

Housing and Health Care: Partners in Healthy Aging

A Guide to Collaboration



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The LeadingAge Center for Housing Plus Services serves as a national catalyst for the development, adoption, and support of innovative affordable housing solutions that enable low- and modest-income seniors to age safely and successfully in their homes and communities.

Visit www.LeadingAge.org/Center-Housing-Plus-Services to learn more about the center's work.

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Housing and Health Partnerships: How This Guide Can Help

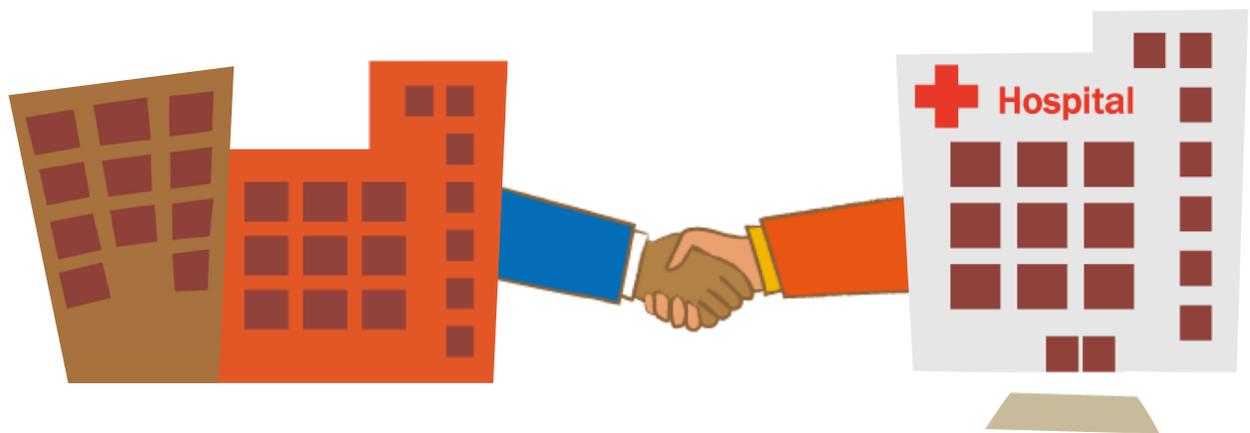
This guide is designed to foster housing-health partnerships that can help meet the health and wellness needs of older residents living in affordable senior housing properties.

The information in this guide is directed toward affordable senior housing providers. However, the guide may also be a useful resource for a variety of organizations, including health care organizations and policy makers.

If you are a housing provider, the information in this guide will help you:

- Understand the changing health care landscape and how it creates opportunities for housing-health partnerships.
- Learn about the types of care issues and challenges that health care entities are facing.
- Identify ways you can support and facilitate the work of your health care partners in addressing these challenges, especially as they provide health care to their more vulnerable older patients.
- Find potential health care partners with whom you can work toward mutual goals.
- Develop a value proposition or business case to pique a potential partner's interest in collaborating with your housing property.
- Establish and sustain your partnerships with health care entities.

In addition, please visit <http://www.LeadingAge.org/Center-Housing-Plus-Services> to find additional tools and resources to help in developing collaborative relationships between affordable housing communities and health care entities.



Why Now?

Over two million low-income older adults live in thousands of affordable senior housing properties all over the country. You will find these properties in every state and in all types of communities—urban, suburban and rural.

Who are the older adults who live in these properties? As the box on page 4 illustrates, senior housing residents generally represent a vulnerable population. Due to their advanced ages, low-income status and other demographic characteristics, many residents are coping with multiple chronic illnesses and/or functional impairments. These conditions put residents at risk for poor health outcomes. They also make it more likely that residents will use costly health and long-term care services.

Increasing numbers of housing providers are recognizing the challenges facing residents who are aging within their housing properties. These providers are working hard to help residents age successfully in their apartments and communities.

Housing providers are not alone in these efforts.

Multiple initiatives are underway at the federal and state level, and in the private sector, to reform our health and long-term care delivery systems. These initiatives have one overriding goal: to help the nation better address the health care needs of all Americans, but particularly the needs of vulnerable populations.

Health care reform efforts focus on lowering health care costs through:

- Timely, preventive care.
- Improved care coordination and service integration.
- Reductions in the over-utilization of expensive health care services.

Opportunity for Housing Providers

The transformation of our health care system gives housing providers a unique opportunity to work more closely with health care entities to achieve common goals. The current health care reform climate is especially conducive to these partnerships because residents of affordable senior housing represent the vulnerable populations that population-based health reform efforts are designed to target.

Health care providers are striving to meet their health reform goals by:

- More effectively managing the care of some of their high-need and costly patients.
- Intervening earlier with lower risk older adults to avoid the need for more expensive care over time.

Affordable senior housing properties can assist in these efforts by helping health care providers and payers:

- Manage chronic illness, both physical and mental.
- Ensure smooth and effective transitions from acute or post-acute settings.
- Minimize avoidable hospital readmissions.
- Address medication-related complications.
- Increase patient engagement.
- Address social determinants of health.
- Tackle the special needs of the health care system's "super utilizers," who make frequent use of high-cost health care services.

The bottom line is fairly simple—and compelling:

Working together, housing and health care partners can launch initiatives that lead to improved health, safety and quality of life for residents, while reducing unnecessary use of health services and achieving cost savings.



A PICTURE OF AFFORDABLE SENIOR HOUSING RESIDENTS

Who lives in affordable senior housing communities? A few studies of older adults receiving assistance from the U.S. Department of Housing and Urban Development (HUD) help to paint a clearer picture of this vulnerable population.

Age

The median age of residents living in HUD-assisted senior housing properties ranged between 70 and 74 in 2006. Roughly 20-30 percent of residents were over the age of 80. Many HUD-assisted properties also house younger persons with physical and mental disabilities.

Race and Ethnicity

The affordable senior housing population is diverse, as illustrated in this table. Many residents are immigrants who bring with them a variety of cultural norms and practices, and have varying linguistic abilities.

Race and Ethnicity	Section 202 Properties	Public Housing Properties
White and non-Hispanic	61.2%	39.1%
Black and non-Hispanic	19.4%	33.2%
Other and non-Hispanic	6.6%	4.3%
Hispanic	12.9%	23.4%

Income

The median income of residents across the different types of HUD-assisted properties was about \$10,000 in 2006. Almost all residents rely on social security or supplemental security income as their primary income source.

Dual Eligibility Status

More than two-thirds (68%) of HUD-assisted residents age 65+ and living in 12 geographic areas were dually enrolled in Medicare and Medicaid, according to one 2014 study.* This rate is likely to be similar across the broader HUD-assisted population, given the median income described above.

Health and Function

More than half (55%) of the HUD-assisted residents living in 12 geographic areas who were dually enrolled in Medicare and Medicaid had five or more chronic conditions, according to the same 2014 study. Other studies have found that approximately one-quarter of residents suffer from depression and/or anxiety. Some residents are also dealing with serious mental illness and/or drug and alcohol addictions.

* See *Picture of Housing and Health: Medicaid Use Among Older Adults in HUD-Assisted Housing* at <http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.pdf>.

Understanding Health Care Reform

As a housing provider, you may be unfamiliar with the workings of the health care system. That's understandable. Up until now, people working in the housing and health care worlds have not had much opportunity to interact.

Times are changing, however. That's why you need a basic understanding of the changing health care landscape before you can pursue partnerships with health care entities. The following primer should help. For more information, see the Appendix of this guide.

Reforming Two Systems

Current health care reform initiatives in the public and private sectors affect two basic systems at the same time:

- **The payment system:** Payment reforms affect how organizations are paid for the services they provide. Payment systems have traditionally reimbursed physicians and hospitals for each service they provide, regardless of the outcomes that patients experience. This is known as a “fee-for-service” or “volume-based” system. Health care reform is moving us away from this type of system. We are now gradually shifting to a “value-based” system that holds health care providers accountable for the outcomes of their services.
- **The delivery system:** Delivery reforms affect how health care is organized and provided to patients. Care delivery is moving away from a system that simply reacts to one crisis after the other. We are now evolving toward a system that works proactively to improve the health of populations.



Population Health Management

Transforming health care's payment and delivery systems is two sides of the same coin.

The payments that health care providers receive in a value-based payment system depend on the ability of those providers to meet performance benchmarks. These benchmarks include population-based metrics like hospital readmission rates and preventative care for chronic conditions.

In order to achieve these benchmarks, health care providers must reorganize the way they deliver care. That's why health care entities, including providers and insurers, are adopting strategies that allow them to better manage the health of the population they serve. The goal of these efforts is to keep a patient population as healthy as possible and minimize the need for expensive interventions like emergency department visits or hospitalizations.

Population health management represents a major shift for our current health care system, which generally approaches health care as a series of isolated, reactive encounters. Now providers need to intervene before a crisis occurs, especially in the case of high-risk patients.

Population health management requires health care entities to:

- Scan their patient populations.
- Identify categories of need across those populations.
- Zoom in on individuals to address those needs.

How does this work? Here's one example: A health care provider might identify a subgroup of patients with diabetes who are at risk for developing complications. The organization would then work with those individuals to better control their condition.

Population health management is being implemented by a variety of entities, including Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs) and health insurance plans. Implementation can take different forms. Generally, it includes the following elements:

- **Prevention and early intervention:** Health entities focus on helping people stay as well as possible. This approach includes screening and health promotion activities, as well as initiatives aimed at helping individuals better manage their chronic conditions and prevent acute episodes.
- **Care coordination:** Patients are viewed more comprehensively and there is an effort to coordinate care across the patient's spectrum of needs and care providers. Those providers might include primary care physicians, specialists, hospitals, nursing homes, rehabilitation facilities, home health care agencies and others.

- **Patient engagement:** Patients spend the majority of their time outside of the doctor's office and, thus, outside the physician's control. Patients, assisted by their family caregivers, need to better understand how to manage their care needs and take an active role in maintaining their own health.

Population health management redefines the boundaries of the health care system and opens up new incentives for health care entities to work with affordable senior housing providers. As health care entities assume the financial risk for maintaining the health of their patients, they must create a seamless care delivery system. They must also integrate their work into patients' daily lives.

As an affordable senior housing provider, you can offer a venue where this integration can take place. You can help health care entities intervene with their more vulnerable and costly patients who live in your housing property. You can facilitate these interventions on a more regular and personal basis than can be achieved within the confines of a hospital, physician office or clinic.

You can help health care entities keep their patients as well as possible and avoid using costly services. In the process, you can help physicians, hospitals, ACOs, PCMHs and health insurers mitigate their financial risk and achieve their quality goals.



An Evolving Health Reform Process

Even health care providers that continue working under traditional payment and care delivery mechanisms will still have good reasons to partner with affordable senior housing settings. In addition, reform efforts are creating new incentives for collaboration. That's why it's important for you to become familiar with the goals and financial incentives of health care organizations in your community.

Keep in mind that we are still in the beginning stages of health care reform efforts. Therefore, health care organizations are still learning how to operate in this new environment. This means that you may need to:

- **Anticipate health reform changes.** The health care organizations in your community may not yet be operating under reform-related models and strategies. Don't let this lull you into complacency. There is a widespread belief that health care is moving to a value-based payment system. Therefore, health care organizations that aren't yet operating under these new types of principles are likely to be doing so in the future.

It would be a mistake to wait until health care reform initiatives are in place before moving ahead with housing-health partnerships. Partnering with you now could help health care organizations begin testing a new way of delivering care.

- **Educate your potential partners.** Health care providers have traditionally operated very inwardly. But new health reform initiatives will increasingly encourage these providers to look externally and collaborate with other entities that also touch their patients. Keep in mind that health care organizations are probably unfamiliar with affordable senior housing properties, and the role you can play in helping to support their patients. It's up to you to educate them about your affordable housing setting and the value that they can gain by collaborating with you.

Keep reading to learn more about the benefits you can bring to health care entities in your community.



Benefits of a Housing and Health Partnership

Affordable senior housing communities offer many benefits that can make them valuable partners for health care providers and payers. Here's an overview of those benefits.



A Concentrated Population

Your affordable senior housing property features a concentration of the types of individuals that have captured the attention of many health and long-term care reform entities. Generally, your residents have reached advanced ages, and have very low-incomes, multiple chronic illnesses, low health literacy levels, and limited engagement in maintaining their own health. A large portion of your resident population is dually eligible for Medicare and Medicaid. This is the demographic that health care providers are focusing on as they work to improve health outcomes and lower utilization of unnecessary health services.

Operating Efficiencies

The concentration of older, vulnerable individuals in a common location like a housing property offers several benefits to health care providers, including:

- + **Streamlined access** to the individuals they want to serve.
- + **The ability to provide cost-effective service delivery and health education programs** that reach multiple individuals in one place at a common time. This service delivery and health education can take place through one-on-one interactions or group programming.
- + **The ability to facilitate greater follow-through and compliance** among their patients. Making onsite services and programs available at the housing property gives residents easier access to those programs and services. Trusted housing property staff and peers living in the building can also remind and encourage those individuals to participate in onsite programs and services.
- + **A more complete understanding of social factors** that may have a bearing on an individual's health status. Health care providers can gain that understanding from visiting a resident in his or her apartment or obtaining information from the housing staff.
- + The opportunity to serve large numbers of individuals who are **frequent users of high-cost health care services**.

Physical and Personnel Infrastructure

Your affordable senior housing property offers an infrastructure that can be valuable to health care providers.

The housing property's physical infrastructure may include office and/or community space that can be used for one-on-one meetings or group activities like health education sessions or fitness classes. There may also be opportunities to co-locate a health clinic or other medical office at the housing property.

Another important aspect of the housing property's infrastructure is its staff. Many housing properties employ a service coordinator to help residents identify and access needed services and supports. Service coordinators can play a vital role in helping to keep residents healthy and independent. For example, they often:

- + Develop trusting relationships with residents and know their preferences, needs and capacities.
- + Observe a resident's living circumstances during visits to the resident's apartment.
- + Monitor residents and notice potential emerging health issues before they become a crisis.
- + Help to remind and encourage residents to participate in activities and appointments.
- + Help residents overcome barriers that may be preventing them from following through on appointments and needed self-care management.

Other housing property staff also build relationships with residents, observe them, and notice problems and changes in condition. These staff members include property managers, maintenance personnel and others who have frequent contact with residents.



Health Care Challenges That Housing Can Help Address

Health care entities will face a number of challenges as they participate in new payment and care delivery models. Housing properties can support and facilitate the efforts of health care organizations to address these challenges, particularly as these organizations deliver services to their more complex and vulnerable older patients.

Here's an overview of each challenge—followed by a checklist of how housing properties can help their health care partners meet the challenge.

Avoiding Unnecessary Hospital Readmissions

Approximately one in five Medicare beneficiaries discharged from the hospital is readmitted within 30 days. More than one-third are re-hospitalized within 90 days. Readmission rates are even higher for older adults with multiple chronic illnesses, functional and cognitive impairments, emotional problems and poor health behaviors.

In October 2012, Medicare began penalizing hospitals when patients with specific conditions were readmitted to the hospital within 30 days of discharge. The penalty is part of an effort to pay hospitals for quality care, not just for the number of patients they treat.

Here are some important facts you should know about readmission rates:

- **Low-income patients are at high risk for being readmitted.** In 2013, Medicare penalized over 2,200 hospitals—about two-thirds of all eligible hospitals. Hospitals serving the poorest patients were more likely to be penalized. A number of factors can contribute to higher readmission rates among low-income individuals. For one thing, language and cultural barriers often make it harder for low-income patients to comply with discharge instructions. Unaffordable medications and fewer options for post-discharge care also contribute to readmission rates among the poor.¹
- **Many hospital readmissions are preventable.** Up to one-third of readmissions among older patients could be prevented.² How? By ensuring that patients and their family members have adequate support. This includes help understanding how to follow complicated medication regimens and when and how to obtain follow-up care.
- **Information is key to preventing readmissions.** Providers often lack the information they need to identify hospitalized patients who are at high risk for readmission and who could benefit most from post-discharge support.³
- **Hospitals raise concerns about their ability to prevent readmissions.** Hospitals maintain that some causes of readmissions are beyond their control, including patient behavior and the performance of the post-acute care provider. They also note that reimbursement policies do not support strategies—like having nurses follow up with patients after discharge—which could help reduce readmissions.

HOW CAN HOUSING PROVIDERS HELP?

Providers of affordable senior housing can help reduce hospital readmission rates by offering:

- ✓ **Easy identification of and access to patient populations** that are at risk for re-hospitalization.
- ✓ **Knowledgeable service coordinators** who can help identify service gaps and ensure that needed resources and supports are in place. Service coordinators can participate in the discharge planning process or interdisciplinary care team. In that role, they can ensure that health care providers have a realistic understanding of the person's capabilities and support networks. The service coordinator can also play a critical role in monitoring certain aspects of the discharge plan.
- ✓ **A program to manage transitions**, if the hospital does not already have one. Service coordinators and/or wellness nurses working in a housing property can help ensure that necessary post-discharge tasks are coordinated and implemented. For example, they can help residents fill prescriptions for new medications, make follow-up medical appointments and acquire needed adaptive equipment. They can also make arrangements to bring food into the home.
- ✓ **A medication review and reconciliation.** Most older people get new prescriptions during a hospital stay. However, the hospital may not be fully aware of the medications that their older patients were taking before hospital admission. A wellness nurse working onsite at a housing property can review a resident's new medications and explain those medications to the resident. The nurse can also identify potential contraindications or duplications with existing medications, and help the resident work with the physician to resolve any problems.
- ✓ **Long-term monitoring.** Most hospital transitions programs only follow individuals for the first 30 days after discharge. Onsite housing property staff can monitor individuals over a longer term.



Addressing Medication Complications

Polypharmacy—the use of multiple medications—is common among older people. Taking multiple prescriptions increases the likelihood that an older person won't take all medications as directed. This is commonly referred to as medication non-adherence. Polypharmacy is also associated with increased adverse drug reactions and drug interactions. All of these complications have the potential to result in costly medical events.

Here are some important facts you should know about medication complications:

- **Medication non-adherence and adverse reactions lead to expensive interventions.** Almost a quarter (23%) of nursing home admissions are due to medication non-adherence. About 30 percent of hospital admissions among older adults are related to non-adherence or adverse drug reactions.⁴
- **Medication complications.** Older adults may find it hard to follow complex drug regimens that involve taking multiple pills that must be taken multiple times a day. These patients may not be able to afford all their medications. Mobility or transportation limitations may make it hard for them to obtain prescriptions. They may stop taking medications because of side effects or because they think the medicine is not working. Conversely, older patients may continue taking medications that have been discontinued. They may have low health literacy, or lack education about the purpose of the medication or the best way to take it. Finally, they may have cognitive impairments.
- **Patients don't always admit they are not taking medications.** These patients may feel guilty or afraid the physician will get angry. They may be embarrassed that they can't manage a complex drug regimen.⁵

HOW CAN HOUSING PROVIDERS HELP?

Providers of affordable senior housing can offer assistance that could help reduce the incidence of medication non-adherence or adverse reactions, including:

- ✓ **Medication review and reconciliation.** An on-site wellness nurse could help review medications and communicate with physicians regarding any identified drug complications. The nurse could also educate residents about the purpose of their medications and the most effective way to take them. These and other interventions could help ensure proper adherence. Conducting reviews in a patient's home also provides the opportunity to see all of a resident's prescription and non-prescription medications and supplements.
- ✓ **Transportation assistance.** The housing property can help identify or arrange transportation assistance to help residents pick up their medications at a pharmacy. The property can also identify pharmacies that will deliver medications.
- ✓ **Medication management.** The housing property can help identify potential medication management assistance mechanisms. For example, it might find a pharmacy that can provide pre-packaged medication doses. It might also help the resident purchase electronic dispensing/reminder equipment or other assistive devices.



Managing Chronic Illness

Older adults have a high and growing prevalence of chronic diseases. These diseases are long-lasting conditions that can generally be managed, but not cured. Examples include heart disease, stroke, diabetes, asthma and arthritis.

Here are some important facts you should know about chronic conditions:

- **Chronic conditions adversely affect some groups.** Low-income older adults and members of certain minority groups are more vulnerable to chronic disease.⁶
- **Many older adults have more than one chronic condition.** The presence of multiple chronic conditions is associated with higher rates of death, disability, adverse effects, institutionalization, use of health care resources and poorer quality of life.⁷
- **Many people with chronic conditions have low health literacy.** They often don't know enough about their illnesses and how best to manage them.⁸ Not surprisingly, lower health literacy is linked to poorer health behaviors and outcomes.⁹
- **Many people self-manage their chronic conditions.** Individuals with chronic diseases often find themselves self-monitoring their conditions. The process of teaching individuals about their diseases and appropriate self-care behaviors must be multi-stepped and tailored to the person's condition and circumstances. It should also include periodic refreshers to ensure that patients maintain their self-management skills over time.¹⁰
- **Physicians have limited time to help.** Physician visits are typically infrequent and short. This leaves the physician with limited time to listen to a patient's concerns, coach the individual about the best methods for managing his or her conditions, and ensure that the patient understands what he or she has been taught. The interaction between physician and patient is further constrained by the stress many patients feel during office visits. This stress may reduce a patient's ability to process and recall information.¹¹

HOW CAN HOUSING PROVIDERS HELP?

Providers of affordable senior housing can improve management of chronic disease because they offer:

- ✓ **An easily identifiable concentration of individuals** who can benefit from assistance and support to better understand and manage their chronic conditions.
- ✓ **A venue for offering evidence-based group programming.** When these programs are offered onsite, residents have easy access to health and wellness education. This convenience can enhance ongoing participation, particularly among residents with mobility or transportation limitations. Support from property staff and peers can also promote and encourage participation in and compliance with programs over the long term.
- ✓ **Coaching and support.** Onsite housing staff have frequent interactions with residents and often develop trusting relationships with them. Staff members, especially onsite wellness nurses, can help reinforce and amplify the advice and directions that a resident receives from the physician. These staff members can also spend extended time during multiple interactions helping residents better understand the nature of their health conditions and how to best control them. Such interactions can benefit individuals who may need to hear messages multiple times, or who can only absorb information incrementally and make changes in small steps.
- ✓ **Extended monitoring.** An onsite wellness nurse can help residents monitor vital signs. The nurse can also help residents recognize signs that they may need to change their behaviors or practices and/or see their physician.
- ✓ **Delivery Efficiencies.** The congregate housing environment provides an opportunity for health care providers to engage in group visits that focus on a specific condition like diabetes. The housing setting also allows providers to conduct multiple house calls at one address with individuals who have difficulty traveling to a doctor's office.

Patient Education and Engagement

Many experts believe that achieving better health depends a great deal on whether patients have the knowledge, skills, confidence and support they need to follow treatment regimens and/or make lifestyle changes that promote wellness. A growing body of evidence suggests that people who are actively involved in their care are more likely to stay healthy. Those who lack the skills and confidence to manage their own care often use more health care services and incur higher costs.¹²

Here are some important facts you should know about patient engagement:

- **Activation rates vary.** The level of patient activation varies considerably within the U.S. population.¹³ Activation levels are especially low for people with low incomes and less education, as well as for Medicaid enrollees and people who self-report poor health.
- **Low health literacy is an obstacle to engagement.** Patient engagement depends on an individual's capacity to obtain, process and understand the basic health information and services needed to make appropriate health decisions. About one-third of adults have limited health literacy.¹⁴ Among all adults, the 65+ age group has the highest proportion of persons with a "below basic" health literacy level.¹⁵ Health literacy is also low among immigrant, minority and low-income populations.
- **Medical practices face obstacles too.** Implementing patient engagement strategies in medical practices requires changes in culture and operations. Studies have identified numerous barriers to making these changes, including time constraints, insufficient provider training, a lack of incentives, and information system shortcomings.¹⁶

HOW CAN HOUSING PROVIDERS HELP?

Providers of affordable senior housing can improve patient engagement and activation by offering:

- ✓ **A concentration of individuals** who are likely to have low levels of health activation.
- ✓ **Education programs.** An onsite wellness nurse or health coach can offer educational programs to increase patients' knowledge and understanding of health conditions and how to manage them. This can be accomplished through general group programming and/or one-on-one assistance. One-on-one assistance provides the opportunity for both extended and frequent conversations, which is particularly helpful for individuals with limited educational, language or cognitive abilities.
- ✓ **Monitoring and tracking of vital signs.** A wellness nurse can help residents monitor and track relevant vital signs. The nurse can also help residents understand how to identify potential warning signs and follow through with their physicians.
- ✓ **Motivation.** Onsite housing staff can help motivate an individual to adopt a healthy behavior. They can also encourage the person to take and continue good self-care actions. Similarly, friends and neighbors living in the property can encourage and support each other.
- ✓ **Access to resources.** A service coordinator can help identify and connect residents with resources that could help them address social issues affecting their ability to address care needs or manage care. For example, service coordinators can help residents arrange for transportation, meal programs, medication management assistance and other services that support healthy aging.

Addressing the Social Determinants of Health

The circumstances in which people are born, grow up, live, work and age can have a greater effect on their health than the medical care they receive. These circumstances are often referred to as the “social determinants of health.”

Here are some important facts you should know about the social determinants of health:

- **Social factors have a big impact on health.** Approximately 80 percent of a person’s health status is attributed to social and economic factors, health-related behaviors and the physical environment.¹⁷
- **The social determinants of health challenge patients and physicians.** Many physicians recognize these challenges. The vast majority (85%) of physicians participating in a recent Robert Wood Johnson Foundation study said that unmet social needs lead directly to poorer health for Americans. Yet, only 20 percent of doctors said they have the ability to help address those needs.
- **Many health care providers are not fully aware of the social context in which their patients live.** In addition, neither they nor their staff members have the knowledge, skills or time to help patients address what can often be complex social issues.



HOW CAN HOUSING PROVIDERS HELP?

Providers of affordable senior housing can help physicians and their patients address the social determinants of health by:

- ✓ **Helping residents access needed economic and social benefits.** A housing property’s service coordinator can help individuals identify and access benefits like food stamps, home-delivered meal programs, heating subsidies or transportation programs. They can also assist with applications and annual re-certifications for public benefit programs. Beneficiaries of these programs often must complete complex applications and provide several forms of documentation in order to ensure the continuity of benefits.
- ✓ **Promoting healthy behaviors.** Housing properties can offer education programs and classes focusing on chronic disease management, nutrition, fitness, smoking cessation and other health issues. They can offer prevention activities and screenings, including flu shots and mammograms. Offering these programs onsite helps ensure residents, especially those with mobility or transportation limitations, have easy access to health-promotion activities. This convenience may encourage greater participation and retention. The influence of trusted staff and neighbors could also help encourage participation and follow-through.
- ✓ **Demonstrating cultural competence.** Housing staff in culturally diverse properties are often familiar with the practices and preferences of the ethnic and cultural groups living in their communities. They may also be bilingual or have access to translators. This knowledge allows staff members to talk with residents about health issues in a way that will encourage, rather than discourage, their participation in care.

“Super Utilizers”

“Super utilizers” are individuals who overuse emergency department and hospital services. These individuals generally have complex physical, behavioral and social needs that are not well met by a fragmented health care system

Here are some important facts you should know about super-utilizers:

- **A relatively small group of people uses the most services.** Spending for health care services is concentrated in a small proportion of people with very high use. Five percent of the population with the highest spending is responsible for nearly half of all health care spending. People who are older or who have multiple chronic conditions or functional limitations are significantly more likely to be among the highest spending patients.
- **States and localities are trying to serve super-utilizers better.** Confronted with the financial impact that comes with lack of care coordination, these jurisdictions are promoting care management programs for super-utilizers.
- **Super-utilizers have social needs.** These needs must be resolved before their health care needs can be effectively addressed, according to the findings from a Super-Utilizer Summit held in 2013 by the Center for Health Care Strategies.¹⁸
- **Care teams are critical.** Care teams often include non-clinicians—like social workers and community health professionals—who help the team address gaps and social service needs, according to the Summit findings. These teams spend a great deal of time working in the community and are persistent in trying to engage patients. They recognize that change may come slowly to super-utilizers. Bringing about that change may require different engagement strategies or interventions.
- **Real-time information about patients helps make super-utilizer programs more effective.** Summit findings suggest that super-utilizer programs must be informed when an individual visits an emergency department or is admitted to a hospital. These programs also

need information about a patient’s capabilities and social situation, including the individual’s support network, living situation, food needs, or substance abuse issues, if there are any.

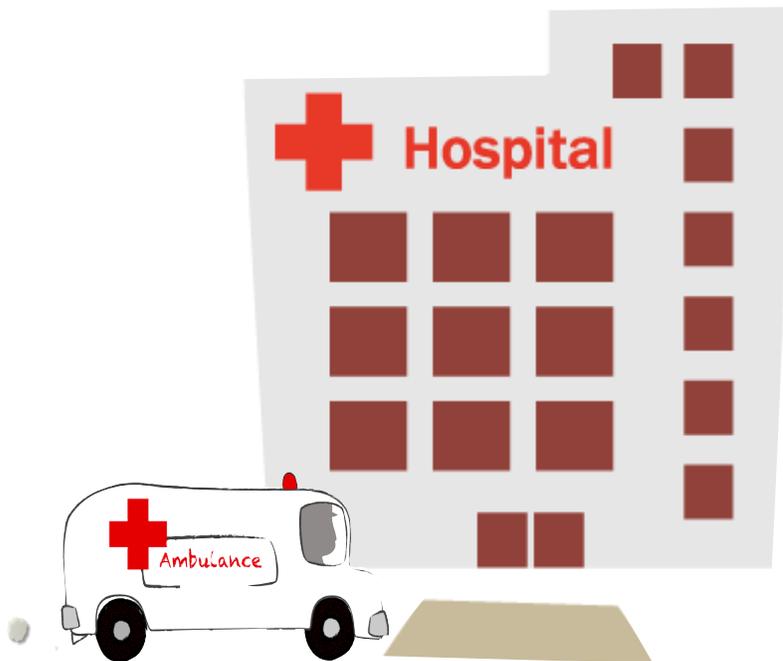
- **Super-utilizers need to learn how to use health care services appropriately.** Reconnecting patients with their primary care physicians (PCP) is a goal of most super-utilizer programs, according to the Summit findings. Super-utilizers often have a PCP. However, they often find it easier to use the emergency department inappropriately for non-urgent reasons.

HOW CAN HOUSING PROVIDERS HELP?

Providers of affordable senior housing can help managed care programs address the needs of super-utilizers by offering:

- ✓ **An efficient avenue for identifying and accessing super-utilizers.** Many residents of affordable senior housing fit the profile of the super-utilizer: that is, they typically have multiple chronic conditions, functional limitations, behavioral health issues and challenging socioeconomic situations.
- ✓ **An extension to the care team.** Housing staff can play an important role in helping health care teams reach, manage and deliver services and supports to patients living in the housing property. Members of the housing staff can share their knowledge of and relationship with residents so care teams have a complete picture of individual patients and their needs, as well as available opportunities to influence care. Onsite housing staff can also help:
 - Monitor individuals.
 - Address barriers to care, including the social determinants of health.
 - Provide education.
 - Help coordinate care and services.
 - Encourage and motivate appropriate behaviors.

- ✓ **A regular, onsite presence.** Members of the housing staff work daily in the place that residents call home. This presence allows housing staff to frequently engage with residents in person, to learn about residents' lives, and to develop trusting relationships with residents. This continual interaction helps housing staff gain a better understanding of what motivates residents and how to encourage them to take action. Staff can also play an important role in helping to support these actions.
- ✓ **A venue for care delivery.** Housing properties can provide care teams with a venue to deliver wellness nursing, health coaching and educational services to super-utilizers.
- ✓ **Education.** Onsite housing staff can help educate super-utilizers about appropriate use of health services. They can help residents make physician appointments and address barriers, including transportation limitations, which might prevent residents from keeping those appointments. Onsite staff can also answer residents' health-related questions in a timely manner. Those answers may prevent a resident from using the emergency department inappropriately.



Keep reading to learn more about how housing and health entities can collaborate.



How Housing and Health Entities Can Collaborate

There are several ways in which affordable housing communities and health care entities can collaborate. The services provided through these collaborations—as well as how those services are delivered—will vary. In addition, the structure of the collaborations, as well as their intensity and formality, will depend on the needs of residents, the mutual goals of the partners, and the resources available to them.

Types of Services

Services delivered through a housing-health partnership can be limited in scope or can include multiple offerings. Types of services could include:

- Education sessions addressing health and wellness topics.
- Wellness and prevention screenings and monitoring.
- Fitness programs.
- Medication management/assistance.
- Care coordination/navigation.
- Transition assistance.
- Physical or occupational therapy.
- Mental health counseling/therapy.
- Primary care.



Delivery Mechanisms

Housing-health partnerships will generally deliver services at a housing property to take advantage of proximity to care recipients. However, those services may be structured in a variety of ways.

- **Who will deliver services?** Services can be delivered by the health care entity's own staff who may spend defined time at the housing community. Alternatively, the health care entity could provide funding so the housing community can hire staff, such as a wellness nurse, who will deliver services. In some locales, this decision will be influenced by a state's licensing requirements and residential care regulations.
- **How often will services be available?** Services could be available on a daily basis or more intermittently. The frequency of services may vary depending on the type of service being offered and the volume of recipients being assisted.
- **How will partners interact?** Engagement between housing and health providers can range from minimal to intense.
 - In a minimal engagement scenario, the housing provider might simply refer residents to the health provider and encourage residents to take advantage of the health provider's services and programming.
 - In a middle-of-the-road approach, housing providers might also provide administrative support to recruit or schedule residents for programs. Housing provid-

ers could also informally discuss residents and share information about how each partner might assist residents with an identified need.

- In a more intense relationship, the two partners could meet on a formal basis to share information about residents receiving services, and collaborate on meeting residents' various needs. Of course, all communication about residents would be conducted within the bounds of applicable confidentiality requirements and with each resident's consent.

Funding

Not surprisingly, obtaining sustainable funding is a major challenge to building partnerships between housing and health care providers. Affordable housing properties generally have limited operating budgets with little room for funding of services. In some cases, their ability to spend money on services may be restricted by financing/regulating entities.

Generally, the health care entity in a housing-health partnership will be the funding source for programming in a housing property. Current health funding structures and requirements provide avenues for supporting such services and activities. Health reform initiatives promise to provide additional incentives and opportunities for these programs and activities in the future.

Possible funding strategies include:

- **Restructuring current interactions.** Housing-health partners might be able to avoid the need for new funding if they can simply restructure how they communicate and coordinate services. For example, a hospital could engage a housing property's service coordinator in its discharge planning process and establish a relationship that involves information exchange and communication designed to ease transitions and avoid a re-hospitalization.

- **Satisfying community benefit requirements.** Nonprofit hospitals are required by federal and state laws to demonstrate that they provide a benefit to the community in exchange for their tax-exempt status. These hospitals can demonstrate their community benefit by providing community health improvement services, subsidized health services, and cash or in-kind contributions. A nonprofit hospital could satisfy the community benefit requirement by supporting programming in a housing property.

Other nonprofit entities, including continuing care retirement communities (CCRC), are also subject to similar social accountability obligations in exchange for their tax-exempt status. A CCRC might demonstrate its social accountability by sending health professionals to a housing property to provide health education, fitness or wellness activities.

- **Billing for services.** Health-related programs delivered in housing properties may include billable services like primary care, physical or occupational therapy, or mental health treatment.
- **Creating field-placement opportunities.** Virtually all health-related professional training programs require a field placement. Schools are always on the lookout for quality, sustainable partners for these field placements. The education program essentially supports on-site services, although additional funds might be sought to enhance programs.
- **Avoiding costs.** A health care provider may support onsite programs in a housing property as part of a "cost avoidance" strategy if the program can help the provider reduce the use of other, more costly services. For example, when individuals use the emergency department for non-urgent reasons, hospitals cannot always capture the full cost of that service and, therefore, may lose money on the visit. Hospitals may be willing to make an investment in an onsite program or service if that investment will help reduce the likelihood that the hospital will pay a penalty for readmitting residents within 30 days of a hospital discharge.

- **Sharing in savings or bonuses.** Participants in some health reform programs can earn financial rewards by meeting quality and outcome measures and lowering costs. Accountable Care Organizations and person-centered medical homes may be interested in establishing programs that help them obtain these financial rewards. These programs could then be funded, in full or part, through the savings that health care organizations create or the bonuses they receive.
- **Funding with flexibility.** Managed care organizations receive a capitated rate to meet the health needs of their assigned clients. This gives them more flexibility to fund different types of services and/or to contract with providers than is possible under the traditional fee-for-service billing system. Managed care organizations may be interested in supporting programs that provide wellness, prevention and care coordination services as a way to prevent individuals from using costlier services like the emergency department or the hospital. These organizations could possibly send their own or contracted staff to provide services at the housing property. Alternatively, they might provide funds so the housing property can deliver certain services.



Partnership Examples

Housing and health care providers who have never worked together might find it difficult to imagine how their partnership might be structured and what activities they might pursue together. Fortunately, a variety of housing-health partnerships now exist around the country. These pioneering partnerships provide many lessons and helpful examples for those considering housing-health collaborations.

Greater Baltimore Medical Center and Catholic Charities of Baltimore Baltimore, MD

As part of its community benefit program, Greater Baltimore Medical Center (GBMC) sends a nurse practitioner to host weekly clinics at multiple affordable senior living communities in the Baltimore area. GBMC believes that providing access to this nurse practitioner:

- Offers an opportunity to intervene before health complications reach a crises level.
- Provides residents with one-on-one guidance for appropriate care.
- Illustrates to residents the importance of complying with existing medications, nutrition, exercise, or self-care directives so they have fewer emergency department visits, hospitalizations and re-hospitalizations.

The GBMC nurse practitioner and the housing property's service coordinator refer residents to each other. They also collaborate, as needed, to help address resident concerns. The nurse practitioner can work with the service coordinator to help individual residents overcome barriers that impede their ability to manage health conditions.

PinnacleHealth and Presbyterian Senior Living **Harrisburg, PA**

After conducting a zip-code analysis of its service area, PinnacleHealth found that residents of a 150-unit property managed by Presbyterian Senior Living (PSL) had a high rate of emergency department and hospital utilization. That information spurred the two organizations to develop a program to help individuals better manage their multiple chronic conditions and more appropriately navigate the health care system. Pinnacle and PSL established a weekly, half-day clinic at the housing property. A physician, nurse navigator and master's level social worker staff the clinic.

The nurse navigator runs a daily report, which identifies residents who have been in the emergency department or hospital. The nurse then schedules these residents for a clinic visit during the next clinic day. The nurse and social worker also monitor residents who have been identified as "super-utilizers" and/or who have two or more chronic conditions that put them at risk for emergency department or hospital visits. These residents receive clinic appointments when necessary. Participation in the clinic is, of course, the resident's choice. Any resident of the housing property can request a clinic appointment.

On clinic days, the physician and nurse visit residents in their apartments. The team focuses on making sure residents are properly managing their chronic conditions, taking the appropriate medications, and complying with discharge instructions. The Pinnacle team may identify potential barriers to health maintenance and suggest strategies for overcoming those barriers. Where warranted, the team works with the hospital social worker or housing property's service coordinator to help address these challenges.

The Pinnacle physician is not intended to replace the individual's primary care physician (PCP). Instead, the physician serves to reconnect residents to the health care system and supplement the primary care they receive from their own PCP. Outside of the onsite clinic time, the nurse and social worker follow up with residents to help coordinate needed care and resources and monitor patients as needed.

Pinnacle originally envisioned the onsite clinic program as a community outreach initiative. Recently, the health system has begun billing for allowable home visits. In the program's first year, residents' emergency department visits were cut in half and hospitalizations fell by 70 percent. Pinnacle has recently expanded the program to two additional housing properties.

Virginia Commonwealth University and Dominion Place **Richmond, VA**

The schools of nursing and pharmacy at Virginia Commonwealth University (VCU) are leading the operation of a weekly health clinic at Dominion Place, a 249-unit affordable senior housing community in Richmond. Dominion Place residents had 112 transports to the emergency department in 2012, according to a recent analysis. Only five of those transports were classified as truly emergent, meaning they might have been prevented if better resources had been available.

The VCU/Dominion Place clinic helps vulnerable residents address and manage their health care needs. It also offers a venue for VCU students to complete their required community rotations. The clinic is staffed by an interdisciplinary team of students and supervisors from the schools of nursing, pharmacy, medicine, social work and gerontology. A clinic coordinator conducts an intake/triage of residents who are seeking care. The coordinator schedules residents' appointments with a team of students.

Residents present their concerns to the student team. Students then assess those concerns from the perspective of their respective disciplines. Students also diagnose, review medications, provide education and coaching on self-care management, and help to coordinate care. The program's goal is to reconnect residents to the health care system and supplement the primary care they receive from their own primary care physician (PCP). If a resident does not have a PCP, the clinic will help them find one.

Supports and Services at Home

Vermont

Supports and Services at Home (SASH) is an affordable housing-based care coordination program that serves as an extender to the community health teams (CHTs) supporting Vermont's statewide medical home model.

Teams composed of housing-based care coordinators and wellness nurses work with dedicated representatives of community-based service agencies to support participating residents in one or more affordable housing communities. The teams may also serve individuals living in the communities surrounding the housing properties.

SASH teams conduct a comprehensive assessment of residents and work with them to develop a plan addressing health- and wellness-related needs. The onsite teams coordinate with the CHTs to help address the needs of complex individuals and monitor them in the community. These teams also work with local hospitals to help support and monitor transitions home after a hospital stay.

Currently, the care coordinator and wellness nurse are being supported through a Medicare demonstration program. Early evaluation results show that the SASH program is slowing the growth of total annual Medicare expenditures for program participants, compared to non-participating individuals.

Serving At-Risk Frail Elders at Home Virginia Premier Health Plan, Virginia Commonwealth University and Richmond Redevelopment & Housing Authority Richmond, VA

Serving At-Risk Frail Elders (S.A.F.E.) at Home was a partnership developed with Virginia Premier Health Plan (VPHP) Dual Eligible Special Needs Plan and the Virginia Commonwealth University Health System (VCUHS) Department of Geriatrics.

The partnership formed after initial conversations between the Richmond Redevelopment & Housing Authority (RRHA) and the Department of Geriatrics.

RRHA was aware that the Department of Geriatrics had nurse practitioners, physicians and social workers who made house-call visits to some residents. It recognized the value of house-call visits and sought to give all of its residents access to this service. The Department of Geriatrics was also interested in finding a way to extend its support to RRH residents and work in tandem with residents' current primary care physicians (PCP).

The Department of Geriatrics approached VPHP, the VCUHS-owned Medicaid and Medicare health plan, to assess interest in a partnership to fund services in RRHA properties. VPHP confirmed that some of its most at-risk members lived in RRHA buildings. The health plan believed the partnership would represent a viable way to deliver enhanced care coordination and a home-based care approach. The partners launched a pilot program featuring in-home visits and geriatric assessments for every resident/member referred to the program. As needed, members received:

- Medication reconciliation from a pharmacist specializing in geriatrics.
- Home visits by a physician and/or nurse practitioner.
- Support for residents/members who were transitioning back to their home after a hospital visit.
- Care coordination services, provided by a social worker. These services included assessing residents' needs and connecting those residents to available community resources.
- An after-hours nurse line that allowed residents to ask for information or guidance from a Geriatrics Department staff person.
- Coordination with and, at times, visits from the resident/member's primary care physician.
- Primary care physician services, if a resident/member did not already have a PCP.

Housing with Services Initiative

Portland, OR

The Housing with Services Initiative in Portland, OR, is a formal network of three affordable housing providers and home and community-based service, health care and behavioral health providers. Care Oregon, a health plan that insures the largest segment of the state's Medicaid population and offers a Medicare Advantage plan, is also a partner in the consortium's limited liability corporation.

A health care navigator and a care coordinator working across eight housing properties will help residents address and coordinate their care needs, including linking residents with the consortium or other service providers when needed. Initially, CareOregon will make a lump-sum investment to support the initiative's assistance of its plan members. The consortium anticipates working toward a per-member, per-month payment for a package of services that could be purchased by health plans or coordinated care organizations.

Eliza Jennings Senior Care

Network Wellness Clinics

Cleveland, OH

Eliza Jennings is an aging services provider in Cleveland, OH, which operates a range of residential and community-based services to older adults. Eliza Jennings operates wellness clinics in multiple affordable senior housing properties. A nurse practitioner and nurse staff the clinics. The nurse practitioner is able to see residents for their primary care needs and is able to bill for visits. Residents can choose to use the nurse practitioner as their primary care physician or the nurse practitioner can supplement existing physicians.

The nurse helps residents monitor their conditions, answers their health-related questions, communicates and coordinates with their health

care providers, and provides health and wellness programming. Eliza Jennings is also able to provide physical, occupational and speech therapy in residents' apartments or at an onsite office, depending on the circumstances. Residents can select Eliza Jennings as their home health and/or therapy provider if needed after a hospital stay or if ordered by their physician. The housing property service coordinator refers residents to the clinic. The clinic staff engages with the service coordinator when they identify possible barriers or areas of need that the service coordinator could assist with.

Personal Health Partners Program

Northeast Ohio

The Personal Health Partners program provides health and wellness-related services in three Northeast Ohio affordable senior housing communities. Laurel Lake Retirement Community, a continuing care retirement community, operates the program.

Personal Health Partners is a nurse-led program designed to empower individuals to make sound, health-related decisions by providing and coordinating education, support, referrals and services, including:

- Comprehensive health assessment, monitoring, instruction, support, referral and follow up.
- Health education.
- Prevention screenings.
- Fitness programs.
- Mental health initiatives.
- Social activities.

A fitness instructor and spiritual coordinator also support the program. The nurse-staffed clinics are open 2 to 4 days a week at each housing property, generally in the morning. Laurel Lake runs the program as part of its organizational mission to support the communities in which it works.

Keep reading to learn more about
identifying and cultivating a partner.



How To: Identifying and Cultivating a Partner

The process of launching a new, health-related program in an affordable housing property is not always quick or straightforward. Most likely, it will take some time to identify a potential partner, cultivate that partner's interest, and determine how you can work together. Before marching into a health provider's office, be sure to take some preliminary steps to help you identify and cultivate the health care partner.

This chapter outlines a number of those steps:

- ✓ Know residents' health and functional status, service needs and gaps.
- ✓ Get to know potential health care partners in your community.
- ✓ Network with other local senior housing properties.
- ✓ Develop the value proposition.

Know Resident Needs

Gathering data on residents' health and functional status helps you identify the services your residents need and the number of residents who could benefit from a particular health care partnership. This knowledge will also help you market your housing property to potential partners as a good site for service delivery.

This step may seem like a "no brainer" for many housing providers. After all, many housing providers think they already know their residents' needs. This isn't necessarily true. The picture you have of your residents often comes from your own observation or from the group of residents who visit the property's service coordinator regularly. In reality, most housing providers have limited information about a select group of residents. That information is far from comprehensive.

The best way to understand a housing property's resident population is to conduct community-wide assessments to capture information about the health and functional status, and the service needs, of as many residents as are willing to participate.

Having this data is helpful for two reasons:

1. It helps the housing property understand the kind of services and supports that would be most beneficial to the residents in the community.
2. It helps the property's staff build a business case for why a health care entity should collaborate with the property.

Case in Point

An assessment of residents living in two Presbyterian Senior Living (PSL) communities in Pennsylvania showed that a large number of residents had diabetes. After PSL shared the data with PinnacleHealth, the two organizations began collaborating on a diabetes education and management program in those properties. Assessment data, which confirmed resident need, was instrumental in securing Pinnacle's interest in the partnership and the potential for an expanded collaboration to address other identified health needs in the future. A subsequent Pinnacle analysis revealed that a number of PSL residents were using Pinnacle's emergency department excessively and inappropriately. This discovery led to the establishment of the weekly onsite clinic that is described on page 22.

A number of assessment tools are available for use by housing properties. Some are free; others must be purchased. Your organization may already have one. LeadingAge offers a basic resident assessment tool to help housing properties gain a broad understanding of residents' health and functional status. You can find the tool and a guide to conducting assessments at: www.leadingage.org/A_Tool_to_Assess_Housing_Residents_Needs.aspx.

Here's what you will want to know about residents in your housing property:

- **Health and functional needs.**
- **Health provider and insurance utilization.** This will include residents' primary care physician, the hospital they utilize, and their health insurance coverage. That coverage might include Medicare (and could be traditional fee-for-service or a Medicare Advantage plan), Medicaid, and other private insurance carriers. You may find that residents do not know how their care is covered. Ask them for current documentation. This will help you in the next step of identifying potential partners.
- **Emergency department and hospital use.** Potential hospital partners may be interested in this information. However, be aware that self-reports of emergency department and hospital use may not be complete or entirely accurate. First of all, you won't have informa-

tion for the individuals who don't complete the assessment. In addition, the information you do collect may be subject to problems with recall and accuracy.

Potential hospital or health care system partners may want to conduct their own analysis to see how residents at a particular address are utilizing their emergency department, inpatient hospital and other services. This process would provide important information about the volume of residents using the organizations' resources, the proportion of "super-utilizers" living in a particular housing property or across a housing network, and the value of pursuing a collaboration.

Case in Point

When Anne Arundel Medical Center (AAMC) in Maryland was looking for a location for its new community-based clinic, a zip code analysis identified a large number of 911 calls and emergency department visits from Morris Blum Senior Apartments and its surrounding community. According to the analysis, 184 residents had made 220 calls to 911 over a 12-month period. Residents had also made 175 emergency department visits in just 6 months. Just nine people had made 40 percent of the emergency department visits. AAMC found it could pay for the clinic's operating expenses by avoiding the cost of the five highest health care users in the property.



Get to Know Possible Health Care Partners

Identifying health care partners involves understanding which providers serve your area, which providers your residents are using, and whether these health care entities are engaged in or subject to any health reform activities or requirements. You will also want to understand who pays for your resident's health services. Here's more information about each step in the process:

1. **Map the health care providers in your area.**

Be sure you understand which providers your residents use. This may be relatively easy in communities with one primary hospital, a few primary care practices, or one large health system. This process will be more complex in geographic areas where residents use an array of health care providers.

Even if residents use a range of primary care providers, it's possible that those providers may work together in a common network like a group practice, a health system or an Accountable Care Organization. In geographic areas where residents' health care use is varied and dispersed, you might seek partnerships with entities that think more broadly about social accountability obligations. These organizations might be more open to considering how they can help the entire community rather than just focusing on their specific patient populations.

2. **Identify health care reform initiatives.** Find out if the health care entities in your community are involved in reform initiatives designed to improve health outcomes and lower health care costs for the type of patients your residents represent. For example, are the local hospitals and/or physician practices serving your residents as part of an Accountable Care Organization? Is there a federal or state-supported activity aimed at better coordinating or integrating care for

high-risk Medicare beneficiaries or individuals dually eligible for Medicare and Medicaid? Health care entities, including providers or insurers, who participate in these efforts are the most likely to be interested in pursuing a partnership with your organization.

3. **Find out who pays for your residents' health care services.** Given their age, most residents of affordable senior housing will receive their primary coverage through the Medicare program. Medicare coverage can vary. To gain a complete picture of Medicare coverage in your property, try to answer these questions:

- Is residents' care paid for on a fee-for-service basis?
- Are residents enrolled in a managed care plan? Is the managed care plan a Medicare Advantage or Special Needs Plan?
- Is the managed care plan a "community affiliated health plan"? These insurance plans focus on serving vulnerable populations, including low-income older adults. The population served by these plans may overlap with your resident population. This overlap may provide greater opportunity for a partnership with a plan in your community. Additionally, because the mission of these types of health plans is to serve at-risk individuals, they have greater experience working with these populations.
- Does your property or network have a large concentration of "dual eligibles" who are currently enrolled in, or will soon be enrolled in, a specific managed care plan participating in your state's Dual Demonstration project (if it has one)?

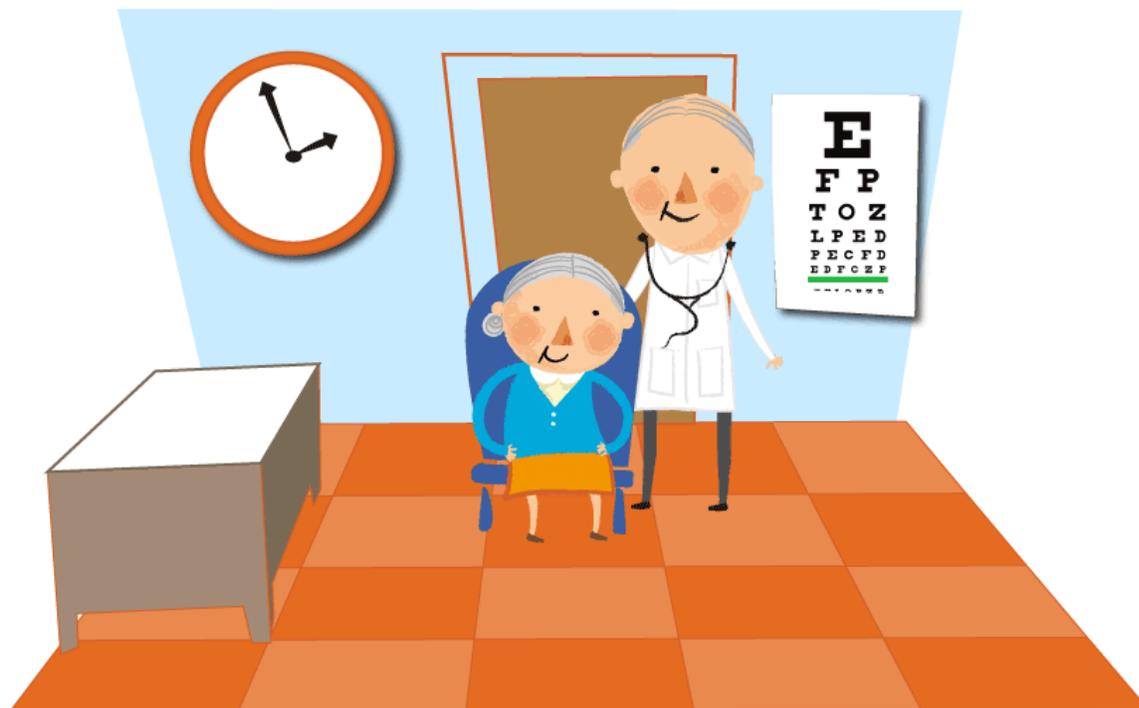
PARTNERSHIP INCENTIVES AND BENEFITS

Health care entities that are reimbursed on a traditional fee-for-service basis may be less interested in collaborating with you than entities participating in some type of population health management or managed care arrangement. That's because fee-for-service providers are driven financially by the volume of services they provide. These providers have fewer incentives to provide care more efficiently at a lower cost.

That being said, some fee-for-service providers may still have other incentives to collaborate with you. For example, a nonprofit hospital may be encouraged to meet its tax-exempt community benefit obligation by providing your property with pro-bono services, like a wellness nurse who

makes periodic visits to your housing property. These hospitals are receiving increased pressure to demonstrate if and how their services produce better quality.

Different health care entities look for different benefits from a housing-health partnership. For example, one managed care organization may be interested in reaching a critical mass of individuals, ranging from very healthy to chronically ill and high-risk populations. Another organization may be less concerned about serving a large number of people. Instead, it might be more interested in finding "super-utilizers" who are driving up the organization's costs. You'll want to have some exploratory conversations with your potential partners to identify their greatest concerns and preferred patient groups.



RESOURCES TO HELP IDENTIFY HEALTH CARE PARTNERS AND REFORM INITIATIVES

The health care landscape is complex, confusing and changing rapidly. If you aren't already familiar with that landscape, review the following resource table. It will help you identify or recognize potential health care partners in your area, and get more information about reform initiatives that are occurring in your community.

Medicare Accountable Care Organizations (ACOs)

- List of ACOs, including the ACO's website that frequently identifies participating hospitals, physicians or physician groups: <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ay8x-m5k6>
- List of hospitals, physicians or physician groups participating in a Medicare ACO: <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/pfam-u3vp>

Patient Centered Medical Homes (PCMHs)

- <http://recognition.ncqa.org>

Federally Qualified Health Centers (FQHCs)

- http://findahealthcenter.hrsa.gov/Search_HCC.aspx

Medicare and Medicaid Integration Activities

- Information about and states participating in the Demonstration to Integrate Care for Dual Eligible Individual initiative: <http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared>
- Other state initiatives to integrate care for dual eligible individuals: <http://www.nasud.org/initiatives/tracking-state-activity/state-medicare-integration-tracker>

State and Local Reform Initiatives

- Check state agency websites to understand more about possible health care reform activities. Check those agencies in your state that are responsible for Medicaid, health and human service programs and aging programs.
- National Association of Area Agencies on Aging
<http://www.n4a.org>
- National Council on Independent Living - Centers for Independent Living
<http://www.ncil.org>
- National Association of State Mental Health Program Directors
<http://www.nasmhpd.org>

Community Affiliated Health Plans

- www.communityplans.net

Create Networks of Housing Organizations

The economics of care delivery may mean that a health care provider must deliver services to a large volume of older adults in order to make that service delivery economically feasible. You can help your prospective partner achieve its desired volume of patients by creating a local network of housing properties interested in developing a housing-health partnership. Once you have this volume of patients, it will be much easier to attract health care partners and to meet your mutual goals.

Creating a network of affordable senior housing communities may be advantageous if:

- Your property has only a portion of residents who engage with a particular health care entity.
- Your resident assessment indicates that you have relatively few high-risk residents to make it worthwhile for a health care organization to collaborate with you.

Increasingly, health care providers are being rewarded for managing the services of large numbers of people. So, bringing a larger group of older patients to the table may pique a provider's interest in collaboration.

Case in Point

The Housing with Services Program in Portland, OR, described on page 23, is a formal collaborative of three affordable housing organizations and multiple home- and community-based service and health care organizations. The collaborative employs a centralized care coordinator and health navigator to provide and manage services for residents across 11 buildings. The program receives financial support from the state's largest insurer of low-income individuals.

For example, an Accountable Care Organization (ACO) that must enroll a minimum of 5,000 participants may not be interested in collaborating with only one housing community. But that same ACO may welcome the opportunity to access a larger pool of individuals across multiple housing properties. The ACO may also prefer working with a centrally located entity that coordinates services across properties, rather than working with each property individually. A housing property network that coordinates service delivery for a larger group of patients could be more efficient administratively and may have the potential to generate better outcomes and/or cost savings from a larger group.

Case in Point

In exploring a partnership with an affordable housing community in Austin, TX, United Healthcare discovered that plan members also lived in several other housing properties. Up until this point, United Healthcare had not been engaged with members living in these housing properties. A housing-health partnership represented a good way to find members and interact with them.

Develop the Value Proposition or Business Case

Developing the business case for a housing-health care partnership requires that you understand your potential partner's interests, goals and financial incentives. You also need to understand how your congregate environment, staff and resident population can help that partner achieve success.

KNOW YOUR POTENTIAL PARTNER

It is important that you understand your potential partner's interests and goals. You also need to know what motivates your partner and what constitutes success for that organization.

Health care entities may be interested in addressing specific health conditions among a property's

resident population. Or they may want to take a broad approach to helping individuals better manage their care. Mission, programmatic requirements, expected performance measures and/or financial interests may also drive these entities.

Ask these questions as you consider how you can sell yourself to potential health care partners:

- **Does your prospective partner have specific programs or initiatives that might directly address the health care education and management needs of your resident population?**

Let's say that a large number of residents in your housing property have diabetes. A hospital or health care system with a strong diabetes management program may be interested in collaborating with your organization to help residents better understand and control this chronic condition. The partner may also have additional expertise in other health education areas like nutrition, exercise and depression management. Education initiatives like these could benefit from a partnership with your property or housing network.

- **Can you leverage the prospective partner's social accountability obligations?** All non-profit organizations are required to provide benefits to their communities in exchange for their tax-exempt status. Nonprofit hospitals have specific community benefit investment and reporting obligations. Beyond providing charity care, the hospital may also sponsor activities to improve population health in its community.

Check your hospital's website to read about its community benefit or outreach plan. This plan should tell you about community needs that the health entity has identified, and how it is currently addressing those needs. The hospital's annual report should also contain details about its community benefit investments.

A nonprofit hospital's community benefit obligation includes a requirement to conduct community needs assessments every three years. The assessment process must be

collaborative and comprehensive, and must include input from community members. This presents an opportunity for an affordable senior housing provider to present data and information about its resident population. Housing providers can also encourage non-profit hospitals to examine how residents of affordable senior housing are utilizing their facility and whether there would be a need to provide additional services to this population.

Case in Point

Greater Baltimore Medical Center (GBMC) identified "access to care services" as a need among low-income seniors in its geographic area. As part of its community benefit program, GBMC employed a nurse practitioner (NP) to provide education and primary care services at five affordable senior housing properties. The NP spends one day per week at each property, helping to coordinate care and providing guidance on needed actions and resources.

Organizations such as continuing care retirement communities (CCRCs) also have social accountability obligations. They may also be interested in collaborating with a housing property around health and wellness activities as an avenue for sharing resources with their community.

- **Is the prospective partner participating in or subject to a specific health reform initiative that may impose certain goals or requirements on them?** Try to understand what the health entity is attempting to achieve. It may be striving to meet specific performance measures, like those laid out for an Accountable Care Organization. Or, it may have more global aspirations like improving management of chronic conditions or reducing use of acute care services.

KNOW WHAT BENEFITS YOU BRING TO POTENTIAL PARTNERS

By now, you should have a good sense of what your potential partner is trying to achieve. Now it's time to gain a better understanding of how you can help that partner reach its goals.

Deciding how you and your prospective partner work together will probably require an ongoing discussion between you and that partner. However, you may be able to strengthen your position by identifying in advance the potential benefits that your affordable senior housing community can bring to the health entity with which you would like to collaborate. This approach could be more effective than simply asking the health entity to provide services to residents living in your property.

Remember: Your ultimate goal should be to create a mutually beneficial partnership. You have to help the health care partner see how it will gain from—and not just give to—the partnership.

Many health care entities are beginning to understand the important role that housing can play in patients' health. However, they often have only a partial understanding of a housing property's value. Most health care entities see housing only as a roof over someone's head. To them, housing properties are places to relocate homeless people off the street or get individuals out of nursing homes.

A few health care entities are investing in the creation of new housing properties or are asking housing communities to set aside units for their patients. Other health care entities are focusing on the impact that poor quality housing can have on an individual's health. These entities are working with legal aid groups to help force landlords to make repairs or remediate the unhealthy or hazardous housing conditions in which their patients live.

There's no doubt that safe, quality housing is important. But housing can be much more than just a structure. Viewed broadly, housing can play a critical and active role in helping health care entities better support the care needs of their patients and improve population health.

CREATING YOUR LIST OF CONTRIBUTIONS

What can you or your network of housing providers offer to a health partner? You will need to give this some thought.

Before you create a list of your potential contributions to a housing-health partnership, review the section starting on p. 4 of this guide. It discusses many of the issues that health care entities face as they deliver services to their more complex and vulnerable older patients. It also presents checklists of how a housing partner might help address those challenges.

Be sure to tailor your partnership contributions to the interests of the potential partner. Here are some things to share with your prospective partner as you build your value proposition:

1. **Describe the resident population of your housing property.** Include information about residents' health, function, social status, needs, insurance and health care providers. Describe how your property's population intersects with the group of patients/clients that the health care entity is seeking to serve or with the broad health-related needs that the health care entity is trying to address.
 - **Is the partner trying to support individuals who face health management challenges or are at risk for unnecessary utilization of acute services?** Provide information about the proportion of residents with multiple chronic conditions and functional limitations. Include details about residents':
 - Average number of medications.
 - Level of appropriate and inappropriate emergency department and hospital visits.
 - Personal mobility and transportation limitations.
 - Family support networks.
 - Social circumstances, like health literacy levels.

HOW HOUSING PROPERTIES CAN HELP FACILITATE POSITIVE HEALTH OUTCOMES

Affordable senior housing properties—through their own resources and/or by incorporating the resources of a health partner—can help health care entities reach a range of possible goals for their patients’ health and health care utilization. Here’s what housing can bring to the table.

- Ability to help health care partners identify and connect with specific populations, including:
 - Individuals with multiple chronic conditions.
 - Disadvantaged populations facing concurrent social-related challenges.
 - Populations with limited health literacy and low patient engagement.
 - Individuals who could benefit from health promotion and screening activities.
 - Complex individuals at risk for high health care utilization and high costs.
- Onsite staff members who can help a health care entity meet its goals. That staff has the ability to:
 - Build knowledgeable and trusting relationships with residents/patients.
 - Monitor residents over the long term during regular interactions. This provides the opportunity to notice emerging health issues before they come health crises.
- Encourage and support individuals so they will adopt and sustain healthy behaviors.
- Provide a flexible and extended in-person presence at the housing property.
- Help residents address social-related needs and reduce barriers to care.
- Congregate environment that facilitates economies of scale for providing services more efficiently, both onsite or through telehealth.
- Venue for offering health promotion and prevention activities. Such venues can provide:
 - Access by health care partners to multiple at-risk individuals who would benefit from education and screening in such areas as disease management, nutrition, fitness and falls.
 - Onsite staff to identify individuals who would benefit from programming, and encourage their participation in that programming.

- **Is the partner worried about readmissions following a hospital stay?** Describe the features of your population that might make residents more vulnerable to a readmission, including:
 - Multiple chronic conditions.
 - Multiple medications.
 - Limited health literacy.
 - Weak support networks.
- **Is the partner interested in teaching people how to adopt healthy behaviors and how to increase their capacity for self-care?**

Discuss these and other relevant features of your housing property’s population:

- Types of chronic conditions.
- Physical activity levels.
- Nutritional status.
- Smoking habits.
- **Does the partner have programs targeting specific diseases or health issues?** Provide details about:
 - The resident population’s experience with the health issues in question.
 - Other information about why residents may be challenged in managing their health conditions.

HOW HOUSING PROPERTIES CAN HELP FACILITATE POSITIVE HEALTH OUTCOMES (cont.)

- A convenient location for program participants to gather for programs. Ease of access will help promote initial and continued participation.
- An opportunity for program participants to interact with a network of peers who can offer support and encouragement.
- Assistance in addressing social determinants of health. Housing property staff can:
 - Ensure that physical living space is clean, livable and safe.
 - Support residents in applying for and maintaining public benefits and health insurance subsidies.
 - Help residents identify and access transportation assistance.
 - Connect residents with a variety of community-based supports, such as congregate meals.
- Assistance in supporting higher risk patients. Housing staff members can:
 - Link residents with community-based services and help them access needed supports.
 - Monitor and have regular interaction with individuals.
- Help residents navigate the health system and follow through on physician orders.
- Encourage a connection with primary care and appropriate use of health care services.
- Support with care management and navigation. A nurse or health educator working in the housing property could:
 - Answer questions about health conditions and physician directives.
 - Monitor vital signs and help identify possible changes in condition.
 - Provide one-on-one education in a flexible manner and comfortable environment.
 - Help residents communicate with their physicians.
 - Coordinate efforts to address residents' health care needs.
 - Provide transitional care support for 30 or 60 days after hospital discharge, and beyond.

2. **Describe the infrastructure and resources you can bring to a partnership.** These resources might include:

- **Staff members**, like a service coordinator, who can assist and support residents.
- **Programming** that could impact an individual's health. These programs might include congregate meals, transportation services or fitness activities.
- **Relevant community partners** that can offer additional resources at your property to impact the wellbeing of the health

care entity's patients. This information can illustrate how the partner would be part of a community network.

- **Physical spaces** where one-on-one meetings or group activities could take place.

3. **Show an interest in and understanding of the partner's interests and goals.** Discuss how the health entity can leverage the population you house, and the resources you bring, to address those interests and meet those goals. Identify goals that you and the health entity share.

4. **Present data illustrating the impact of your programs or efforts.** If you don't have information like this, consider sharing data from studies of other housing and health programs. These studies may not mirror what you have in mind for your partnership. However, they can provide some important clues about the effect these types of collaborations can have. See the Appendix for highlights of some relevant study outcomes. Also consider using some specific anecdotes that provide examples of how you might be able to help a health care entity meet its goals. Tailor your examples to the specific types of issues you are discussing with the entity.

Case in Point

A service coordinator noticed a resident didn't appear to be behaving like her normal self. She decided to go visit the resident in her apartment to see if she might be able to identify what could be going on. In the course of the discussion, the service coordinator discovered that the resident had some new prescriptions and was completely confused about how to take them. One medication was to be taken every other day. For another, a half tab was to be taken twice a day. Because the service coordinator was *onsite and able to identify a change in the residents' behavior, she was more likely to likely to help identify a complication before it grew into a larger health problem.*

Initiating and Cultivating a Relationship

So far, you've explored potential partners and their interests. You've also considered how collaboration could benefit both you and your partner. Next, you'll want to initiate discussions with the health care entity. If you don't already have some sort of connection with the organization, you'll need to identify the most appropriate contact person.

FINDING THE RIGHT DOOR

Health care entities are diverse in their function, staff members, size and geographic spread. In a smaller community-based organization, you might be able to approach the chief executive officer or a board member about a possible partnership. With a larger organization, however, it might be best to make your first encounter at a different administrative level.

Sometimes you will have to knock on several "wrong" doors before you get to the right one. None of these encounters is a waste of time, however. Just focus on getting your message out. Even a knock on the wrong door can help familiarize key organizational leaders with that message.



USING YOUR EXISTING CONTACTS AND CONNECTIONS

Have you been actively engaged with other community organizations or activities? If so, be sure to take advantage of the connections you've established. Ask one of your community partners to help you identify potential contacts within a potential partner organization. Perhaps an existing partner could facilitate an introduction to a potential partner.

A member of your board may be employed by or serve on the board or advisory council of the health care entity with which you'd like to collaborate. Ask that person to help you initiate a conversation with the potential partner. If you don't have anyone with this connection, you might want to think about bringing on a board member from a health care entity. This board member could provide your board with the health care perspective and carry a message about the value of the housing community back to his or her organization.

Similarly, look for opportunities to get involved in conversations around health-related initiatives in your state or local community. Housing organizations are rarely at the table for these discussions. As a result, health and community organizations often aren't familiar with the potential role that affordable housing settings can play. These organizations don't connect your activities to their activities.

STUDYING THE ORGANIZATIONAL CHART

Look at the health care partner's mission and organizational chart. Approach a vice president or director whose title aligns best with the mission and goals of your organization and/or what you are proposing to accomplish together. That person might be the:

- Vice president of community affairs.
- Director of mission integration.
- Director of population health management.
- Head of the geriatric division.
- Physician in charge of internal medicine.
- Head of case or outcome management. This person is likely to be responsible for helping the health care entity reach the goal of preventing 30-day readmissions or reducing unnecessary emergency department use.
- Physician in charge of a family practice that serves a large proportion of the resident population.

TOUCHING BASE WITH THE BOARD

Approach one of the health care entity's board members. Tell that person about your potential collaboration and how it can benefit the health care entity. Ask the board member to recommend an appropriate contact within the organization.

How To: Structuring & Implementing the Partnership

Congratulations! You've identified a health care entity that is interested in partnering with you or your network of affordable housing communities. Now you have to figure out the details of your collaboration. You and your partner have probably already had exploratory conversations about what you want to do, at least in a big-picture sense. Now you'll need to dig into how you are going to do it.

The details you will need to hammer out will vary, depending on the nature of the collaboration you are considering. But here are some common questions that you and your partner should discuss:

- **What services will be provided?** In some cases, the list of services might be pretty clear-cut. For example, the health care partner may want to deliver health education programs, such as the Chronic Disease Self Management Program, at the housing property. However, you and your partner may also be considering a set of services that are not well defined. For example, the health care partner might agree to send a clinician, such as a nurse, to the property. In this case, you will need to clarify the types of services the clinician will and will not provide. The list might include hands-on care like vital signs monitoring or medication review. It might also include such care navigation/coordination services as linking residents with primary care physicians and specialists, testing services, or hospital discharge planners.
- **Who is the target population?** You and your health care partner need to decide on the population that will be receiving the services you identify. Some health care entities may be interested in supporting only high-need, high-risk individuals. This may be appropriate if a particular service is designed for a targeted purpose or population, like transitional care from hospital to home or targeted disease management. However, you may also want to help the health care entity understand how its support for a broader range of residents may also help it achieve the goal of better population health management.
- **How will the services be delivered?** Will the health partner deliver services? Or will the health entity provide funds so the housing provider can deliver or arrange for those services? Perhaps the housing property and health entity staff will deliver services jointly. Maybe a health educator or wellness nurse from the health care entity will team up with the resident service coordinator at the housing property to comprehensively address health and social service needs. In this case, you need to discuss how the two roles will work together. (Keep reading for more tips on good communication between partners.)

You also need to discuss where services will be delivered. This locale may vary, depending on the nature of the service. For example, if the service involves one-on-one engagement with a clinician, will health providers see residents in an office space or in residents' apartments? If this is a service the health partner can bill for, reimbursement policies may dictate where the services are delivered.

- **What will the service frequency be?** Will the services be available daily, weekly or monthly? How many hours per day? Will services be available on weekends? Will service schedules be set or flexible?
- **How will the services be funded?** You've probably already discussed funding, to some degree, during your initial conversations with your partner. It's likely that you have discussed whether the health care partner will be sending its staff or other resources to the property or whether your partner will give you funds to provide the services. Most existing partnerships do not involve direct funding of housing staff. However, the opportunities for this type of arrangement are expanding in light of new health care reform initiatives at the state and local levels.
- **What are the requirements and expectations for continuing the partnership?** You also need to clarify the requirements for—and both partners' expectations about—continued in-kind or financial support from the partner. Does your health care partner need to see a minimum volume of resident participation in its services on an ongoing basis? What are the expected outcomes? Does the health care partner need you to collect certain data to help it track these outcomes?
- **What physical infrastructure is needed?** There are a number of questions to consider in this area, including:
 - What type and amount of space is needed? For example, does the program need communal and/or private office space? Will any spaces require renovation? If so, who will be responsible for

handling these renovations and who will bear the cost? Will the housing property charge the partner rent for any space the partner occupies? Different financing sources may have varying requirements around the use and leasing of space. You'll need to consider any specific parameters for your type of property.

- Will any special equipment be needed? What special needs will the health care partner have? For instance, will your partner need locking file cabinets to store onsite records? Projectors or televisions and video equipment? Exam tables or any other medical-related equipment? Which partner will be responsible for supplying needed equipment?
- Will the partner have any needs related to the Internet or other technology? For example, does the partner need a wireless Internet connection so it can use laptops or tablets to access electronic health records?
- **What information will the partners share?** One advantage of a housing and health collaboration is that the partners can leverage each other's understanding of an individual to better assist that person. However, you and your partner should come to a clear understanding about what details are appropriate to share and under what circumstances. Communication around health-related information can be very complex and sensitive. Due to Health Insurance Portability and Accountability Act (HIPAA) requirements, health care providers are understandably careful about what information they share about patients. While HIPAA may not forbid all communication between the service provider and the housing provider, great care should be taken by both parties in assessing the legal boundaries of their arrangement, since even an unintentional violation of HIPAA privacy or security requirements carry the potential for significant fines. Both parties, therefore, should involve legal counsel in structuring their relationship and in implementing their program.

Similarly, if there is the potential of sharing written or electronic data about residents, you'll want to discuss what is permissible.

If counsel determines that it does not implicate any HIPAA prohibitions, a health care provider, without sharing specifics about a patient's health situation, might tell a housing property service coordinator: "Mrs. Smith could benefit from more healthy food options. Could you help her with identifying possible resources?" A property service coordinator could tell a hospital discharge planner: "Mrs. Smith doesn't have a good social support network and she could benefit from home care assistance when she first comes home from the hospital." The health care provider and housing property aren't sharing detailed health information about the resident. Using their knowledge of the resident, however, they are asking their partner to provide resources or assistance that would benefit the resident.

In addition to the types of information they will share, the partners should also discuss the safeguards that need to be in place to ensure that a resident has authorized the partners to share information about them. Any authorization will need to assure residents that information will be accessible only to those individuals identified in the authorization and/or those necessary for the delivery of services. Again, however, HIPAA has very specific requirements for authorizations so it is best to consult with legal counsel at the outset of the process.



- **How will the partners communicate?** There are several communication-related questions to consider, beyond what information partners will share about residents. For example:
 - How will frontline delivery staff communicate about resident issues? Will they meet informally and discuss issues as they arise? Will they have a formal meeting process? For example, the partners might have a periodic meeting during which they discuss concerns about residents they are jointly assisting or monitoring. Who will be a part of this meeting? What type of documentation and forms will be used to facilitate good communication?
 - What process will the partners use to monitor and evaluate the program/partnership? Inevitably, new programs and partnerships bring with them kinks that must be worked out. As you and your health care partner gain experience with one another, you should take stock of the partnership/program, learn from the challenges you've faced, and make needed adjustments. Partners should also develop a process for updating each other about any developments in either organization that are relevant to the partnership. It's a good idea to set up formal procedures and policies for checking in and resolving concerns. Who will be involved in these discussions? How frequently will they happen? What will be the process for resolving issues?
- **What program data will the partners track?** Program performance will be a key way to keep your partner engaged and perhaps entice them to deepen the collaboration in the future. The right data can help you determine the success of your program and how it can be improved. It can also help partners understand their return on investment. You must first consider what type of data you will collect. Will you track resident participation in programs and services? What about

resident health-related information, such as vital signs, falls or emergency department visits? Will you conduct surveys with residents that ask about their satisfaction with services or how they think the services are benefitting them? It is essential that your partners understand that all information sharing by residents is voluntary.

Next, you'll need to consider how to track the data. Some data may be tracked onsite at the housing property by either the housing property or health care staff. If so, what is the system you'll use for tracking the data? Your health care partner may track other data through its medical records or other administrative systems.

The type of data you collect will be determined by the nature of your services and interventions, as well as the outcomes you are hoping to achieve.

- **Will the housing provider maintain a “preferred provider” relationship with the service provider?** Health entities will be interested in maximizing the rate of resident participation in programs and services as a way to help justify their investment in the partnership. The housing provider needs to be mindful of how it engages with entities that are possible competitors to its health partner and/or may dilute program participation. A housing property cannot limit residents' choice of service providers. But having a partnership with one provider is allowable as long as it is clear to residents that they are not required to use that specific provider. It is important to make these parameters clear to your health care partner.
- **How will you promote resident engagement?** Adequate resident participation in programs and services will be an important part of keeping your partner interested in working with you. How will the two organizations draw residents out of their apartments and keep them interested in programs and services? Some options include holding community sessions to inform residents about the new program, engaging resident leaders as liaisons to help you and your partner shape

the service offerings and recruit participants, and providing some type of incentive to residents who participate.

In addition, you should inform your health care partner about what features and attributes of the program are most likely to engage and retain residents. For example, one housing property in New Jersey established a partnership with a primary care practice to operate an onsite clinic. The clinicians, however, did not know the residents and failed to develop the type of personal relationship that would help the residents feel that the clinicians cared about their patients. As a result, very few residents used the clinic or promoted it among their peers.

This clinic learned an important lesson many other failed enterprises have also learned: older adult residents generally do not want to change their doctors. The convenience of seeing a primary care physician right in your apartment building might seem like a “no brainer.” But older adults are often reluctant to change providers, particularly if they do not know and trust the new provider. This does not mean that all onsite clinics are doomed to failure. Many onsite clinics have found residents do welcome the opportunity to see an onsite clinician who can serve as a liaison with the resident's own primary care doctor.

- **How will insurance and liability concerns be handled?** Many housing providers are concerned about the potential liability associated with offering health-related programs at their property.

As it does when executing any vendor agreement, a housing provider should consider the risks associated with offering programs in collaboration with a health care entity, and insure against those risks accordingly. The governing documents of the partnership agreement should address liability insurance for the services provided. The health care partner should insure against the risks associated with services provided by their employees or contractors in the housing community.

The housing provider might also want to inform its insurance carrier about its relationship with the health partner so that all risks are adequately addressed. Your insurance carrier may suggest language or clauses that should be included in the contract or memorandum of understanding to protect you from liability concerns. A well-drafted contract or memorandum of understanding that addresses liability risks should also help keep insurance costs at a reasonable level and may result in no increase, or a minimal increase, in insurance premiums.

- **What type of structure will you use to govern your partnership?** There are a variety of documents that can be used to govern a housing and health care partnership. These governing documents vary in their degree of simplicity, as well as the legal obligations they require and the protections they provide. You and your partner might sign a Memorandum of Understanding, a Memorandum or Letter of Agreement, a contract, or form a Limited Liability Corporation. Whatever form your government document takes, it should

clearly describe what you and you partner(s) have agreed to do together, how you will work together, who will be responsible for what activities, and how partners will hold each other accountable.

It is possible to establish a partnership through an informal agreement. However, there are certain advantages to establishing a formal relationship with formal documentation. For instance, a formal document helps to ensure the continuity of a partnership. Informal agreements tend to rely on the relationship developed between individual personalities who might leave the organization(s) at some point in the future.

The type of agreement you employ in your partnership will be driven by the complexity of the partnership structure and the types of services you are offering, as well as the particular financial arrangements that are made. Nonetheless, a formal written agreement is preferable to an informal agreement between the parties, so consultation of legal representation might be beneficial.



The Changing Landscape for Health Care Providers

Policy makers and health care leaders across the country have long emphasized the need to improve quality, reduce per capita health care costs, and improve the patient experience of care. This “Triple Aim” underpins efforts to reform the U.S. health care system by transforming several characteristics that are believed to contribute to poor outcomes. These characteristics include:

- Volume-based payments that do not encourage prevention or care coordination, and do not reward the delivery of high-value care.
- A focus on treating people when they become sick, rather than keeping people healthy by preventing illness and disease.
- A fragmented delivery system that does not support communication and coordination among providers and across care settings.

Multiple efforts to change these problematic characteristics are underway. Many pilot initiatives have been developed over the past decade. Passage of the 2010 Patient Protection and Affordable Care Act (ACA) hastened broad implementation and expansion of these initiatives.

The ACA encourages and promotes reforms both in how care is organized and delivered (the “delivery system”) and in how organizations are paid for the services provided (the “payment system”). This transformation encourages a shift in payment systems from one that pays per service (known as a “fee-for-service” or “volume-based” system) to one that pays for value (known as a “value-based” system). Concurrent initiatives are encouraging the health care system to shift from focusing narrowly on individual patients to improving the health of populations. This shift is commonly referred to as “population health management.”

KEY CONCEPT #1: VALUE-BASED PAYMENT MODELS

Changing the way providers are paid is a key strategy in reforming the health care system. The current fee-for-service payment system pays providers for the volume of services they provide, regardless of patient outcomes. The more services patients receive, the more their providers get paid.

Additionally, providers are not reimbursed for certain services or processes that could help facilitate better outcomes. For example, a physician practice could employ a nurse to coach patients so they could better manage chronic conditions, and to help coordinate care that addresses patients’ health-related needs. Hiring a nurse for this purpose would cost the practice money. That investment is hard for many practices to justify, given the fact that they typically will receive no reimbursement for the service. In addition, there is no reward for any good outcomes the nurse might facilitate and no penalty for any poor outcomes that the nurse might help prevent.

Payment reform attempts to enhance value by incentivizing the delivery of higher quality care at lower costs. Value-based purchasing broadly refers to a strategy that holds health care providers accountable for the quality and cost of the services they provide through a system of rewards and/or consequences for those who meet, or fail to meet, a set of established performance measures. While public and private payers are still transitioning to value-based reimbursement systems, many experts predict it will eventually become the nation’s dominant payment model.

Types of value-based payment strategies currently being employed include: Pay-for-Performance, Shared Savings, and Bundled Payments.

Pay-for-Performance

Pay-for-Performance (P4P) refers to a payment arrangement in which providers are either rewarded with bonus payments or penalized by reduced payments based on their ability to meet specified performance measures. For example, a physician practice may be rewarded for reductions in hemoglobin A1c levels among its diabetic patients. A hospital may be penalized for excessive preventable readmissions in certain diagnostic categories. To date, most P4P programs have emphasized bonuses. However, as the Center for Medicare and Medicaid Services develops initiatives like the Readmission Reduction Program and the Hospital-Acquired Conditions and Present on Admission Program, providers are beginning to encounter the downside risk of P4P programs.

Shared Savings

In a shared savings model, providers are rewarded for delivering high quality services while reducing health care costs. If a health care provider meets certain quality measures and reduces total spending for its patient population below the level the payer would have expected to pay (or a similar benchmark), then the provider is rewarded with a portion of the savings.

While P4P and shared savings programs are similar in concept, they differ in the details. Most P4P programs offer bonuses to individual providers that are based on a defined set of indicators within the provider's scope of control. This would include a hospital's rate of infections or a primary care physician's appropriate use of screening tests. Shared savings programs require a greater degree of integration among providers because they typically offer incentives to a group of providers and reflect total population quality and costs.¹⁹

Bundled Payments

A bundled payment reimbursement model pays health care providers a lump sum to care for a patient for a defined episode of care or amount of time. Episodes of care can be defined in different ways, cover varying periods of time and include varying providers.²⁰ For example, these

episodes may cover one year for a chronic condition, or the length of the hospital stay plus 30 days post-discharge. A sole hospital or a group consisting of a hospital and ambulatory care providers may be involved in the episode of care.

Bundled payment amounts are based on the expected costs for the episode. Payment for the episode of care often is adjusted based on financial and quality performance measures. Typically, bundled payments are designed for hospital-based procedures that may require both pre-hospital testing and post-hospital care by a skilled nursing home or home health agency.

Bundled payments put providers at risk. The health care providers must bear the extra costs when patients experience greater-than-expected complication rates.

KEY CONCEPT #2: POPULATION HEALTH MANAGEMENT

The goal of population health management is to keep a defined group of patients as healthy as possible, thus minimizing the need for expensive interventions such as emergency room visits or hospitalizations. Our current health care system has been criticized for focusing on treating people only when they are sick, rather than preventing disease and illness in the first place. But keeping people healthy means that providers must organize and deliver care in a different way than they have in the past.

Population health management requires that the health care system:

- Places a greater emphasis on prevention and health promotion activities.
- Considers the upstream factors—including education, income and living conditions—that also influence health outcomes in a population.
- Coordinates care across providers to ensure that an individual's care is not fragmented and that someone is managing that person's spectrum of care.

- Involves patients in their care while encouraging them to take an active role in managing their health.

Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) are two delivery care models focusing on public health management. ACOs typically organize care at a system level, while PCMHs help individual provider practices organize care more effectively for their patients.

Accountable Care Organizations

An ACO is a network of providers who accept shared responsibility for the quality and cost of health care of a defined patient population. ACOs can include physicians, hospitals and other health care providers. They must have an adequate number of primary care professionals.²¹

Providers participating in an ACO are eligible to receive a share of any savings achieved through their improved care delivery, provided they meet established quality and spending targets. To achieve these targets, ACOs focus on strengthening communication and coordination between providers and helping its patients.

Although the ACO concept is not new, the ACA spurred the growth of ACOs with the creation of the Medicare Shared Savings Program. In January 2014, there were 606 ACOs across the country. A little over half were Medicare ACOs covering over 5.3 million Medicare beneficiaries, or about 10% of the Medicare population.

Patient-Centered Medical Homes

The Patient-Centered Primary Care Collaborative defines the Patient-Centered Medical Home (PCMH) as “a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.”

PCMH initiatives emphasize the primary care office as the organizer and coordinator of all patient-related medical activity. Most PCMH programs receive enhanced fees or bonus payments based on delivery of specific services, achievement of defined performance goals, or a

combination of the two. Typically, these programs assess performance using a mix of metrics that encompasses clinical quality, patient satisfaction, total cost, appropriateness, and possible overuse of services.²²

As of December 2013, almost 35,000 providers across the country have achieved recognition as a PCMH through the National Committee on Quality Assurance, the primary accrediting body for PCMHs.²³

Managed Care

Managed care is any method of organizing health care providers to achieve the dual goals of controlling health care costs and managing quality of care. Commonly, managed care is thought of as a type of insurance plan. Managed care plans have contracts with a network of health care providers to provide services for plan members at reduced rates. The plans receive a set rate for each member, or capitation, to provide all included health services.

Obviously, managed care is not a new concept. However, as the federal and state governments are looking for ways to better control the health and long-term care costs of their most vulnerable populations, they are increasingly turning toward managed care as a mechanism.

Using new authority under the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) has launched demonstrations that seek to improve care and control costs for people who are dually eligible for Medicare and Medicaid. People who are dually eligible often have complex physical, behavioral, and/or psychosocial needs and have not been well served by our fragmented delivery system.

Under the Financial Alignment Initiative for Medicare-Medicaid Enrollees, several states are testing models to integrate care and align financing for dual eligible beneficiaries. Most of these states are piloting the enrollment of dual eligibles into a managed care plan where the plan receives a capitated rate to provide comprehensive, coordinated care to the participating beneficiaries.

Many states have turned to managed care to deliver their Medicaid benefits. Often, long-term services and support benefits have been carved out of managed care, and continued to be delivered through a traditional fee-for-service mechanism. Now, however, more states are transitioning their Medicaid long-term services and supports programs to managed care models too. This transition brings an incentive to help those older adults who are capable of living safely in the community rather than a nursing home.

ASSESSING PROVIDER PERFORMANCE

An increasing focus on outcomes brings with it the need to measure health care provider performance.

There are three kinds of measures used to assess health care improvement:

- **A process measure** records whether or not an activity, such as scheduling an appointment, took place.
- **A quality measure** looks at whether an activity known to be associated with improving the quality of care took place. For example, the diabetes foot exam measure evaluates whether or not the patient had a foot exam within the expected time frames.
- **An outcome measure** evaluates whether the clinical activity made any difference in the patient's health. An example would be whether patients with hypertension have their blood pressure under control.

In value-based payment models, these different types of measures help determine what bonus, share of savings, or penalty a health care provider will receive. Under Medicare's Shared Savings Program, for example, CMS assesses ACO performance through a mix of 33 process, quality and outcome measures. Table 1 details the measures that are used to assess the ACO's performance and to help determine the amount of shared savings that ACO will receive.

The use of outcome measures is not without controversy because health outcomes are often affected by factors beyond the provider's control. For example, providers may follow practice

guidelines for the monitoring of blood sugar levels and counseling diabetic patients regarding their diet. Ultimately, however, patients' eating and exercise behaviors will play a large role in controlling their diabetes.²⁴

A study of Medicaid health plans in California found that offering bonuses to physicians for improving well-child care did not produce significantly positive outcomes in the majority of health plans. Lack of success was attributed to issues like enrollees' lack of transportation and limited staff capacity to conduct outreach to enrollees.²⁵ Another study found that medical groups caring for patients in lower income areas of California received lower P4P scores than others due to the fact that they served patients who experienced language barriers and limited access to transportation, child care or other resources.²⁶

These findings highlight how important it is for medical care providers and other health care entities to engage with community partners, including affordable housing providers as they tackle issues that cannot be adequately addressed or resolved within the confines of a clinic or hospital. Services and supports that help make it easier to access care, better manage chronic conditions, appropriately manage multiple medications, and adopt healthy behaviors will help housing residents maintain their health and quality of life and avoid unnecessary use of costly services.

TABLE 1. Medicare Shared Savings Program Outcome Measures

Measure #	Description
Domain: Patient/Caregiver Experience - Focus on patient's relationship with health care provider, with hope of fostering patient engagement in health management.	
1	Getting timely care, appointments and Information
2	Doctor communication
3	Patients' rating of doctor
4	Access to specialists
5	Health promotion and education
6	Shared decision making
7	Health status/functional status
Domain: Care Coordination/Patient Safety - Focus on the continuum of care delivery required for successful transition from an acute care setting to a lower acuity setting, with goal of reducing costly hospital admissions/readmissions.	
8	Risk standardized all condition readmissions
9	Ambulatory sensitive care admissions: chronic obstructive pulmonary disease or asthma in older adults
10	Ambulatory sensitive care admissions: Heart failure
11	Percent of primary care physicians who qualified for electronic health record incentive payment
12	Medication reconciliation
13	Screening for fall risk
Domain: Preventative Health - Focus on ensuring better population health through early intervention and preventing advancement of disease.	
14	Influenza immunization
15	Pneumococcal vaccination
16	Adult weight screening & follow up
17	Tobacco use assessment & cessation intervention
18	Screening for clinical depression and follow-up plan
19	Colorectal Cancer screening
20	Mammography screening
21	Screening for high blood pressure and follow-up plan
Domain: At-Risk Populations - Focus on five diseases with high incidence rates within the Medicare population.	
22	Hemoglobin A1c Control (<8%)
23	Low-density lipoprotein (LDL) (<100 mg/dL)
24	Blood Pressure <140/90
25	Tobacco Non Use
26	Aspirin Use
27	Diabetes poor control (>9%)
28	% of beneficiaries with hypertension w/blood pressure <140/90
29	% of beneficiaries with Ischemic Vascular Disease (IVD) with complete lipid profile and LDL control < 100 mg/dl
30	% of beneficiaries with IVD who use aspirin or other antithrombotic
31	Beta-Blocker therapy for Left Ventricular Systolic Dysfunction (LVSD)
32	Drug therapy for lowering LDL cholesterol
33	ACE inhibitor or ARB therapy for patients with Coronary Artery Disease (CAD) and Diabetes and/or LVSD

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