VA NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS

*Research-driven solutions to prevent and end homelessness*

# Development and Expansion of Homeless Patient Aligned Care Team (H-PACT) Model

## H-PACT Program Brief

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### OVERVIEW

In this program report we describe the development and expansion of the Homeless Patient Aligned Care Team (H-PACT) model from its inception as a VA National Center on Homelessness Among Veterans (the Center) pilot project. We further describe the emerging peer-reviewed evidence base supporting this approach, stemming from several VA Health Services Research and Development (HSR&D) supported studies and quality improvement assessments. Finally, we describe the platform that H-PACTs have provided for several new projects and initiatives aimed at addressing the care needs of homeless and at-risk for homelessness Veterans who face unique and often insurmountable challenges within our traditional care model.

H-PACT is a multi-disciplinary, population-based medical home model organized around the unique challenges homeless Veterans face accessing and engaging in care. The H-PACT addresses the multiple medical and social needs of these Veterans in one setting by incorporating 5 core elements that distinguish it from traditional primary care models:

1. *Reducing barriers to receiving care*: H-PACTs provide open-access, walk-in care as well as outreach to the community to engage those Veterans disconnected from VA services;
2. *Providing one-stop, wrap around services* that are integrated and coordinated. Mental health, homeless programs, and primary care staff are co-located to create a continuum of care and an integrated care team. Most H-PACTs also provide food and clothing assistance, hygiene items, showers, and laundry facilities and other services on-site to meet the full continuum of Veteran needs;
3. *Engaging Veterans in intensive case management* that is coordinated with community agencies for continuous care;
4. *Providing high-quality, evidence-based and culturally sensitive care* through on-going homeless care skill development for H-PACT staff;
5. *Being performance-based and accountable* with real-time data and predictive analytic applications to assist teams in targeting those most in-need, provide on-going technical assistance and personalized feedback to the field and inform team performance.

## PROGRAM STATISTICS

Launched in 2011 as a pilot project by the Office of Homeless Programs/VA National Center on Homelessness among Veterans (the Center), the H-PACT program began with a total of 32 pilot sites. There are currently 60 active sites with an additional 5 sites in planning stages for implementation. H-PACTs are located in every VISN, in every high-volume homeless city (a.k.a. 25 Cities), as well as in rural communities and are based at CBOCs, VA Medical Centers, and Community Resource and Referral Centers (CRRC).

## PROGRAM EVALUATIONS & QUALITY IMPROVEMENT

The H-PACT model has benefited from and is informed by an extensive and rigorous evaluation effort supported by HSR&D and other sources. To date, nine papers evaluating H-PACT have been published in peer-reviewed literature, with several others pending publication or under review. Evaluations to date focus on health services utilization, cost of care, treatment engagement, housing outcomes, use of peers in this setting, and impact on non-VA payers and community providers (e.g. Medicare).

## KEY FINDINGS

*H-PACT enrollment is associated with lower rates of emergency department use and hospitalizations*

- Six-month patterns of acute-care use pre-enrollment and post-enrollment for 3,543 consecutively enrolled patients showed a 19.0% reduction in emergency department use and a 34.7% reduction in hospitalizations. (O'Toole, et al. Prev Chronic Dis. 2016 Mar 31;13:E44)
- In a national case-control study, the monthly mean number of emergency encounters for all H-PACT enrollees decreased from 0.26 to 0.19 from the six months before enrollment to the six months after enrollment ($p < 0.001$). This decrease was most pronounced among H-PACT enrollees with 2+ emergency department visits in the baseline period. (VA HSR&D study SDR 11-230, "Aligning Resources to Care for Homeless Veterans").
- In a prospective, single blinded, multi-center trial, homeless Veterans in H-PACTs were hospitalized less often than those in PACTs (23.1% vs. 35.4%; $p=0.04$) (HSR&D SDR 11-230)

*H-PACTs are more effective at engaging homeless Veterans in ambulatory care services*

- H-PACT-enrolled Veterans averaged 3-5 primary care visits/year (VSSC Homeless Dashboard)
- They also received more social work support than in a PACT, averaging 4.6 visits per year compared with 2.7 visits/year ($p<0.01$) (HSR&D SDR 11-230)
- They average almost 2 specialty visits/year and over 80% are actively engaged in mental health care and over 90% are enrolled in a VA homeless program (VSSC Homeless Dashboard)

*Care in an H-PACT costs almost $10,000 less per Veteran per year*

- In a single-blinded, multicenter prospective comparison study, the average H-PACT patient cost$9,379/year less to care for compared to a homeless Veteran enrolled in a PACT, driven largely by fewer hospitalization in VA and the community (HSR&D SDR 11-230)

*Intensive outpatient engagement in H-PACTs was associated with significant reductions in emergency department use and identification of undiagnosed conditions*

- Homeless Veterans newly enrolled in an H-PACT who received high intensity outpatient primary and specialty care were significantly less likely to use an emergency department compared to a matched control group (O'Toole et al. Am J Public Health, 2013)

*Veterans enrolled in H-PACTs were housed faster and at higher rates*

- Veterans enrolled in H-PACT gained housing 81.1 days faster than those not enrolled in an H-PACT (HSR&D IIR 07-184 Engaging homeless Veterans in primary care)

## H-PACT AS A PLATFORM FOR NEW INITIATIVES

The H-PACT initiative has also served as a platform for new initiatives and pilot programs aimed at improving homeless Veteran care and access to needed programs and services. Examples of initiatives include:

### *Hospital-to-Housing pilot program*

This partnered initiative (Office of Homeless Programs/the Center, Acute Care, Mental Health service lines) tests the feasibility of providing direct transfers from inpatient care to transitional housing for homeless Veterans with the bridging of health care and care management support by the H-PACT team. The goal is to use the acute hospitalization as an entrée to housing while supporting the respite needs of these Veterans in the process, both saving money and ending that Veteran's homelessness.

### *Staying Housed pilot program*

This is a partnered initiative (Office of Homeless Programs/the Center, Geriatrics and Extended Care) that uses the multi-disciplinary H-PACT team to identify those formerly homeless Veterans now living in HUD-VASH permanent housing who are at increased risk for no longer being able to live independently. The intent is to provide home-based interventions and enhanced structural supports to keep the Veteran independently housed and delay nursing home placement.

### *Predictive Analytics/Super-Utilizer Identification and Intervention Program*

This program is a collaboration between the VHA Support Services Center (VSSC) and the VA National Center on Homelessness Among Veterans to develop a real time predictive algorithm for identifying homeless Veterans at high risk for being "super utilizers" of acute care services in the next three months. Included in this algorithm are pre-identified evidence-based interventions that the H-PACT team can use to mitigate this risk.

### *Mobile technologies to increase treatment retention*

This pilot project tested the use of text messaging to mobile phones to increase treatment retention and care compliance among homeless Veterans enrolled in an H-PACT. By conclusion of the pilot, homeless Veterans had a greater than 20% reduction in no-shows to clinical appointments and an accompanying decrease in emergency department use. (McInnes et al. Am J Public Health. 2014)

### *Food Insecurity Screening*

H-PACTs are being used to screen Veterans for food shortages, particularly at the end of the month when supplemental benefits are exhausted. During pilot testing, almost 50% reported a food shortage in the preceding 3 months. The majority (52.6%) reported averaging two meals per day while 27.3% reported only having one meal per day. In addition, 43.3% reported they experienced hypoglycemic symptoms (anxious, sweaty, chest pain, etc.) when without food. Using these responses, H-PACT teams have been able to mobilize various specialty services and resources to address this previously overlooked need.

### *SOAR Social Security Application*

Partnering with SAMHSA's SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Center, several H-PACT teams piloted the SOAR expedited Social Security application process. SOAR is designed to increase and streamline access to SSI/SSDI among homeless and at-risk patients with mental health diagnoses, medical impairments, and co-occurring substance abuse disorders.

## NEXT STEPS

The past five years have provided the opportunity to create a strong evidence base that supports the need for this type of population-based, tailored care approach. As this program matures and advances beyond its pilot status, it will be important to further define and refine its role within medical centers and across the continuum of care needs for our Veterans who may be challenged in their capacity to access and engage in traditional care models because of their homelessness or risk for becoming homeless.