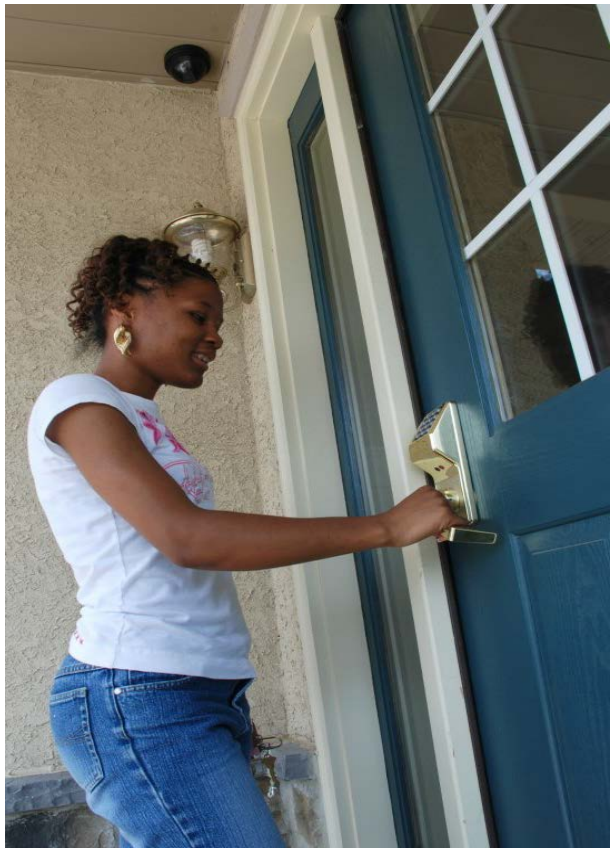
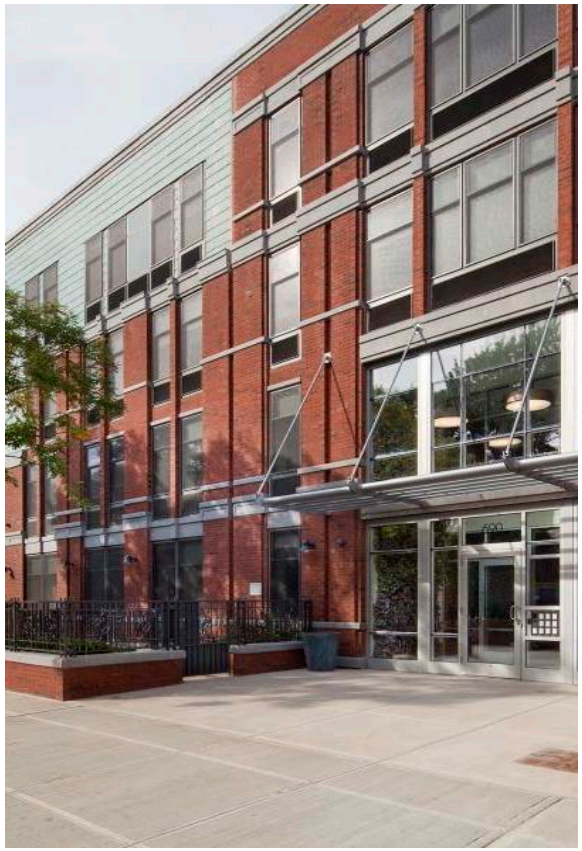
State Activities for Supportive Housing Development

Marcella A. Maguire, Ph.D.

Director, Health Systems Integration

Advancing Housing Solutions That





Improve lives of vulnerable people	Maximize public resources	Build strong, healthy communities

$700 Million
In Loans & Grants

207,000 Homes Created

40,500 Families Housed

124,000 Jobs Created

Lowered costs & improved health outcomes for fragile individuals & families

Economic Impact

$46B

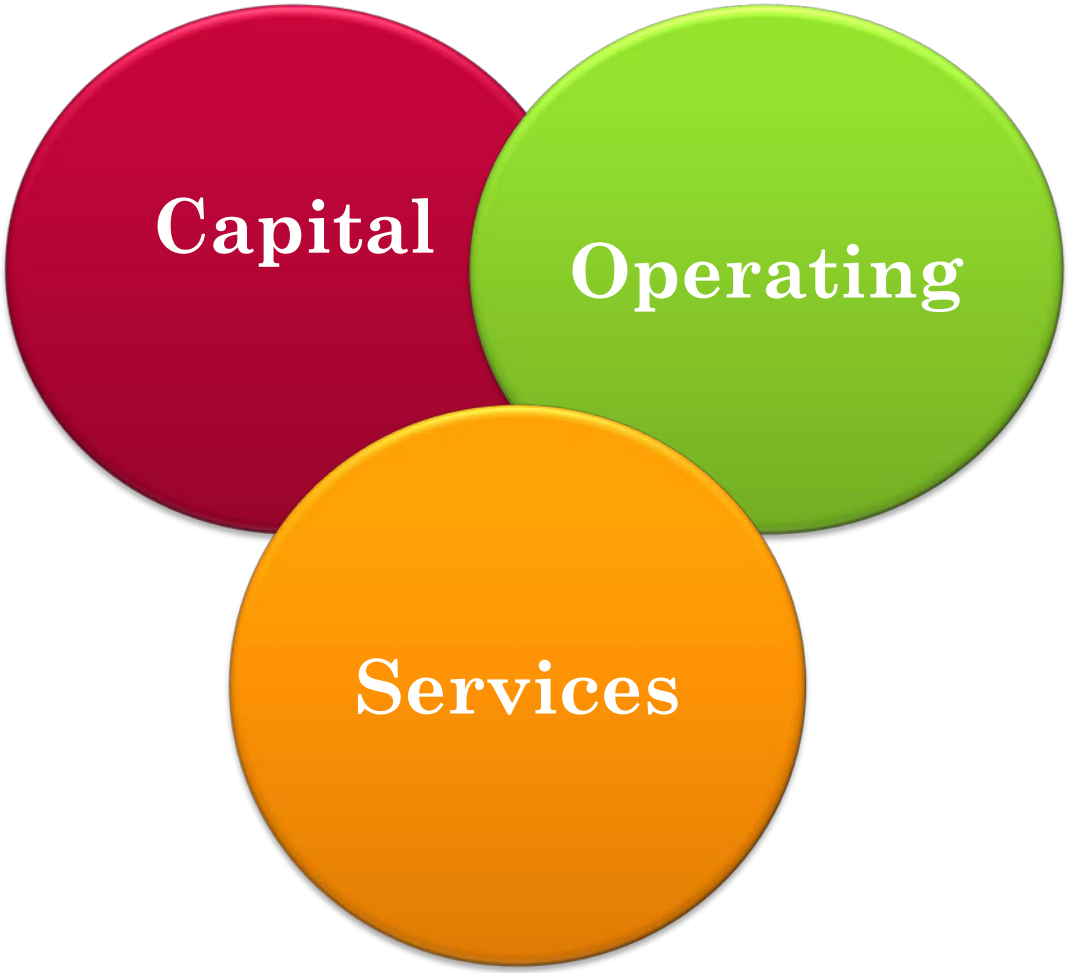
1225 Loans
3030 Grants
300 Communities

Health and Housing is HOT!

- CSH on linking Health Centers and Supportive Housing (2015)
  - http://www.csh.org/wp-content/uploads/2015/12/CSH-Health-Housing-Partnerships-Guide.pdf
- Kaiser Family Foundation on Medicaid and Supportive Housing (2017)
  - https://www.kff.org/medicaid/issue-brief/linking-medicaid-and-supportive-housing-opportunities-and-on-the-ground-examples/
- LIFF and Mercy Housing- Josh Bamberger (2017)
  - Examples
  - http://www.liifund.org/wp-content/uploads/2017/08/Health-and-Housing-LIIF-Mercy-Report-2017.pdf
- Urban Institute (2017)
  - Examples and Strategies
  - https://www.urban.org/research/publication/emerging-strategies-integrating-health-and-housing
- Enterprise on engaging hospitals in housing work (2018)
  - https://www.enterprisecommunity.org/resources/housing-and-community-benefit-what-counts-6230
- Brookings Summary on this intersection
  - https://www.brookings.edu/research/housing-as-a-hub-for-health-community-services-and-upward-mobility/

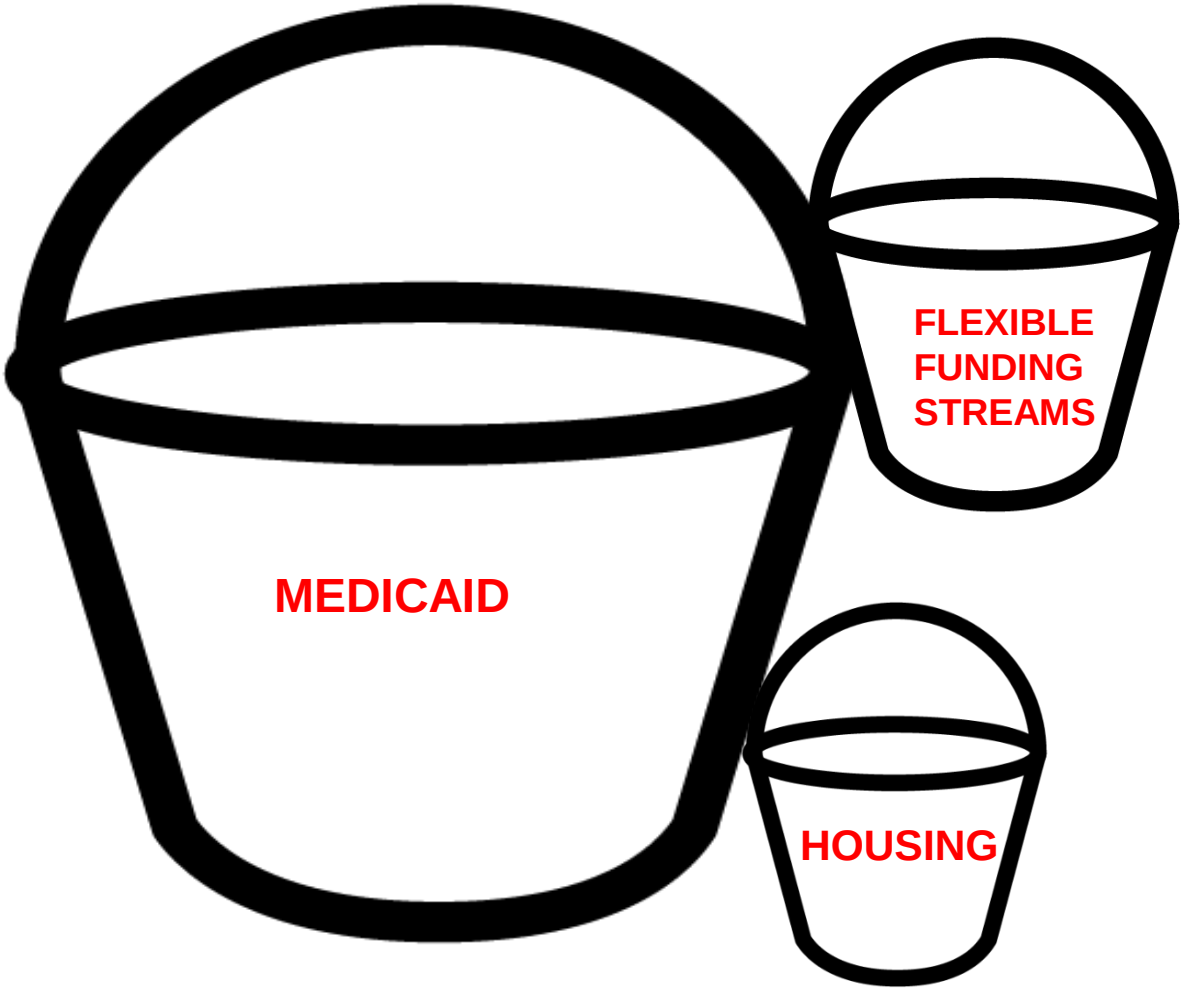
Financing Supportive Housing as a Three-Legged Stool

Three Key Budgets that must be financed

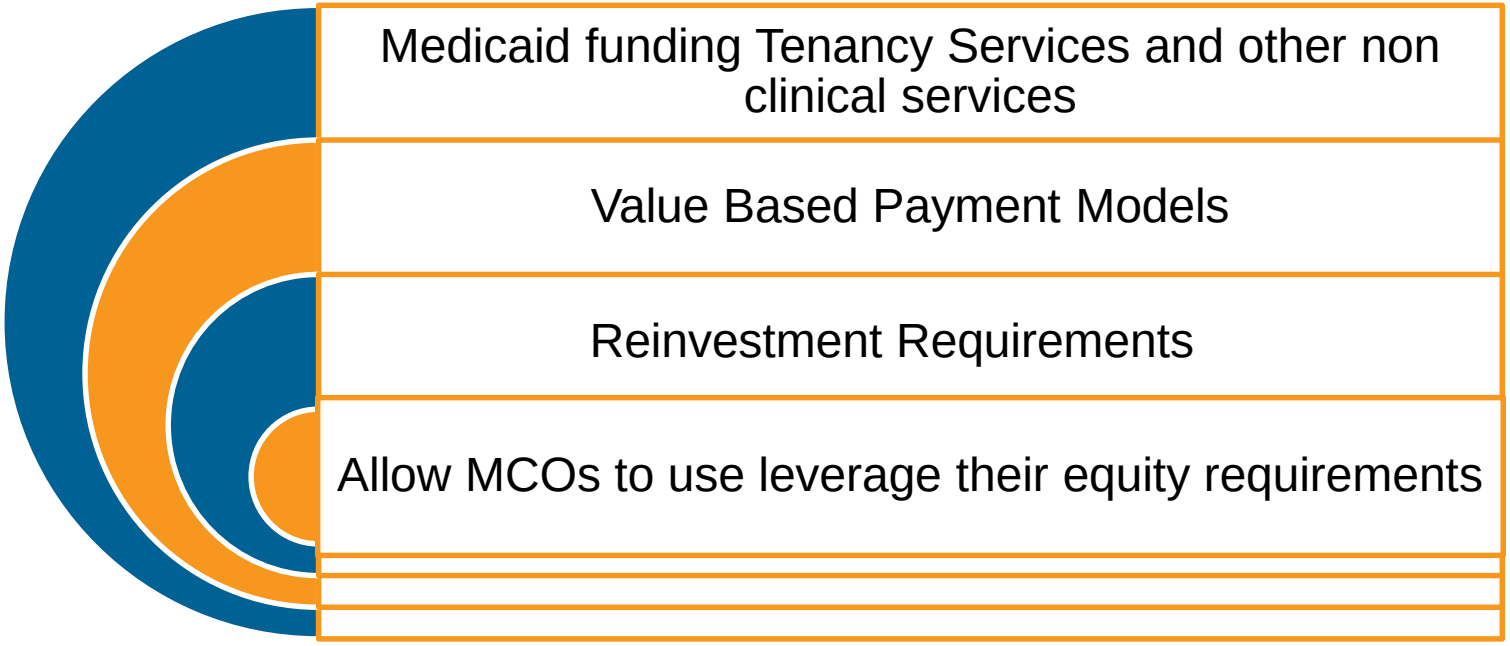


Strategic Financing

GOAL: Expand quality and expand capacity



States need to take a Multi Pronged Approach to Address Social Determinants of Health



Waivers for GOOD!

State Medicaid Calls Out tenancy support services directly

State Medicaid has flexible financing that allows tenancy support services opportunities

States focused on SUD challenges and will soon learn that recovery without housing is seldom sustained recovery

Tenancy Support Services Directly

WA

- Years long advocacy effort led by the state wide Low Income Housing Coalition
- 4,000 people can be served
- State 1115 waiver

MD

- Focus on homeless, but also institutionalized populations
- County driven
- State 1115 waiver

Tenancy Support Services- Indirectly

OR

- Coordinated Care Organizations
- CCOS CAN fund tenancy supports. Needs to be a community priority

MA

- ACO model
- ACOs CAN fund tenancy supports
- Expectation that movement into housing will decrease health care costs

Expanding Substance use Disorder Treatment access through Waivers

1115 waivers

- CA
- DE
- KY
- IL
- LA
- MD
- MT
- NH
- RI
- UT
- VA
- WV

What is newly Medicaid funded?

- Residential Treatment in an IMD (CA, IN, KY, LA, MA, MD, NJ, UT, VA, WV)
- Community Benefit expansion for example now covering Medication Assisted Treatment (DE, HI, KS, MA, MD, NJ, NY, RI, VT, WV)
- Delivery System Reform (AZ, CA, IL, MA, NH)
- Peer Recovery Services (VA)

CSH

What should I do next?

- **LEARN**
  - Where is my state in the waiver process(es)? Align your asks with state priorities
  - What is my state doing about Social Determinants of Health?
- **ADVOCATE**
  - Your voice matters! The voice of the people you serve matters!
- **LEARN**
  - about 1915i State Plan Amendments.
- **STUDY**
  - What are the costs of business?
  - What is the impact of our work?
- **NEW BUSINESS**
  - Are you in the BH or SUD business? Should you be? Do you have new potential partners you need to know?
- **NEW PARTNERS**
  - What mission aligned community based providers need to access a Medicaid billing infrastructure? How can we assist and grow a business line?

CSH

THANK YOU!

Twitter- @cella65

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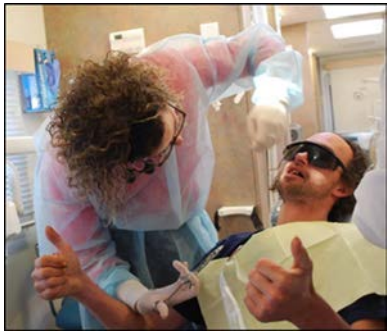
Washington Medicaid's Foundational Community Supports Program (as seen from one HCH Program's perspective)

John Gilvar
Health Care for the Homeless Network
Public Health – Seattle and King County
National Health Care for the Homeless Conference
May 2018

Part 1
Need for enhanced health-related services in supportive housing

Our vantage point…

Health Care for the Homeless Network:
Integrated Care Teams
Representing 10 Partner Agencies
Reaching 20,000 Homeless Individuals
at
200 service sites throughout Seattle & King County



Public Health
Seattle & King County

Homelessness in King County: The Broader Context

- In King County, nearly 2/3 of individuals experiencing homelessness are people of color
  - African Americans are 5 times more likely to experience homelessness than their white counterparts
  - Native American and Alaska Native individuals are 7 times more likely to experience homelessness
- Nearly 30,000 people experienced homelessness in King County in 2016
  - Trails only NYC and LA metro areas
- Over 20,000 people *exited* homelessness in 2016, yet total homelessness is *increasing*
  - 2017 Point-in-Time Count showed a 9% increase in total homeless vs. 2016
  - The count also showed a 21% increase in the unsheltered population, up to almost 6,000

Network Capacity

- 20,707 unduplicated patients/clients served in 2017
  - Over 14,600 of these patients were Medicaid enrollees
- 113,878 visits

Over 450 clinical full-time and part-time providers employed by Public Health Dept and HCHN Contracted partners:

- Physicians
- Nurse Practitioners and Physician Assistants
- Nurses
- Dentists
- Social Workers and Mental Health Clinicians
- Chemical Dependency Professionals
- Case Managers and Outreach/Community Health Workers

HCHN Flexible and Integrated Services

Bring team-based care to homeless services sites such as shelters, encampments, meal programs, supportive housing buildings:

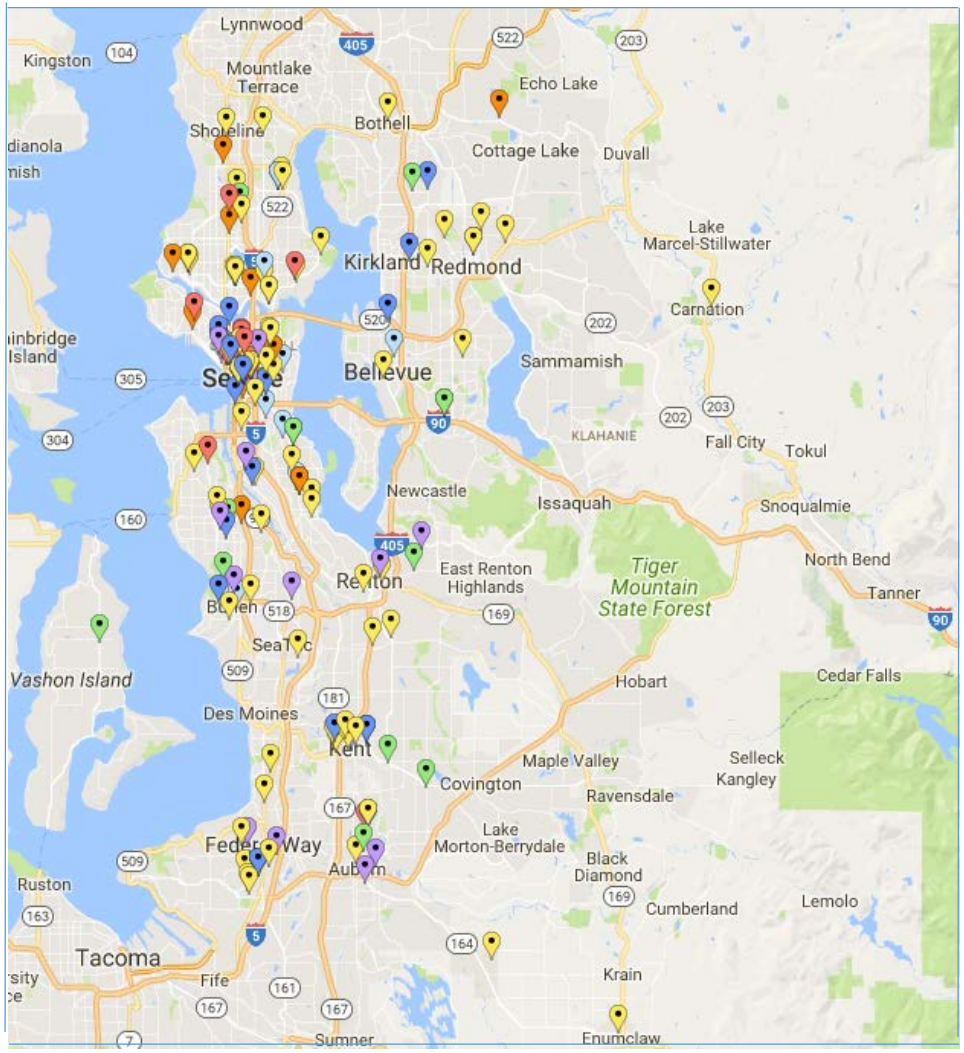
Direct services

- Medical
- Dental
- Mental Health
- Substance Use
- Navigation assistance
- Harm reduction-oriented case management

Integrate medical, dental, behavioral health, and *housing* services to meet complex constellations of health and social needs

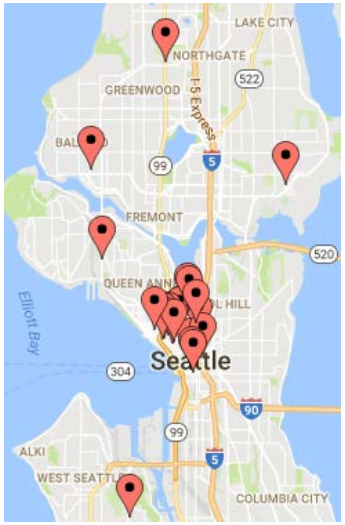
HCHN Cross-disciplinary care teams

- Allow close coordination and client warm hand offs
  - Across disciplines
  - Across agencies
- Address the needs of the whole person
  - Housing/shelter needs and health
  - Team-based case management
- Help with continuity
  - When clients move locations or when linkages to specialty care are challenging
    - Walk with the client patiently from Step A to Step B
    - Address issues such as lack of identity documentation, etc.

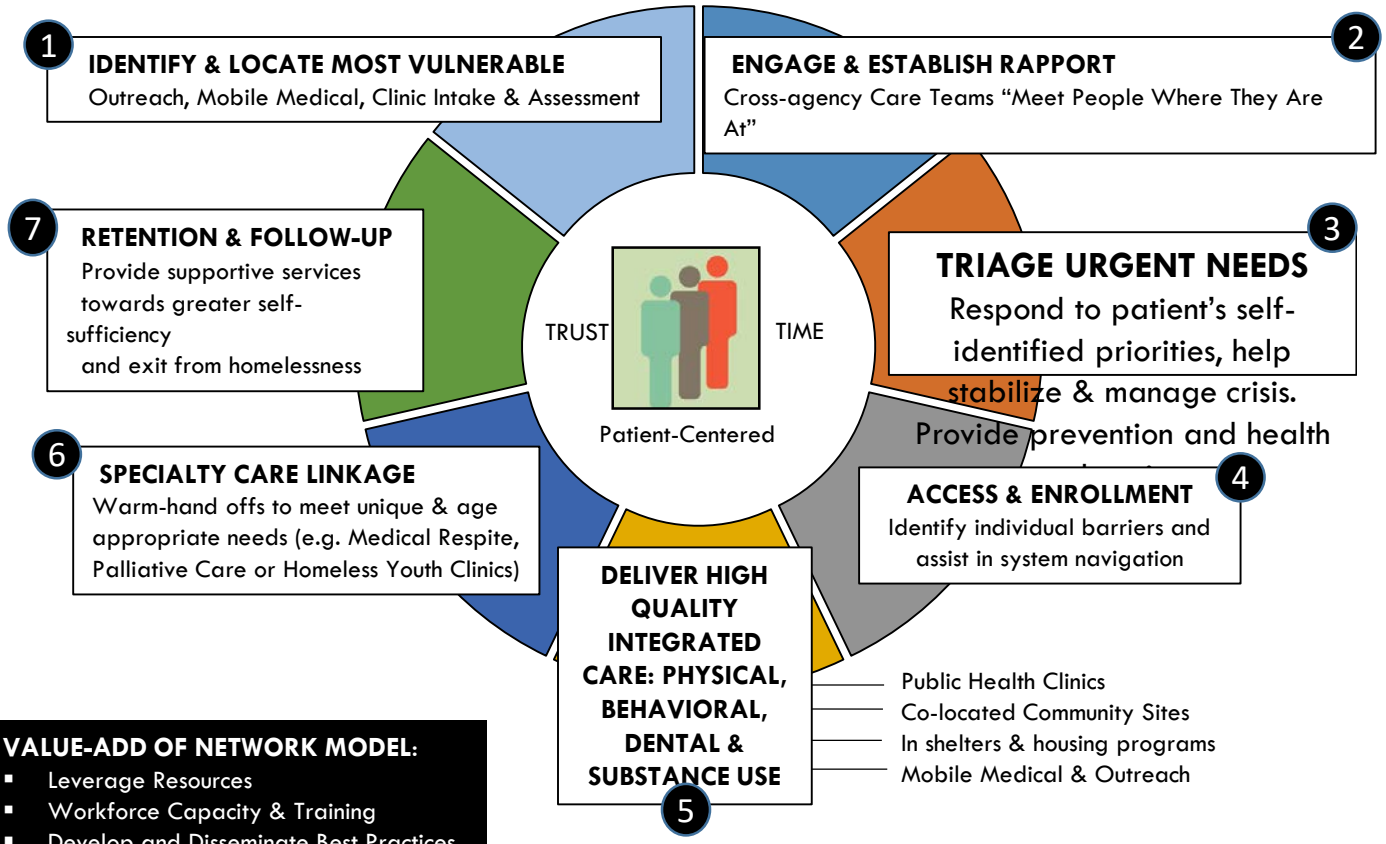


HCHN Service Delivery Sites

- KC Public Health Centers
- Encampments
- Faith Based Orgs and Mobile Medical Program Sites
- Human Service Agencies
- Other sites
- Shelters, Motels, and Day Centers
- Supportive Housing Programs



HCHN Service Delivery Model



VALUE-ADD OF NETWORK MODEL:

- Leverage Resources
- Workforce Capacity & Training
- Develop and Disseminate Best Practices
- Community Convener & Builder
- Bring Innovations to Scale

Public Health
Seattle & King County

Housing Health Outreach Team

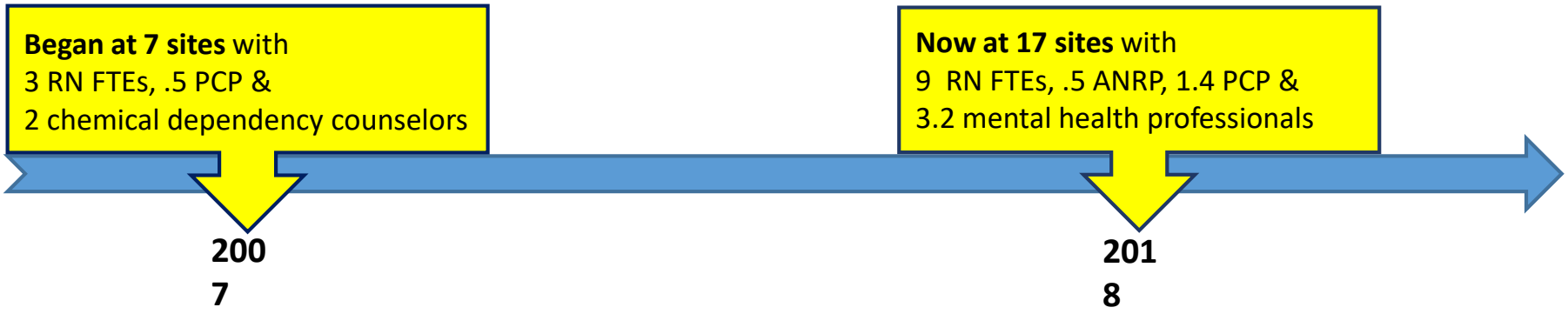
Partnership between HCHN and five community partners to provide on-site physical and behavioral health care to residents in permanent supportive housing buildings.

The HHOT team engages residents with the highest need conditions that create multiple and long-term ongoing barriers to housing stability.

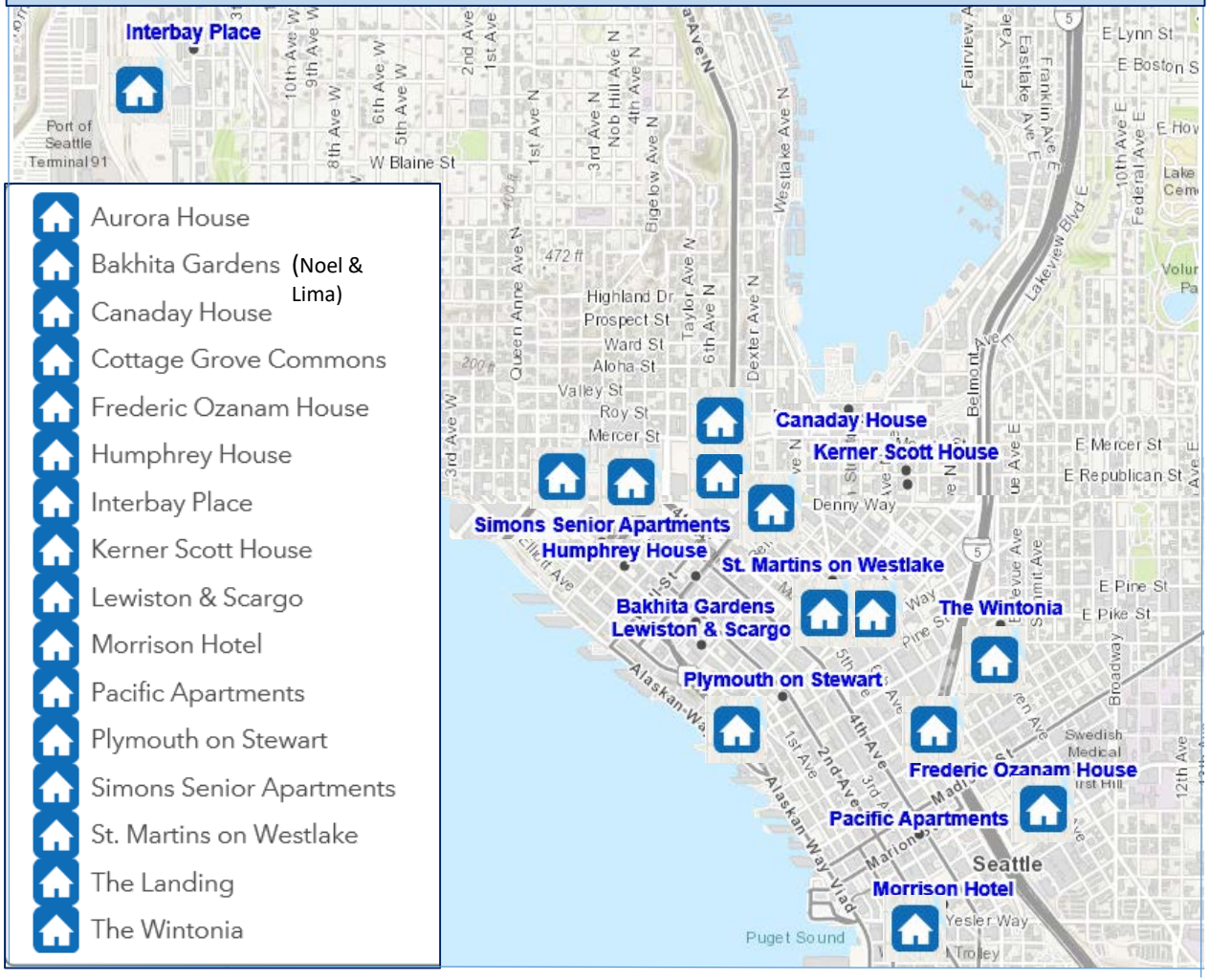
Goal is to improve quality of life through consumer-centered care that responds to how trauma and chronic homelessness impacts health and well-being.

2017 Results

- ✓ **947 residents served**
- ✓ **10,254 visits**
- ✓ **90% housing retention**
- ✓ **83% better self-manage chronic conditions**
- ✓ **43% linked to primary care**
- ✓ **28% engaged in MH/CD services**



Housing Health Outreach Team (HHOT) Sites



North Seattle

West Seattle

South King County

Seattle Permanent Supportive Housing Aging in Place Pilot

- Genesis:
  - Overwhelm reported by HHOT clinical staff and their PSH hosts/partners
    - Average age of PSH admissions increasing rapidly
    - Significant increases in health and case management challenges
      - Dementia and other cognitive impairments, often co-occurring with substance use and MH
  - Partners convened in 2016/17 for year-long pilot planning:
    - WA Aging and Long Term Services Administration (ALTSA)
    - 2 PSH/Housing First providers
      - Plymouth Housing Group (PHG)
      - Downtown Emergency Services Center (DESC)
    - 2 ALTSA-contracted personal care agencies
    - Area Agency on Aging / City of Seattle Aging and Disability Services Division

Pilot Goals and Scope

- Goals:
  - Increase capacity of ALTSA and PSH agencies to meet needs of the increasing percentage of residents needing help with ADLs
    - Increase the flexibility and nimbleness of personal care services delivery in PSH buildings
    - Identify and address challenges around scheduling and case coordination among PSH supportive services staff and visiting personal care providers
    - Align this initiative with WA Medicaid Transformation work to support services in PSH
      - Increase PSH case management capacity through Foundational Community Supports Program
- "Coordinated Personal Care" Pilot Scope:
  - Testing new processes at 3 supportive housing buildings
  - Full Life Care personal care agency gives its care givers greater flexibility…
    - To work with multiple clients during the same visit to a single building
    - To coordinate work with supportive housing case managers

Initial Pilot Outcomes and Challenges

- Outcomes:
  - Fewer clients underserved due to scheduling challenges
  - Improved relationships b/n clients, personal care givers, and housing staff
  - Clients use care giver hours more efficiently
- Challenges:
  - Obstacles around personal care services documentation for billing
    - Time-intensive work-arounds casting doubt on the viability of bringing the pilot to scale
  - PHG has not contracted to participate in Foundational Community Supports
    - Not accessing Medicaid funding to increase case mgt capacity
  - Only new residents eligible for Foundational Community Supports billing
  - No Medicaid support for HHOT services at these or other sites

Part 2
WA Medicaid's Foundational Community Supports Program Basics

Who is eligible to receive FCS benefits?

FCS benefits are reserved for people with the greatest need. To qualify, you must:

1. **Be enrolled in Medicaid**
2. **Be at least 18 years old (Supportive Housing) or 16 years old (Supported Employment)**
3. **Meet the requirements for complex needs**
   - You have a **medical necessity** related to mental health, substance use disorder (SUD), activities of daily living, or complex physical health need(s) that prevents you from functioning successfully or living independently.
   - You meet specific **risk factors** that prevent you from finding or keeping a job or a safe home.

Healthier WASHINGTON

Who is eligible to receive FCS benefits?

Supportive Housing risk factors *One or more*	Supported Employment risk factors *One or more*
✓ Chronic homelessness	✓ Housing & Essential Needs (HEN) and Aged Blind or Disabled (ABD) enrollees
✓ Frequent or lengthy stays in an institutional setting (e.g. skilled nursing, inpatient hospital, psychiatric institution, prison or jail)	✓ Difficulty obtaining or maintaining employment due to age, physical or mental impairment, or traumatic brain injury
✓ Frequent stays in residential care settings	✓ SUD with a history of multiple treatments
✓ Frequent turnover of in-home caregivers	✓ Serious Mental Illness (SMI) or co-occurring mental and substance use disorders
✓ Predictive Risk Intelligence System (PRISM)[1] score of 1.5 or above	

1. PRISM measures how much you use medical, social service, behavioral health and long-term care services.

Healthier WASHINGTON

What benefits are available through FCS?

Supportive housing helps you find a home or stay in your home

- ✓ Housing assessments and planning to find the home that's right for you
- ✓ Outreach to landlords to identify available housing in your community
- ✓ Connection with community resources to get you all of the help you need, when you need it
- ✓ Assistance with housing applications so you are accepted the first time
- ✓ Education, training and coaching to resolve disputes, advocate for your needs and keep you in your home

Healthier WASHINGTON

What benefits are available through FCS?

Supported employment helps you find the right work, right now

- ✓ Employment assessments and planning to find the right job for you, whenever you're ready
- ✓ Outreach to employers to help build your network
- ✓ Connection with community resources to get you all of the help you need, when you need it
- ✓ Assistance with job applications so you can present your best self to employers
- ✓ Education, training and coaching to keep you in your job

Healthier WASHINGTON

What is the Foundational Community Supports (FCS) Program?

It is…

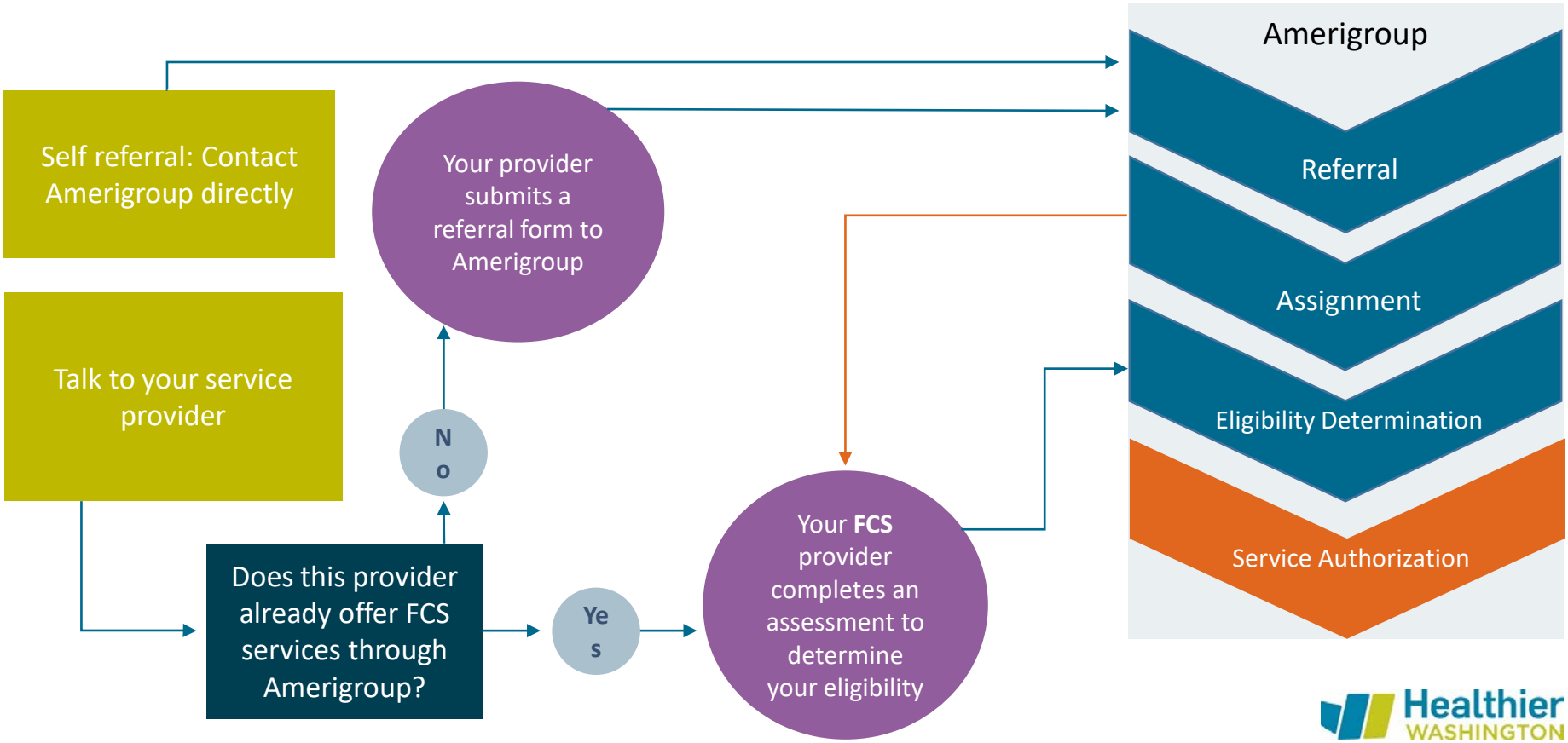
- Medicaid benefits for help finding **housing** and **jobs**:
  - Supportive Housing to find a home or stay in your home
  - Supported Employment to find the right job, right now

It isn't…

- Subsidy for wages or room & board
- For all Medicaid populations

Healthier WASHINGTON

How do you receive FCS benefits?



Healthier WASHINGTON

Where can I find additional FCS resources?

- **Healthier Washington:** *www.hca.wa.gov/hw*
  - Provider Resource Guide
  - Fact Sheets
  - FAQs
- **Amerigroup FCS Provider site:** *https://providers.amerigroup.com/pages/wa-foundational-community-supports.aspx*
  - Provider Manual
  - Quick Reference Guide
  - FCS Referral Form
  - FCS Talking Points
  - Assessment Form
  - Department of Commerce Coordinated Entry Information
  - And more…
- **Amerigroup FCS Client Site:** *https://www.myamerigroup.com/washington-fcs/home.html*

Healthier WASHINGTON

Part 3
How does FCS reimbursement fit into HCHN partners' efforts to address the chronic and complex health needs of supportive housing residents?

WA Medicaid supportive housing benefit…

- Does:
  - Provide Medicaid reimbursement that can help defray certain housing supports costs incurred by supportive housing providers
    - Important new funding source to fill in any gap between the costs of providing housing-based case management and existing funding for these supports
    - Limited to residents who were *not* already living in the building when the contract began
    - Cannot supplant other funding for these housing supports costs
- Does Not:
  - Provide Medicaid reimbursement for nursing or other healthcare or personal care services provided in supportive housing

Thank you!

Questions?

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www.kingcounty.gov/mobilemed

INTEGRATED CARE FOR THE CHRONICALLY HOMELESS INITIATIVE – A MEDICAID 1115 WAIVER PROGRAM IN HOUSTON, TEXAS

Presenter

Frances Isbell, MA
CEO
Healthcare for the Homeless – Houston

fisbell@bcm.edu

FUNDER: MEDICAID 1115 WAIVER (Delivery System Reform Incentive Payment)

- Focus on innovative projects that improve health status while reducing costs
- Participants do not have to be eligible for traditional Medicaid services
- Different states have very different models; projects are often dependent on Intergovernmental Transfer (IGT) entities

INTEGRATED CARE FOR THE CHRONICALLY HOMELESS INITIATIVE

- HHH project – clinical intervention and support for chronically homeless individuals in a Housing First model of PSH

- Participant eligibility:
  - Chronically homeless (as assessed by Houston's Coordinated Access program)
  - 3 or more emergency department visits in 2 years
  - Functional assessment at HHH clinic
  - Clear HUD, Houston Housing Authority and New Hope Housing criteria

EVALUATION CRITERIA

- Stabilized housing
- SF-36v2
- PHQ-9
- Reduced ED visits / hospitalizations
- Increased income

HHH THEORETICAL MODEL: PRIMARY CARE BEHAVIORAL HEALTH CONSULTATION

- Considered “extreme” integration
- Pilot project with homeless population
- Behavioral Health Consultant (BHC) will see patients with Primary Care Clinician at “point of care”
- Theoretical models: TTM, MI, CBT and brief interventions
- Focus on functional assessment, and treatment plans are geared toward functional restoration rather than diagnosis/symptom elimination
- Moved HHH from Level 5 integration: Close Collaboration Approaching an Integrated Practice, to Level 6: Full Collaboration in A Transformed/Merged Practice

SEARCH CLINICAL MODELS OF CARE FOR CASE MANAGEMENT

- Transtheoretical Model of Intentional Behavior Change (TTM), often known as the Stages of Change
- Motivational Interviewing (MI)
- CBT, particularly for substance use disorder

STAFFING PER TEAM

- RN Case Manager (providing on-site nursing services and care coordination)
- 2 Clinical Case Managers (on-site, Masters level)
- 2 Community Health Workers (on-site providing “hands on” healthcare coordination)
- Behavioral Health Consultant (part-time onsite)
- Primary Care Team (at HHH clinics, as needed)
- Off-site clinical leadership/supervision

TOP DIAGNOSES

- Substance Use Disorders (82%)
- Chronic Pain/Pain-related disorders (73%)
- Severe Mental Illness (64%)
- Hypertension (37.5%)
- Diabetes (16%)
- Hepatitis C (19%)

EMERGENCY DEPARTMENT VISITS

- Baseline: average of 12.4 ED visits/participant with the highest being 144 visits in past 2 years
- At the end of Year 1, 54% reduction in number of people who went to ED and 71% reduction in ED visits
- Participants in program 2 or more years, continue ~71% reduction in ED visits
- Significantly related to number of times met with counselor, clinical case manager or community health worker
- Participant with 144 ED visits in past 2 years reduced number of visits to 20 since entering program

OPTUM SF36v2 Health Survey

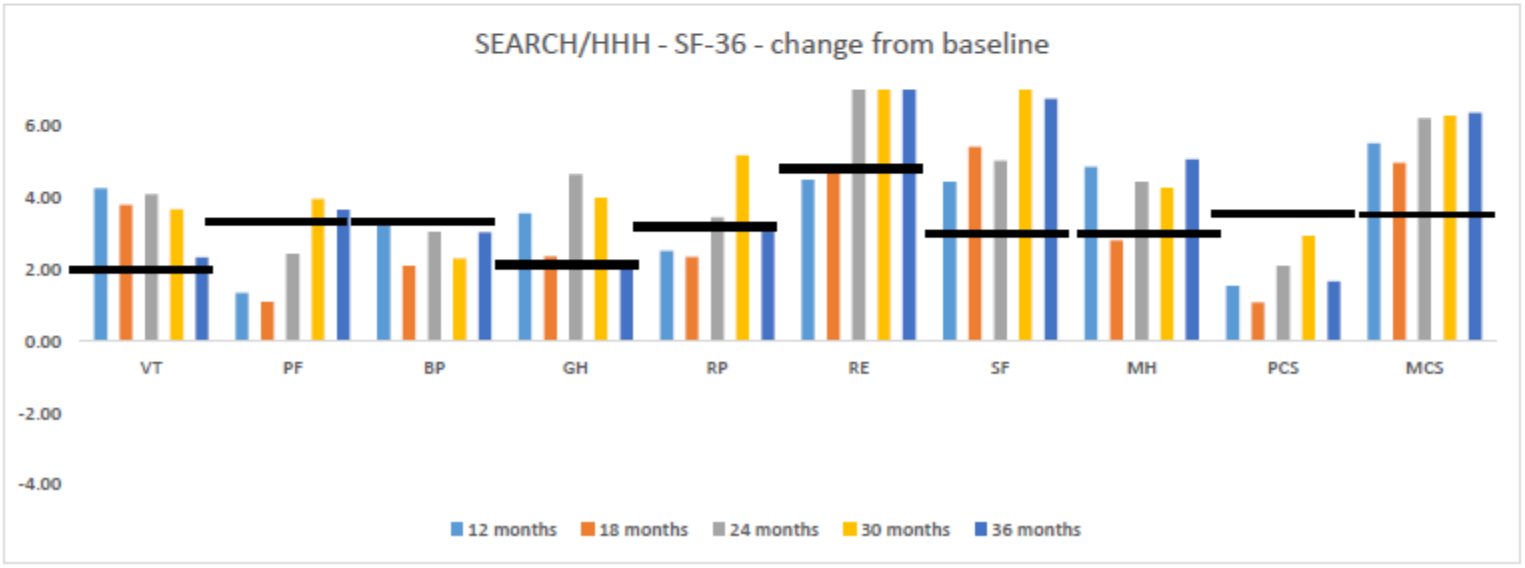
- A multi-purpose, short-form health-related QOL survey consisting of 36 questions measuring functional health and well-being from the patient's point of view
- Yields an 8-scale profile of functional health and well-being scores
- The 8 scales can be combined to assess a Physical Component Summary and a Mental Component Summary

Total Enrolled & Baselined = 264

05/02/18

1115	N = 148			N = 116			N = 86			N = 60			N = 46			N = 35			
	Baseline	12 months	Score difference	Baseline	18 months	Score difference	Baseline	24 months	Score difference	Baseline	30 months	Score difference	Baseline	36 months	Score difference	Baseline	42 months	Score difference	MID
VITALITY	45.25	49.51	4.26	45.02	48.81	3.79	44.69	48.76	4.08	45.17	48.84	3.66	46.01	48.34	2.32	46.32	47.68	1.36	2
PHYSICAL FUNCTIONING	40.93	42.26	1.33	40.22	41.31	1.09	40.34	42.77	2.43	39.36	43.32	3.95	39.61	43.27	3.66	38.62	39.61	0.98	3
BODILY PAIN	37.58	40.88	3.30	37.82	39.92	2.09	37.68	40.73	3.05	37.81	40.10	2.30	37.23	40.25	3.02	36.36	40.79	4.43	3
GENERAL HEALTH PERCEPTIONS	40.23	43.79	3.56	40.85	43.20	2.35	41.40	46.04	4.64	42.16	46.15	3.99	41.57	43.67	2.10	41.39	41.88	0.49	2
PHYSICAL ROLE FUNCTIONING	38.93	41.44	2.50	38.98	41.32	2.34	39.11	42.56	3.45	38.07	43.23	5.16	38.56	41.68	3.12	37.46	41.63	4.17	3
EMOTIONAL ROLE FUNCTIONING	36.78	41.28	4.49	36.48	41.19	4.71	34.71	41.84	7.13	33.83	41.08	7.25	33.76	40.88	7.12	31.99	41.44	9.45	4
SOCIAL ROLE FUNCTIONING	37.29	41.72	4.44	37.07	42.47	5.40	36.00	41.02	5.01	35.70	43.22	7.52	35.11	41.86	6.76	34.42	41.87	7.45	3
MENTAL HEALTH	40.55	45.39	4.84	41.58	44.37	2.80	40.56	45.00	4.44	40.75	45.02	4.27	41.09	46.15	5.06	41.15	46.76	5.61	3
PHYSICAL COMPONENT SCORE	40.47	42.00	1.54	40.24	41.32	1.08	40.99	43.09	2.10	40.58	43.51	2.93	40.50	42.17	1.67	39.71	40.06	0.34	3.5
MENTAL COMPONENT SCORE	39.95	45.45	5.51	40.33	45.30	4.97	38.66	44.87	6.20	38.74	45.01	6.27	38.86	45.21	6.36	38.46	46.43	7.97	3.5

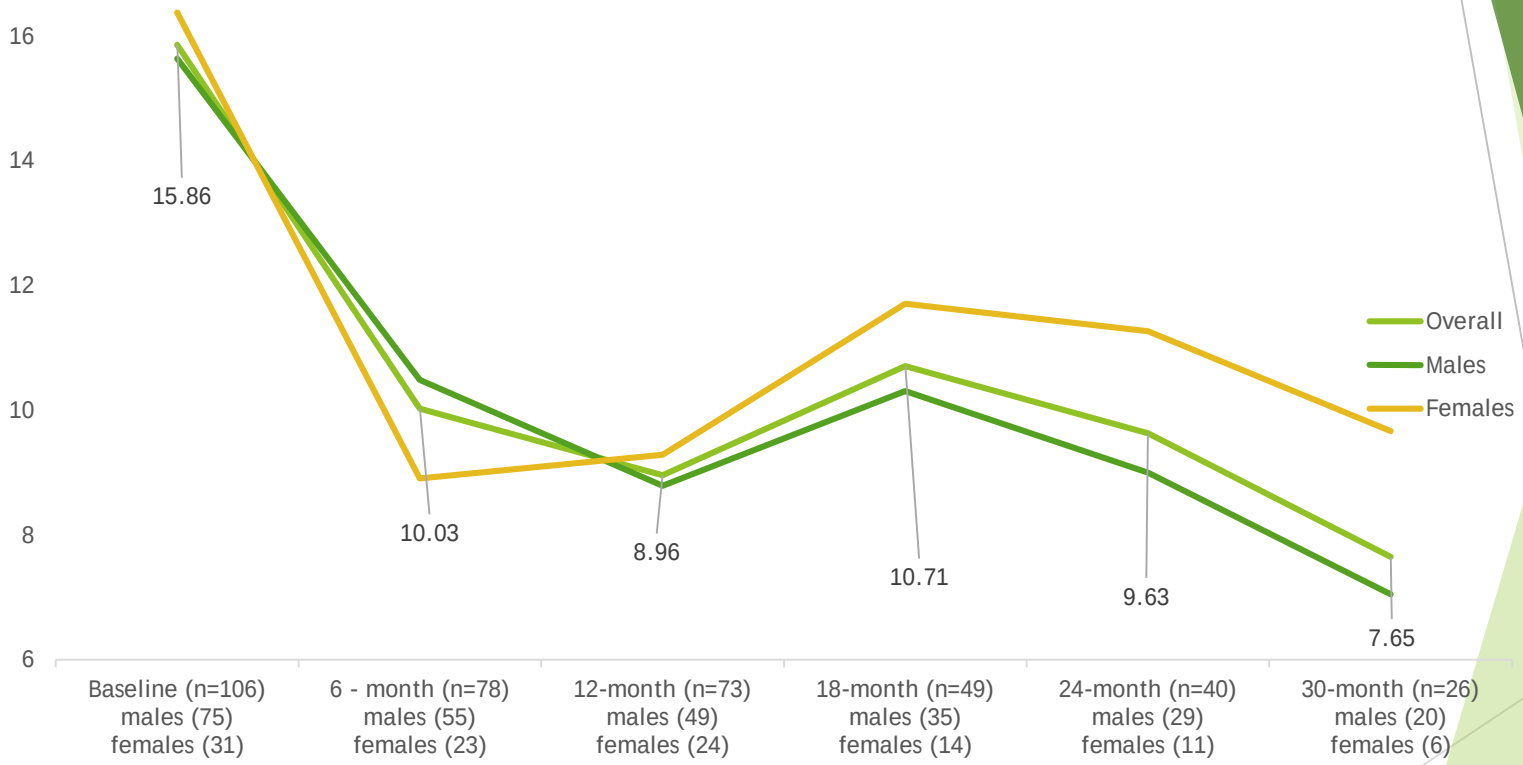
- meets or exceeds MID



Patient Health Questionnaire – 9 (PHQ9)

- screening tool to assist clinicians with diagnosing depression and monitoring treatment response
- Cut point for depression is 10 or higher
- composite baseline score: 10.17
- baseline scores indicated that 51% of the participants scored between moderate and severe depression.

PHQ-9 SCORES OVER TIME



*Analyses are constrained to those participants who had a PHQ9 score of 10 or above at baseline.

CURRENT FUNDING ENDS IN 2021 – THEN WHAT??

- Began working on sustainability plan in 2014
- Initial work with CSH and area MCOs
  - Cost analysis using "Homeless Program Economic Evaluation" Brandeis University tool
  - Identified essential services – challenges in defining step-down/step-up criteria
  - MCOs became increasingly interested in the program as data began to document successes – this took years of meetings; good cost data needed
- CSH was able to bring representatives from Texas Health and Human Services Commission and Medicaid Department to the table

WHERE ARE WE TODAY?

- Multiple presentations to interest groups, local and state officials
- Developing a Value Based Payment model with bundled payments
- Local officials are supportive of request for legislative action
- Biggest challenge at the moment: getting good cost data to develop business model that will ultimately save Texas Medicaid spending
- “Champions” in both Texas House and Senate have emerged

DISCUSSION