following process to monitor and verify case manager compliance with monthly veteran contacts as required by the HCHV Case Management Workflow Guide.

On May 28, 2026, the Health Care for Homeless Veterans (HCHV) Program Coordinator reiterated to HCHV staff the requirements of the HCHV Case Management Workflow Guide. Additionally, HCHV staff were oriented to, and instructed to use a central tracking tool that flags Veterans nearing 30 days without contact.

Beginning in June 2026, the HCHV Program Coordinator will monitor the tracking tool regularly and reconcile it with the VA Homeless Operations Management and Evaluation System (HOMES) census to ensure staff are utilizing the tool as expected. The HCHV Program Coordinator will verify that all Veterans to whom the directive applies are being contacted, at minimum, every 30 days. Additionally, to validate the accuracy of the contacts recorded in the tracking tool, the HCHV Program Coordinator will conduct monthly audits of HCHV staff members by reviewing a selection of their assigned Veterans' health records.

If the HCHV Program Coordinator identifies noncompliance or inconsistencies between the tracking tool and the electronic health record, the HCHV Program Coordinator will address these directly with the responsible staff member and will provide training, clarify expectations, or pursue appropriate personnel action.

Quarterly, the Community Reintegration Services (CRS) Director will review performance with the HCHV Program Coordinator to ensure that staff are consistently meeting requirements. These reviews will include an examination of evidence of the HCHV Program Coordinator's monthly monitoring and verification activities and a review of the VA HOMES census.

The CRS Director will provide a written report of compliance data to the Mental Health Executives, monthly, until 90% or greater compliance has been sustained for three consecutive months. The CRS Director will then issue a closure memo to the Mental Health Executives. The denominator will be the total number of Veterans requiring contact that month and the numerator will be the total number of Veterans contacted.

Recommendation 2

The VA Portland Health Care System Director ensures Health Care for Homeless Veterans staff discharge veterans from the Health Care for Homeless Veterans program in accordance with the facility's *HCHV Case Management Workflow Guide*.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

On February 26, 2026, the HCHV Program Coordinator reiterated to the HCHV team via email the requirements of the HCHV Case Management Workflow Guide including: (1) attempting to contact Veterans who have not been contacted in more than 30 days, (2) discharging dual enrolled Veterans, and (3) adhering to the Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure. Between February 26, 2026, and May 26, 2026, 160 Veterans were discharged from the HCHV Program. On May 26, 2026, the CRS Director instructed the HCHV Program Coordinator to ensure that Veterans who no longer require HCHV services are discharged and directed the HCHV Program Coordinator to report actions and significant progress back to the Community Reintegration Services (CRS) Director by June 18, 2026.

The CRS Director will conduct monthly audits of all Veterans enrolled in HCHV services who have not been contacted within 30 days to evaluate whether they meet discharge criteria, and the CRS Director will provide a written report of compliance data to the Mental Health Executives, monthly, until 90% or greater compliance has been sustained for three consecutive months. The CRS Director will then issue a closure memo to the Mental Health Executives. The denominator will be the total number of Veterans enrolled in HCHV services that month and the numerator will be the total number of HCHV-enrolled Veterans who do not meet discharge criteria.

Recommendation 3

The VA Portland Health Care System Director reviews the quality management evaluations, once completed, for Veteran A's and Veteran B's care, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

The quality assurance review for Veteran A's care was completed on January 7, 2026, and the quality assurance review for Veteran B's care was completed on March 5, 2026. The cases were reviewed by the Peer Review Committee on March 4, 2026, and March 18, 2026, respectively, and service chiefs provided the Peer Review Committee's feedback to each clinician reviewed. No staff met the objective trigger criteria for referral to the Medical Executive Committee for professional practice evaluation, and no staff generated referrals for further management or administrative review. The VA Portland Health Care System Director reviewed the completed healthcare quality assurance reviews on June 2, 2026, and concurs with the evaluations.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 4

The VA Portland Health Care System Director evaluates the Community Reintegration Services reporting structure and resources to determine if the current structure allows for effective oversight of essential homeless programs, and makes modifications if needed.

_X_ Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

In collaboration with the Community Reintegration Services (CRS) Director, Mental Health Executives, and the Chief of Staff, the VA Portland Health Care System Director evaluated the CRS reporting structure and available resources to determine whether the current structure allows for effective oversight of essential homeless programs. The group determined that the actions outlined in this report and surrounding this investigation will ensure effective oversight of essential homeless programs. The team agreed that the current structure can effectively oversee the programs. They also noted that the CRS Director's ability to pursue strategic initiatives, process standardization, and process efficiencies, is limited by the high number of direct reports. Accordingly, the VA Portland Health Care System Director will, with the Chief of Staff and Mental Health Executives, prioritize the addition of leadership or administrative positions in the homeless programs as FTE becomes available.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

The VA Portland Health Care System Director ensures the Community Reintegration Services director monitors and verifies Grant and Per Diem liaisons' compliance with Veterans Health Administration Directive 1162.01 requirements related to conducting veteran contacts.

_X_ Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

On November 4, 2025, the Community Reintegration Services (CRS) Director notified Grant Per Diem (GPD) Liaisons of the expectation that GPD Liaisons ensure each Veteran's electronic health record is consistent with the information contained in the GPD grantee's clinical record, per VHA Directive 1162.01.

To support this compliance, on December 10, 2025, the GPD team developed a central tracking tool to manage timeliness of GPD program participants' progress reviews. The GPD Liaisons have fully adopted this tracking tool, reporting that the automatic flags and visual cues have improved their ability to monitor and engage Veterans within the required timelines. Additionally, on December 31, 2025, the CRS Director implemented a productivity monitoring tool and communicated the implementation to the GPD Liaisons. The tool enables monitoring of timely 90-day-interval contacts, GPD Liaison productivity, and documentation within 7 days of admission. In February 2026, the CRS Director began using this tool to evaluate GPD Liaison performance during the GPD Liaisons' quarterly reviews.

The CRS Director will provide a written report of compliance data to the Mental Health Executives, monthly, until 90% or greater compliance has been sustained for three consecutive months. The CRS Director will then issue a closure memo to the Mental Health Executives. For the first monitor, the denominator will be the total number of Veterans requiring contact that month and the numerator will be the total number of Veterans contacted. For the second monitor, the denominator will be the total number of Veterans who were admitted that month and the numerator will be the total number of Veterans whose admission notes were completed within 7 days of admission.

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