# Effective Practices in HUD-VASH Contracting

An Innovative Practice in VHA Homeless Program Operations

**White Paper**

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Developed by
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## INTRODUCTION

The VHA Homeless Programs Office (HPO) identifies and disseminates innovative practices in homeless program operations. The Housing and Urban Development VA-Supportive Housing (HUD-VASH) Contracting Community of Practice (CCoP) group has been identified as a cohort of sites with strong innovative practices in contracting for HUD-VASH case management services.

As one of the largest permanent supportive housing programs in the country, HUD-VASH serves over 100,000 Veterans annually. Caring for these Veterans requires thousands of dedicated staff from a variety of disciplines including social work, nursing, addictions counseling, vocational development, recreation therapy, psychiatry, peer support, and others. To ensure adequate staffing so that Veterans receive the case management support they needed, many HUD-VASH programs establish contracts with community providers. This was possible due to the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (Public Law [PL] 112-154) which required VA to *consider* establishing contracts with non-VA community providers to help Veterans find suitable housing and to connect Veterans with other services for which they might be eligible.

Sites that established contracts reported many benefits. The VA New York Harbor Health Care System (HCS) found that contracting helped them administer new vouchers that were allocated each year, despite running out of office space for new staff. At the Washington DC VA Medical Center (VAMC), after requiring that contractors be agencies that participated in their local homeless Continuum of Care (CoC), contracting lead to increased collaboration with community partners and agencies. VA Puget Sound HCS noted that contractors often had more flexibility in providing staff recruitment and retention incentives, helping to reduce staff turnover and improve continuity of care. Lastly, at the James J. Peters VAMC in Bronx, NY, contract agency staff were often hired and onboarded more quickly than local VA staff.

Still, as of 2021, only a handful of sites established contracts. Many sites who did not contract experienced significant and ongoing recruitment and retention barriers such as high costs of living and federal wages not being competitive with the private sector. To help mitigate these barriers, in January 2021, Congress passed a new law – the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (PL 116-315). Section 4207 of this new law now made contracting *mandatory* for any HUD-VASH program when 15 percent of their allocated housing vouchers during the preceding fiscal year were unused, and when they had one or more case manager positions that were vacant for at least nine consecutive months. This new mandate went into effect at the start of fiscal year (FY) 2022.

## PRACTICE OVERVIEW

To support sites who were now required to establish contracts, in June 2021, HPO launched a formal HUD-VASH CCoP. This group was intended to facilitate the exchange of ideas and best practices around contracting HUD-VASH case management services, identify cross cutting challenges, and help HPO

disseminate formal guidance. In synthesizing feedback shared during CCoP call discussions, several strong practices emerged that reportedly enhanced the effectiveness of HUD-VASH contracts. These included contracting officer's representatives (COR) and clinical liaisons being the same person, structuring contract teams like standard HUD-VASH teams, and strong practices related to monitoring and billing.

### *Contracting Officer's Representative (COR) and Clinical Liaisons*

A Contracting Officer's Representative (COR) is a formalized and critical role for all federal contracts. As defined by the Federal Acquisition Regulation (FAR)[1], a COR is designated and authorized to perform specific administrative and technical contract functions, such as monitoring performance of the day-to-day work performed by the contractor and inspecting the quality of the deliverables (i.e., services). All HUD-VASH programs that establish contracts are required to designate a COR. However, some sites went further and established an additional role known as a clinical liaison. Though not formalized in the FAR, clinical liaisons serve as important subject matter experts who assist in monitoring performance and quality of services of the contract agency. Clinical liaisons also provide necessary training to the contract agency's staff. Since the roles and responsibilities of these positions significantly overlapped, most of the HUD-VASH CCoP sites elected to have one social worker simultaneously serve as both the Contracting Officer's Representative (COR) and the contract clinical liaison – a COR/liaison. This decision not only simplified communication between the Contractor, the HUD-VASH COR/liaison, and the Contract Officer, but it also made administrative tasks that were shared by both the COR and contract clinical liaison roles more streamlined and efficient.

### *Embedded Team*

While most sites in the HUD-VASH CCoP set up their contracts in a structure that mirrored HUD-VASH case management processes (i.e., unhoused Veterans were assigned to the contractor who housed and provided them with the ongoing case management services), there was variability in how fully the contract agency staff were embedded in the VA HUD-VASH team. "Embedding" was operationalized in a variety of ways. For example, having contract staff:

- Included on all e-mails sent to the HUD-VASH team.
- Participate in VA staff meetings.
- Receive orientation by the VA HUD-VASH program, and
- Granting contract staff access to the VA share drives or SharePoint sites.

VA Northern California HCS and VA Puget Sound HCS engaged in all of these practices, essentially treating the contract staff as though they were one team among many within their HUD-VASH program. They also reported increases in team cohesion, greater standardization training, and improvements in communication.

[1] https://www.acquisition.gov/

### *Monitoring*

Monitoring of the contract agency was generally comprised of three main components: performance reviews, electronic health record (EHR) documentation reviews, and clinical meetings.

Performance reviews started with the development of a quality assurance surveillance plan (QASP) that outlined processes to ensure that the quality of services provided were appropriate. COR/liaisons then used the QASP to manage and evaluate the contractor's performance. The contractor was responsible for developing their own internal processes to achieve the results outlined in the QASP and relay any changes to the standards back to the COR for approval. QASPs were often considered "living documents" with occasional changes being made following approval by the Contracting Officer. All CCoP sites scheduled QASP review meetings with the Contractor as needed, and some went further and scheduled reviews as regular quarterly meetings.

With regard to EHR reviews, all sites arranged for their contractors to document progress notes in the Veterans' official VA EHR. However, there was variability as to whether the COR/liaison or equivalent would be added as a required co-signer or as an additional signer (colloquially known as "tagging")[2]. This difference is subtle but significant, with pros and cons for each. EHR notes that required co-signing were not considered finalized until they were co-signed. Additionally, EHR notes that required co-signers automatically prompted the appropriate COR/liaison or equivalent when notes were ready to be reviewed and signed as a function of VA's current Computerized Patient Record System (CPRS). For sites like the Washington DC VAMC, with a significant proportion of highly vulnerable Veterans, co-signing guaranteed that the COR/liaison had full visibility into all patient care interactions. However, this full visibility also was a heavy administrative burden on the COR/liaison. In contrast, EHR notes that only used additional signers required the contract staff to manually designate the COR/liaison or equivalent as an additional signer to trigger the prompt. This allowed sites like VA Puget Sound HCS to lower the administrative burden and focus primarily on the critical cases. However, there was a risk that critical cases may be inadvertently overlooked. As an added layer of accountability, whether co-

> ***"As HUD-VASH strives to expand case management capacity to meet the needs of all of our Veterans, we're incredibly appreciative of the efforts of the sites that have shared their strong practices and lessons learned.***
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> ***Simply put, their insights will help make the contracting process easier for new sites that want or need to establish contracts."***
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> **Meghan Deal, LICSW**
> **National Director**

[2] As of this writing, VHA is transitioning its EHR from VisTA Computerized Patient Record System (CPRS) to Cerner. The option for co-signatures is not available on the Cerner platform.

signing or additional signing, VA Puget Sound HCS had the COR/liaison or equivalent add an addendum to each note which clearly, and in writing, acknowledged the review of the chart. As there was no clear consensus among CCoP sites as to which process was ultimately “better”, sites are encouraged to consider the pros and cons in the context of the local needs of their Veterans served.

Regarding clinical review meetings, some sites held weekly meetings with the contract clinical supervisor supplemented with quarterly “in depth” case conferencing meetings with the contract agency clinical supervisor on specific Veterans. For all sites, clinical supervision of contract agency staff was required to be provided by the contract agency. VA Greater Los Angeles HCS also encouraged the contract agency’s supervisor to invite contract case managers to these meetings to receive direct consultation on relevant cases. They reported that this greatly improved communication with the contractor and improved care for the Veteran. Additionally, VA Greater Los Angeles HCS developed a comprehensive, spreadsheet-based “white board” to track both administrative and clinical concerns derived from the standards set in the QASP. These “white boards” were frequently shared with both the contract clinical supervisor and the contract director to ensure both clinical and administrative reconciliation of all Veterans.

### *Billing*

Among the CCoP sites, four general price scheduling frameworks emerged across two domains: minimum required visits and acuity level of Veterans served. Figure 1 shows the different frameworks. Price frameworks that included minimum visit requirements only paid the contractor when the minimum number of clinical encounters, commiserate with the Veteran’s case management level, were documented with an appropriate 522 Clinic Stop Code. In contrast, price frameworks that did not have minimum visit requirements paid the contractor regardless of the number of clinical encounters. With regards to acuity, price frameworks either paid a flat rate regardless of acuity or a higher rate for higher acuity Veterans, based on case management level. Different sites chose one of these four frameworks based on their unique local needs.

| CCoP Price Schedule Frameworks | |
|---|---|
| Minimum Visits Required / Flat Acuity Rate | No Minimum Visits Required / Flat Acuity Rate |
| Minimum Visits Required / Higher Rate for Higher Acuity | No Minimum Visits Required / Higher Rate for Higher Acuity |

Figure 1: Price Schedule Frameworks

VA Greater Los Angeles HCS, for example, used the Minimum Visits Required / Flat Acuity Rate framework where they paid the contractor only for Veterans who received the minimum number of required clinical encounters based on the Veterans’ case management stage. Many CCoP sites in the northeast used the Minimum Visits Required / Higher Rate for Higher Acuity framework, paying the contractor based only when Veterans received the required number of visits, but at a higher rate with Veterans in more intense case management stages. VA Puget Sound HCS utilized a No Minimum Visits Required / Flat Acuity Rate framework that, because of their strong relationship with the contractor, they believe lead to exceptional outcomes. Interestingly, VA Puget Sound noted that, when a strong and effective collaboration exists, the No

Minimum Visits Required / Flat Acuity Rate framework may encourage staff to go above and beyond for Veterans with major service challenges in ways they did not believe would happen with either of the variable frameworks. VA Northern California HCS had a unique version of the No Minimum Visits Required / Flat Acuity Rate framework as their contract was established across their health system's Social Work Service. Their price schedule also paid the contactor a set rate per hour based on whether that staff member is licensed or unlicensed.

Some programs within Veterans Integrated Service Network (VISN) 2 covering New York and New Jersey established two additional terms to address missed visits or client no shows. First, the contractor may receive a prorated monthly payment for any missed case management visits (i.e., if a weekly visit was missed, the contractor would not be paid for that visit but the other visits that month will be paid on a prorated basis). Second, VA Northport HCS included a "due diligence standard" that outlined the contractor's responsibilities when they were unable to reach a Veteran for a scheduled visit. If the due diligence standard was appropriately followed after a no-show to a scheduled visit, the contractor could be paid for that missed visit.

## CONCLUSION

With more HUD-VASH sites anticipated to establish contracts, the HUD-VASH CCoP will continue to serve as a venue for guidance and support as well as for surfacing strong and innovative practices. This will be in conjunction with efforts by the HPO and the VA National Contracting Office to streamline and increase efficiencies in contracting processes as well as to develop and disseminate guidance on initiating contracts.

We would like to thank the dedicated staff at VA Greater Los Angeles HCS; the VA Hudson Valley HCS; the James J. Peters VAMC in Bronx, NY; the VA New Jersey HCS; the VA New York Harbor HCS; the VA Northern California HCS; the VA Northport HCS; the VA Puget Sound HCS; the VA San Diego HCS; the San Francisco VA HCS; and the Washington DC VAMC for sharing their practice with us. For more information, please contact Meghan Deal, LICSW, ACSW, National Director for the HUD-VASH at Meghan.Deal@va.gov.