Keeping Veterans Healthy at Home: Lessons from the VA's Home-Based Primary Care Program

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Home-based primary care (HBPC) programs provide comprehensive, long-term primary care at home for older adults with multiple chronic conditions and functional limitations or people with disabilities who have difficulties attending office visits. The Department of Veterans Affairs (VA) runs the largest HBPC program in the U.S., serving around **59,000 patients** yearly. Nearly half of all enrollees are dependent in two or more activities of daily living, and many have caregivers who also have functional limitations. The HBPC program seeks to maximize independence and quality of life for enrolled patients while minimizing hospitalization and institutionalization. Care is delivered by an interdisciplinary team that engages different providers and supports as needed to provide the appropriate level of care for each patient.

Created in 1974, the VA's HBPC program — the longest-standing HBPC model in the country — has generated significant evidence on improved health and cost outcomes for high-need patients. The *Better Care Playbook* recently spoke with Samuel T. Edwards, MD, MPH, a primary care physician and researcher at the VA Portland Health Care System to learn how the VA's approach to HBPC has been successful and how other organizations can replicate this model. The program's innovations can help inform health care stakeholders and policymakers in understanding how to effectively design and scale HBPC programs for individuals with complex health and social needs.

Q: What has the VA learned about the impact of HBPC models on health and cost outcomes for individuals with complex health and social needs?

A: We've done a few studies on the impact of HBPC on hospital use and cost in the VA. In a **study** of recently hospitalized patients with diabetes and a second chronic condition, enrollment in HBPC care is associated with a 27 percent decreased probability of hospitalization for an ambulatory care-sensitive condition (ACSC). Another **study** looking at VA and Medicare costs for veterans enrolled in HBPC and similarly sick veterans who did not enroll in HBPC found that enrollees experienced an 11 percent decrease in total costs and a 25 percent decrease in all hospitalizations. There is strong evidence that HBPC reduces hospitalization and costs — they're still getting a lot of care, it's still expensive, but it's a notable and significant decrease.

Our **research has also shown** that the more medically complex the patient is, the more likely that HBPC would reduce hospitalization rates for ACSCs. However, the least medically complex patients can have more hospitalizations for ACSCs when they enroll in HBPC. This shows that it's hard to assess effectiveness of programs that target very complex patients who use a lot of health care. Patients in HBPC have roughly a 25 percent annual mortality, but supporting veterans who wish to die at home without unnecessary medical intervention is an explicit program goal, so mortality is not necessarily an indicator of program effectiveness. Similarly, hospitalization, even for ACSCs, is often patient-centered and appropriate care, as is nursing home care for certain patients. In our work, we're thinking about how to evaluate programs more holistically and what success looks like.

Q: How can HBPC programs support the social needs of adults with complex medical needs?

A: With every home visit, HBPC providers can get this rich understanding of the patient's life that allows them to identify social needs and refer to appropriate resources. But in a lot of cases, medical and social needs are so intertwined that hitting a checklist of social needs with specific referrals doesn't always work. For example, I saw a patient who was low income, food insecure, and had depression related to being the primary caregiver to his wife, who was dying of lung cancer. The reason why there wasn't food in the home was not because he couldn't afford the food, but because he was grieving, and his appetite was suffering as a result.

By going into the home, seeing the whole picture, building these relationships, and gaining people's trust, HBPC teams have the flexibility to address all these needs together in creative ways. This patient might get meals delivered to the home, but he would also benefit from a visit from the team psychologist, and the social worker can help make sure his wife gets hospice care. It's really this holistic approach to the

interdependent needs that make a big difference.

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Q: What care team roles are key for delivering home-based primary care, and what do you think makes an interdisciplinary team particularly effective?

A: In most VA sites, HBPC is a nursing-led program. The primary nurse develops a relationship with their patients, does the most visits, and oversees the care plan and coordination with the rest of the team for different needs. The primary care provider is always involved for medications, referrals, and then bringing in the other specialties as needed. Social work is involved in most cases to address ongoing needs identified by the team. Some patients need all the team members: a pharmacist to clean up complex medication regimens and fill pillboxes; a psychologist to address mental health needs and caregiver depression; a rehab therapist to assess the house for home safety and need for assistive devices; and a dietician to help with specific diets tailored to chronic conditions. Not every patient requires care team members from every discipline, but having that flexibility to engage them as needed is very powerful.

In terms of making the team effective, leadership is super important. I've witnessed team leaders really work hard to promote open communication and psychological safety and keep the mission of the program in clear focus — keeping veterans healthy at home. HBPC teams also have extremely high ratings of team function. You witness this when you go to visit them — everyone gets along, there's lots of joking around, they're sharing food, but they're also very serious and really care about the patients. You frequently see them writing condolence cards to family members of veterans who have died. So it's leadership and staying focused on the mission, but I've also witnessed really impressive teamwork.

Q: How can organizations promote collaboration across silos in health care and empower interdisciplinary teams to provide effective care for each patient?

A: The best way to motivate teams across boundaries is to focus on the patient and their needs. Patients don't care who's responsible for what or what the scope of practice is, they just want help. A team that's really motivated to care for that person will find ways to work around structural barriers. HBPC teams' extraordinary teamwork and flexibility allows them to do this. If a nurse is in a veteran's home and sees that the veteran can't read because the light bulb is out, they just change the light bulb, they don't have to place a referral.

Communication is also important. What team members encounter in homes can be very challenging and surprising, and they're frequently not trained to address specific scenarios. On our teams, there are informal policies where they can call each other in the moment for advice to solve problems. If they don't

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know what to do, but they know someone on the team could probably help, they have a two-ring system where you call once and they don't pick up, but if you call again, you really need to talk. Facilitating strong communication among team members and giving people flexibility and autonomy really helps people work across boundaries.

Q: What are some of the lessons and challenges in designing HBPC programs within the VA that can be applied outside the VA setting?

A: The biggest challenge in HBPC is that the individual sites across the country are all different from one another. They all focus on complex patients and have interdisciplinary teams, but they vary a lot in the way they work. This is challenging from a management standpoint. It would be simple if everyone was doing the same thing, but each program has adapted to their local constraints and has found ways to be successful in their particular context.

When I think about HBPC efforts in other settings, it's going to involve looking at the local health system's resources and understanding where the gaps are and where home-based medical care makes the most sense. Big interdisciplinary teams may be more appropriate because everyone that's coming out of the hospital has needs that aren't being addressed. In other circumstances, a leaner team such as a nursing-led program or the simple addition of in-home doctor visits may be more fitting. As new programs emerge, it will be important to understand how to tailor efforts to individual context and how to evaluate that work in a sensitive way.

Q: What excites you about the future for HBPC models?

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A: As the demographics of the country shift to an increasing number of older adults, home-based primary care must be part of the solution. We don't have the long-term care capacity to do it any other way. I'm really excited to see all the innovations in the startup space around this.

Home-based primary care is one of the most patient-centered, thoughtful, holistic approaches to care I've seen. I'm excited to see it spread. The big challenge is trying to figure out how to do it well while being cost effective, and how to ensure quality while allowing for flexibility and not burdening programs with tons of unnecessary measurement. It's a hard balance, but from what I've seen in the VA, the care is pretty incredible and is possible.