GRANT & PER DIEM NATIONAL PROGRAM OPERATIONAL GRANTEE CALL

October 8, 2024

RECORDING LINK: https://veteransaffairs.webex.com/webappng/sites/veteransaffairs/recording/20f8823167cd103dabfa0efcae2a31ab/playback

RECORDING PASSWORD: Homeless1!

Choose VA

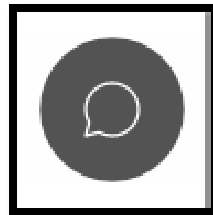
VA

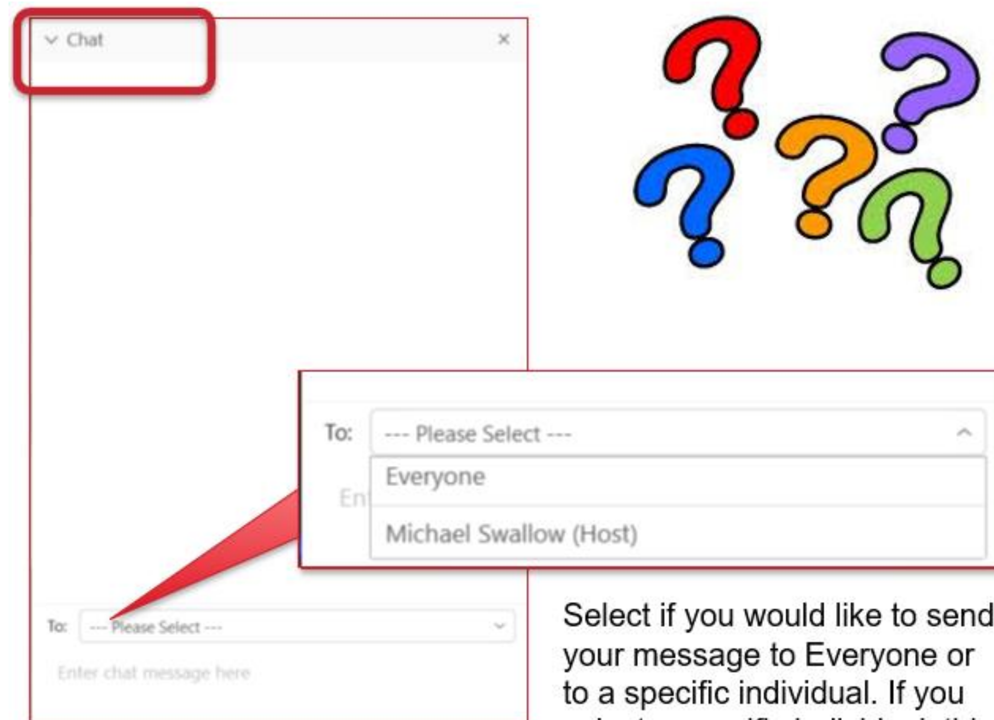
U.S. Department of Veterans Affairs

HOUSEKEEPING

- This meeting is being recorded.
- Past recordings are available on the GPD provider website: https://www.va.gov/HOMELESS/GPD_ProviderWebsite.asp
- The webinar will last approximately 60 minutes.
- Mics and video are disabled (but always check to make sure you're on mute).
- Questions can be submitted using the Chat function.

Select the Chat icon on the tool bar at the bottom of the screen.





Select if you would like to send your message to Everyone or to a specific individual. If you select a specific individual, this will send the message privately so no one else in the meeting will see it.

AGENDA

- **Announcements and Updates:**
  - **Upcoming NOFOs & grant cycles**
  - **Updates to the transitional housing grant recipient guide**
- **Presentations**
  - **Health Update COVID-19, Influenza, & RSV :** Kenny Bruemmer, Homeless PACT National Program Office
  - **Learning from your peers: Connecting GPD Veterans to healthcare**
    - Jennifer Kimbrough, GPD Liaison N Indiana Health Care System
    - Lani Vivirito, Grantee, Robert L. Miller Veteran Center at the Center for the Homeless
    - Kenny Bruemmer, Program Analyst, Homeless PACT National Program Office
  - **Quarterly assessments**: Dr. Angela Smittie, Program Specialist, GPD National Office
  - **Financial management updates:** Nancy Hegel, Supervisory Financial Analyst, GPD National Office

ANNOUNCEMENTS & UPDATES

UPCOMING NOFO AND GRANT CYCLE

Case Management (CM):

- Current CM grant awards end FY 2025 (September 30, 2025)
- Case Management NOFO expected publication sometime between November 2024 - January 2025
  - NOFOs are published on Grants.gov and the GPD Website

Per Diem Only (PDO) and Transition In Place (TIP):

- FY 2025 is the first option year for PDO and TIP grants
- Download a copy of the fully executed option year agreement from the eGMS website
  - How-To: retrieve your executed option year grant agreement

Special Need (SN):

- Current SN award period is through September 30, 2026; no option year or NOFO in FY 2025

FY 2025 OPERATIONAL UPDATES

- Grantees and VA staff should regularly refer to the **grant recipient guides**: https://www.va.gov/HOMELESS/docs/GPD/providers/Recipient_Guide_Transitional_Housing.pdf
- There is a functional, hyperlinked table of contents and search functionality
  - **Please try searching the guide!**
- A summary of major changes for this FY 2025 are in the grant recipient guide and will be reviewed in the next slide

VA Grant & Per Diem

Fiscal Year 2025
Transitional Housing Grants

Per Diem Only Models
Special Need
Transition in Place

Grant Recipient Guide

FY 2025 SUMMARY OF CHANGES

- **Changes noted (page 1)**
  - Special Need grants are new awards this year and will have new FAINs and will require initial inspections this year
  - Effective July 2, 2024, GPD grantees must provide written notice to Veterans and prospective Veterans about religious protections (page 7)
  - Grantees with ongoing operational deficiencies (e.g., repeat inspection or Veteran care deficiencies) may be placed on an operational high-risk list where a longer period of monitoring may be enforced (page 13)
  - Bed flexing guidance for PDO grants has expanded for FY 2025 (page 14)
  - Updated language about billing for Veterans with minor dependents (page 18)

FY 2025 SUMMARY OF CHANGES

- **Grantees with ongoing operational deficiencies (e.g., repeat inspection or Veteran care deficiencies) may be placed on an operational high-risk list where a longer period of monitoring may be enforced (page 13)**
  - There may be operational circumstances where additional corrective action monitoring is warranted.
  - If a grantee is determined to be at high risk for operational noncompliance, VA may adopt additional terms and conditions of the grant award. Please see 2 CFR 200.208 for more detail.
  - For example, a VAMC team may determine after consulting with the GPD NPO that a grantee might remain in high-risk status for a period of time, during which, if any deficiencies that have been previously resolved occur again, the next due-process sanction will be in applied (instead of starting the CAP process again from step one).
  - The responsibility for the ongoing compliance monitoring remains with the VAMC team; however, before a grantee may be considered for high-risk progressive action, the VAMC team must consult with the GPD NPO.

FY 2025 SUMMARY OF CHANGES

- **Bed flexing guidance for PDO grants has expanded for FY 2025 (page 14)**
  - First mentioned on this meeting in August
  - **Grantees may flex beyond the guidance in the NOFO**
  - Grantees may now “over flex” into any model in their grant award, **including SI**
  - Grantees may only **use models they are awarded** (i.e., if a grantee did not apply for the SI model, they cannot now add SI)
  - Grantees **may not bill for more Veterans than their grant award** allows (i.e., if a grantee has a 20-bed total award, they may not bill for more than 20 Veterans at a time)
  - Please notify the GPD NPO and your GPD liaison if you need to over flex
  - **This flexibility is temporarily granted in response to changing community demands**

HEALTH UPDATE:
COVID-19, INFLUENZA, & RSV

QUESTION

Drop in the chat box if your site is hosting any flu vaccination events for GPD Veterans or any other coordinated efforts with your local VA team

HEALTH UPDATE: PROTECT YOURSELF!

"Triple Threat" of viral respiratory illnesses this season:

- **COVID-19**
  - Can be very contagious and spread quickly; most people have mild symptoms
  - Vaccination available to protect against serious illness from COVID-19
    - Important to stay up-to-date with vaccination as protection decreases over time and protect against current circulating strains of the virus
    - 2024-25 mRNA COVID-19 vaccine FDA approved in August and available now
- **Influenza**
  - Contagious and generally infects nose, throat, and sometimes lungs
  - Vaccination available to reduce risk from flu and its potentially serious complications
- **Respiratory Syncytial Virus (RSV)**
  - Usually causes mild, cold-like symptoms but can be serious (e.g., pneumonia or bronchiolitis) especially for babies and older adults
  - Vaccination available
    - Adults 60 and over and babies

HEALTH UPDATE: PROTECT YOURSELF!

- **Prevention tools**:
  - Vaccinations
  - Handwashing and cleaning
  - Air quality improvements
  - Masks
  - Physical spacing (stay away from sick people)
  - Testing
  - Treatments
- **Special considerations**:
  - Children under 5
  - Older adults
  - Immunocompromised
  - People with disabilities
  - People with underlying health conditions

HEALTH UPDATE: HOW TO GET VACCINATED

- **COVID-19 & Influenza**
  - Vaccinations are free and available at VA or in the community (e.g., Walgreens, CVS, etc.)
    - www.vaccines.gov
  - Recommended for everyone from aged 6 months
- **RSV**
  - Vaccinations available for adults 60 and over and babies
    - Especially adults with: chronic heart or lung disease, weakened immune systems, living in nursing homes or long-term care
  - Ask Primary Care Provider
  - Visit Where to Find Vaccines

HEALTH UPDATE: ADDITIONAL RESOURCES

- **COVID-19**
  - VHA COVID-19 Vaccine SharePoint
  - VHA COVID-19 Vaccine Dashboards
  - CDC: Resources to support people experiencing homelessness

- **Influenza**
  - VHA Seasonal Influenza SharePoint
  - VHA Influenza Data Dashboard\
  - CDC: Influenza

- **RSV**
  - CDC: Respiratory Syncytial Virus (RSV)

THANK YOU

Kenny Bruemmer, Program Analyst

Homeless PACT National Program Office (HPACT)

VHA Homeless Programs Office
Kenneth.Bruemmer@va.gov

LEARNING FROM YOUR PEERS: CONNECTING GPD VETERANS TO HEALTHCARE

CONNECTING GPD VETERANS TO HEALTH CARE: CLINICAL REVIEW

- Is this tackled the first 30 days the Veteran enters the GPD program by the team (grantee and liaison)?
- Is **health care** listed in the Veterans individual service plan with goals and objectives?
- Can you find WHO is the Veterans heath care provider in the your (grantee's) individual service plan (ISP) and in the Liaison's progress notes?
  - Does it list the clinic or healthcare plan a Veteran is assigned to?
  - Is the primary care name and contact number listed?
- How does partnership building occur for those seeking community healthcare or Veterans non healthcare eligible?
  - Is there a booster training session on community healthcare resources needed for grantee staff?
- Teachable moments: My Health*E*Vet Home - My HealtheVet - My HealtheVet (va.gov)

PRESENTER INTRODUCTIONS

Jennifer Kimbrough, LCSW, LCAC, ACSW, BCD: GPD Liaison, Northern Indiana Health Care System

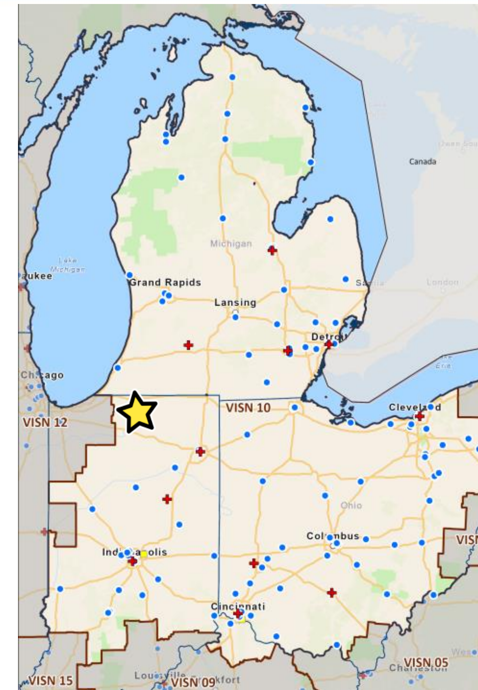
- Began her career with the VA in 2008 as a Mental Health Therapist, transitioned into HUD/VASH and now with the GPD program since 2012. Jennifer has 24 years of experience in community mental health, transplant/ dialysis, probate/ juvenile cases, public health as a fetal infant mortality case reviewer and prenatal care coordinator. She is a strong advocate for Veteran Equity.

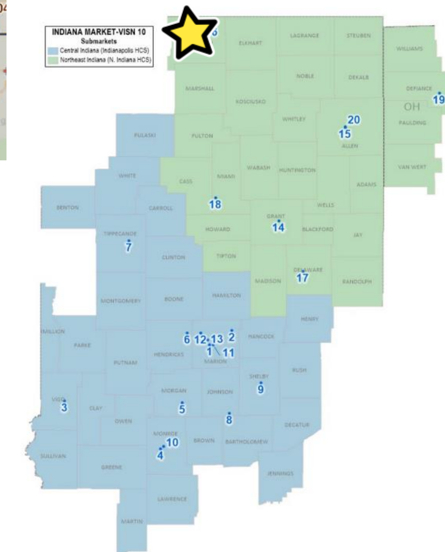
Lani Vivirito, LCSW: Director, Robert L. Miller Veteran Center at the Center for the Homeless

- For nearly 30 years, Lani has specialized in working with disenfranchised groups, such as people experiencing severe mental illness, substance use disorders, trauma, and homelessness. She has overseen this GPD project since the initial application for capital funding in 2010.

PROGRAM INTRODUCTION

- The VA – Northern Indiana Health Care System or “VANIHCS” (VISN 10) catchment area is composed of 25 counties in the northeastern corner of Indiana and 4 counties in Ohio. Its medical centers are in the eastern and southern portion of our catchment area, with an expanded “mega CBOC” available to cover the western portion of the catchment area.
- The GPD grantee, the Center for the Homeless (“CFH") is an integrated community that is staffed 24/7 and has been providing life-changing services to homeless men, women, and children since December 1988. It is located 90 miles from the nearest VA Med Center, but only 7 miles from the CBOC in the urban center of our county.
- CFH is able to provide interim housing for the far western sector of VANIHCS catchment area, but can also accommodate overflow need from Battle Creek Med Center (Southwest Michigan, also VISN 10) and Jesse Brown Med Center (Chicagoland/Northwest Indiana, VISN 12), as the boundary of their catchment areas are less than 10 miles from CFH and their nearest GPD projects are more than 60 miles away.





A COLLABORATIVE EFFORT

- Referrals are reviewed by both liaison and grantee to ensure the appropriate supports and structures are in place for veterans.
  - Liaison provides clinical consultation to the grantee and augments some of the case management services.
- Pre-screening, assessments, and service planning are shared and staffed between VA and GPD staff within the first week.
- Liaison takes lead on coordinating VHA services, grantee takes the lead on community care.
  - Grantee has several established MOA's for primary care, mental health/SUD, employment, education, et cetera
- All referrals/providers tracked in the client record.

COLLABORATIVE EFFORTS ACROSS DOMAINS

Service plans include not only the housing plan, but also any other barriers to independent living, including primary care, as identified by the veteran.

Center for the Homeless – Robert L. Miller Sr. Veteran's Center
TREATMENT PLAN

Veteran Name: Date: Click here to enter text.

☐ Initial Treatment Plan Initial TP Date: Click here to enter a date.

☐ Treatment Plan Review TPR Date:

Next TPR Due: Click here to enter text.

Veteran Protective Factor Assessment:

	None or N/A	Marginal	Fair	Good	Excellent
Resilience	☐	☐	☐	☐	☐
Meeting Basic Needs	☐	☐	☐	☐	☐
Employment	☐	☐	☐	☐	☐
Living Stability	☐	☐	☐	☐	☐
Social Support	☐	☐	☐	☐	☐
Spiritual Faith	☐	☐	☐	☐	☐
Ability to Care for Oneself	☐	☐	☐	☐	☐
Perceived Self-Determination	☐	☐	☐	☐	☐

Individualized/ Specialized needs/ assistive tech/ reasonable accommodations:
☐ N/A ☐ Dialysis ☐ Chemotherapy ☐ Special diet ☐ Eye glasses ☐ Hearing aids
☐ Memory Care ☐ Durable Medical Equipment (e.g.: wheelchair, shower chair, etc.)
☐ Other: Click here to enter text.

Identified safety and health risks:
☐ N/A ☐ Fall risk due to chemo or other medical condition ☐ End Stage Renal Disease
☐ Immunocompromised ☐ PTSD with Irritability ☐ Open wound ☐ Active MRSA
☐ History of pneumonia ☐ Other: Click here to enter text.

Readiness to learn/ Barriers to learning:
☐ Veteran is ready and willing to participate in programming.
☐ Veteran has limited ability to read at this time.
☐ Veteran states he does not do well in group settings to participate in such learning opportunities.
☐ Veteran needs hearing aids to assist with his efforts to learn new skills.
☐ Veteran needs to have his eye checked to assist with his efforts to learn new skills.
☐ Others: Click here to enter text.

Veteran Comments (in their own words):

Clinical Staff Comments:

Problem Areas To Be Addressed (see attached):
☐ Housing ☐ Income ☐ Mental Health ☐Legal
☐ Budgeting ☐ Physical Health ☐ Substance Use ☐Resources

Veteran Signature Date

Counselor's Signature/Credentials Date

Clinical Supervisor's Signature/Credentials Date

COLLABORATIVE EFFORTS ACROSS DOMAINS

Service plans include not only the housing plan, but also any other barriers to independent living, including primary care, as identified by the veteran.

Treatment Plan Problem Area: Housing

Goal: Veteran to secure and maintain permanent housing

Objective 1: Veteran will submit documents to CCM that are needed for leasing by __(date)__. CCM to assist veteran when needed by reminders or applying for documents during weekly meeting.

Date Established	Date Completed

Reviews:

Objective 2: Veteran will apply to __(number)__ housing options by __(date)__ and/or ask CCM to assist during weekly meeting so that veteran can obtain permanent housing.

Date Established	Date Completed

Reviews:

Objective 3: Veteran will attend meetings and schedule tours of housing options by __(date)__ to narrow housing options.

Date Established	Date Completed

Reviews:

Objective 4: Veteran will secure required housing deposits by __(date)__ for the purpose of obtaining secure housing. Veteran to establish budget to save for deposit and report budget to CCM during weekly meeting.

Date Established	Date Completed

Reviews:

Objective 5: Veteran will update CCM at weekly meeting of progress being made to secure permanent housing.

Date Established	Date Completed

Reviews:

Veteran Name: Click here to enter text. TP/TPR Date: Click here to enter a date.

Rev. 7/2023

Treatment Plan Problem Area: Physical Health

Goal: Veteran to establish care for their physical health needs so that veteran can maintain a positive long-term health status.

Objective 1: Veteran will call VA and/or PCP to make a health appointment by __(date)__. Veteran to report to CCM date and time of appointment for reminders and or transportation requests.

Date Established	Date Completed

Reviews:

Objective 2: Veteran will continue to attend appointments and inform CCM of appointment date and times for reminders and/or transportation.

Date Established	Date Completed

Reviews:

Objective 3: Veteran will sign a release of information by __(date)__ for health provider so that MVC staff can assist in appointment reminders and/or transportation.

Date Established	Date Completed

Reviews:

Objective 4: Veteran will comply with taking any medications that are recommended by health professionals and MVC staff will assist with reminders of medication.

Date Established	Date Completed

Reviews:

Objective 5: Veteran will allow CCM to call health professional monthly for continued update on veteran's health if needed.

Date Established	Date Completed

Reviews:

Veteran Name: Click here to enter text. TP/TPR Date: Click here to enter a date.

Rev. 7/2023

CASE SCENARIO #1

Case 1- James is a 35-year-old, USMC Combat Veteran who is 30% SC for Schizophrenia that presented to the VA requesting transitional housing. He is new to the catchment area.

- Liaison completes the program intake assessment on 8 domains:
  - Housing, transportation, ADL's/meal planning, financial/ debt, employment/other meaningful activities, legal, mental/SUD and medical
  - *Example of charting:*
    - *Mental health: hx of schizophrenia, has been stable on psychopharmacology. States he is on Invega (paliperidone) IM q 4 weeks and is due in a week. Confirmed he is scheduled with the BHIP RN for 00/00/00 for his next injection.*

    - *Medical: history of ankle pain, tobacco pain, alcohol dependence, HTN. Discussed starting medical services at the CBOC, he is agreeable. Called his last VA pharmacy to assist with refilling his HTN and Invega medication until he can get into his vesting appointment.* Does not utilize any assisted devices.

ACTION STEPS

- Liaison requests a vesting appointment using the PCMM

Progress Note Properties

Progress Note Title: PCMM <PCMM COORDINATION NOTIFICATION NOTE>

PCMM <PCMM COORDINATION NOTIFICATION NOTE>
PCMM <PCMM TRAVELING VETERAN COORDINATOR NOTE>
PCMM COORDINATION NOTIFICATION NOTE

All Required Fields have Values

☑ PCMM COORDINATION NOTIFICATION NOTE
- ☑ New Enrollment
  - ☐ Site requested:
    - ☐ Fort Wayne
    - ☐ Defiance
    - ☐ Huntington
    - ☐ Marion
    - ☐ Muncie
    - ☐ Hoosier
    - ☐ Jackie Walorski Clinic
- ☐ Reestablishing care
- ☐ Transfer within NIHCS
- ☐ Change of Provider (PCMM use only)
- ☐ Care in the Community Provider-Mission Act
- ☐ Other:*

CONNECTING

- Completing additional consults for mental health and/or home health care to support while in transitional housing.
- Once cleared by PCMM (eligibility) within 24 hours, a vesting appointment request is sent to the MSA.
- Having a connection with the MSA to schedule directly (PC and mental health appointments)
- Providing the pharmacy number and rx numbers to veteran and provider
- On the coversheet is the PACT team members- PCP, RN, MSA
- GPD provider creating a medications list to close communication should an ambulance need to be called

- **Weekly Staffing-** providing VA appointments, looking at medication tab for reminding for the Veteran to complete during their weekly case management visits with the GPD provider.
- **Monthly reviews** with the Veteran and GPD Case manager- reviewing the domains and referring or providing additional support to maintain access to care.

CASE SCENARIO #2: GPD ONLY

- Primary care is available on the CFH campus through a partnership with the Indiana Health Center, a Federally Qualified Health Care (FQHC) provider.

- Case 2 - Ronald is a 62-year-old veteran of the US Army. Although he served for six years, he had conflict with a first sergeant toward the end of his service that resulted in an OTH discharge.
  - Veteran was literally homeless prior to admission, having been living in the woods. He had been identified at a Stand Down event and came into the program with no documents.
  - Assessment revealed a significant veteran and family history of stroke and heart attack. He had been without his cardiac meds for quite some time.
  - Stat referral to IHC included a warm hand off including initial correspondence with the clinic manager apprising them of his lack of documents, and physical escort to clinic to provide introduction.
  - Veteran was able to resume his cardiac medications within 12 hours of being seen.
  - In addition to establishing primary care, IHC provided a copy of his medical record with a “wet signature” which along with his DD214 could be used to order SSC, paving the way to obtain all other documents needed for his housing portfolio.

HEALTH PROMOTION ACROSS THE BOARD

- **Weekly house meeting**
  - Promotes community health opportunities
  - Reinforces universal precautions
- **Community health opportunities posted throughout facility**
- **Training for staff**
- **Eliminating barriers:**
  - Clinical coverage process in place for the liaison in the event she is off duty
  - Grantee has process in place for after hours walk ins
  - The IHC clinic is a 400-foot walk from the MVC.
  - CFH also provides prescription assistance for veterans whose Medicaid application is still pending.
  - Grantee had several laptops for VVC appts
  - Encourage use of MyHealth*E*Vet
  - Transportation available with notice
  - ENGAGEMENT

HPACT & CONNECTING GPD VETERANS TO CARE

Connecting Veterans to VHA Health Care Initiative

Goal: To increase health care engagement and screening among Veterans receiving services through programs addressing social needs (homelessness, Veteran justice, food security) but who are not getting health care at VHA.

BLUF:

- This is a **Social Determinant of Health** project intended to ensure these Veterans are getting the full complement of VHA care.
  - These populations have high rates of chronic disease along with premature morbidity and mortality from preventable conditions that often go untreated.
- For many stations this is work that is ongoing with several approaching 100% enrollment.
- Not linked to any FTEE or $$ request.
- Memorandum released May 2024.

HPACT & CONNECTING VETERANS TO CARE

What is the role of HPACT?

Homeless PACT

- Special population PACT available at 60 sites across the VHA system serving over 22,000 Veterans.
- Provides a "medical home" designed around unique needs and challenges homeless Veterans face when accessing and engaging in health care.
- 5 Core Elements of HPACT:
  1. **Reduce barriers to care**: provide open-access, walk-in care, and community outreach
  2. **Provide one-stop, wrap-around services**: integrated care that is co-located and addresses SDoH
  3. **Engage Veterans in intensive case management**: coordinated with VA and community partners
  4. **Provide high-quality, evidence-based, and culturally sensitive care**: research evaluation and ongoing education
  5. **Provide care that is performance-based and accountable**: using real-time data to assist field teams

HPACT & CONNECTING VETERANS TO CARE

UNITED STATES
WASHINGTON
MONTANA
NORTH DAKOTA
MINNESOTA
OREGON
IDAHO
WYOMING
SOUTH DAKOTA
WISCONSIN
MICHIGAN
MAINE
VT.
N.H.
N.Y.
MASS.
R.I.
IOWA
NEBRASKA
NEVADA
UTAH
ILLINOIS
OHIO
PA
COLORADO
KANSAS
MISSOURI
INDIANA
WEST VIRGINIA
MD
N.J.
DELAWARE
KENTUCKY
VIRGINIA
CALIFORNIA
OKLAHOMA
TENNESSEE
NC
ARIZONA
NEW MEXICO
ARKANSAS
SC
ALABAMA
TEXAS
MISSISSIPPI
GEORGIA
LOUISIANA
FLORIDA
HAWAII
Gulf of Mexico

ChooseVA

VA

U.S. Department of Veterans Affairs

HPACT Mobile Medical Unit (MMU) Program

- A MMU provides HPACT staff with the necessary infrastructure to provide care in community-based settings in a safe and confidential space with medical supplies and equipment readily available.

MMU Model	Projected Delivery Date	HPACT Location
F550	8/1/23	V08 (675) Orlando, FL
Sprinter	9/1/23	V19 (635) Oklahoma City, OK
Sprinter	9/8/23	V22 (691) Los Angeles, CA
Sprinter	9/8/23	V23 (618) Minneapolis, MN
Sprinter	9/15/23	V07 (508) Atlanta, GA
Sprinter	9/15/23	V22 (664) San Diego, CA
Sprinter	9/22/23	V10 (539) Cincinnati, OH
Sprinter	9/22/23	V07 (619) Montgomery, AL
Sprinter	9/29/23	V19 (660) Salt Lake City, UT
F550	9/29/23	V01 (689) West Haven, CT
Sprinter	9/29/23	V20 (663) Tacoma, WA
Sprinter	10/2/23	V20 (663) Seattle, WA
Sprinter	10/16/23	V06 (590) Hampton, VA
F550	10/16/23	V12 (537) Chicago, IL
Sprinter	11/6/23	V07 (534) Charleston, SC
Sprinter	11/6/23	V08 (516) Bay Pines, FL
Sprinter	11/13/23	V09 (596) Lexington, KY
F550	11/13/23	V10 (541) Cleveland, OH
Sprinter	11/20/23	V23 (636) Omaha, NE
F550	11/20/23	V07 (521) Birmingham, AL
F550	12/18/23	V21 (654) Reno, NV
F550	12/22/23	V21 (593) Las Vegas, NV
F550	1/22/24	V16 (629) New Orleans, LA
F550	1/29/24	V22 (678) Tucson, AZ
F550	2/26/24	V21 (662) San Francisco, CA

HPACT & CONNECTING VETERANS TO CARE

HPACT connects Veterans to VHA health care

- Medical “home” for Veteran.
- Primary care (PACT) that connects Veterans to other resources and services (e.g., suicide prevention, toxic exposure screening, specialty care services).
- Prevention services such as vaccinations and health screenings.
- Outreach medical services:
  - MMU
  - GPD sites
  - HUD-VASH
  - Collaboration with HCHV Outreach
- Evidence shows enrollment in HPACT reduces ED visits and inpatient admissions.
- Refer to HPACT where available.

THANK YOU

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QUARTERLY REVIEWS

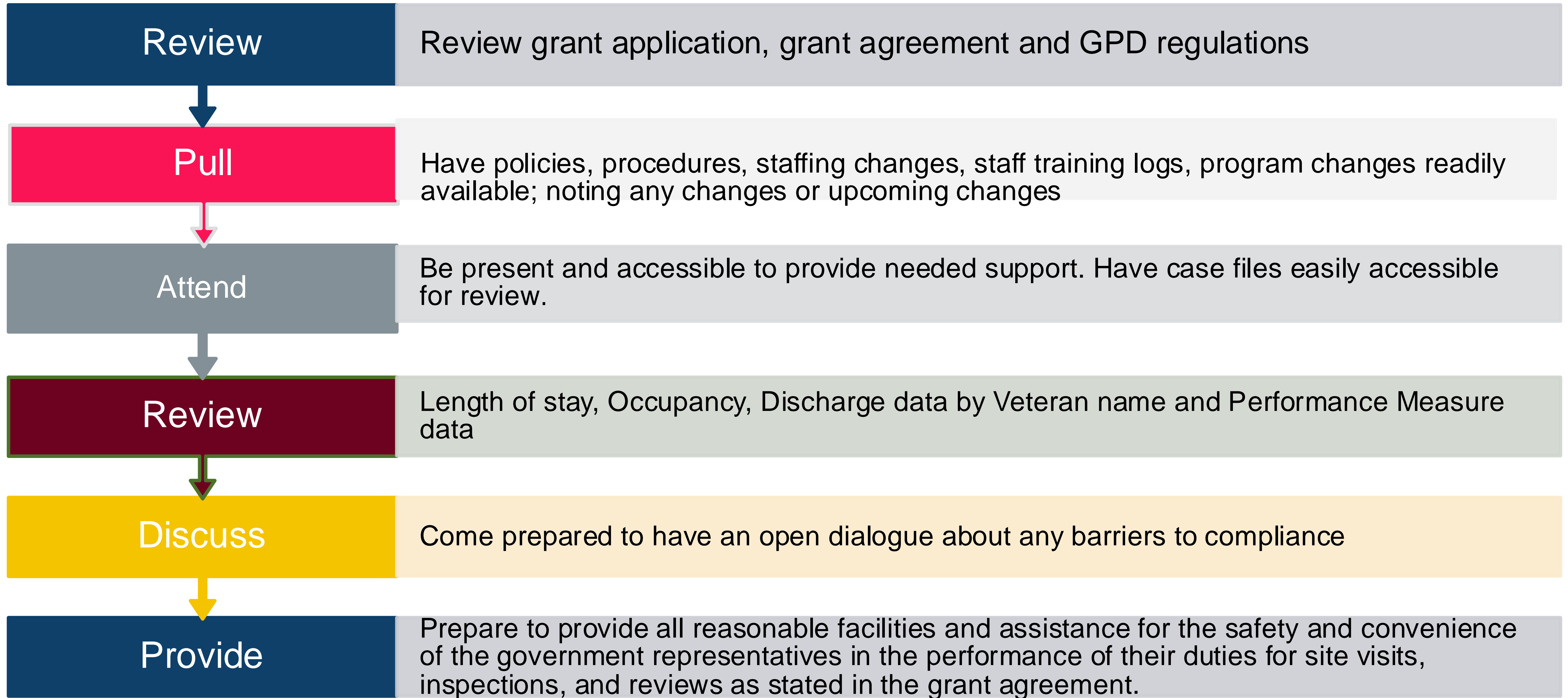
WHAT IS A QUARTERLY ASSESSMENT?

- A formal review of each FAIN that occurs at least once per fiscal quarter. The findings of this compliance review must be documented in a memorandum for the record with a copy provided to the GPD grantee. This review includes:
  - Performance measure outcomes
  - Programmatic accomplishments and challenges
  - Grant Compliance (staffing, trainings, services provided etc.)
  - Length of Stay & Occupancy
  - Best practices/areas of improvement
  - Opportunities for collaboration and coordination
  - Veteran interviews
  - A separate environmental review

PURPOSE OF A QUARTERLY ASSESSMENT

- Provides a formal opportunity to engage in dialogue with GPD liaison
- Opportunity to share ideas and review successes and challenges together in person
- Opportunity to review program performance metrics and grant compliance
- No surprises at annual inspection
- Opportunity to give and receive feedback

PREPARING FOR YOUR QUARTERLY ASSESSMENT



WHAT TO EXPECT

WHAT IS INCLUDED IN A QUARTERLY REVIEW

- A cursory environmental review of the GPD facility to identify any potential hazards or deficiencies. If the GPD Liaison identifies any areas of concern, they must consult with a subject matter expert to ensure that the item meets inspection criteria.
- A random review of the GPD grantee's clinical charts to ensure grant and regulatory compliance.
- Performance measure outcomes

– An assessment of quantifiable as well as non-quantifiable goals.
  - Examples include, but are not limited to, a description of grant agreement-related activities, such as: Hiring and training personnel, community orientation/awareness activities, programmatic activities, or job development; and

– Identification of administrative and programmatic problems, which may affect performance and proposed solutions.

WHAT TO EXPECT

If, after reviewing a recipient's assessment, VA determines that it falls more than five percent below any performance goal for any two (2) consecutive quarters , then VA may require the recipient to create and follow a performance improvement plan (PIP) as outlined in 38 CFR Part 61.80(c)(vi)

Discussions about performance are not punitive. PIPs are an opportunity to review current practices and outcomes and develop a concrete plan for improvement. This should serve both the liaison and grantee in ultimately reaching enhanced performance goals.

The GPD Program Office *does not* require copies of PIPs, unless there are significant performance issues and the grantee and liaison do not agree on goals and outcomes.

HOW OFTEN DO QUARTERLY ASSESSMENT TAKE PLACE?

At least once per fiscal quarter:

(A) Quarter 1 no later than January 30;

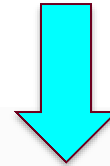
(B) Quarter 2 no later than April 30;

(C) Quarter 3 no later than July 30; and,

(D) Quarter 4 no later than October 30

WHERE CAN I FIND INFORMATION ON QUARTERLY ASSESSMENTS?

Regulations.eCFR :: 38 CFR Part 61 GPD:



§ 61.65 Inspections.

VA may inspect the facility and records of any applicant or recipient when necessary to determine compliance with this part or an agreement under § 61.61. The authority to inspect does not authorize VA to manage or control the applicant or recipient.

(Authority: 38 U.S.C. 501, 2011, 2012, 2061, 2064)

§ 61.80 General operation requirements for supportive housing and service centers.

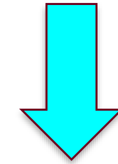
(ii) A valid assessment must include the following:

(A) A comparison of actual accomplishments to established GPD performance goals for the reporting period addressing quantifiable as well as non-quantifiable goals. Examples include, but are not limited to, a description of grant agreement-related activities, such as: Hiring and training personnel, community orientation/awareness activities, programmatic activities, or job development; and

(B) Identification of administrative and programmatic problems, which may affect performance and proposed solutions.

Other resources:

- Grant and Per Diem Program: Provider Website - VA Homeless Programs



Grant Agreement:

U.S. Department of Veterans Affairs

Veterans Grant Program Grant Agreement

In accepting a Department of Veterans Affairs (VA) award, the grantee (or recipient) assumes legal, financial, administrative and programmatic responsibility for administering the award. All applicable appropriations, laws, statutes, rules, regulations (e.g., 38 C.F.R. part 61, 2 C.F.R. part 200), Notice of Funding Opportunity (NOFO) requirements, Executive Orders governing assistance awards, statutory and national policy requirements (e.g., 2 C.F.R. § 200.300 and 41 U.S.C. § 4712) and these terms and conditions are hereby incorporated into this award by reference. While VA may provide grantees with reminder notices regarding award requirements, the absence of receiving such notice does not relieve grantees of responsibility to meet all applicable award requirements. Under this agreement, the grantee agrees to provide what is outlined in the grant award and application along with any modifications that have occurred or will occur as a result of official changes approved by the VA GPD Program Office.

FINANCIAL MANAGEMENT UPDATES

FEDERAL FINANCIAL REPORT (SF-425)

- **All grantees are required to submit a** Federal Financial Report (SF-425) documenting actual costs incurred during fiscal year (FY) 2024.
  - Reporting period is from October 1, 2023 – September 30, 2024.
  - A separate report must be submitted for each FAIN.
  - Submission of these reports is a condition of these awards and a requirement to receive Federal funding.

- SF-425's will be reviewed by VA's Office of Business Oversight (OBO).
  - Submit the completed SF-425 ***and*** the supporting documentation (general ledger) to GPD425@va.gov.
  - Signatures on the SF-425 must be wet ink or a true electronic signature by an authorized representative of your organization.

- SF-425 submissions **due no later than Thursday, January 30, 2025.**
  - Early submissions are encouraged.
  - GPD will issue a withholding of payments for any grant projects that have not submitted a properly completed SF-425 and general ledger by the due date.

View Burden Statement

Federal Financial Report
(Follow form Instructions)

OMB Number: 4040-0014
Expiration Date: 02/28/2022

1. Federal Agency and Organizational Element to Which Report is Submitted
2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)

3. Recipient Organization (Name and complete address including Zip code)
Recipient Organization Name:
Street1:
Street2:
City: County:
State: Province:
Country: USA: UNITED STATES ZIP / Postal Code:

4a. DUNS Number
4b. EIN
5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)

6. Report Type: Quarterly, Semi-Annual, Annual, Final
7. Basis of Accounting: Cash, Accrual
8. Project/Grant Period: From: To:
9. Reporting Period End Date

10. Transactions	Cumulative
(Use lines a-c for single or multiple grant reporting)	
Federal Cash (To report multiple grants, also use FFR attachment):	
a. Cash Receipts	0.00
b. Cash Disbursements	0.00
c. Cash on Hand (line a minus b)	0.00
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	0.00
e. Federal share of expenditures	0.00
f. Federal share of unliquidated obligations	0.00
g. Total Federal share (sum of lines e and f)	0.00
h. Unobligated balance of Federal Funds (line d minus g)	0.00
Recipient Share:	
i. Total recipient share required	0.00
j. Recipient share of expenditures	0.00
k. Remaining recipient share to be provided (line i minus j)	0.00
Program Income:	
l. Total Federal program income earned	0.00
m. Program Income expended in accordance with the deduction alternative	0.00
n. Program Income expended in accordance with the addition alternative	0.00
o. Unexpended program income (line l minus line m or line n)	0.00

2 C.F.R. Updates

•Indirect Cost Rate (2 C.F.R § 200.412-415):

- •Certification of De Minimis Indirect Cost Rate
  - **15%** de minimis rate of modified total direct costs (MTDC)
  - Allows for MTDC to include subawards up to $50,000
  - Complete and Upload an updated Certification of de minimis form to your organization profile in eGMS

•Request pre-approval for all expenses over **$10,000**, includes both equipment and capital expenditures and (2 C.F.R. § 200.439) and maintenance and repair costs (2 C.F.R. § 200.452)

OFFICE OF BUSINESS OVERSIGHT

Upcoming Fiscal Reviews:

– Wisconsin Department of Veterans Affairs – October 14 – 18, 2024
– Altamont Program, Inc. – October 21 – 25, 2024
– Harbor Homes – October 21 – 25, 2024
– Veterans Northeast Outreach Center, Inc. – October 21 – 25, 2024
– Roof Above – October 21 – 25, 2024
– St. Francis House, Inc. – November 4 – 8, 2024
– YWCA Rhode Island – November 4 – 8, 2024
– Montachusett Veterans Outreach Center, Inc. – November 4 – 8, 2024
– Rowan Helping Ministries – November 18 – 22, 2024
– Caring Services, Inc. – November 18 – 22, 2024
– Steps to Recovery, Inc. – November 18 – 22, 2024
– Joseph House, Inc. – November 18 – 22, 2024
– The Salvation Army (Atlanta) – November 18 – 22, 2024

WRAP UP

- Our next meeting is
  - **Tuesday, November 12th** @ 2pm EST, 1pm CST, 12pm MST/AZ, 11am PST, 9am HI