

## Successful H2H Launch: Illustrative Examples of Teams with Successful H2H Implementation

Theme	Illustrative Example
<b>Perception of Value of Hospital-to-Housing</b>	<p><i>“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.”</i></p>
	<p><i>“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.”</i></p>
	<p><i>“At the end of the day, we have little control over the health of the Veterans; but we can offer support where 24-7 staff can check on the Veteran.”</i></p>
	<p><i>“I would not consider placing [Veterans suitable for H2H] in a different model like SITH. That would be short-sighted.”</i></p>
<b>Capacity to Successfully Collaborate with their Partnered VA</b>	<p><i>“[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.’”</i></p>
	<p><i>“Our H-PACT is great at collaboration. Just great collaboration! Our VA is fantastic. Dr. [Name Redacted] will get people right in. We call him Saint [Name Redacted]!”</i></p>
	<p><i>“We met with [partnered VA]. The Chief of Social Work directly educated her staff to not refer Veterans that cannot be successful [in H2H].”</i></p>
	<p><i>“Our H-PACT always answers the phone and they even come to us. We do not have an adversarial relationship. They’re easy to work with. We literally talk every day. They’re part of the team! They’re so close to us and email isn’t necessary. Bureaucracy is not a barrier at all.</i></p>
	<p><i>““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.”</i></p>
<b>Logistical Barriers</b>	<p><i>“Much of the population is aging and have disabilities. There aren’t a lot of options and it can be hard to assess the true needs of the patients while they’re still in the hospital.”</i></p>
	<p><i>“One of our greatest challenges? Transportation! We’ve been lucky though to get an Uber grant.”</i></p>
	<p><i>“We’re considering expanding in the next NOFA, but we need to tighten up procedures first.”</i></p>
	<p><i>“VA Social Workers didn’t have a clear understanding [of what H2H is].”</i></p>

<b>GPD Grantee Staff Capabilities &amp; “Mission Stretch”</b>	<i>“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.”</i>
	<i>“[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.”</i>
	<i>“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.”</i>
<b>Impact of Data Metrics and Administrative Requirements on Model Viability</b>	<i>“Our early referrals had too high of need and that means bad numbers.”</i>
	<i>“The numbers’ are a struggle. We don’t have a lot of permanent housing. We try to prioritize VASH for H2H Veterans, but our community is prioritizing chronically homeless. We use the VA SPIDAT and our Veterans are very vulnerable, but they are not ‘chronically’ homeless.”</i>
	<i>“Using percentages as a metric when you only have 5 beds makes it easy to say a program isn’t working out.”</i>
	<i>“It’s nice to be able to talk about this. It’s so frustrating with ‘the numbers.’ If you have two beds and have one ‘negative’ discharge a quarter [in a community with limited permanent housing], you’re labeled as failing.”</i>
	<i>“Our Vets come in, get stabilized, then go AWOL. This is a negative discharge. They feel better, want to get work, then leave.”</i>

**Unsuccessful H2H Launch: Illustrative Examples of Teams Unsuccessful at H2H Implementation**

<b>Theme</b>	<b>Illustrative Example</b>
<b>Perception of Value of Hospital-to-Housing</b>	<i>“The advantage to H2H is that it serves beyond the acute issue. Regular respite is too short term.”</i>
	<i>“We flexed our beds to SITH and Low Demand. Because of the Veterans have to have functional ADLs, we’re serving the same Vets anyway.”</i>
	<i>“We were very excited by it [H2H]. We thought it was a great resource... Don’t over-complicate things. Implementing and keeping occupancy up can be challenging. More models isn’t necessarily better. It was trial and error, but we still feel like we are serving the same Veterans.”</i>
	<i>“When the new NOFA came out, we went for all 4 models to diversify. Now we’re not using H2H or Bridge. We’re increasing SITH and Low Demand, but are still holding on to H2H.”</i>

<b>Capacity to Successfully Collaborate with their Partnered VA</b>	<p><i>“There was lots of bureaucracy. Everyone [at VA] was wonderful, but there were 7 staff in the room just to talk about 10 [H2H] beds. Was it worth all the energy? We’re working already with our liaison.”</i></p>
	<p><i>“VA staff is stretched too thin and has zero in-person capabilities. It shouldn’t take 3 months to get primary care.”</i></p>
	<p><i>“After almost a year of coordinating [with VA], nothing happened.”</i></p>
	<p><i>“3-month delays happen all the time. We have a Health Care for the Homeless grant. I thought we would have more of a relationship with [VA] Mental Health for urgent issues [like suicide]. It’s still a couple of weeks. Veterans just go to the local emergency room. We had a Veteran come here from [major city] and say, ‘I can’t believe how long everything takes here!’”</i></p>
	<p><i>“I received so much push-back from my liaison, I just put [the Veteran] in Clinical Treatment, but I thought I would have more leverage if he was in H2H.”</i></p>
<b>Logistical Barriers</b>	<p><i>“[Grantee’s location] housing vacancy rate is 2%. We’ve received no HUD-VASH vouchers in over a year. Without SSVF, I don’t know what we would do.”</i></p>
	<p><i>“Hiring was an issue with H-PACT. Dr. [Name Redacted] was very frustrated with inability to timely hire. Other than the lack of staffing, VA would have been a viable partner.”</i></p>
	<p><i>“We had good intentions on both sides [grantee &amp; VA]. There was trouble staffing the H-PACT at the VA.”</i></p>
	<p><i>“We’re struggling with technical assistance. Other teams don’t have our problems [with rurality]”</i></p>
<b>GPD Grantee Staff Capabilities &amp; “Mission Stretch”</b>	<p><i>“I was tasked with training VA staff. Our VA is 2 hours away. Our MOU says education is handled by our liaison. No education was coming down the line. [A VA provider] told me to educate the VA staff.”</i></p>
	<p><i>“We just had to say that we can’t take a discharge after 12pm on Friday. Inevitably, it’ll be late on a Friday and we’ll be asked to take someone not knowing he’s on oxygen and needs Depends.”</i></p>
<b>Impact of Data Metrics and Administrative Requirements on Model Viability</b>	<p><i>“With the challenges at our local VA, we were too worried about outcomes [and how they reflected upon the organization]. The time-line was way too long and it affected our occupancy.”</i></p>
	<p><i>“We couldn’t leave beds open waiting for H2H Veterans.”</i></p>