Understanding the Difference: *Health Care Coordination & Housing Case Management*

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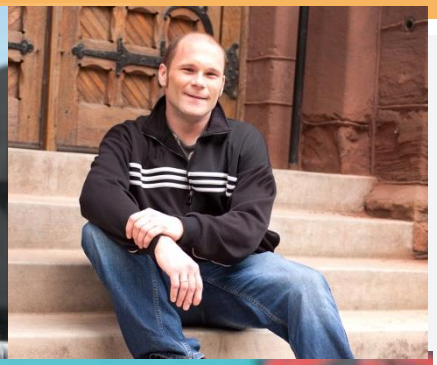
Improving Lives

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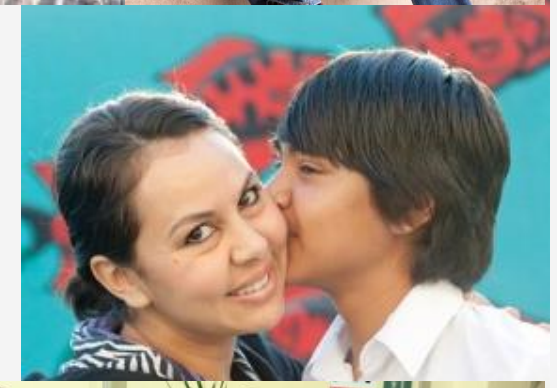


What I'll Cover Today…

- Supportive Housing 101
- Successful Housing & Health Partnerships
- NY's Health Homes Experiment
- Lessons Learned Integrating Health & Housing

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Supportive Housing is the Solution

Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity.

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Supportive Housing is…

Permanent, affordable, independent, tenant centered, flexible, voluntary

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Defining Supportive Housing

1. Targets households with barriers
2. Is affordable
3. Provides tenants with leases
4. Engages tenants in voluntary services
5. Coordinates among key partners
6. Connects tenants with community

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Supportive Housing Services

Tenancy Supports	Housing Case Management
Outreach and engagement	Service plan development
Housing search assistance	Coordination with primary care and health homes
Collecting documents to apply for housing	Coordination with substance use treatment providers
Completing housing applications	Coordination with mental health providers
Subsidy applications and recertifications	Coordination of vision and dental providers
Advocacy with landlords to rent units	Coordination with hospitals/emergency departments
Master-lease negotiations	Crisis interventions and Critical Time Intervention
Acquiring furnishings	Motivational interviewing
Purchasing cleaning supplies, dishes, linens, etc.	Trauma Informed Care
Moving assistance if first or second housing situation does not work out	Transportation to appointments
Tenancy rights and responsibilities education	Entitlement assistance
Eviction prevention (paying rent on time)	Independent living skills coaching
Eviction prevention (conflict resolution)	Individual counseling and de-escalation
Eviction prevention (lease behavior requirements)	Linkages to education, job skills training, and employment
Eviction prevention (utilities management)	Support groups
Landlord relationship maintenance	End-of-life planning
Subsidy provider relationship maintenance	Re-engagement

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Housing & Health Care Integration

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Health Center + Housing Models

On-Site Health Center

-Health Center (such as an FQHC) is co-located with single site supportive housing.

-Works well with a high need population

Off-Site Health Center

-Patients can live in either single site or scattered site housing

-Increases clients connections beyond housing in to the community

-Proximity and transportation are important

Mobile Services Model

-Providing healthcare out of a clinic and in the community

-Works with both single and scattered site housing

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Benefits of Partnership

Well Planned and Implemented Care Coordination

Allows care coordinators to address the social determinants of health for a high need population

Improve patient's health outcomes and their experiences with the health care system

Reduce health care costs and/or wasteful spending

Decreases inefficient use of health care systems

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Housing as Health Care — New York's Boundary-Crossing Experiment

NEJM Knowledge+

A better way to learn. Watch the video >>

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Perspective

Housing as Health Care — New York's Boundary-Crossing Experiment

Kelly M. Doran, M.D., M.H.S., Elizabeth J. Misa, M.P.A., and Nirav R. Shah, M.D., M.P.H.

N Engl J Med 2013; 369:2374-2377 | December 19, 2013 | DOI: 10.1056/NEJMp1310121

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Article | References | Citing Articles (6)

Among the countries in the Organization for Economic Cooperation and Development (OECD), the United States ranks first in health care spending but 25th in spending on social services.[1] These are not two unrelated statistics: high spending on the former may result from low spending on the latter. Studies have shown the powerful effects that "social determinants" such as safe housing, healthful food, and opportunities for education and employment have on health. In fact, experts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest.[2] Lack of upstream investment in social determinants of health probably contributes to exorbitant downstream spending on medical care in the United States. This neglect has ramifications for health outcomes, and the United States lags stubbornly behind other countries on basic indicators of population health.

Audio Interview

Interview with Dr. Nirav Shah on New York State's decision to address housing needs as a social determinant of health. (10:56)

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Redesigning
THE MEDICAID PROGRAM

Stakeholders Representing All Sectors of the Health Care Delivery System

- *Hospitals; Hospital Associations*
- *Managed Care Plans*
- *Advocates, Trade Associations, Unions*
- *Housing Providers, Developers*
- *State & Local Gov't*
- *Criminal Justice*
- *Medical, Behavioral, Social Services and Long-term Care Providers*

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

- Governor Andrew M. Cuomo,

January 5, 2011

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NY's Medicaid Redesign

- **Care Management for All**
- **Universal Access to High Quality Primary Care**
- **Global Spending Cap**
- **2% Across the Board Cut in Services**

- **<u>Health Homes</u>**: Multi-disciplinary teams of providers working together to coordinate care for highest utilizers of Medicaid

- **<u>Targeting the social determinants of health</u>:** Medicaid now actively addressing issues such as housing & health disparities *through innovative strategies like* ***supportive housing***

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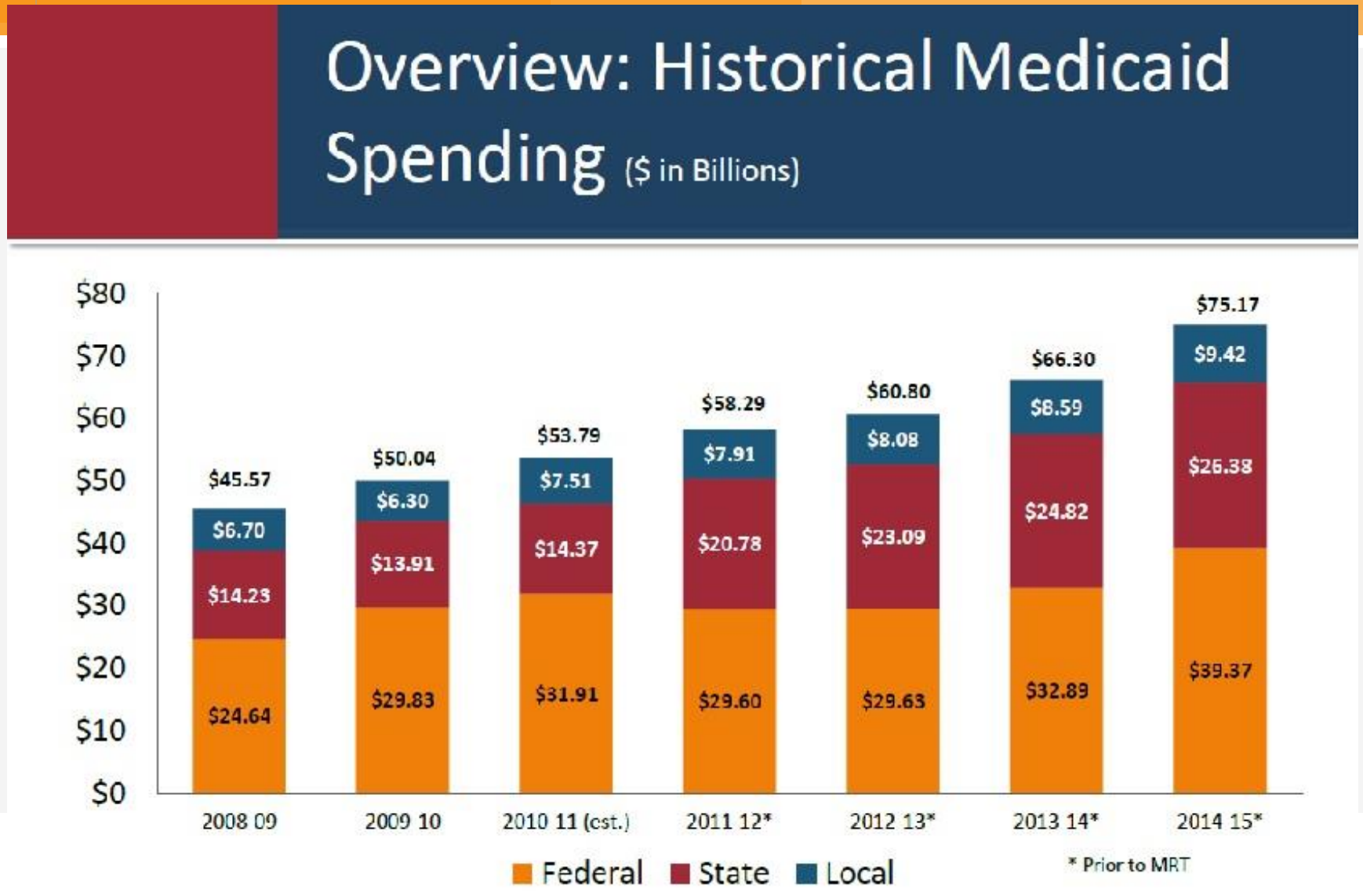
How We Got Here



What is A Health Home

Medicaid Health Home:

An integrated service delivery model that builds linkages to community and social supports, and enhances coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses

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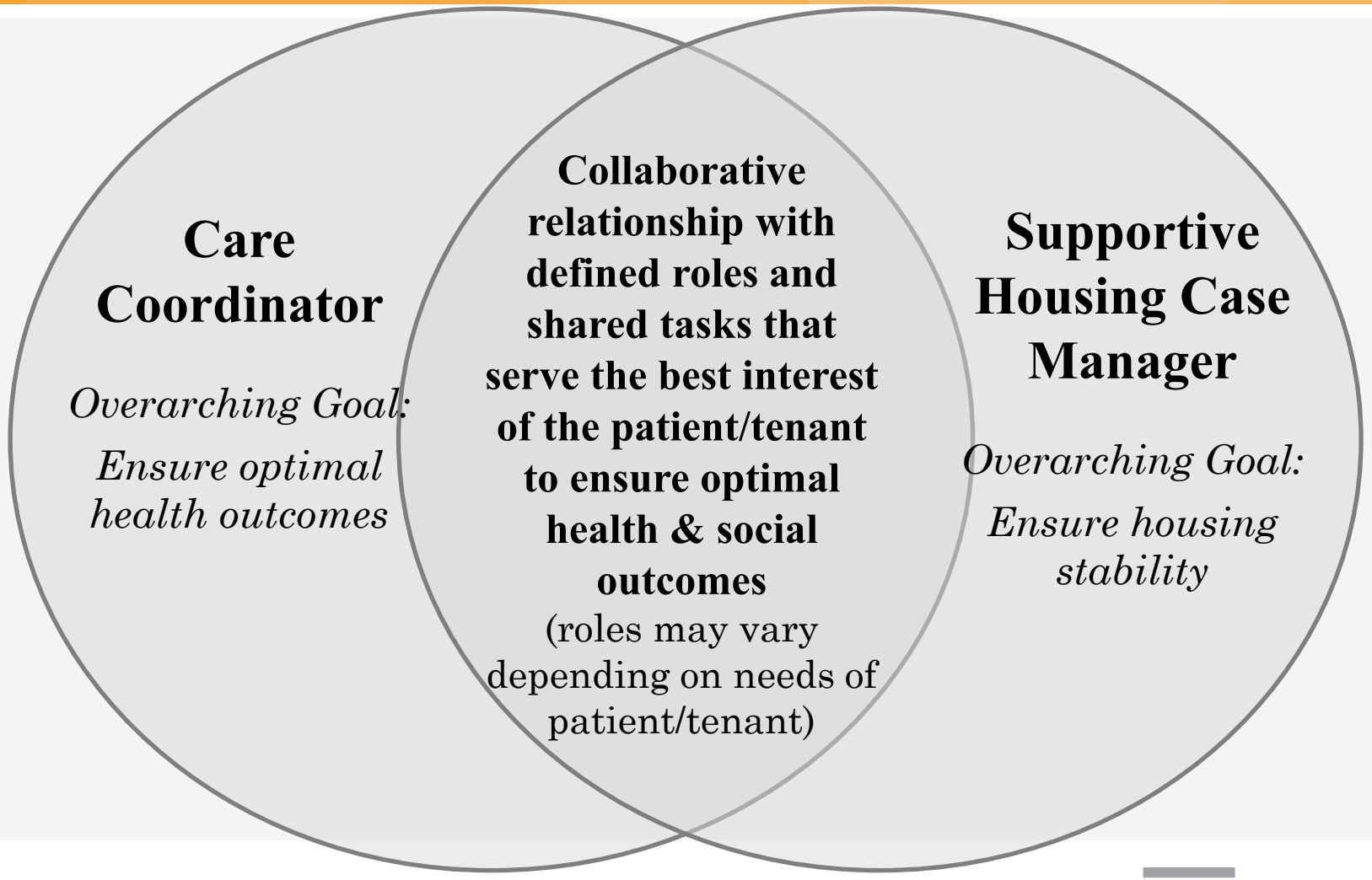
Shared Goals



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Integrated Service Delivery Model

Care Coordinator

- Target and identify homeless/ at-risk patients
- Establish network of providers including housing providers
- Develop & monitor person-centered, single plan of care
- Assess housing status and need for other community/ social supports

Collaborative Working Relationship: Core Responsibilities

- Discuss changes in patient's status and need to revise care plan
- Crisis intervention
- Monitor/support/ accompany patient to medical appointments
- Ensure medication management/ monitoring
- Participate in interdisciplinary case conferences
- Maintain benefits

Supportive Housing

- Join plan's network
- Develop and operate housing units or liaison with private landlord
- Mitigate housing and/or tenant issues
- Ensure successful integration into community and housing stability through critical supportive services provided

Pieces to Successful Partnerships

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Basic Partnership Needs

Coordination between partners:

- Property Management
- PSH case management
- Health Care Provider

Regularly scheduled meetings

- All partners meet regularly to touch base on mutual patients/tenants

Memorandum of Understanding

- MOU that lays out roles and responsibilities of each organization and discusses financial obligations or liabilities

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When it Works: Coordinated Care Partnerships

Assemble appropriate team of health care professionals	Facilitate continuous communication between care team members	Clearly Define Roles
Engage patients in their own care plan	Provide regular face-to-face patient follow-up to identify shifting needs or priorities	Ensure health record accuracy and data sharing within the team
Engage Property Owners & Landlords	Promote linkages to community resources (SU, MH, transportation, legal, etc.)	Get to Know Housing Providers

Integrated Care Management: Caring for the Chronically Homeless

Presenters

Frances Isbell, MS
CEO, Healthcare for the Homeless – Houston

Cathy Crouch, LCSW
Executive VP, SEARCH Homeless Services

"Political" Environment

- National homeless system has undergone key strategic changes as a result of the HEARTH act
- Houston/Harris County critically short of resources to provide needed services to chronically homeless persons prioritized for Permanent Supportive Housing
- Ending chronic homelessness is prioritized by the US Interagency Council on Homelessness for completion by the end of 2015; prioritized also by Houston Mayor and Harris County officials

1115 Medicaid Waiver (Delivery System Reform Incentive Payment)

- Focus on innovative projects that increase health status while reducing costs
- Participants do not have to be eligible for traditional Medicaid resources
- Majority of projects in Texas focus either on decrease of unnecessary ED visits or MH issues
- HHH/SEARCH project – clinical intervention and support for chronically homeless individuals who have a dx of SMI, with 3 or more ED visits in past 2 years

Definitions

- **chronic homelessness,** HUD definition: an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years

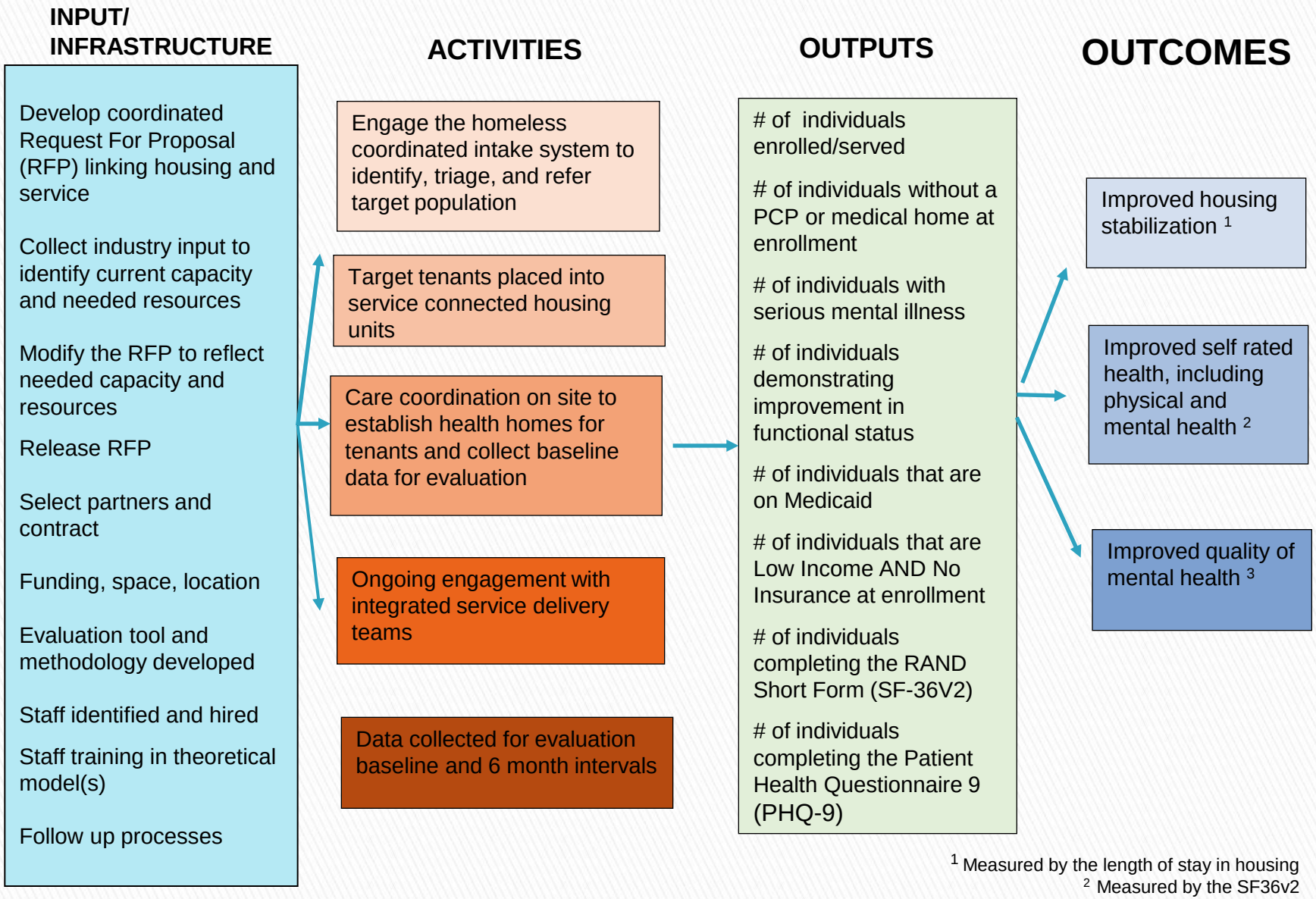
Definitions

- **Permanent supportive housing (PSH)**: decent, safe, affordable, community-based housing that provides tenants with the rights of tenancy and links to voluntary and flexible supports and services for people with disabilities who are experiencing homelessness. Permanent supportive housing is a proven, effective means of reintegrating chronically homeless and other highly vulnerable homeless families and individuals with psychiatric disabilities or chronic health challenges into the community by addressing their basic needs for housing and providing ongoing support

BACKGROUND: Homelessness & Health

- Homeless have mortality rates 3-6 X higher
- Estimated reduced life span of 13-32 years
- Deterioration of health status from:
  - Delays in seeking medical treatment
  - Exposure to the environment
  - Cognitive impairment
  - Lack of preventive care
  - Lack of access to care
  - Lack of continuity of care
- Medical costs account for 62% of service costs (LA study)
- 9 – 13 x more ED visits; 3 x more hospital days

Logic Model



[1] Measured by the length of stay in housing
[2] Measured by the SF36v2
[3] Measured by PHQ9

Evaluation Criteria

- Stabilized housing
- SF-36v2
- PHQ-9
- Reduced ED visits / hospitalizations
- Standard FQHC health status indicators
- Increased income

Theoretical Models: HHH/SEARCH
"Primary Care Behavioral Health Consultant"

- Considered "extreme" integration
- Pilot project with homeless population
- Behavioral Health Consultant (BHC) will see patients with Primary Care Clinician at "point of care"
- Focus on CBT, MI, brief interventions
- Moved HHH from Level 5 integration: Close Collaboration Approaching an Integrated Practice, to Level 6: Full Collaboration in A Transformed/Merged Practice (SAMHSA, *A Standard Framework for Levels of Integrated Healthcare*)

Theoretical Models: HHH/SEARCH

- Transtheoretical Model of Intentional Behavior Change, often known as the Stages of Change
- Motivational Interviewing (MI)
- Client-centered interventions

Team Participants – HHH/SEARCH

- RN Case Manager (HHH, providing nursing services and serves as staffing coordinator)
- Case Manager Lead (part time, SEARCH)
- Director of Social Services (part time, HHH)
- 2 Clinical Case Managers
- 2 Community Health Workers
- Behavioral Health Consultant (part time, HHH)
- Primary Care Team (as needed, HHH)

Baseline SF 36 Scores

- a multi-purpose, short-form health survey consisting of 36 questions
- yields an 8-scale profile of functional health and well-being scores
- the eight scales can be combined to assess a Physical Component Summary and a Mental Component Summary
- baseline composite scores for enrolled individuals indicates that on each of the eight scales, the aggregate scores are significantly lower than the norm-based comparisons

Baseline SF 36 Scores/cont.

- Composite baseline score:45.2078
- baseline scores indicate that that project participants scored 57% below the norm on the Physical Component Summary and 75% below the norm on the Mental Component Summary
- of the individual scales, the three most disparate scores fell in the areas of Social Functioning (80% below the norm), Role Emotional (68% below the norm) and Mental Health (70% below the norm

Patient Health Questionnaire – 9 (PHQ9)

- survey tool to assist clinicians with diagnosing depression and monitoring treatment response
- composite baseline score: 8.8815
- baseline scores indicated that 38% of the participants scored between moderate and severe depression. This is interesting to note, because when compared to the baseline scores of the SF36, these aggregate scores appear to be lower than those on the SF36, which reported 64% in Positive Depression Screening.

Early Lessons Learned

- HUD & HRSA regulations not always alike
- RN critical in “interpreting” between medical and case management staff
- Initial increase in not only SMI acuity, but also physical health crises
- Deepened knowledge & skills of all staff
- Housing providers somewhat hesitant
- Significant funding challenges – traditional Medicaid would not cover costs
- Working on no-show rate at clinic