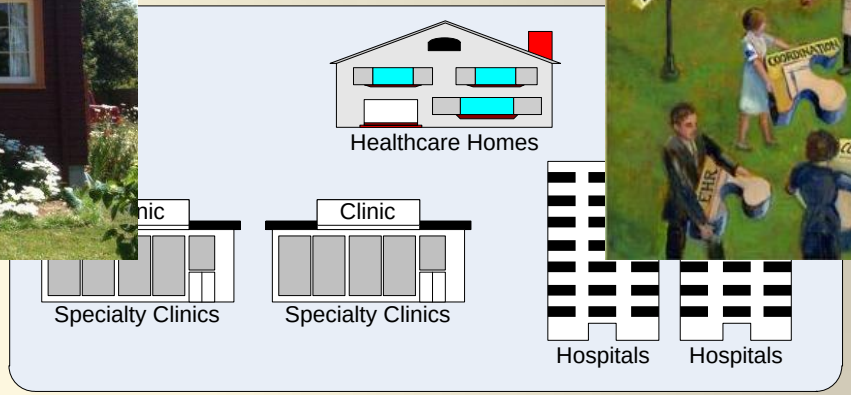
July 21, 2011

Health Homes: Where Does Supportive Housing Fit?

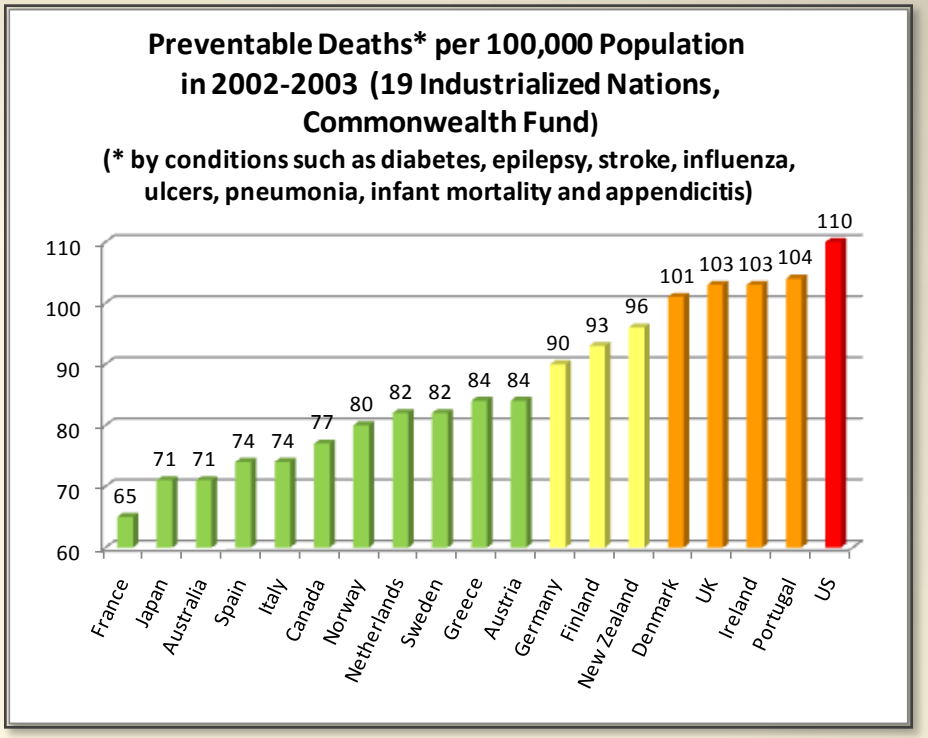
“Health Homes: Where does Supportive Housing Fit?”



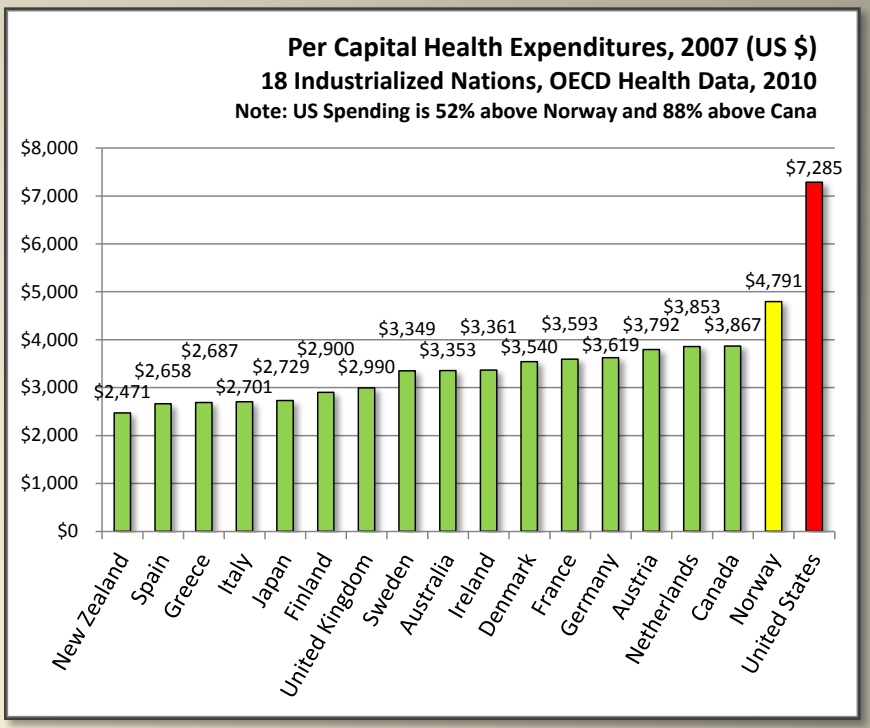
Dale Jarvis, CPA
Seattle, Washington
dale@djconsult.net

DALE JARVIS & ASSOCIATES, LLC

Do We Need to Fix the Healthcare System? The U.S. Quality and Cost Problems



110 Preventable Deaths per 100,000



$7,285 Per Capita Health Expenditure

2

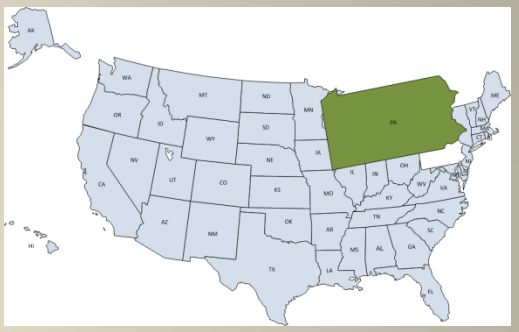
The U.S. has a *Sick Care* System not a *Health Care* System

- 45 percent of Americans have one or more chronic health conditions (asthma, diabetes, heart disease...)
- Over half of these people receive their care from 3 or more physicians
- Treating these conditions account for 75% of direct medical care in the U.S.
- In large part due to the fact that money doesn't start flowing in the US healthcare system until *after* you become sick

The Fix: Service Delivery Redesign and Payment Reform

In Denmark, over the last few decades, the number of hospitals has dropped from 155 to 71 today, a 54% drop, due to the implementation of health homes. *(Sources: Paul Grundy, Director of Healthcare, Technology and Strategic Initiatives for IBM Global Wellbeing Services and Atul Gawande in the New Yorker article, The Hot Spotters)*

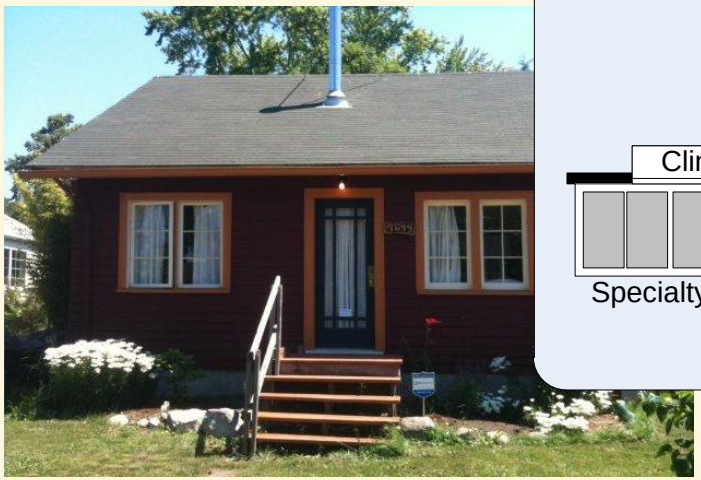
And in the US: "Pilots in the U.S. include Geisinger's, which Grundy says has been remarkably successful, yielding … a 12% reduction in ER utilization, a 20% reduction in hospitalization, and a 48% reduction in rehospitalization. *(excerpt from David Harlow's Health Care Law Blog 9/15/2009)*

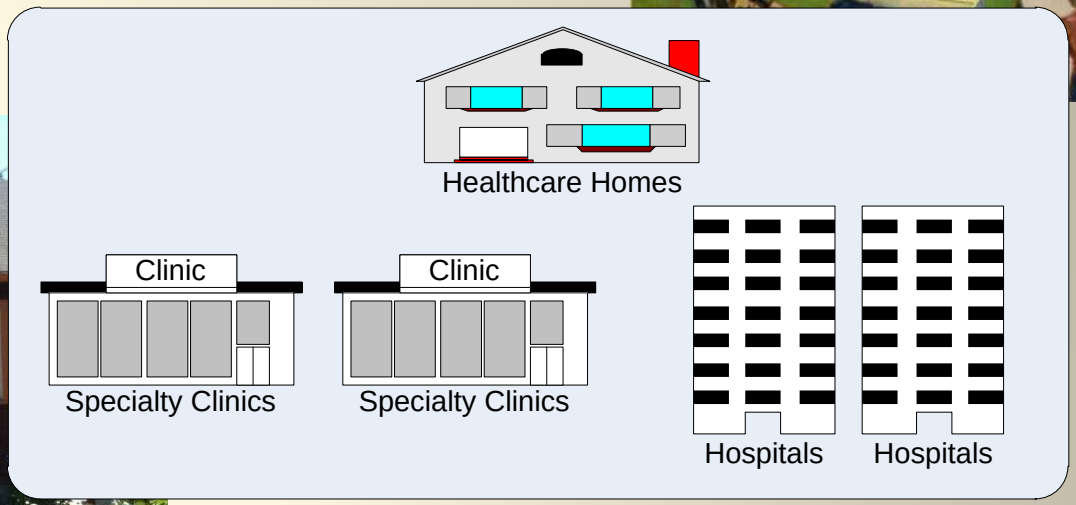


4

Service Delivery Redesign: Everyone is talking about Health Homes

- What are they?
- Where did they get that name?
- Why are they important?





Health Homes: What are They?

- Trying to navigate the healthcare system in the U.S. is like trying to find your way through a tangled maze
- Especially if you are one of the 45% of Americans with a chronic health condition such as diabetes or hypertension

- Most of whom have three or more doctors that don't talk with each other or share information

Health Homes: Primary Care Clinics that Look and Act Differently

Picture a world where everyone has...

- An **Ongoing Relationship** with a PCP
- A **Care Team** who collectively takes responsibility for ongoing care
- And **Provides all Healthcare** or makes **Appropriate Referrals**
- Helping ensure that **Care is Coordinated and/or Integrated**

And where...

- **Quality and Safety** are hallmarks
- **Enhanced Access** to care is available (evenings & weekends)
- And **Payment** appropriately recognizes the **Added Value**

(Joint Principles of the Patient-Centered Medical Home: www.pcpcc.net)

7

Health Homes: What are They? Oregon's Description…

ACCESS TO CARE
Be there when I need you.

ACCOUNTABILTIY
Take responsibility for making sure I receive the best possible health care.

COMPREHENSIVE WHOLE PERSON CARE
Provide or help me get the health care and services I need.

CONTINUITY
Be my partner over time in caring for my health.

COORDINATION AND INTEGRATION
Help me navigate the health care system to get the care I need in a safe and timely way.

PERSON AND FAMILY CENTERED CARE
Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.

Health Homes: Where did they get that Name?

- Actually there are several names:
  - Patient-Centered Medical Home (PCPCC)
  - Person-Centered Healthcare Home (National Council for Community Behavioral Healthcare)
  - Patient-Centered Primary Care Home (Oregon)
  - Medical Homes
  - Health Homes
- All of which are trying to convey the message that the primary care clinic of the future isn't going to look like most primary care clinics today

Health Homes: Why are They Important?

The Group Health Cooperative Story

2002-2006: Move towards Medical Home

- Email your Doctor
- Online Medical Records
- Same Day/Next Day Appointment

(Increased patient satisfaction but also saw provider burn-out and decline in quality scores)

2007: More robust Healthcare Home Pilot

- Added more staff (15% more docs; 44% more mid-levels; 17% more RNs; 18% more MAs/LPNs; 72% more pharmacists)
- Shifted to 30 minute PCP slots

(Reduced burnout, increased quality scores, broke even in the first year, reduced ER usage by 29%, reduced inpatient usage by 6%, reduced PMPM costs by $10.30 over the 21 month pilot)

But wait… what about folks in the safety net?

- For many children and families, especially those in the safety net, good healthcare is not enough
- Consider a mom with depression and diabetes
- Add to this scenario the facts that she is the head of household of a family of three, has lost her job, is experiencing domestic violence and she and her children are on the brink of homelessness

A REPORTER AT LARGE

THE POVERTY CLINIC

Can a stressful childhood make you a sick adult?

BY PAUL TOUGH

Nadine Burke at her San Francisco clinic. Photograph by Alessandra Sanguinetti.

THE NEW YORKER, MARCH 21, 2011

Will health homes work for folks in the Safety Net? Not without the "Customization" of Medical Homes

- Analogy: Generic Hospital Beds and ICU
- Customization of Medical Homes – different models for different needs
  - Seniors in nursing homes
  - Youth in Families receiving TANF
  - Adults with a Serious Mental Illness
- For example, Person-Centered Health Homes that include Mental Health and Substance Use services are critical to for improving quality and bending the cost curve for persons with these conditions

A New Vision: The "Healthcare Neighborhood" The Next Generation Safety Net Healthcare System

- The Fulton County Georgia (Atlanta area) Neighborhood Union Primary Care Partnership's One Stop Shopping:
  - Well patient care
  - Sick-patient care
  - OB/GYN services
  - Travel immunization services
  - Communicable disease intervention
  - WIC/nutrition education
  - Oral health services
  - Behavioral health services
  - A day center for parents receiving services
  - Employment assistance
  - Disability and vocation rehabilitation services
  - Foreclosure prevention services
  - Housing assistance
  - A reading room/information center that offers ESL classes
  - A farmer's market
  - A community garden
  - A walking trail

How to Pay for this work, beginning with… Section 2703 Health Homes

Service Definitions

Section 1945(h)(4) of the Act defines health home services as "comprehensive and timely high quality services," and includes the following health home services to be provided by designated health home providers or health teams:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

- Other Sources: Innovation Center grants, new Prevention dollars, expanded Home and Community Based Waiver Options and more

Section 2703 Health Homes

Health Home Population Criteria

Section 1945(a) of the Act permits States the option to offer health home services to "eligible individuals with chronic conditions" who select a designated health home provider. The chronic conditions include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25. The Act authorizes the Secretary to expand the list of chronic conditions reflected in this provision.

The health home population the State elects must consist of individuals eligible under the State plan or "under a waiver of such plan" who have:

- at least two chronic conditions
- one chronic condition and be at risk for another, or
- **one serious and persistent mental health condition**

- Each state will develop a set of rules about covered populations and what is required to become a "designated health home" and then receive 90% federal match

Now, on to our next speaker…

Health Homes: Where Does PSH Fit?

Peggy Bailey
Senior Policy Analyst
Peggy.bailey@csh.org

CSH Health Webinar Series

July 21, 2011

Overview of Presentation

- What is Supportive Housing
- Challenge of Financing Services
- Benefits of Medicaid/Supportive Housing Partnership
- Supportive Housing Within Health Home Concept

Corporation for Supportive Housing

CSH is a national non-profit organization that helps communities create permanent housing with services to prevent and end homelessness.

We have offices in 12 states and the District of Columbia

For 20 years, CSH has been advancing its mission by providing **advocacy**, **expertise**, **leadership**, and **financial resources** to make it easier to create and operate supportive housing.

What is Supportive Housing

- **Housing**
  - **Permanent:** Not time limited, not transitional.
  - **Affordable:** To very low income people (due to financing with minimal to no conventional debt coupled with rent subsidies)
  - **Independent:** Tenant holds lease with normal rights and responsibilities.
- **Services**
  - **Flexible:** Responsive to tenants' needs. Focused on housing stability.
  - **Voluntary:** Participation not condition of tenancy

Challenges of Financing Services

- Often the last piece of the puzzle
- Mostly short term grants
  - Narrow in scope
  - Extensive reporting requirements
  - Unpredictable
- Limited community resources
  - Provider shortages
  - Little experience with our population and model
  - Restricted public budgets

How Medicaid Can Help PSH Providers and Residents

- Stable services funding source
- Covers both primary and behavioral health
- Strengthens partnership with health system
- Improved chronic disease management

How PSH Can Help Medicaid

For those <u>Currently</u> Medicaid Eligible, PSH Can:

- Reduce costs
  - Those experiencing homelessness, especially chronic, often are high cost, high users of emergency rooms, inpatient hospital stays and nursing homes

Medicaid Cost Study Findings

- Downtown Emergency Shelter Center in Seattle showed **41 percent in Medicaid savings** by reducing ER visits and hospital inpatient stays.

- CSH's Frequent Users of Health Systems Initiative found that:
  - **Prior** to housing, residents of supportive housing had ER and hospital inpatient costs over **$58,000**
  - **Two years after housing**, residents incurred only **$19,000**

- Chicago - PSH saved almost $25,000

- Portland, Maine - Medicaid costs were reduced by almost $6,000

- Direct Access to Housing in San Francisco found that supportive housing reduced nursing home costs by $24,000.

* All $$ amounts are per person, per year

How PSH Can Help Medicaid, cont.

- Improve and coordinate care
  - Residents keep appointments
  - Coordinate providers and provider advice for residents with complex needs
  - Follow doctor advice (eat better and more regularly, take medication, reduce risky behavior)

Supportive Housing Improves Health Outcomes

- SF study found 5-year survival rates of 81% for PLWAs in supportive housing compared with 67% who remained homeless
- Chicago study found 55% survival for PLWAs in supportive housing compared with 35% of control group, and lower viral loads among housed group
- Denver study found 50% of tenants improved health status and 43% had improved MH
- Seattle study found 30% reduction in alcohol use among chronic alcohol users in SH

How PSH Can Help Medicaid, cont.

For Newly Eligible in 2014, PSH Can:

- Assist with outreach and enrollment
  - Traditionally difficult to reach population
  - Substance use, Childless adults, Non-disabled adults

- Control costs
  - Increased initial federal match can be used to improve future system

And one way for PSH to connect with Medicaid is as a partner in a health home service delivery model

Role PSH Service Providers in Health Homes

DSMD Letter Guidance

- Population – those with 2 chronic conditions, 1 chronic condition and at-risk of another or one serious mental illness

  Chronic conditions include: mental health, substance use, asthma, diabetes, heart disease, and obesity among others

Supportive Housing Comparison

- Supportive housing typically targets those who are medically vulnerable and have serious mental illness

Role PSH Services Providers in Health Homes

DSMD Letter Guidance

General services include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including follow-up
- Individual and family support
- Referral to community and social support services
- The use of health information technology to link services and improve quality

Supportive Housing Comparison

- Case management
- Connection to primary care
- Mental health services
- Substance use treatment or connection to treatment
- Peer support services
- Employment services
- General social supports
- Connection to housing

Communicating Role of PSH if States Implement Health Homes

Language should be health focused

- Message to Medicaid and health partners should be aboaut funding services (not rents, bricks and mortar, etc.)
- Use your state's cost information on frequent users of health and current Medicaid enrollees
- Put PSH service delivery in context of health home goals
- Few supportive housing services providers would lead but many can be team members and most should be 'neighbors'
- Enter discussions starting with community health centers, public and non-profit hospitals and behavioral health clinics to educate them on supportive housing projects and services and explore health reform implementation partnerships – including creating health homes

Medicaid Limitations

- States restrict Medicaid billable providers
- General Reimbursement
  - Can be slow
  - May not support team oriented care
- Requires strong administrative infrastructure
- Does not cover all PSH services
  - Experts estimate that Medicaid has ways to fund between 80 – 90% of services in PSH
  - Things like housing search, move-in expenses, and related case management are not usually covered
  - Gap between what Medicaid currently covers and it's full potential (this can be fixed and health reform helps)

Understanding Health Home: Resources

- CMS Dear State Medicaid Director Letter - November 16, 2010
  http://www.cms.gov/smdl/downloads/SMD10024.pdf

- History of Medical Home Concept - Pediatrics
  http://www.napnap.org/Files/HistoryoftheMedicalHomeConcept.pdf

- AHRQ Innovation - Mobile Clinic Provides Comprehensive Medical Home for Homeless and At-Risk Youth, Reducing Emergency Department Visits and Increasing Follow Up Care
  http://www.innovations.ahrq.gov/content.aspx?id=2477

- National Council for Community Behavioral Healthcare: Behavioral Health/Primary Care Integration and the Person-Centered Health Care Home
  http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

- National Council for Community Behavioral Healthcare - Implementing Medicaid Health Homes for Enrollees with Chronic Conditions
  http://www.thenationalcouncil.org/galleries/policy-file/CMS%20Medicaid%20Health%20Home%20Synopsis.pdf

Contact Information

Peggy Bailey
Corporation for Supportive Housing
Senior Policy Advisor
peggy.bailey@csh.org
Desk: 202-558-1110
Cell: 917-596-6337

Health & Disability Advocates

Opportunities for PSH providers with the Health Home Option

Webinar for CSH

July 23, 2011

Illinois landscape

- Illinois is still mostly a fee-for-service Medicaid state, although legislation just passed to get 50% into coordinated care by 1/1/15;
- Medicaid agency is overwhelmed, short-staffed, with little to no planning capacity;
- Medicaid is in a separate agency from Mental Health and Substance Abuse, and MH and SA are in separate divisions within another agency;
- A positive is that the Director is a long-time supporter of PSH and understands its importance;
- Agency says it wants to explore health home option but has not submitted anything to CMS.

We are working with two Chicago providers interested in HHO

- Heartland Health Outreach, which is a FQHC and healthcare for the homeless grantee – is interested in becoming a health home – may want to have two different configurations;
- One, work with AIDS Foundation of Chicago to serve as the primary care provider for high users of medical services;
- Other would be a larger HHO with other organizations where it would provide behavioral health and primary care.

AIDS Foundation of Chicago

- 50 individuals who are enrolled in Medicaid and identified by Illinois Medicaid as high users of high cost hospital-based, nursing home, pharmaceutical and medical services (e.g., individual with HIV, diabetes, mental health, substance abuse, and cancer.)
- Collaborate with Heartland Health Outreach to serve as the primary care provider.

AIDS Foundation of Chicago

- AFC will braid funding from at least three public funding sources, as well as some private dollars, to house and support these individuals –a recently awarded grant from HUD to provide housing, a grant from SAMSHA to provide alcohol and substance abuse treatment, (and when applicable, Ryan White funds will also be part of the braided sources) and Medicaid reimbursement through fee for service (Health Home Option) for case management and medical services;
- AFC would like to maximize any available Medicaid reimbursement to fund case management which may result in more housing capacity under the HUD grant for housing.

Challenges

- Medicaid Agency's lack of planning capacity and conservative nature;
- Aligning two or more organizations with different capacities, leadership, etc.
- Bringing on hospitals to shift some of the risk;
- The biggest challenge –figuring out what a financially viable bundled rate would look like and who shares the risk.

Illinois's Division of Mental Health

- The Director of State Division of Mental Health is very interested in developing health homes for a number of PSH providers who house people with serious mental illness – they are calling it "bi-directional care."
- Historically and currently, there is distrust and animosity between the DMH providers and the DMH leadership due to funding cuts and reallocation of resources to the Olmstead plaintiffs instead of to those serving the homeless population.

Opportunities for PSH providers

- Every State is in a different place – find out what your State Medicaid agency is doing on ACA implementation;
- Talk to your State legislators about how PSH can be a partner in health care reform, Olmstead implementation;
- Talk to your local Community Mental Health Clinics, FQHCs and hospitals about their plans for care coordination;
- Learn to talk differently about supportive services– Many of the services delivered in supportive housing are medically necessary, Medicaid reimbursable services with a direct impact on health outcomes.

Opportunities for PSH providers

- Help get your tenants on Medicaid! In Illinois, almost every State program will only pay for services delivered to Medicaid recipients.
- Learn what Medicaid fiscal authorities your State uses to pay for services –what waivers does your State use for providing case management, employment services, etc.; or what they could use to pay for supportive services

IL Crosswalk Report

- Partners include Heartland Alliance, Health & Disability Advocates (HDA), and the Corporation for Supportive Housing (CSH), in collaboration with the Chicago Alliance to End Homelessness, Supportive Housing Providers Association, and the AIDS Foundation of Chicago.
- Analyzes current Illinois landscape of Medicaid reimbursement, eligibility, and funding in PSH.
- HDA developed crosswalk to describe the key federal fiscal authorities that currently pay for the various services provided in supportive housing, and identify what services could be paid for by federal fiscal authorities.

IL Crosswalk, con't.

- CSH conducted a survey of PSH providers in Illinois to assess current services provided and their potential fit with Medicaid as a source of funding.
- Findings:
  - PSH serves many current and future Medicaid eligible persons;
  - IL uses disproportionate amount of General Revenue Funds to pay for supportive services;
  - Supportive services provided are Medicaid-reimbursable services;
  - State puts up barriers to providers in billing process and in where and what services can be provided under Medicaid.

IL Crosswalk, con't.

- Paper makes policy recommendations to prepare Illinois to maximize federal and state funding for supportive services.
- Similar exercises can be done in other states to encourage states to take advantage of provisions in the ACA, such as the Health Home Option.

HOMEFRONT

Your source for supportive housing news.

CSH 20 YEARS

If you'd like to stay in touch with CSH— to learn more about webinars like this one and other CSH news—we invite you to sign up for our biweekly newsletter Homefront.

Sign up online at www.csh.org/homefront