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Homeless Patient Aligned Care Team (HPACT)

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. HPACT addresses these unique needs of our homeless Veterans in one setting. The HPACT care model centers on five core elements that distinguish it from traditional primary care models:

1. **Reducing barriers to care** by providing open-access, walk-in care in addition to community outreach to engage those Veterans disconnected from VA services.
2. **One-stop, wrap-around services that are integrated and coordinated** and include mental health, homeless programs, and primary care staff that are co-located to create a continuum of care and integrated care team. Most HPACTs also provide food and clothing assistance, hygiene items, showers, laundry facilities, and other services on-site to meet the full spectrum of Veteran needs.
3. **Engaging Veterans in intensive case management** that is coordinated with community agencies and partners and other VA services for continuous care with more seamless transitions.
4. **Providing high-quality, evidence-based, and culturally-sensitive care** that is validated through research evaluation and achieved through the provision of on-going homeless education for HPACT staff.
5. **Being performance-based and accountable with real-time data and predictive analytics** to assist teams in targeting Veterans most in-need, provide ongoing technical assistance and personalized feedback to teams, and inform field-based performance.

Program Statistics and Evaluations

Launched in 2011 by the VHA Homeless Program Office, HPACT began with 32 pilot sites and now has 54 sites across the US in VA Medical Centers (VAMCs), Community Based Outpatient Clinics (CBOCs), and Community Resource and Referral Centers (CRRCs). HPACTs are located in every VISN, in high-volume homeless cities as well as in rural communities, with over 182 full time equivalent staff serving over 22,000 Veterans annually. Compared to standard primary care, HPACT is associated with lower rates of emergency department use and hospitalizations¹, more effective at engaging Veterans in ambulatory care with decreased care cost², assists Veterans in obtaining housing faster³, and provides better care experiences for homeless Veterans⁴.

HPACT as a Platform for New Initiatives

HPACT serves as a platform for new initiatives and pilot programs aimed at improving homeless Veteran care and access to key programs and services. Examples include:

- **Hospital to Housing Program:** This partnered initiative 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 HPACT team. The goal is to use the acute hospitalization as a facilitator to start the housing process while supporting the respite needs of these Veterans, both saving money and ending that Veteran's homelessness.

- **Predictive Analytics/Super-Utilizer Identification Tool:** This tool works by developing 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 HPACT 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 a HPACT. Text messaging for appointment reminders and to receive updated general health information is now widely available to all HPACT Veterans. One example is the use of the VA Annie messaging application to advise Veterans about Coronavirus precautions and assist with monitoring symptoms.
- **Medical-Legal Partnerships (MLP):** This pilot project embeds lawyers specializing in civil law into the HPACT setting to provide legal assistance to Veterans experiencing or who are at-risk of homelessness. MLP lawyers also consult with clinicians on issues that may affect a Veteran's healthcare and provide training to healthcare staff on how to identify social needs with legal underpinnings.

Next Steps

HPACT presents a unique model that can enhance access and integrate VA resources in an efficient way while caring for the whole Veteran. As HPACT reaches across the continuum of care, needs are met for our homeless and at-risk Veterans who may be challenged in their capacity to access and engage in traditional care models. In FY20-21, the focus of HPACT is centered on adjusting funding to expand the model to additional sites while supporting new positions that enhance Veteran care and developing collaborative programs both within and outside the VHA Homeless Program Office to continue to address the physical, mental health, and social needs of this vulnerable population..

Additional Information

For additional information or questions please contact the HPACT National Program Manager, Jillian Weber, PhD, RN, CNL via email at jillian.weber@va.gov

1. O'Toole et al. (2016). Tailoring care to vulnerable populations by incorporating social determinants of health: The Veterans Health Administration's "Homeless Patient Aligned Care Team" program. *Preventing Chronic Disease*, 13. DOI: [10.5888/pcd13.150567](https://doi.org/10.5888/pcd13.150567)
2. O'Toole et al. (2018). Populations-tailored care for homeless Veterans and acute care use, cost, and satisfaction: A prospective quasi-experimental trial. *Preventing Chronic Disease*, 15. DOI: <http://dx.doi.org/10.5888/pcd15.170311>
3. Johnson et al. (2017). No wrong door: can clinical care facilitate veteran engagement in housing services? *Psychology Service*, 14(2). DOI: [10.1037/ser0000124](https://doi.org/10.1037/ser0000124)
4. Jones et al. (2019). Providing positive primary care experiences for homeless Veterans through tailored medical homes: The Veterans Health Administration's Homeless Patient Aligned Care Teams. *Medical Care*, 57(4). DOI: [10.1097/MLR.0000000000001070](https://doi.org/10.1097/MLR.0000000000001070)