Homeless Patient Aligned Care Team (HPACT) Model of Care

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Learning Objectives

1. Understand the need/rationale for the Homeless Patient Aligned Care Team (HPACT) program.

2. Describe the HPACT model, development of the program, and current operations.

3. Identify ways to integrate HPACT with GPD and other homeless program services to serve Veterans.

THE NEED FOR HPACT

Homeless Populations & Health: The Need for HPACT

- **Homeless populations:**
  - Suffer from higher rates of chronic disease including mental health issues. [1-3]
  - Higher age-adjusted mortality than housed counterparts.[2,4]
  - Unmet health care needs[5]
- **Homeless populations and acute care use:**
  - Homelessness is one of the most common characteristics of people accessing the emergency department (ED) for care.[6-8]
    - Smaller sample of ED population but significant number of visits
  - Longer lengths of stay as inpatients.[9,10]
- **Homeless populations and barriers to care**:[11-15]
  - Unstable sheltering
  - Limited availability and/or fragmented health services
  - Difficulty scheduling and keeping appointments
  - Stigma and/or perceived stigma of homelessness
  - Lack of trust and social isolation
  - Competing needs (i.e., food, shelter, safety)
  - Transportation

What is Unique About HPACT

- Collaborative Primary Care-Homeless Program treatment model for eligible homeless Veterans who have difficulty accessing and engaging in services.
- What is unique about HPACT?
  1. **HPACT is organized and placed in settings that enhance access and engage homeless Veterans in clinical care earlier in their homelessness while reducing emergency department and other acute care use (i.e., reach high-risk, high-need Veterans).**
     - Open-access, walk-in care, same-day services
     - Community outreach and referrals
     - CRRC setting
  2. **Providing comprehensive medical, mental health, case management, and social services in one setting.**
     - Co-located to create a continuum of care (i.e., one-stop)
     - Wrap around services (food and clothing assistance, hygiene items, showers, laundry facilities, transportation support, etc.)
     - Integrated care team (i.e., destigmatized care)
  3. **Tailoring care to the specific medical, mental health, and homeless service needs of homeless Veterans.**
     - Evidence-based, culturally-sensitive care
     - Use of real-time data

HPACT Program: Research Outcomes

HPACT enrolled Veterans:

- Are associated with lower rates of emergency department use and hospitalization. [16]
- Show a significant decrease in ED usage among the highest ED utilizers compared with usual care.[17]
- Cost over $9,000 less/year to care for compared to a homeless Veteran enrolled in a PACT.[18]
- Gain housing faster than those not enrolled in HPACT.[19]
- Receive more primary care visits and social services compared to standard primary care and are more likely to report positive experiences with access, communication, office staff, providers, and comprehensiveness.[20]
- Report a greater reduction in unfavorable experiences.[21]

HPACT MODEL AND CURRENT OPERATIONS

HPACT Development

HPACT is a multi-disciplinary, population-tailored medical home designed around the unique needs and distinct challenges homeless Veterans face both accessing and engaging in health care.

- Piloted in 2011 by HPO
- Efficacy and approach of the model generated by VHA HSR&D funded research
- Serves as platform for new projects and initiatives to address population care needs

HPACT Model: 5 Core Elements

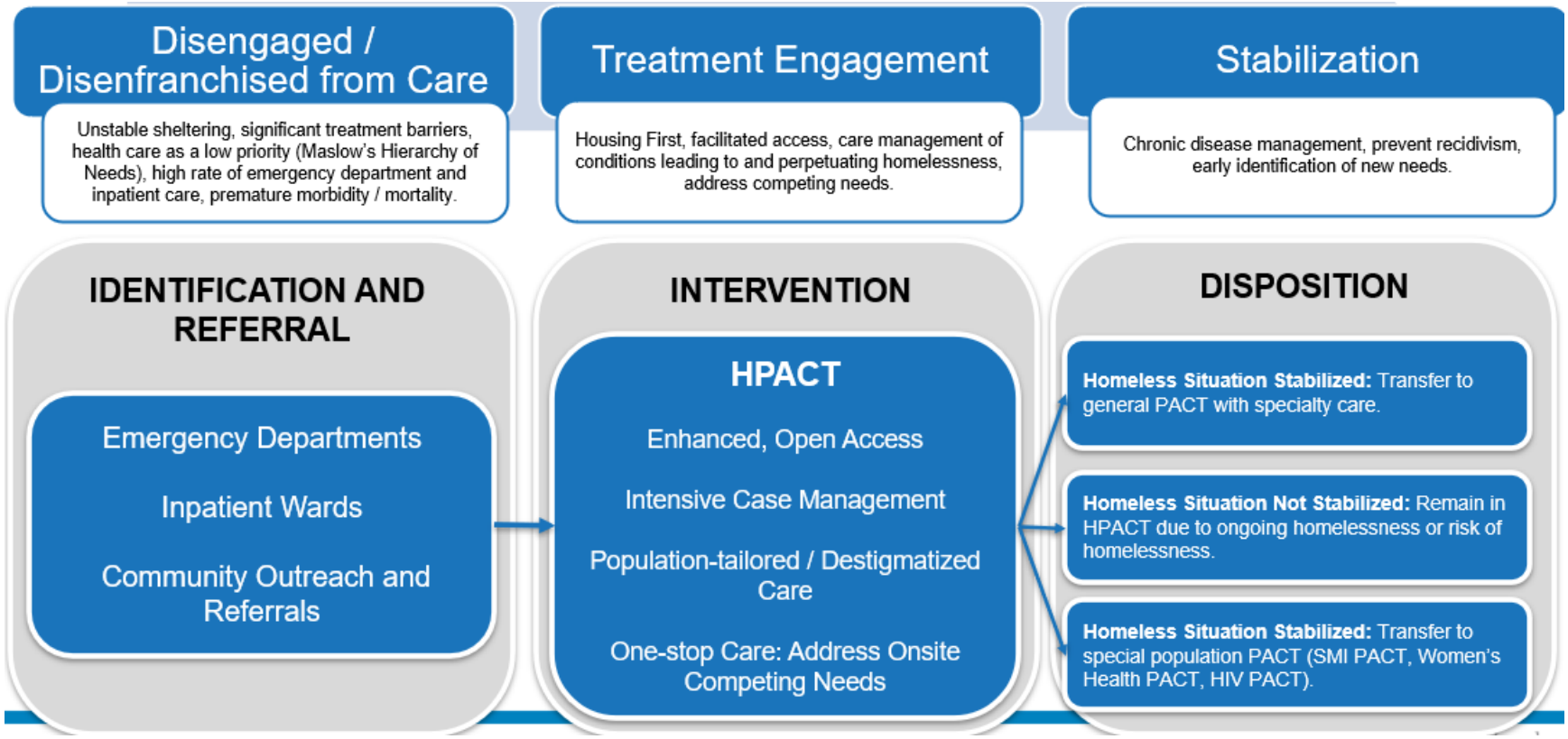
1. **Reducing barriers to care:** Provide open-access, walk-in care in addition to community outreach
2. **One-stop, wrap-around services:** Care that is integrated and coordinated including mental health, homeless programs, and primary care staff that are co-located to create a continuum of care and integrated team. Many provide food/clothing assistance, hygiene items, showers, laundry, etc.
3. **Engaging Veterans in intensive case management:** Coordinated with other VA services and community partners to create continuous care that is seamless.
4. **Providing high-quality, evidence-based, and culturally-sensitive care:** Validated care through research evaluation and achieved through on-going homeless education for staff.
5. **Performance-based and accountable:** Using real time data and predictive analytics to assist teams in targeting Veterans most in-need.

HPACT Models of Care

- Comprehensive HPACT model
  - Primary care delivered by HPACT co-located and integrated with Homeless Program services
    - "One-stop care"
    - Includes outreach services
    - Facilitate access to VHA services and non-providers as needed

- Community Resource and Referral Centers (CRRC) based HPACT model
  - Care provided in non-traditional setting likely to attract homeless Veterans
    - Urban location
    - Immediate assistance
    - Event-based care

HPACT Treatment Model



National HPACT Program

National HPACT Program	FYTD22
Active VA Locations	57
Number of Providers (Teamlets)	87
Veterans Currently Enrolled	16,718
Veterans Served in FY21	>22,000
% Women	5.44%
% OEF/OIF/OND	11.11%
% > Age 65	29.10%
Average Age of Veterans	57

Current HPACT Locations

Real-Time Data Commonly Used by HPACT

- **Homeless PACT Dashboard**
  - Provides a quick and easily accessible overview of HPACT panel including patient characteristics, risk factors, and care provided.
- **Homeless Patient Aligned Care Team Report**
  - Broad report that provides patient enrollment and service utilization information.
  - National level, VISN level, facility level and can be drilled down to individual SSN.
- **Homeless Registry Hot Spot Reports**
  - Hot spot utilizers (2 ER visits or inpatient admission in last 3 months) both assigned to PACT and unassigned to PACT.
- **Prevention and Screening products**
  - Immunizations by PACT
  - COVID-19 vaccine tools

National HPACT Panel: RISK Factors

RISK Factor	FY22YTD
Average HPACT Patient Nosos Risk Score	2.36
Average Primary Care Patient Nosos Risk Score	0.96
Percent of Panel with CAN score > 75	57%
Percent of Panel with CAN score > 90	38%

National HPACT Panel: CARE Provided

CARE Provided	FY22YTD
HPACT Avg Visits per Year	5.53
Mental Health Avg Visits per Year	9.97
Homeless Avg Visits per Year	7.15
% Flu Vaccine >12 months	66%
% COVID Vaccinated	65%

Homeless Registry Veterans: Hot Spot Report

- Homeless Registry Veterans assigned and those not assigned to PC or HPACT panel.
- Includes Hot Spot Veterans assigned/not assigned if they have had 2 ER visits or admission in the past 3 months.
- Can drill down to Veteran enrollment in specific homeless program.
- Allows HPACT teams to proactively reach out to unassigned Veterans (and particularly Hot Spot Veterans) through close coordination and collaboration with homeless program staff.
  - Equals increased engagement/access.
  - Reaching high-risk, high-need Veterans.

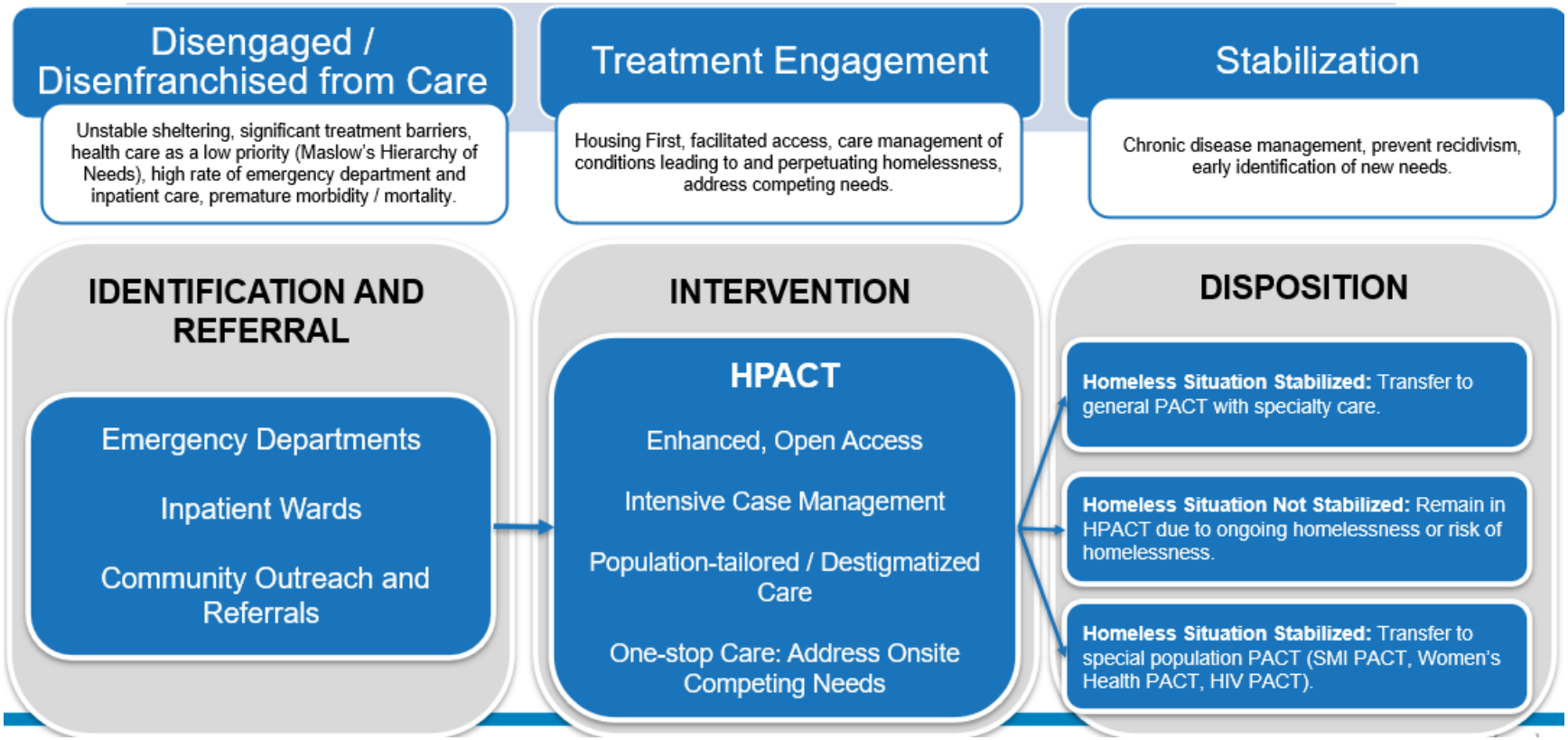
HPACT INTEGRATION WITH OTHER HOMELESS PROGRAMS

Veteran Stabilization

- HPACT Goal
  - Engaging high-risk, high-need Veterans in care and services while reducing ED and other acute care use.

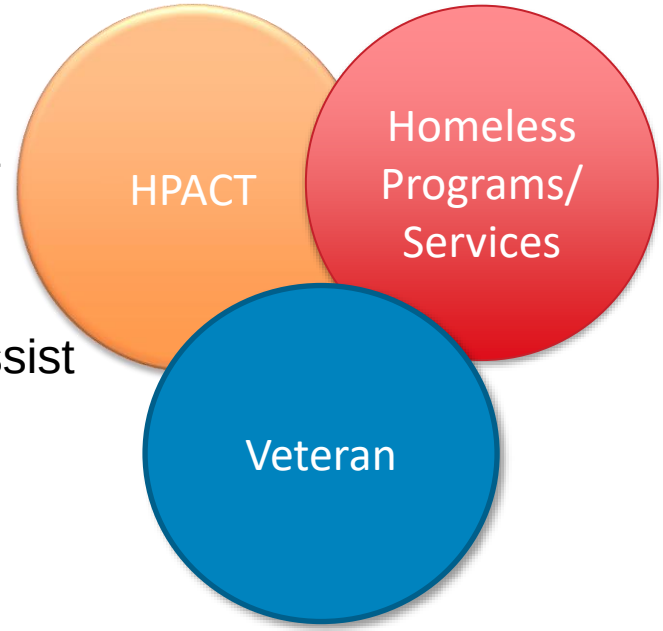
- Homeless situation stabilized – "Graduate" from HPACT
  - Clinical and social stabilization
  - Able to successfully navigate healthcare system
    - Keep regularly scheduled appointments
    - Does not have frequent visits to an ED or Urgent Care setting
  - Effectively self-manage chronic diseases
  - Early identification of new needs
  - Stably housed for at least 6 months

How to Achieve Stabilization



Considerations for Practice

- **Collaboration and Communication**
  - Homeless programs (VHA and community partners) work to address needs of Veterans experiencing or at-risk of homelessness
    - Collaboration key to connecting Veterans with medical/mental health services through HPACT
    - Open communication, team-based to provide optimal care for Veteran
  - Rely on other services (internal/external) to assist with identifying Veterans needing HPACT services.
    - ED, inpatient, PC – not always entry point
  - HPACT utilize screening tools/prevention
    - Homeless screening, food insecurity screening, suicide, SDoH, medical screening indicators(i.e., cancer, immunizations, etc.)



Summary

- HPACT is a multi-disciplinary, population-tailored medical home.
  - Designed to address the unique needs and distinct challenges homeless Veterans face both accessing and engaging in health care.
- 5 core elements to the model to help address barriers/challenges to care faced by this vulnerable population.
- HPACT reliant on both VHA and community partners to assist with referrals, facilitate access, and collaborate for optimal Veteran outcomes.
- Consider HPACT referral/consultation for all medically eligible Veterans when a team available.

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