Medical Respite for Homeless Veterans

Impressions of the Hospital-to-Housing model of care from Grant & Per Diem Providers

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HOMELESS MEDICAL RESPITE

"MEDICAL RESPITE IS SHORT-TERM **RESIDENTIAL CARE** THAT ALLOWS HOMELESS INDIVIDUALS THE OPPORTUNITY TO **REST IN A SAFE ENVIRONMENT** WHILE **ACCESSING MEDICAL CARE AND OTHER SUPPORTIVE SERVICES.** MEDICAL RESPITE CARE IS OFFERED IN A **VARIETY OF SETTINGS** INCLUDING FREESTANDING FACILITIES, HOMELESS SHELTERS, NURSING HOMES, AND TRANSITIONAL HOUSING."

NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

U.S. Department of Veterans Affairs

WHY HOMELESS MEDICAL RESPITE

- Disproportionally high rates of hospitalization
- High rates of emergency and urgent care use
- Longer costly inpatient stays
- Disproportionally high rates of 30-day readmissions
- Opportunity to engage in housing and other psychosocial services

COMMUNITY, NON-VA RESPITE MODELS

- As of October 2016, 80 respite programs in 29 states
- Most in large, urban areas
- Require large initial and on-going financial resources
- Underwritten by large hospitals, Robert Wood Johnson Foundation
- No permanent housing requirement for discharge
- Less research on smaller, less financially intense models

COMMUNITY, NON-VA RESPITE MODELS

Barbara McInnis House
Boston Health Care for the Homeless
Boston Medical Center campus

104-bed, 24/7 admissions
Average length of stay: 9-11 days

VA RESPITE WITHIN GRANT & PER DIEM HOSPITAL-TO-HOUSING

- Test of concept by VA National Center on Homelessness Among Veterans, May 2016
- Hospital-to-Housing (H2H) Operationally launched within GPD as a bed model, October 2017
- No infrastructure or medical staff requirements
- **Veterans must have functional ADLs**
- Strong reliance on VA outpatient teams for post-discharge care
- **Permanent housing placement at discharge**

H2H FIRST YEAR CHARACTERISTICS

- **41** GPD providers with over 350 beds available
- Average of beds requested by provider: **8**
- Largest number of beds requested: **20**
- Most providers in urban areas
- Rural providers: **1**

H2H FIRST YEAR DEMOGRAPHICS

OF 200 H2H VETERANS

- Chronic medical condition: 70%
- Mental health condition: 65%
  - Depression: 53%
  - PTSD: 38%
- Comorbid mental health condition & substance abuse: 47%
- Age 55-64: 51%
- Age 65+: 25%
- **Average length of stay: 136 days**
- **Negative discharge rate: 12%**

H2H FIRST YEAR ACUTE & OUTPATIENT CARE USE

All H2H Veterans (N=200)			
Service utilized	**Pre-H2H (%)**	**Post-H2H (%)**	**McNemar P-value**
Acute Care	134 (67.0%)	79 (39.5%)	*<0.01*
ED	115 (57.5%)	71 (35.5%)	*<0.01*
Inpatient	87 (43.5%)	28 (14.0%)	*<0.01*
Primary Care	95 (47.5%)	156 (78.0%)	*N/A*
H2H Veterans with Pre-existing Mental Health Conditions (N=129)			
Service utilized	**Pre-H2H (%)**	**Post-H2H (%)**	**McNemar P-value**
Acute Care	97 (75.2%)	52 (40.3%)	*<0.01*
H2H Veterans with Pre-existing Substance Abuse Disorder (N=114)			
Service utilized	**Pre-H2H (%)**	**Post-H2H (%)**	**McNemar P-value**
Acute Care	87 (76.3%)	41 (36.0%)	*<0.01*
H2H Veterans with Pre-existing Mental Health & Substance Abuse Disorder (N=93)			
Service utilized	**Pre-H2H (%)**	**Post-H2H (%)**	**McNemar P-value**
Acute Care	71 (76.3%)	35 (37.6%)	*<0.01*

GPD PROVIDER H2H FEEDBACK

QUALITATIVE INTERVIEWS WITH 7 GPD PROVIDERS

Major Themes

- Need for & value of H2H
- Ability to successfully collaborate with VA
- “Mission stretch”
- Best practice recommendations

GPD PROVIDER H2H FEEDBACK NEED FOR & VALUE OF H2H

"**The need is so great.** These Veterans linger in the hospital until they can get a SNF or state home placement. We had a [homeless] Veteran stay inpatient for two months. **There just aren't a lot of options**."

"We were excited for the opportunity [to apply for H2H]. [Our VA] got **dinged recently on [inpatient] lengths-of-stay** for Veterans. We have a good relationship with our VA and this seemed like a great opportunity."

"The advantage to H2H is that it serves beyond the acute issue. **Regular respite is too short term**."

GPD PROVIDER H2H FEEDBACK COLLABORATING WITH VA

"[VA GPD liaison] is an excellent case manager. She is very direct and helps **address things like medication non-compliance and missed appointments** with the Veteran. She keeps them from being labeled 'non-compliant.'"

"**The team building aspect of H2H is the critical link.** All have to be willing to help. We are working together on changing the referral paperwork and finalizing a check list. It's really good to all get together."

"We met with [partnered VA]. **The Chief of Social Work directly educated her staff** to not refer Veterans that cannot be successful [in H2H]."

GPD PROVIDER H2H FEEDBACK "MISSION STRETCH"

"Our initial concern was very ill patients, patients too sick to [permanently] house. In the back of my mind was, despite all the [GPD National] model calls saying not to provide nursing home care, **we'd end up a nursing home**."

"We've done all the other models and this [H2H] **was a little scary**. But we expected it to be a **work-in-progress**. [Grantee staff] was very accepting of trial and error."

"[**GPD grantee staff**] goes to VA to meet with the care team, visits with Veterans inpatient, meets with inpatient social workers. **She's trying to get a good outcome**."

GPD PROVIDER H2H FEEDBACK BEST PRACTICES

- Regular communication
- Involve GPD liaison, inpatient social workers, outpatient care team, H-PACTs (if available)
- Iron out referral process (and keep refining)
- Strong checklists
- Ability to change admission process as needed
- Regular meetings, daily emails to VA GPD liaison
- Tracking appointment compliance
- Review each enrolled Veteran's case

FUTURE H2H OPPORTUNITIES

- **New NOFA 2020**
- Opportunity for new providers to apply
- Current providers must reapply
- Start discussion with medical center early
- Open communication lines
- Assess feasibility

CLOSING SUMMARY

- Well-received by GPD providers
- Need is strong
- Low infrastructure requirements as compared to community-underwritten models
- **GPD model = time for permanent housing to be obtained**
- Enrollment in H2H reduced reliance on acute care
- Helps contribute towards health system goals surrounding readmissions and acute care use

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