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

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Business Acumen Webinar
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Center for Housing Plus Services

Seniors in assisted housing are. . . .

Poor	Growing older	Diverse
Median income = $10,236	Median age (2006) = 74 ≈ 30% 80+ Median age (at move in) = 70 ≈ 14% 80+	Hispanic = 13% Black = 19% White = 56% Other = 19%

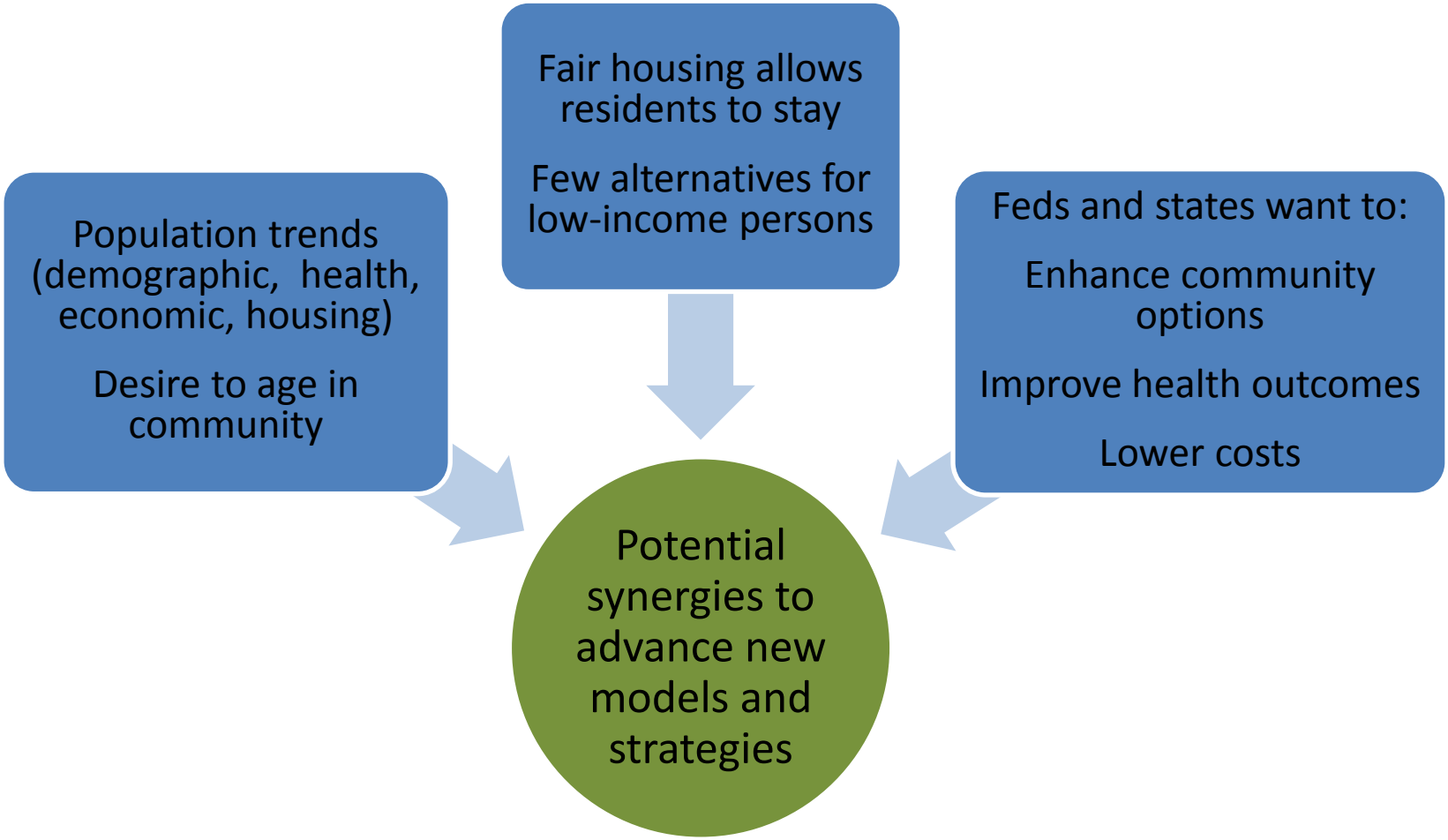
Chronic conditions and functional limitations more prevalent among advanced ages, lower incomes, minorities

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



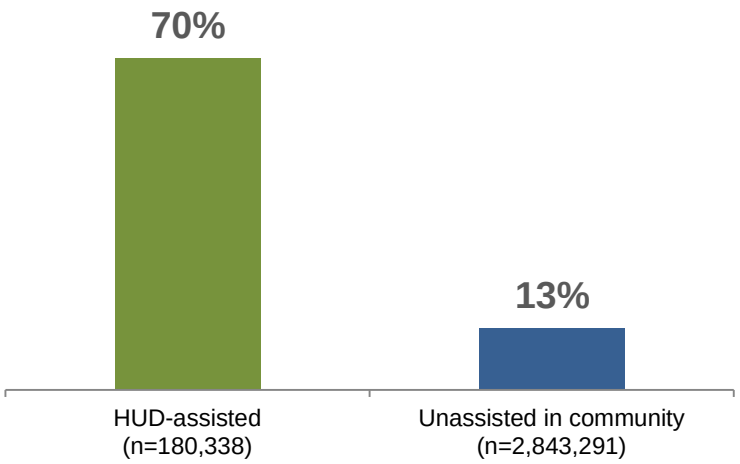
Value of Housing Plus Services

- 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

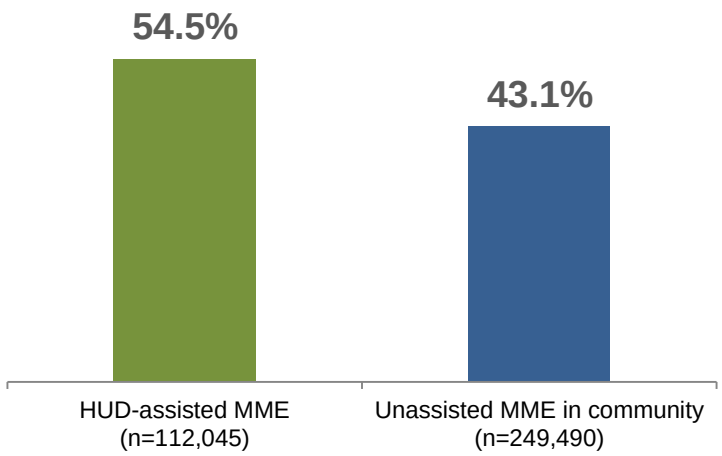
“A Picture of Housing & Health”

Medicare per member per month (PMPM)	HUD Assisted Medicare Beneficiaries	Unassisted Medicare Beneficiaries	% Difference
	$1,479	$937	57.8%

Proportion of Medicare beneficiaries dually enrolled in Medicaid.



Proportion of Medicare-Medicaid enrollees (MMEs) with 5+ chronic conditions



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

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

	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%

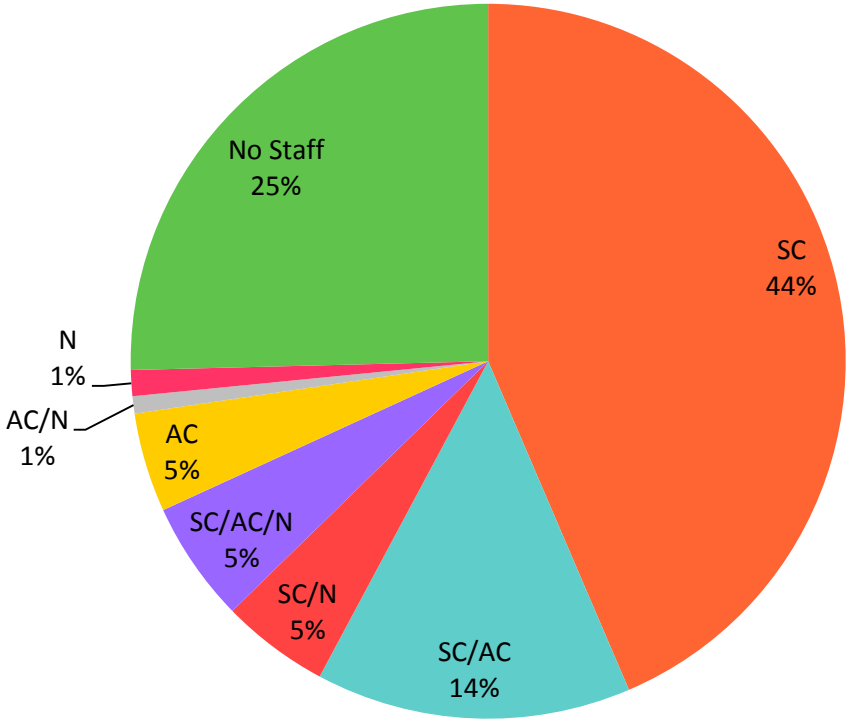
HUD Assisted Medicare-Medicaid Enrollees (MMEs) Spend More: Medicaid cost and service comparison

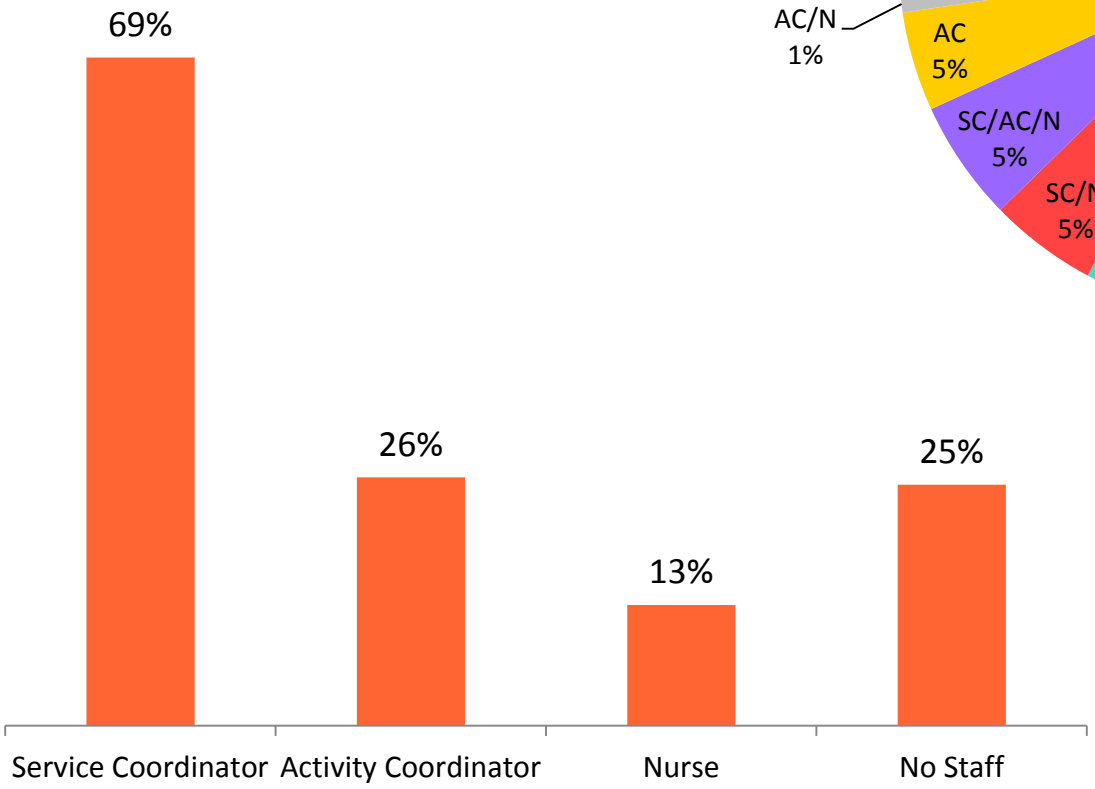
	HUD-Assisted MMEs	Unassisted MMEs	% Difference
	N = 106,764	*N = 227,186*	
Average Medicaid PMPM	$1,180	$895	32%

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%

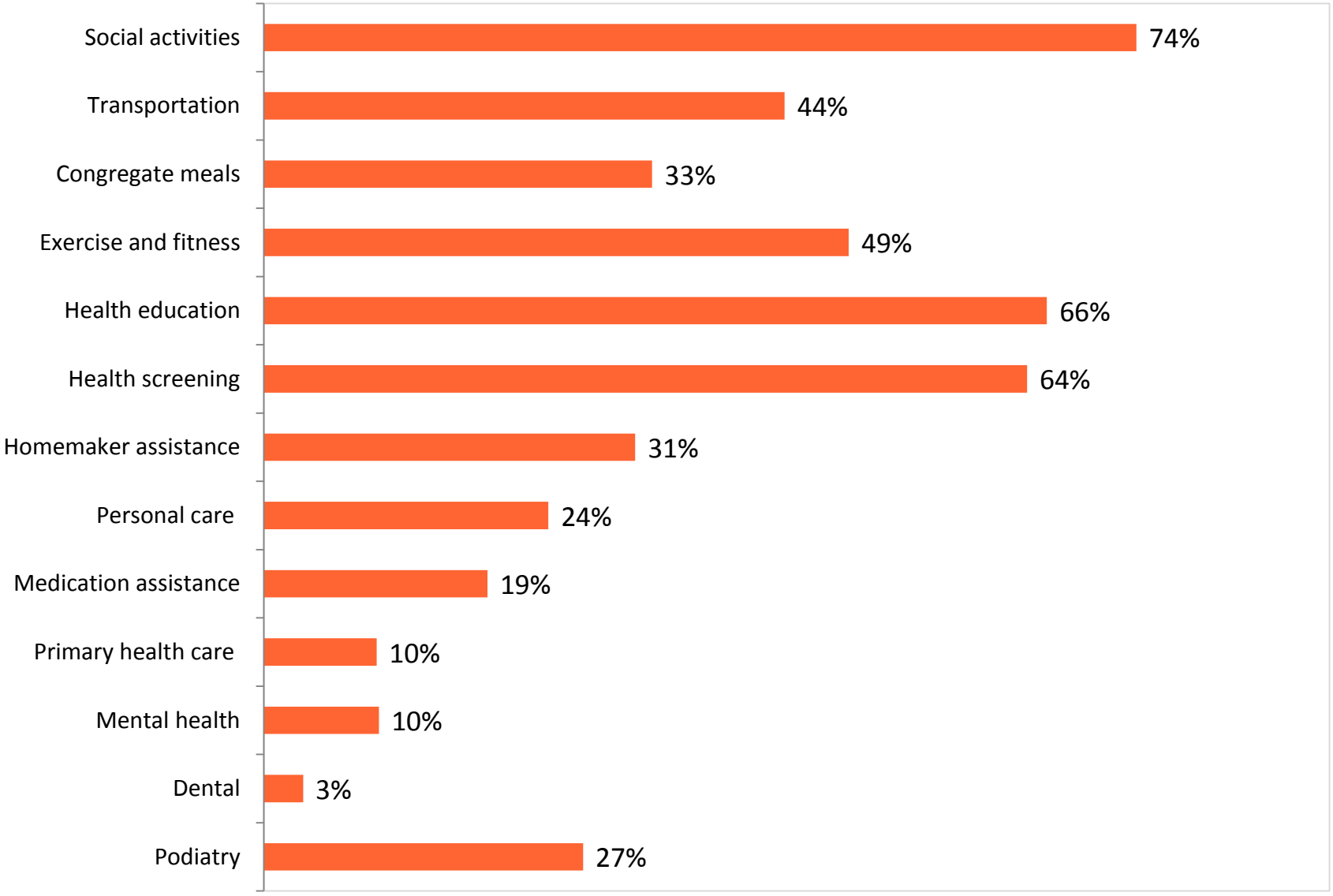
Other HCBS services includes private duty nursing, adult day care, home health, rehab, targeted case management, transportation and hospice.

Services Staff, 2008





Onsite Services, 2008



Association with Onsite Service Availability

(preliminary results: do not cite)

	Increases	Decreases
ER visits per enrolled month, 2008 (outpatient visit only)	Exercise	
Odds of having at least one ER visit, 2008 (outpatient visit only)		Service Coordinator
Acute stays per enrolled month, 2008		Exercise *Primary Care* *Nurse*
Odds of at least one acute stay during 2008	Mental Health	Exercise Service Coordinator *Nurse*
Office visits per enrolled month, 2008		*Primary Care*
Medicare expenditures per enrolled month (medical only)		Exercise
Medicare expenditures per enrolled month (Part D only)		Primary Care
Medicaid expenditures per enrolled month (among full duals)	Mental Health *Exercise* *Service Coordinator*	Medication management

Non-italicized results are significant ($p<.05$). *Italicized results are borderline ($p<10$)*.

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

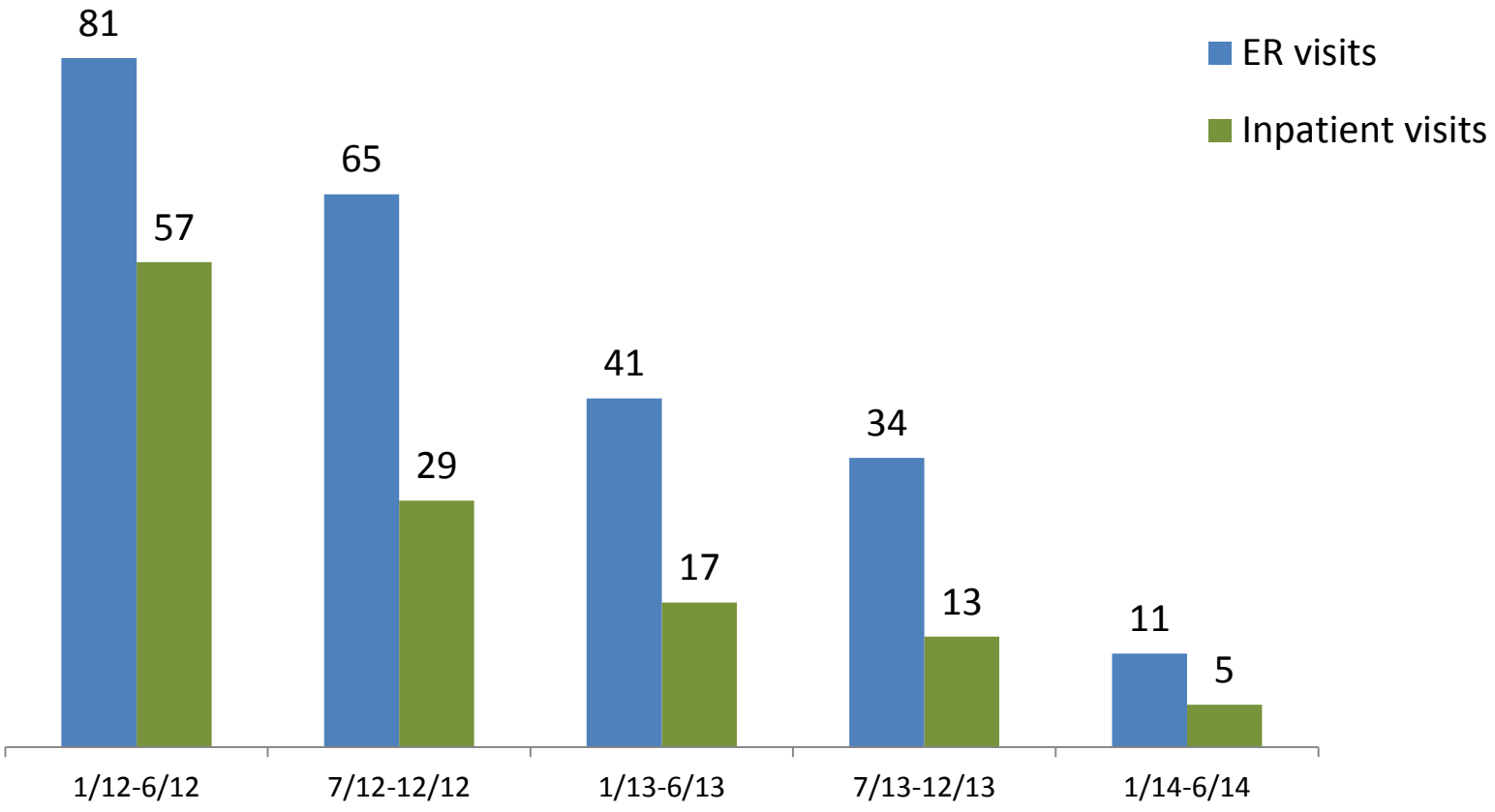
- Comparing SASH participants to:
  - Individuals in MAPCP demo, non-SASH properties (in VT)
  - Individuals not in MAPCP demo, non-SASH properties (in NY)
- Early results: SASH is bending cost curve
  - Growth in annual total Medicare expenditures was $1,756 - $2,197 lower for SASH participants than for two comparison groups

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

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



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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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**

About Discern

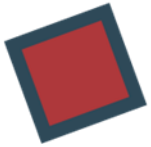
Discern Health is a consulting firm that works with clients across the private and public sectors to improve health and health care. Our focus is enhancing the value of health care services through quality-based payment and delivery

Measure

- Measure alignment and gap assessment
- Measure selection and strategy
- Measure implementation and data anal

Inform

- Measure reporting strategy
- Development of performance-based payment models
- Analysis of payment systems



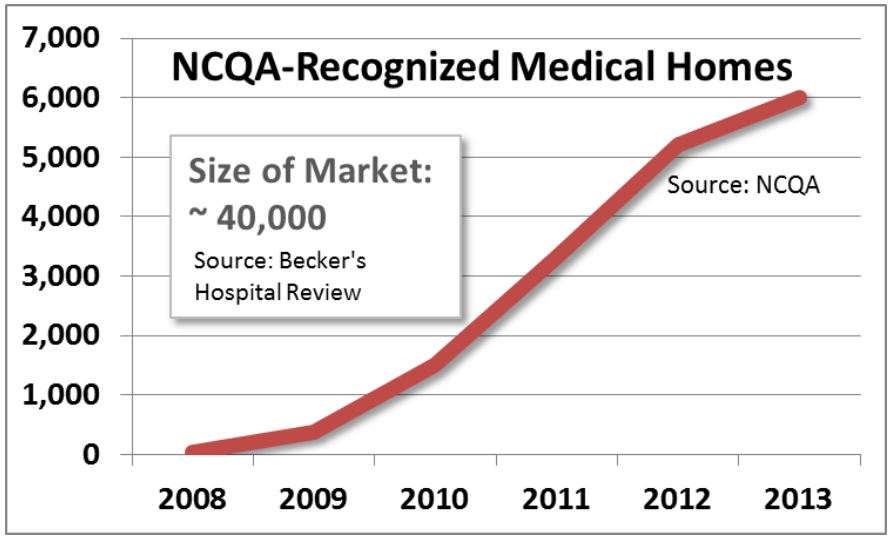
Transform

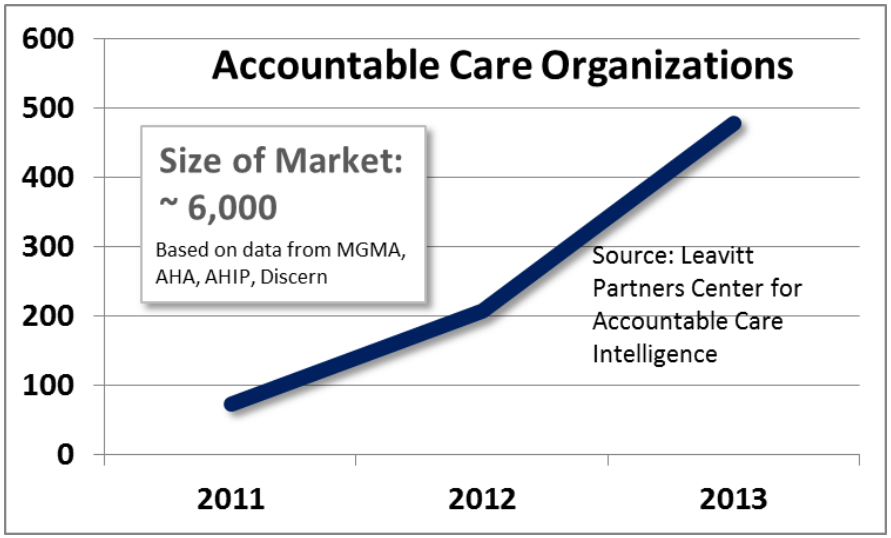
- Re-design of care delivery models
- PCMH transformation and recognition coaching
- Accountable care strategy



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

	Characteristics	Examples
First Generation (2000 – present)	Process and structure quality measures; internally-focused; "siloed"; volume-based revenue with some pay-for-performance	Hospitals, physician practices (i.e., "traditional" medical providers)
Second Generation (2010 – present)	Process and outcome measures; externally-focused on other clinical providers; clinical integration; mix of volume and value payments	Accountable care organizations (ACOs); patient-centered medical homes (PCMHs)
Third Generation (2015?)	Population outcome-focused; integrated with community resources; global risk-based payments	???

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

Calculator to Estimate Value

- 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.