COVID-19 HUD-VASH Nurse Telephone Contacts

A Strong COVID-19 Practice in VHA Homeless Program Operations

INTRODUCTION

The VHA Homeless Programs Office identifies and disseminates strong, emerging practices in homeless program operations during the COVID-19 National Emergency. The Danville VA Medical Center's (VAMC) Housing and Urban Development-VA Supportive Housing (HUD-VASH) program has instituted a protocol by which the HUD-VASH Registered Nurse (RN) makes telephone clinical contacts to help minimize disruption in care management for targeted Veterans in the HUD-VASH program during the COVID-19 National Emergency.

PRACTICE OVERVIEW

In the early days of the COVID-19 National Emergency, Veterans in the Danville VAMC HUD-VASH program were at risk of disruptions to their community-based outpatient care due to COVID-19 related challenges and barriers such as safety concerns when using public transportation and decreased office hours and access to community-based providers. With the passage of the Mission Act in May 2018, a significant number of Veterans in the Danville VAMC catchment area received specialty health care services from non-VA providers. Prior to COVID-19, HUD-VASH social workers worked as care coordinators, ensuring appropriate linkage and continuity of care between the VA Patient Aligned Care Teams (PACT) and those community providers. However, due to the changes to operations brought about by the pandemic, the HUD-VASH team established a protocol to coordinate care for Veterans who meet high COVID-19 vulnerability criteria, according to Centers for Disease Control (CDC) guidelines.

For those Veterans who had highly complex health care needs and were engaged in three or more community-based specialty services, the HUD-VASH team's RN is now charged with making focused telephone contacts.

These contacts accomplish many tasks including:

- Care coordination between PACTs and community providers.
- Enhanced care coordination for those Veterans who are not well engaged with their PACT.
- Ensuring that Veterans understand and follow-up with urgent and emergent care discharge instructions.
- Refilling medications through mail-order pharmacy services.
- Closing any service gaps during the downtime when patient records are transferring from community providers to VA.
- Nursing education as needed.

The impact on Veterans has been monitored since implementation. Initially, from late-March to mid-April, the RN noted that those who were the most receptive to telephone outreach were Veterans who had respiratory

illnesses such as COPD or who were recently treated for pneumonia. The immediate impact observed was improved engagement and reconnection to primary and specialty care providers by Veterans who had disengaged for a variety of COVID-19 related reasons.

During the next few weeks in late-April to early-May, the RN again observed that those who were receptive to the calls began to ask more questions about their healthcare such as current diagnoses, inquiries about medical equipment and medication issues, and plans of care. This suggested that the Veterans felt more confident in self-managing their care and more confident in independently following up.

This pattern of increasing engagement and continued in mid-May, particularly for Veterans who had three or more specialty care providers. While it was initially planned that the RN would simply help re-connect the Veteran to their established care or support continuity of care, the RN ended up providing integrated care coordination as part of a multidisciplinary team of VA and non-VA providers.

Prior to the development of an internal COVID-19 At-Risk Veteran Report, the RN and HUD-VASH lead reviewed their HUD-VASH roster to identify vulnerable Veterans based on the CDC guidelines. Today they are able to use the COVID-19 At-Risk Veteran Report to streamline ongoing targeting.

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