Housing and Health Webinar

#TRCCWebSeries
Objectives

• Discover programs and partnerships that are addressing housing insecurity

• Hear personal experiences from the panelists, including challenges, successes and plans for growth

• Gain ideas for how to pursue housing insecurity interventions within your own community
Today we will learn from:

Jamie Almanza, MBA
Executive Director
Bay Area Community Services

Dustin Harper, MBA
VP of Strategic Partnerships
Institute on Aging

Joshua Bamberger, MD, MPH
Assistant Clinical Professor
University of California, San Francisco

Improving Health and Housing in Their Communities
Housing Fast Support Network

An Opportunity to Continue to Transform Homeless Services
Models

• Housing First
• Critical Time Intervention
• Housing as a Prescription for Health
• Flex Funds for Housing as Intervention
Model Design

- Designed as the FIRST Program of its kind locally to serve homeless single adults using traditional funds in an unconventional way.

- Interim housing model with singular goal of permanent housing.

- Focus on flow = High impact.
Types of Housing

• Interim Housing (up to six months while permanent housing is secured)
• Medical Respite
• Permanent Housing
Program Design – Interim Housing

• HFSN is not Housing: It is an Engagement Strategy
• Use of evidence-based practices
• Focus on locating housing rapidly
• Flexible, persistent engagement strategies by staff
• Stays with a person until housing sticks
Population Characteristics

<table>
<thead>
<tr>
<th>Age</th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-61</th>
<th>62+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion</td>
<td>6%</td>
<td>16%</td>
<td>14%</td>
<td>31%</td>
<td>23%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**ETHNICITY**
- Black or African-American: 69%
- White: 16%
- Multiple Races: 10%
- Asian: 1%
- American Indian or Alaska Native: 2%
- Native Hawaiian or Other Pacific Islander: 1%
- Don't Know/Refused: 1%

**GENDER**
- Male: 66%
- Female: 33%
- Other: 1%
Characteristics of HFSN Participants

All Participants must be from shelter or places not meant for habitation...

Highest-utilizer profile - a person who is:

• General Assistance
• Substance Use
• 45-54 Year Old
• Male
• African American
• Able-bodied
• Sleeping outdoors
• Generational Poverty/Trauma
Focus on Respite

• Post-discharge plan for inpatient, emergency rooms
• Designed for Homeless who need a place to recuperate
• Reduce Recidivism for High Utilizers
Approach

- Room and Board
- Stays under 30 days for Medical
  - Stays under 3-10 days for Bx Health
  - Medical Meals
  - Pharmacy Coordination
  - Basic Nursing Care
  - Doctors Appointments
Added Benefits

- Benefits
- Finding Housing Options
- Linkage/Brokerage
Facility Design

- Single Room Capacity for high needs
- Accessibility Design (wheelchairs, walkers)
  - Access to laundry
  - Separate Fridges for Meds
- Lockers
- No Tenant Rights Established
Year One Pilot

• 10 Beds
• Full from the get go
• 3,650 Bed Days used in 13 months for Medical
SNFs Enter the Scene for Medical

- 6 months in to pilot, Hospital System wanted SNF Referrals
- Referral Mix Changed from 100% direct from Inpatient to 60% from SNF
Partnerships

Between the Health Care Entity and the service provider:

• Sharing of Data
• Sharing of Risk
• Sharing of Reward
Biggest Rewards

• Replicability of Partnership
• Scalability of Model
• Efficiency and Flexibility of Intervention
Biggest Challenges

• Different Parts of the Sector: Different Languages

• Different Priorities/Philosophies

• Sharing of Data – breaking down barriers
Outcomes

• Length of Stay of Homeless Inpatient Reduced by 400% in the hospital
• Access and clearing of SNF Beds Unparalleled
• For Bx Health, 25% reduction in re-admittance to Psych Emergency in 30 days
Data Snapshot for One Year Respite

• Medical Respite
  • 10 beds totals 202 Patients
  • 8 Deaths while in Respite
  • 42% discharge to stable living situation

• Behavioral Health Respite
  • 10 beds totals 450 Patients
  • 21% discharge to stable living situation

• Routine Dx: Schizophrenia, Bipolar, Acute SUD
A Real Person

Born and raised in Oakland. Has **zero** income and has been **homeless** for 7 years, agreeing to come to HFSN after a recent relationship ended with a partner in an **encampment** home. The participant has active **Substance Use** (heroin, alcohol) and sleeps most of the day. Participant has been denied SSI, family is estranged, and participant **suffers** from Major Depression. Participant has not seen a **doctor** in over ten years and is **afraid** they may have an STD. Participant has three **jail** stays in last 2 years.
Contact

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Growing old can be

Root Cause Coalition Webinar

August 3, 2017
Program of All-Inclusive Care for the Elderly (PACE)

Integrated Behavioral Health Services

Community Living Solutions

Social Day Programs

Private Duty Homecare and Support Services

Elder Abuse & Suicide Prevention

Trusted Advocate for Older Adults and Individuals with Disabilities
Enable transitions to lower levels of care
Support community placements
Improve member flow through ‘system’
Currently, ~15,000 Medi-Cal beneficiaries are in custodial care that don’t need to be at that level of care. Most of them would prefer to live in a more independent setting.

High volume Medi-Cal hospitals have 20-30 members on daily ‘mass referral’ lists seeking placement due to limited custodial bed resources.
Based on our experience in San Mateo, the projected average value of a Community Month (total cost savings between a month in custodial care and a month in a community placement) is $4,000. This represents an annual statewide cost savings opportunity of $720 million dollars.

*This does not include potential savings to hospitals generated by reducing daily ‘mass referral’ list.*
HPSM Total Long Term Care Costs
2013 vs. 2016

2013: $108 Million
2016: $65 Million
**PMPM Costs**

**Pre-Transition vs. Post-Transition**

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre-Transition</th>
<th>Post-Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>$461</td>
<td>$2,566</td>
</tr>
<tr>
<td>Healthcare</td>
<td>$2,234</td>
<td>$1,483</td>
</tr>
<tr>
<td>LTC/SNF</td>
<td>$6,439</td>
<td>$232</td>
</tr>
</tbody>
</table>

**Diagram Description:**
- The bar chart compares PMPM costs before and after a transition.
- The chart shows a significant decrease in costs post-transition, particularly in the LTC/SNF category.
- The Y-axis represents cost ranging from $0 to $10,000.

**Legend:**
- Other
- Healthcare
- LTC/SNF

**Source:** AgeOn Institute on Aging
The solution is really pretty straightforward (and generally widely agreed upon amongst providers):

1) Provide a range of housing alternatives to match client needs

2) Provide an enhanced set of services/benefits coordinated by an intensive non-medically focused care manager
Why have we created a system where we’ll pay for ‘housing’ at the nursing home but not in a community-based alternative?
In places where we’ve given financial risk for long term care to Medicaid Managed Care plans, how do we expect them to ‘manage’ those costs if they can’t provide a comparable set of benefits (housing + services) in the community?
Medi-Cal Health Plan Financial Dis-Incentives

<table>
<thead>
<tr>
<th>Pre-Transition</th>
<th>Post-Transition</th>
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<tbody>
<tr>
<td>Health Plan Cost</td>
<td>Health Plan Cost</td>
</tr>
<tr>
<td>Health Plan Revenue</td>
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AgeOn. Institute on Aging
Community Care Settings Pilot

For many years, older adults and younger adults with disabilities have found it difficult, if not impossible, to access the services necessary to allow them to continue living independently in their homes, or to return to community living from institutional placement.

The Community Care Settings Pilot (CCSP) connects clients with home and community-based services, or a combination of goods and services, that help individuals who are currently or at risk of being institutionalized.

Three-Pronged Program Approach:

1. Coordinated case management – CCSP connects clients to community services such as transportation, meals, personal care, housing assistance, etc.
2. Purchase of services – CCSP provides the needed resources and services, not available through any other mechanism, to Health Plan of San Mateo members. CCSP is considered the payer of last resort.
3. Housing retention and placement – CCSP identifies, secures, and maintains appropriate community-based housing.

Groups Served:

- Individuals living in long term care facilities who are willing and able to return to living in the community with additional supports and services.
- Individuals in acute care hospitals or short term rehab settings being recommended for long term placement, but are willing and able to live in the community.
- Individuals in the community determined to be at imminent risk of institutionalization, who are willing and able to remain living in the community.

Eligibility Criteria:

- Be 18 years and older
- Be a Health Plan of San Mateo Member
- Be willing and able to live in the community with appropriate supports.
- Have demonstrated a need for a service and/or resource that will serve to prevent institutionalization or enable community living.
- Assistance needed with at least 2 activities of daily living (ADLs) or 3 instrumental activities of daily living (IADLs).
- Medical conditions must be able to be managed in the community.

Just call Institute on Aging 415.750.4111 or 650.424.1411 or visit www.ioaging.org
## Facilitating Multiple Housing Channels

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Market Rate Corporate Lease</th>
<th>Market Rate Housing Authority Voucher</th>
<th>Affordable General Pool</th>
<th>Affordable Set-Asides</th>
<th>RCFE Assisted Living</th>
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</thead>
<tbody>
<tr>
<td>Bypass barriers in rental criteria</td>
<td>Affordable for member &amp; program</td>
<td>Affordable for member &amp; program</td>
<td>Affordable for member &amp; program</td>
<td>Affordable for member &amp; program</td>
<td>24/7 Supervision</td>
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<tr>
<td>More widely available</td>
<td>Member holds their own lease</td>
<td>Member holds their own lease</td>
<td>Member holds their own lease</td>
<td>Member holds their own lease</td>
<td>More frequent redirection for dementia-related behaviors</td>
</tr>
<tr>
<td>Immediate housing access</td>
<td>Additional onsite supports</td>
<td>Additional onsite supports</td>
<td>Additional onsite supports</td>
<td>Bypass standard waitlist process</td>
<td>Provides potential ‘step down’ path from SNF</td>
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<td></td>
<td></td>
<td></td>
<td>Immediate access</td>
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<table>
<thead>
<tr>
<th>Challenges</th>
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<tbody>
<tr>
<td>Broad rent ranges, increasing market rates</td>
<td>Lack of landlord participation</td>
<td>Difficulty accessing due to lengthy or closed housing waitlists</td>
<td>Requires sometimes lengthy negotiation and planning</td>
<td>Shortage of facilities skilled in managing more difficult behaviors</td>
<td></td>
</tr>
<tr>
<td>Limited accessible floorplans</td>
<td>Limited accessible floorplans</td>
<td></td>
<td>Short window of opportunity to put in place</td>
<td></td>
<td>Assisted Living Waiver at statewide capacity</td>
</tr>
</tbody>
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Advantages:
- Bypass barriers in rental criteria
- More widely available
- Immediate housing access

Challenges:
- Broad rent ranges, increasing market rates
- Limited accessible floorplans

Affordability:
- Market Rate Corporate Lease
- Market Rate Housing Authority Voucher
- Affordable General Pool
- Affordable Set-Asides
- RCFE Assisted Living
Next Steps

• Replicate CCSP with other Medi-Cal Health Plans that currently have financial risk for long-term care

• Advocate for policy changes re: restrictions on using Medicaid funding for housing and current rate-setting dis-incentives

• Develop Social Impact Bond / Pay for Success Initiative with State of California and Sorenson Impact Center in regions of California where health plans do not have financial risk for long term care
https://prezi.com/wqjrxxygq2yb/?utm_campaign=share&utm_medium=copy&rc=ex0share
Questions?

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