The Missing Link:
Stable Housing as a Key Determinant of Health in Medicaid Populations

Speakers:
John Lovelace, President, UPMC for You
William C. Kelly, Jr., Strategic Advisor, Stewards of Affordable Housing for the Future
Mike Nardone, Managing Principal, Health Management Associates

Dec. 12, 2014
HMA Information Services Webinar
Housing as a Foundation for Health

Stable, Affordable Housing

Comprehensive Supports

Direct Interventions
Evidence on Supportive Housing for Homeless Individuals

• Substantial body of evidence documenting the impact of supportive housing on:
  – Health outcomes, e.g., improved health status, better mental health, lower substance abuse rates, higher survival rates for residents of supportive housing
  – Utilization rates and cost, e.g., lower ED and inpatient hospital admissions, lower detox and psychiatric admissions
  – Bolsters argument that stable, affordable housing is a foundation for better health outcomes and lower health costs

• Despite the research and recognition of housing as a key social determinant, the two systems remain “siloed”
Times, They Are a Changin’….

- Expansion of Medicaid under the ACA
- Increased reliance on managed care and new delivery system models, e.g. ACOs
- Increased focus on a more holistic approach to care and achievement of the Triple Aim
- New tools available through the ACA, e.g. health homes
- Housing organizations are becoming more focused on tracking outcomes/measuring impact on health related metrics
- Housing organizations providing service supports on site as natural partners in efforts by payers to achieve health outcomes
Some of the barriers to be addressed include:

• Housing historically not defined as Medicaid reimburse-able

• Type of services provided not consistent with the medical model

• Capacity of housing organization as service provider

• Pressure on Medicaid funding

But a necessary first step:

• Bridging the language divide - housing providers and healthcare payers will need to interface, understand and speak each others languages, in order to foster effective collaborations
Changing Dynamics  →  Innovation

• Despite these and other challenges, much interest and activity in this area

• Initiatives driven by states, counties, health plans, housing organizations

• All working to find the best ways to achieve the goal of successfully linking housing and health care and addressing this major social determinant

• Today we will hear from two individuals and organizations on front lines of these efforts:
  – John Lovelace, President, UPMC for You
  – William Kelly, Strategic Advisor, Stewards of Affordable Housing for the Future (SAHF)
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John Lovelace
President, Government Programs
UPMC Health Plan

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A Strong Value Network

**Commercial and Medicare (HMO)**

More Than 132 Hospitals

- 95% of all hospitals in region including full access to UPMC

More Than 14,000+ Doctors

- 96% of all physicians in region

More Than 30,000 Pharmacies

- Major chains and independents

**Access to Urgent Care Centers**

- 98% of all in region

**National & Worldwide Coverage**

- Super-Med network Medical Mutual of Ohio
- MultiPlan in all states; 4,200 hospitals; 630,000 professionals
- World-wide through Assist America

**Medicare (PPO)**

- National Complementary Plan includes any provider who accepts Medicare

NCQA Accreditation

“Excellent”
Homelessness continues to be among the most important social problems facing our nation. Since the 1980s a significant body of research has documented the multiple social, psychological and health problems that co-exist among homeless populations. The evidence documenting the extent and impact of chronic medical illnesses within this population is extensive.
Chronic Medical Illness and the Homeless

• Among people experiencing homelessness, 31-46% report having a chronic medical problem. A high prevalence of HIV, cardiovascular disease, diabetes, and latent TB infection have been consistently documented.

• Substance abuse is also common and is estimated to affect 40-60% of the population.

• Among those with substance use disorders (SUD), the prevalence of chronic medical illnesses is even higher, estimated at 53%.
Service Utilization and Health Outcomes

- Homeless adults are hospitalized 4-5 times the rate of the general population for medical issues.

- When compared with other low-income populations, hospitalization rates are 2.7 times higher.

- Inpatient lengths of stay for medical issues have also been consistently found to be longer than the general population.

- Homeless patients are more likely to be frequent utilizers of emergency department services, particularly those with substance use disorders.
Service Utilization and Health Outcomes

• Despite the fact that people experiencing homelessness use a tremendous amount of medical services, they continue to have poor health outcomes.

  - mortality rates are 3-4 X greater than the general population

  - earlier mortality (severe mental illness (SMI), multiple co-morbidities)
Evidence on Supportive Housing for Homeless Individuals

- Health outcomes, e.g., improved health status, better mental health, lower substance abuse rates, higher survival rates for residents of supportive housing

- Utilization rates and cost, e.g., lower ED and inpatient hospital admissions, lower detox and psychiatric admissions

- Bolsters argument that stable, affordable housing is a foundation for better health outcomes and lower health costs
Cultivating Health for Success: The Partners

• The member

• One primary care practice, committed to working with people with psychosocial challenges: Metro Family Practice

• Local HUD authority (Allegheny Co. Housing Authority)

• Housing support agency: Community Human Services

• UPMC Health Plan
Clinical Perspectives
Eligibility

• Medicaid or D-SNP member (low-income by HUD definition)

• Disabled, as determined by the PCP

• Lengthy history of repeated inpatient hospitals stays and ED visits

• Homeless/unstable permanent housing, by HUD definition
Current Enrolled Population Demographics

• **Age**
  – Range (23 – 61)
  – Mean (46.88)

• **Race**
  – African American (48%)
  – Caucasian (48%)
  – Hispanic (4%)

• **Behavioral Health Conditions (76%)**
  – Schizophrenia
  – Bipolar
  – Multiple personality disorders
  – Depression
  – Anxiety

• **Physical Health Conditions**
  – CAD, Hypertension
  – Diabetes
  – COPD, Asthma
  – Chronic Pain – back, abdominal
  – Epilepsy
  – HIV
  – Chronic Liver Disease
  – Morbid Obesity
  – Sickle Cell Disease

• **Substance Use Disorders (76%)**
  – History / In active treatment (74%)
  – Not engaged in treatment (26%)
Program Interventions

- Review member eligibility for the program
- Conduct member assessments and obtain member consents (program agreement; release of PH/BH PHI)
- PCP initial appointment and care plan development
- Assist member in finding fair market housing (1 BR)
- Assist member in obtaining transportation assistance
- Medication reconciliation and review/address barriers that impact medication adherence
- Follow up after emergency room visits
- Visit member during inpatient hospitalization for care coordination; assist member in scheduling follow up visit with PCP and/or specialists after IP
# Daily Utilization Tracking Report

<table>
<thead>
<tr>
<th>Member PCP ID</th>
<th>Current Admit Type</th>
<th>Provider Referring Name</th>
<th>Provider Hospital Attending</th>
<th>Provider Hospital Name</th>
<th>Visit Admit Date</th>
<th>Visit Discharge Date</th>
<th>Visit Chief Complaint</th>
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<td>EMERGENCY DEPT - EMERGENCY DEPT</td>
<td>JOE SUYAMA</td>
<td>(MAGEE-WOMENS HOSP; ATTENDING: GREG SWARTZENTRUBER)</td>
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<td>(UPMC - PASSAVANT(MCCA NDLESS); ATTENDING: NOEL RESSLER)</td>
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Case Study

• 54 year-old male. PMH: CHF, Viral Hep C from IV drug abuse, COPD, Hx of Pulmonary Emboli, Rheumatoid Arthritis, Cirrhosis of the Liver, A Fib, Tricuspid Regurgitation, HTN, Lung Nodule, hypothyroidism.

• Member had a significant heart attack after entering the program with a month-long hospitalization followed by SNF stay of 25 days. Member also had a diagnosis of lung cancer during his enrollment period and has seen an increased number of specialists due to his multiple chronic conditions.
Program Assessment
Population Characteristics

• Targeted enrollment
  – 250,000 Medicaid beneficiaries
  – 15,000 Medicare Dual SNP beneficiaries

• Fiscal Year 2010, identified those members whose medical spending was in the top 5% (inpatient admissions)

• Average of 5.6 admissions/year/beneficiary

• 10-20% are homeless (HUD definition, including temporary or unstable housing) in the course of a year
Opportunity Assessment

• **SNP:**
  - 105 beneficiaries who accounted for the top 5% spend for admissions
  - Average overall PMPY cost = $137,214
  - Average of 5.7 admissions/year (IP, SNF and Rehab)
  - Reduction of one admission/year saves approximately 17,000

• **Medical Assistance:**
  - 199 beneficiaries account for top 5% spend for admissions
  - Average overall PMPY - $85,960
  - Average of 5.5 admissions/year (medical-surgical, excluding BH and maternity)
  - ALOS = 9.2
  - Average cost per day = $1,701
Methodology- Scope

• Pre and During enrollment data was collected and averaged per member per month (PMPM) and examined for several categories:
  – Total medical cost
  – Unplanned care cost and utilization (ER, inpatient, skilled nursing facilities and rehab)
  – Pharmacy cost and utilization
  – Total medical and pharmacy cost combined

• One year prior to the earliest members program start date, January 2010 through the most current data (September 2014) was used as the evaluation period

• Each member is evaluated based on number of months each was a member prior to and during enrollment
Cost of Care

- Post enrollment data shows a decrease of 8.3% for average PMPM expenses (medical and pharmacy)

### Average Expenses PMPM by Period

<table>
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<th>Pre</th>
<th>Post</th>
<th>Percentage Change</th>
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<tr>
<td>Average PMPM Medical</td>
<td>$2,231</td>
<td>$2,001</td>
<td>-11.5%</td>
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<tr>
<td>Unplanned Care Costs</td>
<td>$1,349</td>
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<td>Average RX PMPM</td>
<td>$456</td>
<td>$481</td>
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<td>Average RX and Medical</td>
<td>$2,687</td>
<td>$2,482</td>
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</table>
Cost of Care

- Post enrollment data for unplanned care categories decrease for Inpatient and Emergency Room but increases for Skilled Nursing/Rehab expenses
- SNF/Rehab accounts for 8% of unplanned care in post enrollment period
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William C. Kelly, Strategic Advisor
Stewards of Affordable Housing for the Future
www.sahfnet.org

HOUSING IS HEALTH:
Building on the Housing with Services Model

Dec. 12, 2014

HMA Information Services Webinar
Stewards of Affordable Housing for the Future

- BRIDGE Housing
- Homes for America
- Mercy Housing
- National Church Residences
- National Housing Trust/Enterprise
- Preservation of Affordable Housing
- Retirement Housing Foundation
- The Community Builders
- The Evangelical Lutheran Good Samaritan Society
- The NHP Foundation
- Volunteers of America
The SAHF network provides housing to 104,000 low-income families, seniors, and persons with special needs.
Member Portfolios: Mercy Housing Example

Mercy Housing
Serving 152,600 people
17,400 apartment units, 290 properties in 20 states

Resident Annual Median Income

- $18,779 FAMILY
- $11,861 SENIOR
- $9,289 SPECIAL NEEDS

Source: http://www.mercyhousing.org/facts
SAHF’s Approach

• SAHF’s mission is to support and enhance its members’ efforts to provide affordable housing and to enable the residents to improve the quality of their lives.

• SAHF is a leader in practice-based policy, working with its members, to develop solutions that are effective on the ground.

• SAHF focuses on pursuing innovation where the scale of the collaborative can have unique and substantial impact.

• SAHF members share and leverage each other’s best practices and collaborate on business and mission opportunities.
Resident Services: Tackling the Social Determinants of Health

Resident Services Coordinators:

- Have BA/MA training in social work
- Identify resident needs, coordinate programming, encourage resident participation and foster peer support
- Build community partnerships that bring social and health services to the property
- Deliver direct services (in some cases)
- Track outcomes
The SAHF Outcomes Initiative: Measure Impact

- Housing stability
- Work, income and assets
- Youth and education
- Community engagement
- Health and wellness

Improved well-being
SAHF Outcomes Initiative: Building Successful Linkages

Working with HMA to identify:

• Metrics important to govt/managed care
• Demonstration concepts that improve health plan program metrics
• Partners to develop and implement pilots to achieve the Triple Aim among residents
Locating High-Need Plan Beneficiaries Served by Affordable Housing Developers

Medicare and Medicaid use among seniors is subsidized housing compared to seniors in unsubsidized housing:

- 68% of seniors who lived in HUD-assisted housing were dually eligible for Medicare and Medicaid beneficiaries. Of these, 55% had 5 or more chronic conditions (28% higher than unsubsidized seniors).

- 13% higher: emergency department visits
- 26% higher: physician office visits
- 32% higher: PMPM Medicaid costs

Assessing Need

Percent of HUD-Assisted Seniors 65+ by Chronic Disease State

Other: Anemia, Hyperlipidemia, Hyperplasia, Hypertension

Preventing Unnecessary Health Care Costs and Movement to Skilled Nursing Facilities

- **Remote Technologies:** *The Evangelical Lutheran Good Samaritan Society* uses sensor technology to promote wellness and safety for clients in their homes. The sensor devices detect how active someone is, their sleep patterns, or if they've had a fall -- highlighting critical risk factors or condition deterioration enabling quick responses and better care.

- **PACE (Program of All-Inclusive Care for the Elderly):** *Volunteers of America* manages PACE centers in CO, NC, and VT.

- **Area Agencies on Aging:** *Preservation of Affordable Housing* contracts with AAAs to provide service coordination at some senior properties.

- **Evidence-Based Programming:** As resources allow, members increasingly applying tools used in the community to affordable housing populations (CDSMP (Chronic Disease Self-Management Program), A Matter of Balance (falls prevention), Java Music Club, etc.).
Detecting and Reducing the Severity of Depressive Symptoms in Seniors

Volunteers of America: Implementing the Healthy IDEAS community depression screening program to detect and reduce the severity of depressive symptoms in seniors. Starting with 26 senior properties in Texas and Florida.

Healthy IDEAS Program Design

- **Location:** in the resident’s unit on a one-to-one basis by service coordinators over a 3-6 month period.
- **Resources:** Trains existing staff with established relationships with residents.
- **Materials:** Trainees use a manual that outlines the steps and includes written worksheets, client handouts and forms to support and document the process and resident outcomes.
Enriched Supportive Housing Pilot
More than Pays for Itself

Background: Mercy Housing pilot: Mission Creek Apartments
• 7 year study period from 2006-2014.
• 51 formerly homeless (12 from a city-operated SNF) housed in 51 supportive housing units of a 139-unit senior property.
• San Francisco Department of Public Health Direct Access to Housing (DAH) Program provided wrap-around services.

Study findings:
• Avoided 16,433 days at a SNF for the former SNF residents.
• Avoided $9.2 million Medicaid/Medicare costs over the study period which more than covered all costs of the Mercy housing-based approach.
• Total cost for 51 tenants over study period was $8.5 million (incl. rent, hospital-based care and adult day health services).
• 51% of formerly homeless/33% from SNF attended adult day health program (includes: functional activities, nursing services, food, PT, OT, and socialization).

Assisted Living Pilot Saves 49% Over Nursing Home Costs

**Background:** National Church Residences pilot

- 90 nursing home residents (mean age of 79) moved to assisted living apartments
- Ohio Assisted Living Medicaid Waiver
- HUD Assisted Living Conversion Program
- HUD rental subsidies
- Kresge Foundation supported HMA costing study

**Study findings:**

- Cost savings: $73.08/person/day
- Improved health outcomes with higher levels of satisfaction

Source: National Church Residences Housing Study Project: A Final Report; 2012
Achieving the Triple Aim

- Improve Experience of Care
- Decrease Per Capita Costs
- Improve Population Health
Next Steps: Move Beyond Pilots

SAHF member organizations:

- Bring strong institutional capacity.
- Have demonstrated strategies that improve the health of and significantly decrease health costs for residents.
- Have been limited to foundation funding and special funds (e.g., Medicaid Waivers) that benefit a limited number of (e.g., 51 formerly homeless, 90 nursing home residents).
- Are positioned to scale up across properties and populations (104,000 households).
Next Steps: Build Partnerships with Health Payers and Providers

Work together to:

• **Close service delivery gaps** by supporting demonstration projects that build a continuum of services across sectors and into the homes of residents.

• **Support housing policies** that meet the increased demand for affordable housing created by the new health care paradigm supported by the ACA.

• **Improve communication** and information sharing to promote partnerships and accelerate implementation of successful partnership models.
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Managing Principal, Health Management Associates

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Stewards for Affordable Housing of the Future (SAHF)

- SAHF is a network of eleven social enterprise nonprofits who together provide affordable housing to over 100,000 households across the country, including 49 states and the District of Columbia.

- Many SAHF properties have staff on site who support residents in meeting their health care and other social support needs.

- SAHF, through a grant from the Kresge Foundation, has embarked on an effort to demonstrate the positive impact of affordable housing across several service sectors, including healthcare.

- Health Management Associates (HMA) engaged to work with members to develop a comprehensive approach for measuring and demonstrating the value of affordable housing to the healthcare system, and foster collaborative relationships with healthcare partners.
Current Services Align with Triple Aim

Current Health-Related Services
- Assistance With Benefits
- Assistance with Healthcare
- Coordination of Activities of Daily Living
- Monitoring of Community Services
- Health Education Programs
- Care Coordination
- Health Fairs, Community Events
- Onsite Health Screenings
- Nutrition and Exercise
- Aging in Place

High Value Service Areas
- Maintaining Health Coverage
- Care Coordination/Navigation
- Health Education/ Risk Reduction/ Outreach
- Care Transitions Support
- Direct Healthcare Services (Onsite)
- Stable, Affordable Housing

Healthcare Outcomes
- Increased Access
  (Individual Experience)
- Reduced Costs
  (Affordability)
- Improved Quality
  (Population Health)
The Cornerstones of a Demonstration Concept

- Healthcare Challenge
- Population/Property Type
- Service Intensity/Intervention
- Outcomes
SAHF-MCO Health Care Roundtable
May 2014

• Participants included SAHF Members, Medicaid MCOs, representatives from foundations, trade associations, and policy think tanks.

• Goals of Session to:
  – Provide feedback on overall approach in developing housing/health care linkages
  – Get Suggestions on how to strengthen the business case
  – Explore possible demonstration projects
Key Roundtable Take-Aways

• Recognition of the assets which housing providers can bring:
  – Can be “eyes and ears” for health plans, providing real-time information on life factors that impact health of members
  – Trusting relationship housing providers have with residents can be a platform to more fully engage them in their health care
  – Can be an effective partner as plans seek to go beyond health care utilization as way of defining/understanding needs of beneficiaries
Potential Roles for Housing Entities

• Examples of specific challenges housing providers could help address:
  – Locating high risk members who are residents
  – Helping residents maintain insurance eligibility
  – Addressing medication compliance
  – Peer programs to help residents manage chronic conditions
  – Health education efforts to improve health literacy and prepare residents for appointments
Next Steps

• Continued efforts to bridge the language divide
• Matchmaking process to connect housing providers to health plans interested in collaboration
• Developing demonstration projects that can meet the health and wellness goals for residents and help health payers achieve outcome goals
• Establish communication mechanism and collaborate on many issues where there is a shared mutual interest
  – Continuous eligibility for Medicaid
  – Availability of More Affordable Housing
Q & A

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