Aging in Place: Housing and Health Integration for Low-Income and Chronically Ill Seniors

Community Catalyst Learning Community

December 1, 2016

Roadmap

1. Webinar logistics
2. Community Catalyst/Center for Consumer Engagement in Health Innovation Goals/Role
3. National Perspective
4. State Perspective
5. Local Example
6. Q & A

Community Catalyst

Webinar Logistics

1. We have reserved time for Q & A following all the presentations.
2. Submit questions at any time through the chat box. We will answer as many as possible during the Q&A.
3. Make sure your computer speakers are turned on and turned up to hear the audio.
4. For technical issues, send a message through the chat box.
5. For customer service during the conference, call Ready Talk at 800.843.9166.
6. Please complete our survey after the webinar.

Community Catalyst

Community Catalyst

Community Catalyst is a national non-profit advocacy organization that works with national, state and local consumer organizations, policymakers and foundations to build consumer and community leadership to improve the health system and the health of vulnerable populations.

We support consumer advocacy networks that improve state and federal health policy, and ensure consumers have a seat at the table as health care decisions are made.

COMMUNITY CATALYST

Why Health and Housing?

- Increasing national focus on the effects of housing and other social/economic factors on health
- Need to address harm to health from
  - Residential racial segregation
  - Lack of affordable healthy housing
  - Homelessness
- Need for housing tailored to needs of vulnerable populations

Community Catalyst Work on Housing

- Health System Transformation: Medicaid and supportive housing
- Substance Use Disorders: Integrating housing into services for addiction and diversion from arrest & incarceration
- Hospital Accountability Project: Healthy housing and asthma prevention
- Children's Health: Leveraging community health workers for housing screening and referral

Goals for Today's Webinar

Participants will:

- Have a better understanding of why an aging population requires more effective integration of housing and health care systems,
- Have a better understanding of the impact that affordable housing has on older adults' ability to live at home and in the community, and
- Learn about some promising practices at the local and state level to address the issues associated with aging in place.

AGING IN PLACE: Housing and Health Integration for Low-Income and Chronically Ill Seniors

December 1, 2016

Carol Regan, MPH

Senior Advisor

CENTER FOR CONSUMER ENGAGEMENT *in health innovation*

Center for Consumer Engagement in Health Innovation

- Community Catalyst advocates for high-quality, affordable health care for all
- Networks in over 40 states
- The Center focuses on advancing the role of consumers in efforts to improve payment and delivery with a focus on vulnerable populations

Center for Consumer Engagement in Health Innovation (CCEHI)

- Focus on Vulnerable Populations
- State and Local Advocacy
- Leadership in Action
- Research and Evaluation
- Federal Advocacy
- Support Services to Delivery Systems and Health Plans

OUR POLICY PRIORITIES

1. Structures for meaningful consumer engagement
2. Payment arrangements that incentivize people-centered health care
3. Resources for community and population health
4. Consumer protection
5. Person-centered culture of care
6. Health equity for underserved populations

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COMMUNITY CATALYST

Aging in Place: Integrating Health and Housing for Low-Income and Chronically Ill Seniors

Robyn Stone
Executive Director
LeadingAge Center for Applied Research

Community Catalyst Webinar
December 1, 2016

LeadingAge™
Center for Housing Plus Services

Seniors in assisted housing are. . . .

Poor

Median income = $10,236

Growing older

Median age (2006) = 74
≈ 30% 80+

Median age (at move in) = 70
≈ 14% 80+

Diverse

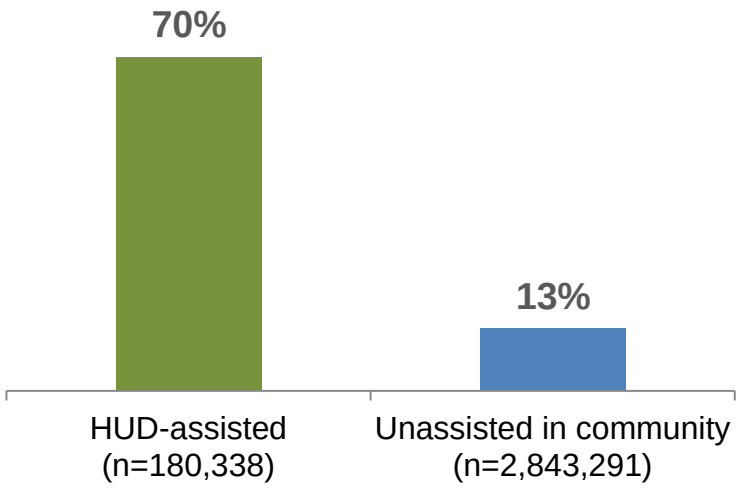
Hispanic = 13%
Black = 19%
White = 56%
Other = 19%

Chronic conditions and functional limitations more prevalent among lower incomes, advanced ages, minorities

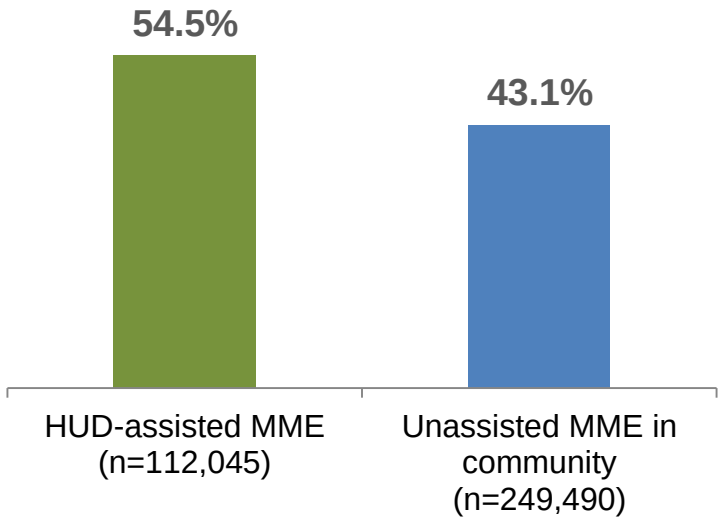
Source: *Section 202 Supportive Housing for the Elderly Program Status & Performance Measurement;* Data is for residents of Section 202 housing properties, 2006

High Level of Chronic Illness

Proportion of Medicare beneficiaries dually enrolled in Medicaid



Proportion of Medicare-Medicaid enrollees with 5+ chronic conditions



Source: *A Picture of Housing & Health*, found at http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.pdf

High Medicare Use and Costs

	HUD-Assisted MMEs	Unassisted MMEs	% Difference
	N=112,045	*N=249,490*	
Average Medicare PMPM	$1,222	$1,054	16%

Medicare services utilization per 1000 member months	HUD-Assisted MMEs	Unassisted MMEs	% Difference
	N = 112,045	*N = 249,490*	
Acute stay admissions	31.4	29.4	6.8%
Hospital readmissions	5.2	4.9	6.1%
Medicare home health visits	581.5	445.5	30.5%
Total emergency room visits	58.4	51.6	13.2%
Physician office visits	1,652.3	1,307.9	26.3%
Ambulatory surgery center visits	14.5	10.0	45.0%

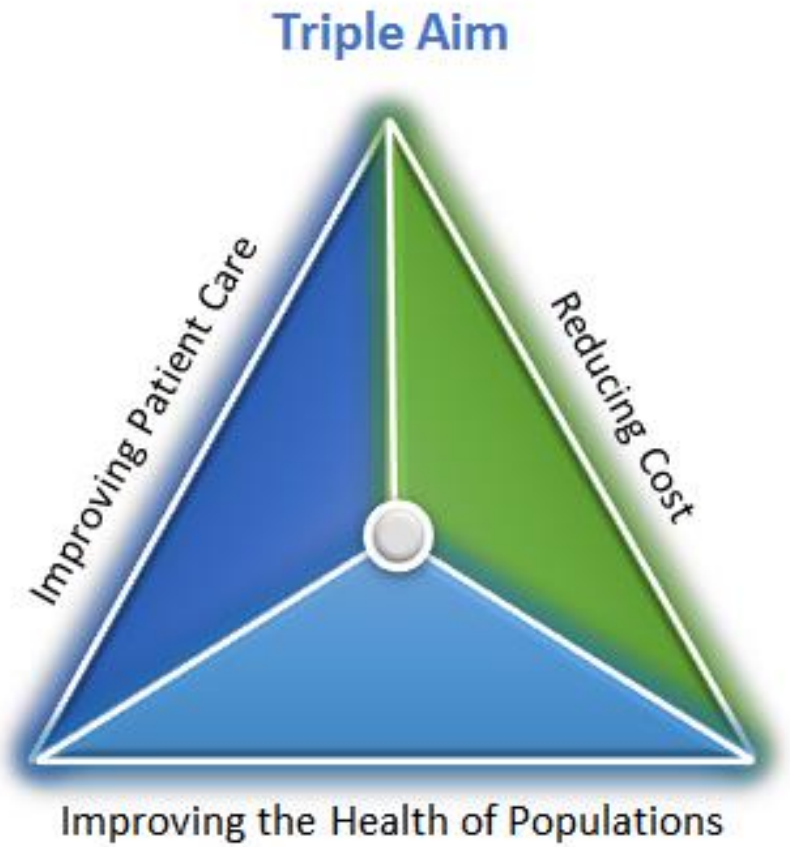
High Medicaid Use and Costs

	HUD-Assisted MMEs	Unassisted MMEs	% Difference
	N = 106,764	*N = 227,186*	
Average Medicaid PMPM	$1,180	$895	32%

Medicaid services utilization per 1000 member months	HUD-Assisted MMEs	Unassisted MMEs	% Difference
	N = 106,764	*N = 227,186*	
Personal Care services	4,512.4	2,149.1	110.0%
DME	380.0	227.7	66.9%
Other HCBS services	3,309.8	1,840.6	79.8%

Other HCBS services includes private duty nursing, adult day care, home health, rehab, targeted case management, transportation and hospice.

Health Care System Reform



Population Health Management

Individual focused

Reactive; sick care

- vs -

Population focused

Proactive; keep populations healthy and intervene before crises occurs

Population Health Management

- Greater emphasis on prevention and early intervention
- Consider social determinants (education, income, living conditions, etc.) that also influence health outcomes
- Coordinate care across providers to ensure care is not fragmented
- Engage patients in understanding how to manage their care and to take an active role

Health Care Challenges

- Manage chronic illness, both physical and mental
- Ensure smooth and effective transitions from acute or post-acute settings; minimize avoidable hospital readmissions
- Address medication-related complications
- Increase patient engagement
- Address social determinants of health
- Tackle the special needs of the health care system's "super utilizers"

Advantages Affordable Housing Brings

- Concentrated population
- Operating efficiencies
  - Streamlined access
  - Programming that reaches multiple individuals
- Physical and personnel infrastructure
  - Trusting relationships
  - Monitoring
  - Facilitate greater follow-through and compliance
  - More complete understanding of social factors

What Service Coordinator Can Offer

- Trusting relationship; know preferences needs and capacities
- Observe living circumstances
- Monitor and notice emerging issues

What Service Coordinator Can Offer

- Remind and encourage participation and follow through
- Help overcome social determinants/barriers
- Availability of service coordinator in senior housing associated with 18% reduced odds of having a hospitalization in a year (LeadingAge & The Lewin Group, 2015)

Examples of Affordable Senior Housing & Health Care Partnerships

Supports and Services at Home (SASH) , Vermont

- Care coordination model anchored in senior housing
- Interdisciplinary team
  - Housing-based staff: SASH coordinator, wellness nurse
  - Network of community-based providers: home health agency, area agency on aging, mental health providers, etc.
- Integrated with state's health reform efforts
  - Medical homes supported by community health teams
  - SASH extender of community health teams
- Statewide expansion supported through Medicare MAPCP demonstration

Supports and Services at Home (SASH), Vermont

- 2nd annual report results: SASH helping bend Medicare cost curve
  - Based on first 3 years of implementation (July 2011 – June 2014)
  - June 2014 – 49 panels/3,485 participants (analysis includes only housing-based participants)
  - **Growth in annual total Medicare expenditures was $1,536 lower per** participant in early panels (established before April 2012) than beneficiaries in comparison group
  - No statistically significant change in growth for participants in late panels (established after April 2012)

Source: *Support and Services at Home (SASH) Evaluation: First Annual Report*, found at: http://aspe.hhs.gov/daltcp/reports/2014/SASH1.pdf

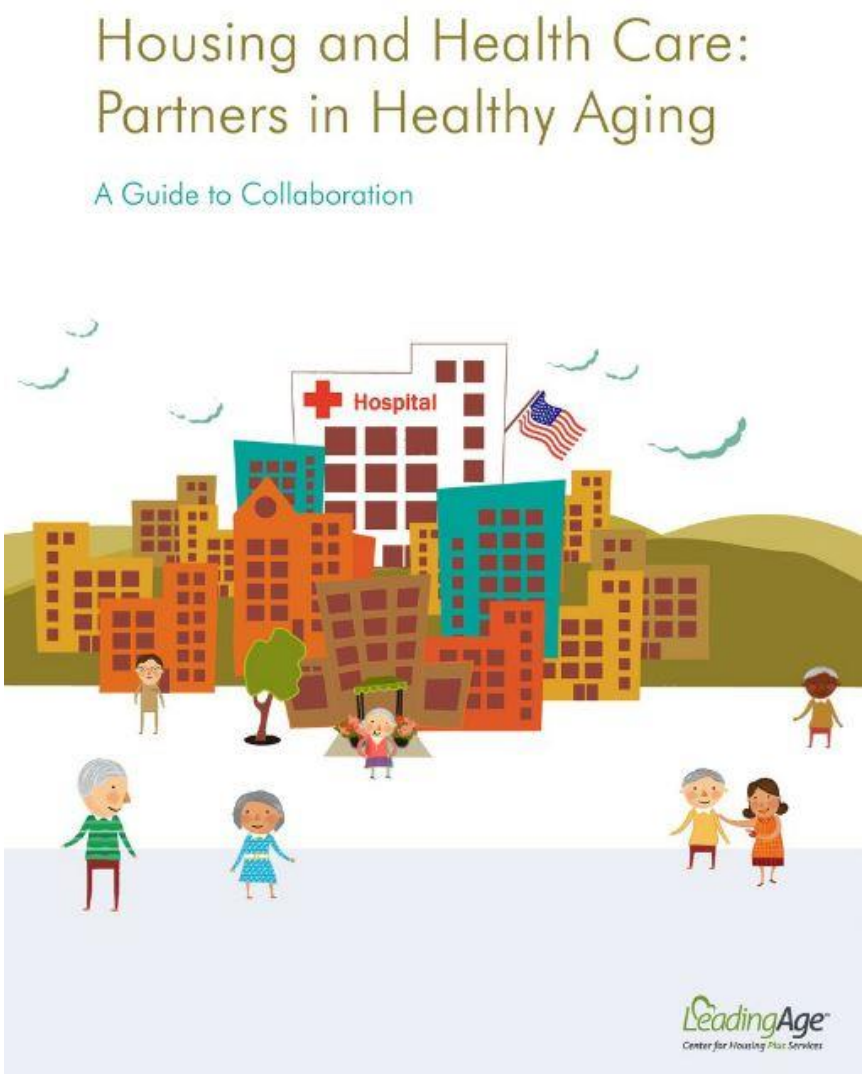
Other Models of Housing Linked with Services

- Housing with Services Initiative Portland, OR--Formal consortium of housing and service providers (physical and mental health, social, long-term care)
- Staying at Home Program, Pittsburgh PA– UPMC Social worker and RN provide care coordination and additional health services in congregate housing
- Presbyterian Senior Living & PinnacleHealth Partnership--Weekly onsite clinic operated by health system, staffed by MD, RN, MSW in collaboration with service coordinator
- Richmond Health and Wellness Program--Weekly, VCU interdisciplinary student-run clinic in 5 affordable senior housing properties

Increasing Federal Attention

- Bipartisan Policy Center Health and Healthy Aging report and recommendations
- Multi-year SASH quantitative and qualitative evaluation funded by HHS and HUD
- HUD randomized control trial of enhanced service coordinator/wellness nurse housing-based team

Housing and Healthcare Partnerships Toolkit



Contents

www.leadingage.org/housinghealth

Housing and Healthcare Partnerships Toolkit

- Return on Investment Calculator
- Videos
  - How housing can help healthcare
  - Healthcare providers on value of housing
  - Why housing should be interested
- Other resource materials

Craig Jones, MD, discusses how the Support And Services at Home (SASH) program has contributed to Vermont's health reform efforts. Based in affordable senior housing, SASH helps participants address and coordinate their health and social service needs. Learn more about SASH.

www.leadingage.org/housinghealth

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

State Approaches to Ensuring Stable Housing for Seniors and People with Disabilities

Nancy Archibald, Center for Health Care Strategies

December 1, 2016

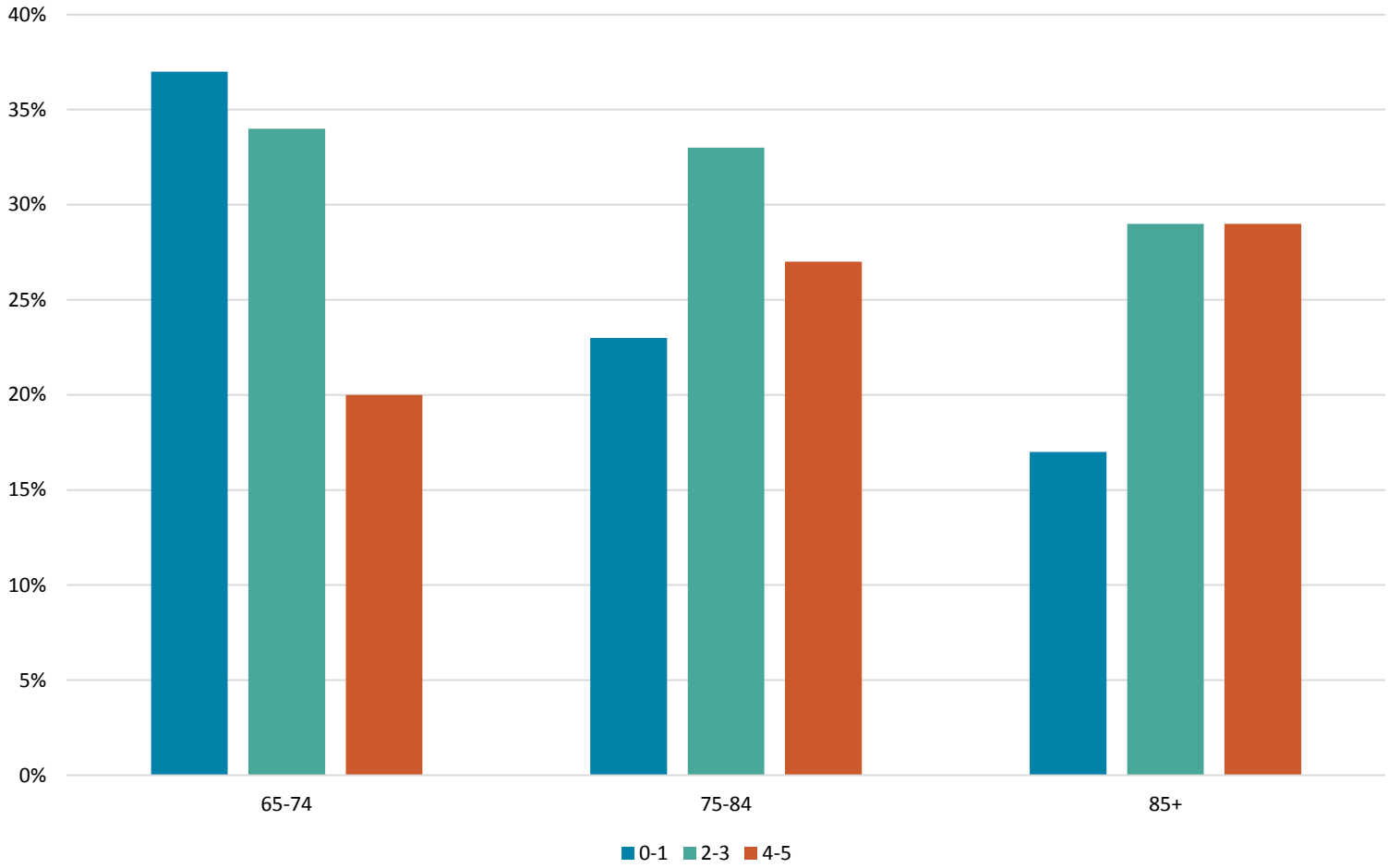
About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans

Overview

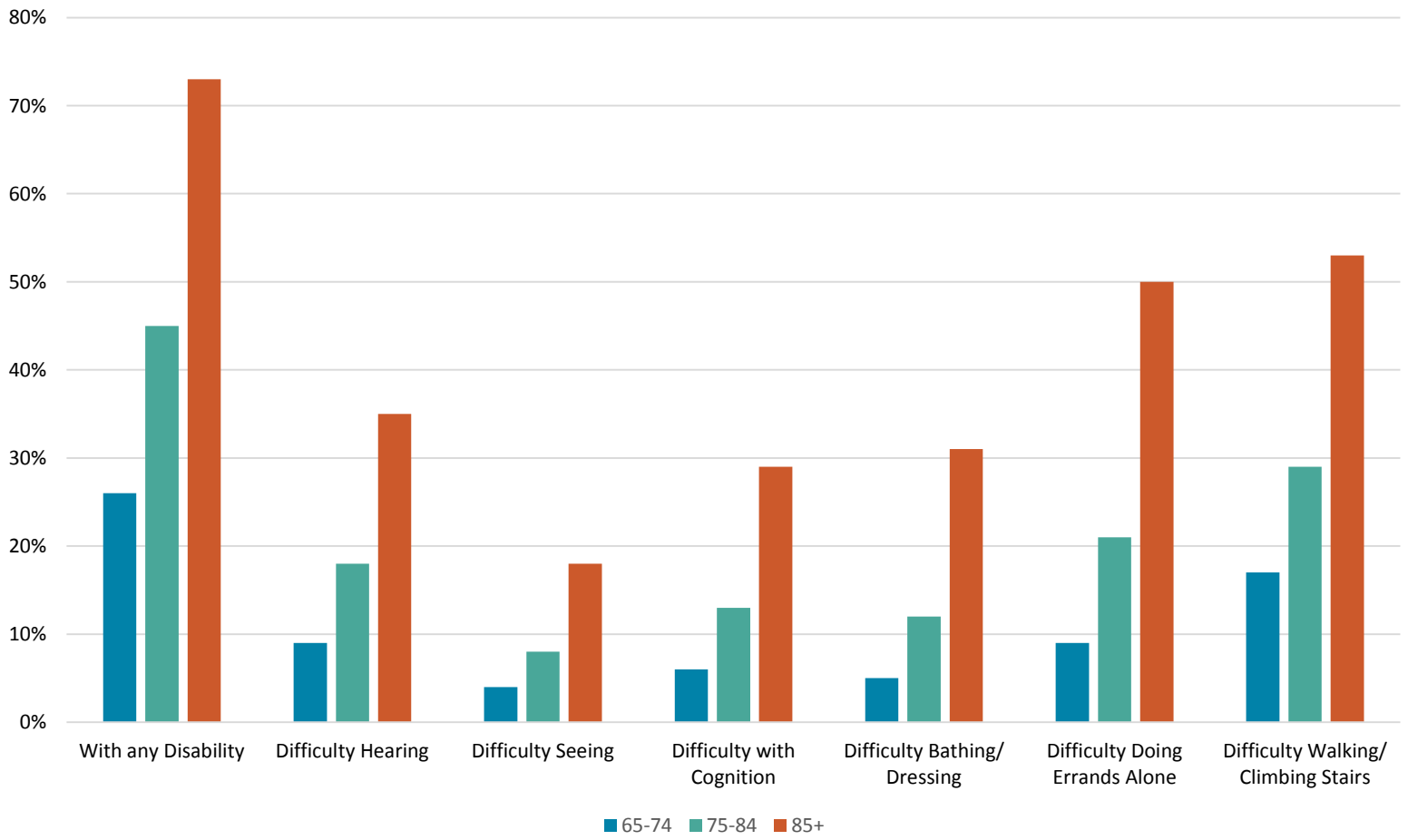
- Need for Long-Term Services and Supports
- Rebalancing Long-Term Services and Supports
- Housing as Health Care
- Role of State Medicaid Agencies
- Examples of State Innovation

Chronic Conditions in Individuals Age 65+



SOURCE: Centers for Medicare & Medicaid Services. "Chronic Conditions Among Medicare Beneficiaries." 2012. Figure 1.2b. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

Functional Limitations in Individuals Age 65+



SOURCE: United States Census Bureau. "65+ in the United States, 2010." June 2014. Figure 2-14. Available at: http://census.gov/content/dam/Census/library/publications/2014/demo/p23-212.pdf.

What are Medicaid Long-Term Services and Supports?

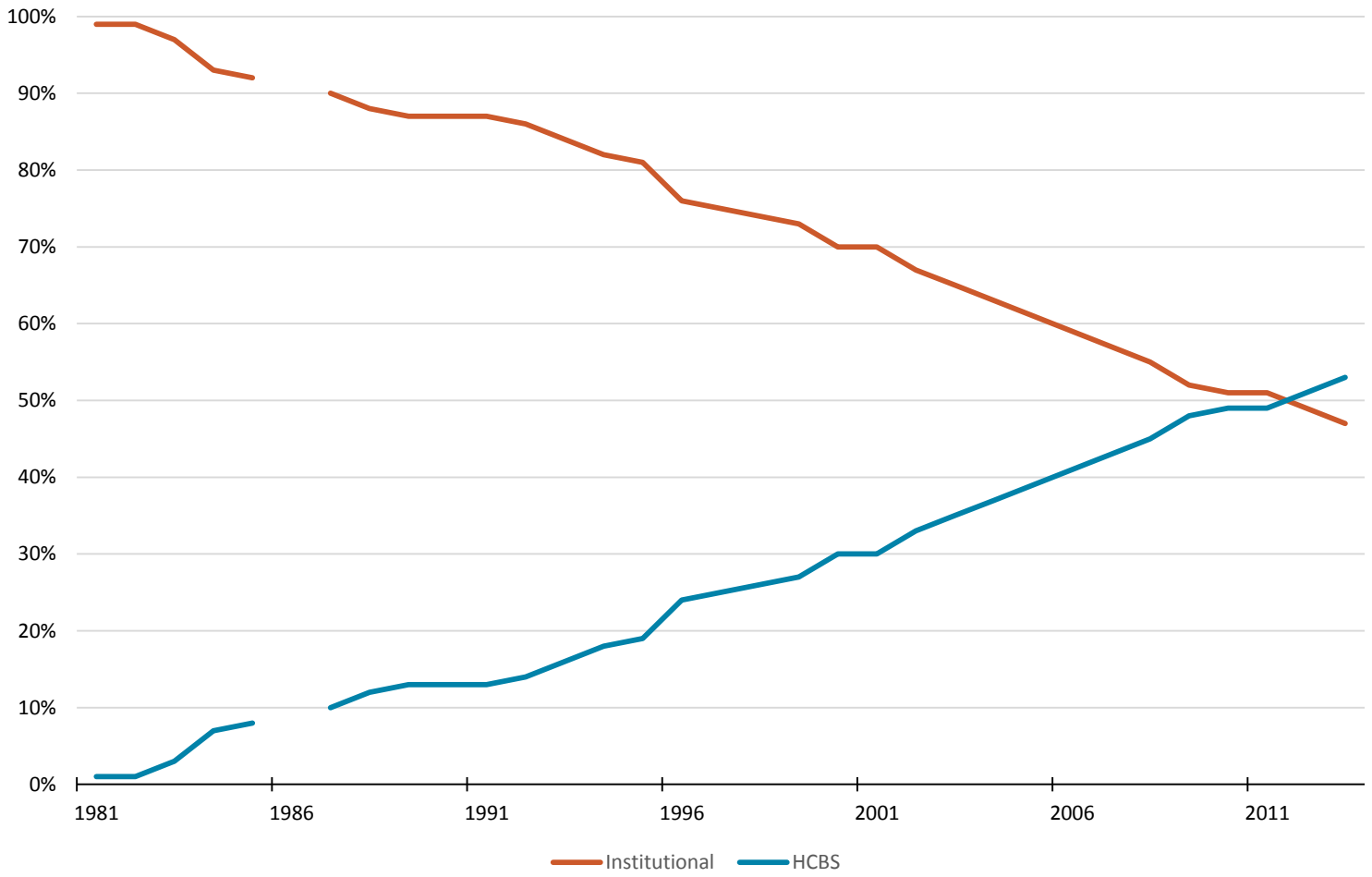
- Medicaid long-term services and supports (LTSS) include facility-based care and home- and community-based services (HCBS)
- Facility-based care is a Medicaid "entitlement"
- Medicaid HCBS provided through waivers (e.g., 1915(c)) and Medicaid state plan (e.g., personal care, 1915(i), and 1915(k))
- HCBS provide assistance with activities of daily living (bathing, dressing, using the toilet) or instrumental activities of daily living (shopping, meal preparation, laundry)
- HCBS include: personal care, chore assistance, transportation, meal delivery, adult day services

What is LTSS Rebalancing?

- Rebalancing: shifting Medicaid spending to HCBS instead of institutional care
- Efforts are driven by:
  - Beneficiary preferences for HCBS
  - HCBS is typically less expensive than comparable institutional care
  - States' community integration obligations under the Americans with Disabilities Act and the *Olmstead* decision

SOURCES: Woodcock, C. H. Long-term Services and Supports: Challenges and Opportunities for States in Difficult Budget Times, The Hilltop Institute for The National Governors Association, December 2011; Kaye, H. S., et al. Long-term Care: Who Gets It, Who Provides It, Who Pays, and How Much?, *Health Affairs*, 29, no. 1 (2010): 11-21.

Medicaid Spending on HCBS and Institutional Care as a Percentage of Total Medicaid LTSS Spending, 1981-2014



SOURCE: A. Wenzlow, S. Eiken, K. Sredl. "Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014." Truven Health Analytics, June 2016. Figure 1. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf.

Seniors at Risk

- Stable housing is especially needed by individuals:
  - Living at home but at risk of nursing facility placement
  - Transitioning from hospital, sub-acute care, or rehabilitation
  - Returning to the community after long-term nursing facility stay

Medicaid Coverage of Housing Services

- State-only Medicaid funds can be used for direct housing support, but this spending does not qualify for federal match
- Medicaid funds can be used for certain housing-related activities and services
  - Individual housing transition services
  - Individual housing and tenancy sustaining services
  - State-level housing related collaborative activities

SOURCE: Centers for Medicare & Medicaid Services. CMS Informational Bulletin. "Coverage of Housing-Related Activities and Services for Individuals with Disabilities." June 26, 2015. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

1115 Demonstration Waivers

- **New York** pioneered use of Medicaid 1115 waivers for housing services
  - Tried to cover rent, but not approved by CMS
  - Using Delivery System Reform Incentive Payment (DSRIP) program funds to provide supportive housing services
- **California's** 1115 waiver, Medi-Cal 2020, creates Whole Person Care pilots
  - Coordinate health, behavioral health, and social services
  - Partner entities (county, city, hospital or health authority, managed care organization)
  - Tenancy-based services, direct rental subsidies, housing projects

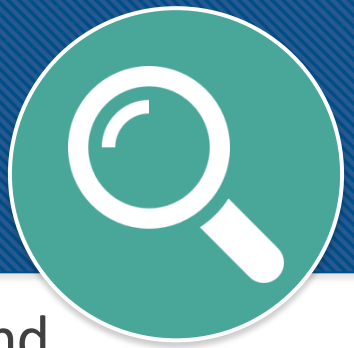
1115 Demonstration Waivers

- **Tennessee's** managed long-term services and supports program TennCare CHOICES
  - 3 managed care organizations provide LTSS
  - MCOs employ housing specialists
  - Statewide housing conferences brought together stakeholders, built connections going forward
- **Oregon** created Coordinated Care Organizations (CCOs)
  - 16 regionally-based CCOs provide transitional housing supports, home improvements, rental assistance, utilities, moving expenses, deposits
  - Can cover transitional, stable housing for members during care transitions

1915(i) State Plan Option

- **Connecticut** wants to use a 1915(i) state plan option to optimize Medicaid coverage
  - Leveraging Money Follows the Person demonstration
  - Using HUD funding and state-only funds
  - Mining data to guide efforts
- **Nevada** also plans to use a 1915(i) state plan option to develop a supportive services package
  - Building on previously created partnerships- Governor's Interagency Council on Homelessness
  - Developing an affordable housing pipeline

1915(k) Community First Choice (CFC) State Plan Option



- Used to provide community-based attendant services and supports to beneficiaries who need a nursing facility level of care with incomes up to 150% FPL
- **California**, **Maryland**, **Montana**, **Oregon**, and **Texas**
- Required services: attendant care services and supports that help with ADLs and IADLs; acquisition, maintenance, and enhancement of skills to complete those tasks; back-up systems to ensure continuity of care; and voluntary training consumer direction of services
- Optional services: Costs related to transitioning from an institution to the community (e.g., security and utility deposits, first month's rent, and basic household supplies)
- Excludes home modifications, room and board

Takeaways for Stakeholders

- Understand state Medicaid landscape and available mechanisms
- Participate in coalitions with state and other stakeholders
- Assess available housing resources and existing services
- Conduct gap analyses

Contact Information

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Health, Housing, and Social Support Services Partnerships

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CHCS Center for Health Care Strategies, Inc.

History

- Services located in Oakland, Berkeley, West Contra Costa County
- 53,000 patients served annually
- 15 Primary Care Clinics + Urgent Care, Adult Day Health, Supportive Housing, School-Based Clinics, Dental
- Founded by Gray Panthers
- Special history with elders and care for complex adult populations including disabled and homeless

Special Populations Served

- Elderly
- Permanent Supportive Housing Residents
  - SROs – Project Based
  - Scattered Site: Shelter Plus Care, VASH
- Currently homeless (Respite Care, TRUST Clinic)
- Frequent Users of ED
- High cost & Disabled (CMS Innovation Grant, Care Neighborhood)

Housing History

- Partnership with Senior Housing for screening and referral back to services
- Long term presence in Supportive Housing for Chronically Homeless: rich service presence
- Elder clinic located in building with HUD senior housing
- Partnerships to look at future senior housing/community models

Partnerships and Funding

- Managed Care Plans
- City/County Government
  - Behavioral Health
  - Housing Departments
  - Public Health
- Hospitals
- Center for Independent Living
- Health Care for the Homeless
- Housing Developers
- Community Based Organizations/PACE

Structural Drivers

- Services dependent on Medicaid/Medicare funding
- California has decentralized health care delivery systems – delegated from state to local managed care plans
- Housing availability and cost difficult
- Fee for service billing and unaligned financial incentives, don't pay for value

Financing Challenges

- Funding case management by non-licensed providers
- Fragmented & diagnosis driven funding
- Blended funding = multiple reporting/documentation requirements
- Productivity concerns – longer appointments needed for complex populations which include family members, support teams, etc.
- Need to demonstrate cost savings

Service Delivery Challenges

- Unlinked, multiple IT systems creates challenges
  - Identifying target populations
  - Tracking patient utilization
  - Assessing outcomes across the system of care
- Staff recruitment/retention
- Silos of service delivery
- Housing not available … subsidized or for homeless elders

Opportunities

- Medicaid/Medicare focus on value and high cost users
- Improved coverage of mental health services
- Integration of primary/behavioral health care
- Managed care plans focus on high cost members
- Recognition of impact of social determinants of health (esp. housing)
- Increased need for medical respite care given focus on reducing hospitalizations

The Future

- Virtual System of Care
- Continuum of Elder Living Arrangements: Independent in Own Home, Subsidized Elder Housing, Assisted Living
- Seamless Services delivered throughout continuum
- Enhanced Technology
- Care when patient/customer needs and wants it.

Q & A

THANK YOU!

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Thank You