Business Acumen Webinar: Tools for Building Housing and Health Care Partnerships

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Alisha Sanders
LeadingAge Center for Housing Plus Services

Administration for Community Living
Business Acumen Webinar
May 15, 2015
Seniors in assisted housing are . . . .

<table>
<thead>
<tr>
<th>Poor</th>
<th>Growing older</th>
<th>Diverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median income = $10,236</td>
<td>Median age (2006) = 74</td>
<td>Hispanic = 13%</td>
</tr>
<tr>
<td></td>
<td>≈ 30% 80+</td>
<td>Black = 19%</td>
</tr>
<tr>
<td></td>
<td>Median age (at move in) = 70</td>
<td>White = 56%</td>
</tr>
<tr>
<td></td>
<td>≈ 14% 80+</td>
<td>Other = 19%</td>
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Chronic conditions and functional limitations more prevalent among advanced ages, lower incomes, minorities

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

- Expansion of home and community-based services
- Improve coordination and integration of health and long-term care services and supports
- Increased focus on dual eligibles
Bringing It All Together

- Population trends (demographic, health, economic, housing)
  - Desire to age in community

- Fair housing allows residents to stay
  - Few alternatives for low-income persons

- Feds and states want to:
  - Enhance community options
  - Improve health outcomes
  - Lower costs

Potential synergies to advance new models and strategies
Value of Housing Plus Services

- Build on existing infrastructure of housing, health and supportive service networks
- Provides potential concentration of high-risk/high-cost individuals (including many dual eligibles)
- Offers economies of scale; can increase delivery efficiencies for providers and affordability for seniors
- Provides residents easy access to services; may encourage greater utilization and follow-through
- Offer a more regular staff presence on site with residents; can help build
  - Knowledge of resident needs, abilities and resources
  - A sense of trust among residents, which encourages better use of services
  - Early recognition of potential issues before they become costly crises
- Help preserve seniors’ autonomy and independence
**“A Picture of Housing & Health”**

<table>
<thead>
<tr>
<th>Medicare per member per month (PMPM)</th>
<th>HUD Assisted Medicare Beneficiaries</th>
<th>Unassisted Medicare Beneficiaries</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,479</td>
<td>$937</td>
<td>57.8%</td>
<td></td>
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</tbody>
</table>

Proportion of Medicare beneficiaries dually enrolled in Medicaid:
- HUD-assisted: 70% (n=180,338)
- Unassisted in community: 13% (n=2,843,291)

Proportion of Medicare-Medicaid enrollees (MMEs) with 5+ chronic conditions:
- HUD-assisted MME: 54.5% (n=112,045)
- Unassisted MME in community: 43.1% (n=249,490)

**HUD-Assisted Medicare-Medicaid Enrollees (MMEs) Spend More: Medicare cost and service comparison**

<table>
<thead>
<tr>
<th></th>
<th>HUD-Assisted MMEs</th>
<th>Unassisted MMEs</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Medicare PMPM</strong></td>
<td>$1,222</td>
<td>$1,054</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Medicare services utilization per 1000 member months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute stay admissions</td>
<td>31.4</td>
<td>29.4</td>
<td>6.8%</td>
</tr>
<tr>
<td>Hospital readmissions</td>
<td>5.2</td>
<td>4.9</td>
<td>6.1%</td>
</tr>
<tr>
<td>Medicare home health visits</td>
<td>581.5</td>
<td>445.5</td>
<td>30.5%</td>
</tr>
<tr>
<td>Total emergency room visits</td>
<td>58.4</td>
<td>51.6</td>
<td>13.2%</td>
</tr>
<tr>
<td>Physician office visits</td>
<td>1,652.3</td>
<td>1,307.9</td>
<td>26.3%</td>
</tr>
<tr>
<td>Ambulatory surgery center visits</td>
<td>14.5</td>
<td>10.0</td>
<td>45.0%</td>
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</tbody>
</table>
HUD Assisted Medicare-Medicaid Enrollees (MMEs) Spend More: Medicaid cost and service comparison

<table>
<thead>
<tr>
<th>Medicaid services utilization per 1000 member months</th>
<th>HUD-Assisted MMEs</th>
<th>Unassisted MMEs</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 106,764</td>
<td>N = 227,186</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care services</td>
<td>4,512.4</td>
<td>2,149.1</td>
<td>110.0%</td>
</tr>
<tr>
<td>DME</td>
<td>380.0</td>
<td>227.7</td>
<td>66.9%</td>
</tr>
<tr>
<td>Other HCBS services</td>
<td>3,309.8</td>
<td>1,840.6</td>
<td>79.8%</td>
</tr>
</tbody>
</table>

Other HCBS services includes private duty nursing, adult day care, home health, rehab, targeted case management, transportation and hospice.
Services Staff, 2008

- Service Coordinator: 69%
- Activity Coordinator: 26%
- Nurse: 13%
- No Staff: 25%

- SC: 44%
- SC/AC: 14%
- SC/N: 5%
- SC/AC/N: 5%
- AC: 5%
- AC/N: 1%
- N: 1%
- No Staff: 25%
<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social activities</td>
<td>74%</td>
</tr>
<tr>
<td>Transportation</td>
<td>44%</td>
</tr>
<tr>
<td>Congregate meals</td>
<td>33%</td>
</tr>
<tr>
<td>Exercise and fitness</td>
<td>49%</td>
</tr>
<tr>
<td>Health education</td>
<td>66%</td>
</tr>
<tr>
<td>Health screening</td>
<td>64%</td>
</tr>
<tr>
<td>Homemaker assistance</td>
<td>31%</td>
</tr>
<tr>
<td>Personal care</td>
<td>24%</td>
</tr>
<tr>
<td>Medication assistance</td>
<td>19%</td>
</tr>
<tr>
<td>Primary health care</td>
<td>10%</td>
</tr>
<tr>
<td>Mental health</td>
<td>10%</td>
</tr>
<tr>
<td>Dental</td>
<td>3%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>27%</td>
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</table>
### Association with Onsite Service Availability

*(preliminary results: do not cite)*

<table>
<thead>
<tr>
<th>Service &amp; Setting</th>
<th>Increases</th>
<th>Decreases</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits per enrolled month, 2008</td>
<td>Exercise</td>
<td></td>
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<tr>
<td>(outpatient visit only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odds of having at least one ER visit, 2008</td>
<td></td>
<td>Service Coordinator</td>
</tr>
<tr>
<td>(outpatient visit only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute stays per enrolled month, 2008</td>
<td></td>
<td>Exercise</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Primary Care Nurse</em></td>
</tr>
<tr>
<td>Odds of at least one acute stay during 2008</td>
<td>Mental Health</td>
<td>Exercise</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Service Coordinator Nurse</em></td>
</tr>
<tr>
<td>Office visits per enrolled month, 2008</td>
<td></td>
<td><em>Primary Care</em></td>
</tr>
<tr>
<td>Medicare expenditures per enrolled month</td>
<td></td>
<td>Exercise</td>
</tr>
<tr>
<td>(medical only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare expenditures per enrolled month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Part D only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid expenditures per enrolled month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(among full duals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-italicized results are significant (p&lt;.05).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Italicized results are borderline</em> (p&lt;10) (p&lt;10).</td>
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</tbody>
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Supports and Services at Home (SASH) Program Evaluation

- 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.
- Linked in 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) Program Evaluation

- Comparing SASH participants to:
  - Individuals in MAPCP demo, non-SASH properties (in VT)
  - Individuals not in MAPCP demo, non-SASH properties (in NY)

- Early results: SASH is bending cost curve
  - Growth in annual total Medicare expenditures was $1,756 - $2,197 lower for SASH participants than for two comparison groups

Partnership: Presbyterian Senior Living & PinnacleHealth

- Weekly onsite clinic
  - Staffed by MD, RN, MSW; work with service coordinator
- Care navigation program – clinical and social
- ID high utilizers
  - Identify barriers to care – navigate through health system or help coordinate needed social services
  - Coordinate with PCP (or serve as PCP, if one needed)
- Utilize Pinnacle’s HIE
Partnership: Presbyterian Senior Living & PinnacleHealth

ER visits
Inpatient visits

1/12-6/12: 81 ER visits, 57 inpatient visits
7/12-12/12: 65 ER visits, 29 inpatient visits
1/13-6/13: 41 ER visits, 17 inpatient visits
7/13-12/13: 34 ER visits, 13 inpatient visits
1/14-6/14: 11 ER visits, 5 inpatient visits
Housing & Health Partnerships: Why Now?

- Health and long-term care reform efforts at national and state level
- Goal: Better address health care needs of all Americans, particularly vulnerable populations
- Affordable senior housing residents represent the vulnerable individuals population-based health reform efforts are designed to target
Housing & Health Partnerships: Why Now?

- Striving to address population health
  - More effectively managing care of high-need and costly patients
  - Early intervention with lower-risk patients to avoid need for more expensive care over time

- Focus on lowering health care costs through
  - Timely, preventative care
  - Improved care coordination & service integration
  - Reduction in over-utilization of expensive services
Benefits of Affordable Senior Housing

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

- Affordable senior housing properties can assist by helping health care entities
  - Manage chronic illness, both physical and mental
  - Ensure smooth transitions from acute/post-acute settings
  - Minimize avoidable hospital readmissions
  - Address medication complications
  - Increase patient engagement
  - Address social determinants of health
  - Tackle special needs of “super-utilizers”
Housing and Healthcare Partnerships Toolkit

- Guide: “Housing & Health Care: Partners in Healthy Aging”
  - Understanding health care reform
  - Benefits of a housing and health partnership
  - Health care challenges that housing can help address
  - How housing and health entities can collaborate
  - Identifying and cultivating a partner
  - Structuring the partnership

- Other materials: videos, ROI calculator, resources

www.LeadingAge.org/housinghealth
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www.LeadingAge.org/housinghealth
Housing and Healthcare Partnerships Toolkit

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

www.LeadingAge.org/housinghealth
The Value of Housing in Accountable Care Systems

- Guy D’Andrea
- Administration for Community Living
- Business Acumen Webinar
- May 15, 2015

www.discernhealth.com
About Discern

Discern Health is a consulting firm that works with clients across the private and public sectors to improve health and health care. Our focus is enhancing the value of health care services through quality-based payment and delivery

- Measure alignment and gap assessment
- Measure selection and strategy
- Measure implementation and data analysis
- Measure reporting strategy
- Development of performance-based payment models
- Analysis of payment systems
- Re-design of care delivery models
- PCMH transformation and recognition coaching
- Accountable care strategy
Health Care Is Changing

- Performance measurement, value-based purchasing, and health delivery re-design are shaping the future of the health care system.
- Health care providers and their partners need to navigate new market demands.
## Value-Based Health Care Systems

<table>
<thead>
<tr>
<th>First Generation (2000 – present)</th>
<th>Characteristics</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Process and structure quality measures; internally-focused; “siloed”; volume-based revenue with some pay-for-performance</td>
<td>Hospitals, physician practices (i.e., “traditional” medical providers)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Generation (2010 – present)</th>
<th>Characteristics</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Process and outcome measures; externally-focused on other clinical providers; clinical integration; mix of volume and value payments</td>
<td>Accountable care organizations (ACOs); patient-centered medical homes (PCMHs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Third Generation (2015?)</th>
<th>Characteristics</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Population outcome-focused; integrated with community resources; global risk-based payments</td>
<td>???</td>
</tr>
</tbody>
</table>
Defining Value

- HHS has stated a goal to move most health care payment to alternative arrangements by 2018
- Most alternative payment models define value by:
  - Setting performance benchmarks for defined quality measures, such as following care guidelines, enhancing patient satisfaction, or reducing complication rates.
  - Measuring total cost of care for patients.
- Health system that meet these goals will earn payment incentives
Discern Health worked with Leading Age to develop a calculator that quantifies potential value of housing to Medicare ACOs.

Tool to:
- Understand ACO quality measures
- Understand cost of care
- Assess potential impact of housing
- Support collaborations with ACOs

Focused on Medicare ACOs, but concept apply to other accountable care arrangements.
Medicare ACO Basics

- Integrated networks of hospitals, doctors, and ancillary providers
- Serve a defined population of at least 5,000 Medicare beneficiaries.
- Are evaluated on patient satisfaction, chronic care management, preventive care, and care coordination.
- Continue to receive fee-for-service payment. Can earn “shared savings” if their total population costs are below national trend.
- Shared savings eligibility is tied to quality performance.
Key Questions for Housing Providers

• How can we impact quality measures?
  • Engaging with patients
  • Facilitating access to needed care
  • Screening for health risks
• How can we impact costs?
  • Improved well-being and health outcomes
  • Avoidance of ER use, hospitalizations, and readmissions
  • Managing the social determinants of health
Calculator Demonstration
Using the Calculator

• Understand how an ACO will assess collaboration with a housing organization. This can help frame the discussion relevant to their quality and fiscal performance needs.
• If the necessary data is available, calculate the potential value housing can bring to the ACO.
• Use as an evaluation framework going forward.