Housing With Services: Pooling Resources to Serve Residents of 11 Affordable Housing Properties

PORTLAND, OR

Conducted September 2016

LeadingAge®
Center for Housing Plus Services

MacArthur Foundation

This case study was funded through a grant from the John D. and Catherine T. MacArthur Foundation.
The views expressed are those of the authors and are not those of the foundation.

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Housing with Services: Pooling Resources to Serve Residents of 11 Affordable Housing Properties

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Housing with Services (HWS) in Portland, OR, is a care navigation program based in affordable housing properties that serve older adults and younger people with disabilities. A multidisciplinary care navigation team of physical health, mental health, and social work professionals collaborates with property-based resident service coordinators to provide onsite assistance to residents in 11 affordable housing communities in the Portland metropolitan area.

This case study explores two features of the HWS program:

1. A service delivery mechanism that brings services to residents living in a network of affordable senior housing communities.
2. A funding mechanism that pools resources from multiple stakeholders to support program services.

These program features address two key challenges faced by programs that link affordable senior housing communities with health and supportive services:

1. **Volume:** Individual housing properties may not have a large enough pool of residents to entice service and/or funding partners to collaborate with them on a service-delivery initiative. The volume challenge may be even more problematic for health care providers or payers that have responsibility for only a portion of property residents.
2. **Ownership:** Residents in affordable senior housing properties choose their own health care providers and insurers. Therefore, residents in one housing property may be patients or members of a variety of physician practices, hospital/health systems, Medicare Advantage/Special Needs Plans, or other managed care plans. As a result, no single health provider or insurer serves all of the residents in a property.

Background

The HWS program was initiated by Cedar Sinai Park, an aging services organization in Portland. After acquiring four affordable housing properties between 2007 and 2012, Cedar Sinai Park partnered with Portland State University (PSU) to conduct an assessment of resident characteristics and needs in its newly acquired properties.

The assessment revealed that the properties housed a vulnerable population with high levels of physical and mental health problems and significant challenges related to social determinants of health, including access to nutritional food. These issues put the population at high risk for excessive or inappropriate use of emergency rooms (ER) and hospitals, as well as movement to nursing homes.

In early 2012, the Affordable Care Act (ACA) was passed in response to national discussions about the need to reform health care delivery systems, improve health outcomes, and contain the growing Medicare and

Medicaid budgets. Cedar Sinai Park felt that the vulnerable population in its affordable housing communities, and in other housing properties around Portland, put it in a good position to have an impact on issues that the ACA was attempting to resolve.

Cedar Sinai Park's chief executive officer (CEO) believed that the ACA's goals could only be achieved through greater communication and collaboration among providers working with vulnerable individuals. Cedar Sinai Park began crafting a model based on this idea and started talking with state leaders – including the heads of the Oregon Department of Human Services and Oregon Health Authority and the governor's health advisor – and other potential stakeholders.

Buoyed by a positive response to the concept, Cedar Sinai Park organized a 2011 summit during which approximately 90 participants discussed the potential of developing a care collaboration model based in affordable senior housing communities. Summit participants resoundingly endorsed the idea and began envisioning a planning process to develop and evaluate a pilot model.

At the same time, the State of Oregon was in the process of applying to the Centers for Medicare and Medicaid Services for a State Innovation Model (SIM) grant. SIM grants provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that are designed to improve health system performance, increase quality of care, and decrease costs for Medicare and Medicaid beneficiaries. The state agreed to incorporate the HWS concept into its application and allot a portion of the grant funds to help support the HWS planning process.

Cedar Sinai Park assembled a working group of more than 20 representatives from nonprofit and governmental agencies, including the State of Oregon and Multnomah County, to begin the planning process. The working group met for over a year. Ultimately, a group of nine organizations developed a formal consortium to operationalize the HWS program. These entities included:

- Three housing providers: Cedar Sinai Park, Home Forward, and REACH Community Development.
- One health plan: CareOregon.
- Two mental health care providers: Cascadia Behavioral Healthcare and LifeWorks Northwest.
- Three community-based service providers: Asian Health & Service Center, Jewish Family & Child Services, and Sinai In-Home Care.

In 2013, the consortium members used support from the state's SIM grant and other grant funds to begin planning in earnest for the HWS program.

The group considered various types of organizational models under which it would operate, and ultimately decided to form a limited liability corporation (LLC). The LLC structure required each partner to make a financial investment, defined as an equity share, in the enterprise. Group members believed that this financial stake in the entity's outcome would encourage every partner to collaborate more effectively during the planning process. The HWS LLC was officially formed in May 2014 after the Operating Agreement was finalized and approved by the boards of each partner organization.

The HWS planning process entailed extensive discussions among the nine partners about the mission and values of the new enterprise. The subsequent program development process ran more smoothly because the partners had all agreed in advance about what they were attempting to achieve together.

Cedar Sinai Park's CEO says the group was looking to operate at "the edge of the health care and social service systems" where it could "enhance and create a level of coordination that didn't exist before." This vision guided group members as they developed a coordination model rather than a direct-service model. Several other factors also informed this approach:

- LLC members did not want it to appear that service providers that were not a part of the LLC would be excluded from working with residents in the participating buildings.
- LLC members did not want residents to feel pressured, either directly or through limited access to other providers, to use services that appeared to be provided by the housing property.
- LLC members wanted to leverage and enhance the relationships that some LLC members had developed through their contracted provider networks.
- As a coordination entity, the LCC would not need to meet the same level of Health Insurance Portability and Accountability Act (HIPAA) requirements as a service entity.

The LLC members also wanted the housing with services model to have a resident-centered focus and felt it was important for residents to have a sense of ownership in the project. LLC partners promoted this sense of ownership by creating a resident advisory council that included representatives from each of the 11 housing properties. The advisory council provided input on the needs and interests of residents, and feedback on the model design as it was developed. Advisory council members also helped educate fellow residents about the HWS program, and encouraged their peers to participate in the program once it was launched. The advisory council continues to meet regularly and provides ongoing feedback about the HWS model and the services being provided in their housing properties.

During the planning process, the LLC enlisted PSU researchers to survey residents in the 11 properties about their service needs and interests. CareOregon and other service partners also examined resident service utilization patterns. Based on the information gathered through this analysis, and input from the resident advisory council, the LLC created a model that focused on providing health care navigation, mental health services, culturally specific services, food insecurity interventions, prescription medication management, eviction prevention, and community inclusion and social support activities.

Ultimately, the LLC established the following goals for the HWS program:

- Improve health outcomes for an underserved population.
- Decrease utilization of hospital and ER services.
- Increase residents' use of primary care.
- Delay entry into long-term care when possible, and promote appropriate entry into long-term care when necessary.
- Facilitate care transitions that improve health and prevent re-institutionalization and/or hospital readmissions.
- Increase housing stability and decrease evictions.
- Create a culture of wellness by focusing on social determinants of health; community engagement; and access to culturally specific and effective services, mental health and addiction services, and preventive health care.
- Achieve successful collaboration among partner agencies and with health care stakeholders, including coordinated care organizations, insurance providers, and hospital systems.
- Achieve financial sustainability and measurable cost savings.
- Replicate the HWS model in other locales.

The HWS program began delivering services in September 2014.

Service Delivery Model and Staffing

The HWS program serves just over 1,400 residents across 11 geographically proximate housing properties. Table 1 provides an overview of the resident demographics in each property.

Table 1: Resident Demographics in HWS Properties

	Cedar Sinai				REACH			HomeForward			
	1	2	3	4	1	2	3	1*	2	3	4*
Residents	96	264	155	55	118	55	41	196	277	206	77
Gender											
Female	52%	67%	45%	29%	23%	29%	37%	38%	43%	47%	N/A
Male	48%	33%	55%	71%	77%	71%	63%	62%	57%	53%	N/A
Age											
Under 62	23%	10%	13%	24%	25%**	50%**	63%**	82%	70%	74%	72%
62+	77%	85%	87%	76%	75%**	50%**	37%**	18%	30%	26%	28%
Ethnicity											
Hispanic	N/A	N/A	N/A	N/A	4%	2%	5%	5%	5%	11%	4%
Not Disclosed	N/A	N/A	N/A	N/A	0%	25%	2%	22%	0%	0%	24%
Race											
White	67%	53%	68%	71%	76%	53%	85%	59%	75%	81%	75%
Black	2%	1%	9%	7%	15%	21%	5%	17%	18%	15%	11%
Asian	19%	38%	9%	7%	3%	0%	3%	1%	6%	2%	1%
Pacific Islander/ Native American	1%	0%	2%	2%	3%	1%	0%	2%	4%	3%	1%
Other	4%	1%	8%	0%	2%	0%	5%	0%	0%	0%	1%
Not Disclosed	7%	6%	4%	13%	1%	25%	3%	21%	0%	0%	11%

*Demographics are reported for Head of Households. However, in both properties most households are one-person households, so the reported data are largely representative of all residents. In Property 1, there are 188 heads of household and in Property 2, there are 76.

**Data was reported for residents age 65 and above.

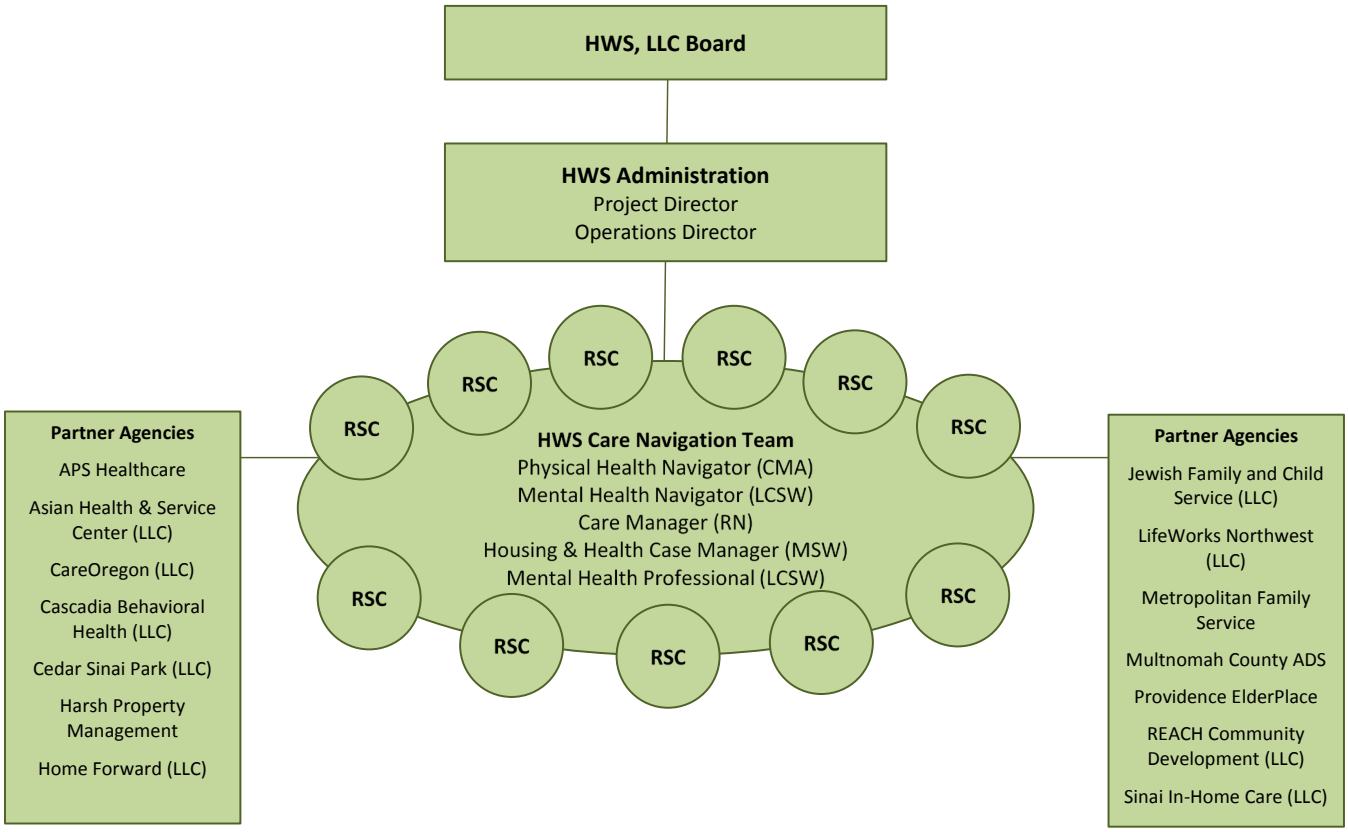
N/A= Not Available

The HWS service delivery model consists of three components:

1. A centralized **care navigation team** works onsite across the 11 housing properties with assistance from culturally specific care navigators, when needed.
2. **Resident service coordinators** work in each of the 11 housing properties, either full-time or part-time.
3. **Partner agencies** (including LLC members) provide targeted services to the properties or have agreed to formal communication and/or coordination channels.

Figure 1 provides a diagram of the HWS organizational and staffing structure.

Figure 1: HWS Program Organizational DiagramCare Navigation Team



Care Navigation Team

The roles of care navigation team members have evolved over time as the LLC partners recognized a need to shift or add skill sets, or as additional partners have become engaged in HWS. However, staffing roles have generally included physical health, mental health, and social work professionals. The care navigation team currently consists of:

- A physical health care navigator provided by CareOregon.
- A mental health care navigator provided by CareOregon.
- A care manager provided in two housing properties by Providence Health Plan.
- A housing and health case manager provided through Asian Health & Services Center and funded by FamilyCare.
- A mental health professional provided by LifeWorks Northwest. (This position is currently in flux, as discussed in the Program Funding section.)

Members of the care navigation team are “plan blind” and will engage with any resident regardless of his or her insurer. The team has dedicated hours each week in each of the housing properties. The only exception is the Providence Health Plan care manager, who works in the housing properties at different hours to maximize a presence in the buildings. The team is available from one to two hours at a time, depending on the size of the building. The Providence care manager is available for an additional four hours each week in each of the two properties the organization serves.

The care navigation team sets up in a common space, where residents can drop by and interact with them. Team members may visit also residents in their apartments during their designated time at the property. However, at least one team member remains in the common space so residents always have a reliable place and time to connect with the HWS program.

Care navigation team members may also visit residents outside of designated hours. These visits might take place at the request of a resident or property staff member, or if CareOregon's or Providence's notification system signals that a significant event, like an ER visit or hospital stay, has occurred and requires follow-up. Team members may also hold education sessions or support groups at alternate times.

Physical and Mental Health Care Navigators

CareOregon's initial in-kind staff included a nurse and a care navigator. The care navigator position initially focused on health system navigation and did not require any clinical licensure. After analyzing the types of questions and requests that the care navigator was fielding from residents, CareOregon decided to require that the care navigator have at least a paraprofessional license. The care navigator would still help residents understand their insurance benefits and access the health system. But the navigator could also check blood pressure, educate residents about their health conditions, and help the team keep tabs on participants' health. This revamped position was filled initially by a licensed practical nurse (LPN) and later by a certified medical assistant (CMA).

After gaining additional experience with resident needs, CareOregon realigned its HWS staff roles again to have a focus on physical health and mental health. When the team's first nurse moved to another job, CareOregon filled the position with a licensed clinical social worker (LCSW), who provides mental health-related supports. CareOregon has kept the CMA in the physical health position because it feels she has knowledge and experience beyond her licensure. However, a nurse will fill this role if the current CMA decides to leave.

CareOregon believes it has achieved the correct staffing roles. However, the health plan is currently evaluating if the physical health and the mental health navigators are being deployed in the most effective manner. The health plan is considering whether the two navigators should be in a building at the same time, how often each navigator should be in a particular building, and whether the navigators should have regular hours, the same number of hours, or more flexible hours based on needs in the property.

The CareOregon care navigators assist residents in a number of areas, including:

- Checking blood pressure.
- Answering health-related questions and educating individuals about their health conditions.
- Helping residents understand their health insurance, including what benefits they have, how to access those benefits, and what providers they can see. In particular, care navigators work with immigrants whose first language may not be English and who may not be familiar with a western health system. When necessary, the care navigators collaborate with culturally specific navigators to address language challenges.
- Encouraging residents to pursue needed initial and/or follow-up care and helping residents put that care in place. This role may involve helping residents call physicians or other health providers.
- Building relationships with residents who have undiagnosed or untreated mental health needs, and encouraging those residents to engage in care. This is often referred to as "pre-engagement" work.
- Helping residents access durable medical equipment, or make needed repairs or replacements.
- Helping residents arrange transportation for medical appointments.

Care Manager

In November 2015, Providence Health Plan began sending a care manager to the two HWS properties with the largest concentration of its members. The Providence case manager spends four hours each Monday at each property. Providence and CareOregon are scheduled to be in the buildings on different days so the two organizations can jointly maximize a presence in the buildings. Staff members from each organization inform one another if they assist a member of the other plan, and if that member needs a follow-up.

A registered nurse (RN) staffs Providence's care manager position and generally provides the same type of assistance as the CareOregon care navigators. The care manager offers blood sugar checks to augment the blood pressure checks provided by CareOregon, provides education about health conditions, helps connect residents with health care providers, answers general questions about insurance benefits, and helps members access their benefits.

The care manager also follows up with Providence health plan members who may have been in the hospital or ER. Providence recently rolled out a real-time alert system that allows the care manager to receive a notice when a member who lives in one of the buildings is in the ER. Once the alert is sent, the care manager will follow up with the resident either in person or by telephone. The care manager can also coordinate with the CareOregon care navigators to follow-up if they will be in the building when the resident returns home.

If a Providence member is hospitalized, the care manager works with the member and/or his or her family to identify unanticipated discharge needs with a goal of reducing the likelihood of a rehospitalization.

Housing and Health Care Manager

In November 2015, the HWS LLC received a grant to support a housing and health case manager position from FamilyCare, a health plan and one of the Portland area's Coordinated Care Organizations (CCO). (See the Program Funding section for more information about CCOs.) Asian Health & Service Center, an HWS LLC member, hires and manages the position.

A staff person with a master's degree in social work (MSW) fills the housing and health case manager position, which focuses on more difficult and complex cases, including crisis situations and eviction prevention. The housing and health case manager functions as a central point of communication and coordination across the entire navigation team and with community agencies. This manager accompanies CareOregon care navigation team members during their dedicated hours each week.

Mental Health Professional

Cascadia Behavioral Health and LifeWorks Northwest, both mental health services agencies and members of the HWS LLC, each dedicated a full-time mental health professional to the HWS properties during the first two years of the project. Initially, the two organizations divided the properties between themselves, with one agency covering participating properties owned by one LLC housing organization, and the other serving properties owned by the LLC's other two housing organizations. These mental health professionals accompanied the CareOregon navigation team members during their designated weekly hours at each property, and also helped service coordinators in the buildings respond to potential mental health needs.

For example, a service coordinator concerned about a resident who is not coming out of his or her apartment might ask the resident if he or she would be interested in meeting with the mental health professional. That professional might then reach out to the resident. Depending on the resident's interest and needs, the mental health professional could provide individual therapy, or help with access to psychiatric medication management services and/or other needed social supports and resources.

Cascadia and LifeWorks charge Medicaid or Medicare accordingly for billable services. However, there are limitations on what services can be billed and under what circumstances. As a result, both organizations have struggled to sustain their staff positions in the buildings. Cascadia Behavioral Health recently pulled its dedicated staff member from the buildings. LifeWorks Northwest is considering whether it will be forced to do the same. The issues surrounding this challenge are discussed in more detail in the Program Funding section of this case study.

Culturally Specific Navigators

The HWS LLC has contracts with four community organizations that assist with navigation services for residents speaking Chinese, Vietnamese, Korean, Russian, Spanish, and Farsi. Those organizations include Asian Health & Services Center, Islamic Social Services, Jewish Family and Child Services, and Catholic Charities. Navigation services include both language assistance and cultural fluency. The LLC pays each organization an hourly rate for any assistance provided. Grant funds support this service.

Resident Service Coordinators

Each participating housing property has a resident service coordinator who is available on a full- or part-time basis. The authors of this case study were only able to interview two service coordinators employed by two of the participating housing organizations, and cannot state that the method of working with the care navigation team is the same for all service coordinators and housing organizations.

Service coordinators are a primary referral source for the care navigation team. Service coordinators generally make referrals to the care navigation team when issues arise that are out of their scope of expertise. This occurs primarily in cases involving health issues, or issues that are complex and have multiple components.

Continued collaboration between the service coordinators and the care navigation team after a referral is made varies depending on the situation and the resident's choice. Because referrals are often based on health-related issues, the care navigation team will often limit its communication with the service coordinators after receiving a referral due to restrictions imposed by HIPAA.

Service coordinators ask residents to sign releases allowing them to share necessary information about the resident to help gain access to services and resources. One service coordinator noted that the resident must also sign a form allowing the care navigation team to share information with the service coordinator. The service coordinator estimated that there is a 50% chance that a resident will give this permission, even after being informed that the service coordinator cannot stay involved after the referral unless the resident signs this form.

Partner Agencies

Some LLC members provide services targeted to residents in the HWS properties, in addition to assigning staff to the LLC's care navigation team.

CareOregon uses two of its programs to help address specific issues facing the resident population, including social isolation and food insecurity:

- **Give2Get:** Give2Get is a peer-to-peer volunteer initiative through which residents exchange services. Members of the care navigation team, service coordinators, or residents can request assistance through the Give2Get coordinator, who then matches the resident who needs a service with a resident who is willing to provide that service. The Give2Get coordinator also helps support the HWS resident advisory council.
- **Food Rx:** The Food Rx program provides access to food and education on healthy eating. Each week, the Food Rx program facilitates the delivery of approximately 1,500 pounds of fresh food to the HWS

properties. The Give2Get program organizes resident volunteers to package and distribute the food to residents across the 11 properties.

The resident advisory council assisted with the development of these two programs and plays an active role in their operation.

Two case managers from Asian Health & Services work across all 11 properties with Asian immigrants, many of whom have limited English language skills. The case managers maintain an office in one of the HWS properties that has the largest Asian resident population. The case managers help these residents identify and access needed services and supports, and understand and navigate their health care needs and benefits. They also provide mental health assistance. Case managers also present group health and wellness programs, including Living Well with Chronic Conditions, in Mandarin and Korean. The authors of this case study were not able to interview Asian Health & Services and are not able to fully describe the case managers' role and interaction with the care navigation team.

The HWS LLC has entered into an interagency agreement with several additional community-based and local government agencies. The agreement establishes a collective understanding of the HWS program's mission and values, and creates a structure to ensure interagency communication, coordination of services, and a process for making referrals.

Program Enrollment and Communication

The HWS program does not currently have formal processes to enroll or assess participants. The LLC took this approach for two reasons:

1. The LLC wanted to create a navigation model through which staff helped residents gain access to and coordinate services.
2. The LLC was concerned that residents who were wary of a formal process or signing up with another program might not seek services from the HWS program. LLC members felt it was important to minimize any potential barriers to resident engagement with the care navigation team. This approach was particularly important for residents with potential mental health concerns.

The care navigation team does have a release of information form, but found that many residents were unwilling to sign it. Many residents initially wanted to ask questions of the care navigation team, but were not ready to engage with a formal system. The HIPPA-required releases discussed the possibility that LLC staff would be communicating with mental health and other health services providers. Residents did not understand why they had to sign such a form in order to have a question answered.

Service coordinators working for the housing properties use their own release of information forms to gain permission to communicate on a resident's behalf with the HWS care navigation team or other entities. The care navigation team does not believe that this release gives permission for team members to communicate with the service coordinator. Instead, the care navigation team uses a separate, HIPPA-compliant release that residents can sign to permit a narrow, need-to-know sharing of information between the team and the housing property.

With the signed form in place, members of the care navigation team can tell the housing staff that they are working with a resident or that the resident is seeking care, and can offer advice on how property staff might work with or support the resident. For example, a care navigator who knows that a female resident has a history of sexual trauma may advise the housing property that the resident may benefit from a particular resource or from interacting only with female property staff.

As residents became more familiar with the care navigation team, many eventually signed the care navigation team's release of information form. However, a CareOregon representative believes that if more residents had signed the forms earlier, the care navigation team would have been more successful in its efforts to connect residents with needed services.

LLC partners are currently discussing how they will handle the release of information form going forward. One option would involve asking residents to sign the form during the move-in or housing recertification process. Residents would be informed that their voluntary signature on the form would allow the housing property to reach out to its partners in the LLC if the resident had a need or might benefit from the HWS program's services.

The HWS LLC is also considering the use of an intake form or questionnaire that would give the care navigation team a baseline understanding of a resident's well-being. This form would help the care navigation team tailor its approach to individual residents and gain a better understanding of building-wide needs. The health plan partners could also use this form as a health risk assessment for Medicare-eligible residents.

The HWS program currently uses the FamilyMetrics software system to track its engagement with HWS participants. The system has two sides:

- The care navigation team uses one side of the software system. All team members can access the system to review the information entered by other team members. This access is possible because team members represent HIPPA-covered entities that have signed a business associate agreement.
- The service coordinators use the other side of the FamilyMetrics system to record resident information and track their interaction with the residents they assist.

The two sides are separated by a firewall, which prevents care navigators and service coordinators from seeing each other's data. This firewall is necessary because the housing properties are not HIPPA-covered entities and, therefore, cannot be part of the business associate agreement that allows members of the care navigation team to share resident information.

The care navigation team, resident service coordinators, care managers from Asian Health & Services Center, and representatives from other communicate partners participate in conferences calls every other week. The calls are led by the HWS operations director and participants address resident issues, share information about Medicaid and Medicare coverage and other service programs, and address systems coordination and cross agency communication challenges. Due to HIPAA-related concerns, the needs of individual residents can only be discussed in general terms during these meetings. Formal case conferences about specific residents can be held if the resident has signed a HIPAA release. For example, the team recently met to develop a comprehensive care plan for a resident with mental health issues, with multiple members of the team contributing services and resources to the plan.

Program Administration

A project director and an operations director manage the HWS program. A consultant currently fills the .7 FTE project director position. The project director:

- Reports to and provides support to the LLC's board of directors.
- Develops and manages relationships with funders, provider partners, and government agencies.
- Provides leadership on program design and development.
- Is responsible for resource development.
- Supervises the operations director.

The operations director is a full-time employee of Cedar Sinai Park who is assigned to the LLC with responsibility for overseeing the program's day-to-day activities. The operations director:

- Develops and maintains referral partnerships.
- Manages collaboration with housing property managers.
- Manages the program budget and performance.
- Develops and maintains program policies and procedures.
- Monitors and ensures HIPAA compliance.
- Works with the care navigation team and resident service coordinator to solve problems arising from complex resident situations.
- Coordinates health promotion events and resident activities.
- Manages the resident advisory council.

Program Funding

The HWS program is funded through a combination of LLC member equity contributions, in-kind staffing by LLC members and other partner organizations, and foundation and health sector Community Benefits grants. Equity contributions and grants are used to support program administration staff and related activities, while the care navigation team has been supported primarily through in-kind staffing arrangements. There is one grant-supported position on the care navigation team.

In an early design concept, the HWS LLC would have employed the care navigation team directly. The intention was to support the care navigation team through a per member per month (PMPM) payment that would be funded through pooled contributions from multiple health care entities. Cedar Sinai Park proposed a PMPM payment that covered costs for all aspects of the program, including administration and care navigation staff.

CareOregon suggested an alternative approach. The LLC partner, which serves approximately 40% of building residents through its Medicare and Medicaid health plans, proposed that it directly staff the care navigation team. CareOregon hoped that other LLC members and community partners would also dedicate staff members to the care navigation team.

CareOregon suggested this approach for several reasons:

- The proposed PMPM was set at a higher level than CareOregon felt it could afford.
- CareOregon had experience providing case management and health navigation with high-risk/high-utilization populations through other programs it already operated.
- CareOregon wanted the opportunity to "roll up [its] sleeves and figure out" how to provide navigation services in this new housing setting while learning more about the target population.
- CareOregon employs clinical supervisory staff, including medical doctors and registered nurses, which was a missing component from the original LLC direct-staffing design.
- CareOregon wanted the opportunity to build relationships with community partners by working with them on the ground.

LLC members eventually agreed to this alternative approach, and created a variation of a pooled-funding mechanism. Multiple stakeholders dedicated their staff to the care navigation team and currently serve residents across the 11 HWS properties.

Environmental Context

Oregon's health reform activities provided encouragement for the development of the HWS program. In 2012, Oregon launched a statewide system of 15 regional Coordinated Care Organizations (CCOs) to help achieve the state's dual goal of improving the health of Medicaid beneficiaries while containing program costs.

CCOs are networks of health care providers, payers, and other stakeholders that accept a single global budget to provide integrated physical, mental, and dental health care to Medicaid enrollees. CCOs are responsible for a specific geographic region and focus on enhancing wellness, preventing disease, and helping individuals manage chronic conditions.

By design, CCOs have the flexibility to support the delivery of coordinated and person-centered care and to reduce health disparities. Among the tools at their disposal is a pot of flexible funds that can be used to purchase non-traditional services that might improve a person's health. For example, if a person's chronic illness is exacerbated by heat, a CCO could purchase an air conditioner for that individual.

CCOs are at full financial risk for their global budgets. They can retain any savings they create, but they are also responsible for covering any budget overruns. CCOs are also accountable for quality. A percentage of each CCO's annual budget (4% in 2016) is withheld and the CCO can earn the money back based on its performance on 17 incentive metrics during that year.

Two CCOs operate in the Portland metro area: FamilyCare and Health Share. Both CCOs are directly or indirectly involved with the HWS program. A grant from FamilyCare, which is also a Medicaid and Medicare health plan, funds a position on the HWS care navigation team. CareOregon and Providence, which provide in-kind staff to the care navigation team, are founding members of Health Share.

Residents of HWS properties have a mixture of insurance coverage. Some residents have Medicaid only, some have Medicare only, and a large proportion is dually eligible for both programs. CCOs have no financial responsibility for Medicare-covered services, and Medicaid-covered long-term services and supports have been carved out of their responsibilities.[1] Nonetheless, Health Share and FamilyCare state that they will assist any resident in the HWS properties even if the CCOs are not formally responsible for that resident's care. The

1 While almost all Medicaid beneficiaries must join a CCO, dual eligible beneficiaries are exempt from this requirement. Dual eligible individuals can also move in and out of CCO enrollment as they want. In the renewal application for the state's Medicaid 1115 waiver, which authorizes the CCOs, the state will request permission to automatically enroll duals in the CCOs and allow them to opt out. It should be noted that managed care plans participating in the CCOs may also operate Medicare Advantage and/or Special Need Plans and, therefore, would be interested in the health care needs of dual eligibles.

rationale behind this approach is that CCOs are responsible for improving community health and all residents are part of the community.

A representative of one CCO noted that managed care organizations generally focus on a short-term return on investment. If the organization can manage immediate service utilization, it reaps a financial benefit. By contrast, Oregon policy makers designed CCOs to take a longer term outlook that involves working to address the social determinants of health and where the reward is shared with individuals and the community in the form of better health.

One of the ways Oregon encourages this, according to the CCO representative, is by establishing incentive metrics that focus on vulnerable populations. For example, one metric addresses developmental screenings for kindergarten readiness. Initially, the CCO simply ensured that the screenings occurred. Then, it began asking whether children were receiving the services that the screening results indicated were needed. With that information in hand, the CCO began making additional investments in this area.

CCOs are tracked on the 17 incentive metrics and 16 additional performance metrics. Several of the metrics address issues affecting the dual eligible population, such as hospital readmissions. CCOs are not financially responsible for hospitalizations for dual eligibles because Medicare covers this cost. However, readmissions are still counted in a CCO's metrics. The state expects CCOs to facilitate successful care transitions for vulnerable dual eligibles because it believes the health care system is burdened by unnecessary utilization regardless of whether that utilization results in a Medicare or Medicaid expense.

Interests and Incentives

The health care entities supporting the HWS program had some common interests and incentives in getting involved with the program, including:

- Testing a new setting in which to deliver services and mode of engaging with plan members.
- Expanding the opportunity for early intervention, which could help prevent high-risk members from experiencing adverse outcomes that result in the use of costly services.
- Leveraging resources provided at the housing property or through other partners as a way to bring added benefit to plan members and staff.

New Approach to Member Interaction

CareOregon is currently the primary supporter of the HWS program, dedicating two FTEs to the care navigation team. The nonprofit health plan offers a Medicaid plan, a Medicare Advantage Plan, and a Medicare Special Needs Plan for dual eligible individuals.

HWS offered CareOregon an opportunity to enhance how it engaged with members who lived in the 11 HWS housing properties, half of whom were dual eligibles. CareOregon had been helping its provider network develop patient-centered medical homes that offer comprehensive and coordinated care. With complex patients, this often involves addressing both health and social needs, and enhancing access to and engagement in health care. The HWS model gave CareOregon a way to further explore this care approach with vulnerable members outside of the physician's office.

Providence Health Plan became interested in the HWS program in the fall of 2015 after its umbrella organization, Providence Health and Services, awarded a Community Benefits grant to the program. Providence chose to award the grant because the HWS program addressed several key areas of need identified through a community health needs assessment in its service area, including enhancing access to care, improving self-care management, and meeting basic needs such as food insecurity and housing instability.

Providence's community health division, which awards the Community Benefits grants, had been participating in several community discussions around affordable housing and health. The division was searching for areas of alignment between better serving the individuals cared for by Providence's health system and supporting affordable housing communities. It pulled in Providence's health plan, which identified that about 126 plan members were living across the 11 HWS properties and were primarily clustered in two of the buildings.

Providence Health Plan was interested in testing out a different mode of contact and care management with the plan members in these buildings. Up to that point, Providence conducted most of its care management by telephone. However, the health plan was aware that face-to-face interaction could represent a more successful strategy for engaging with certain populations, including non-native English speakers who face significant challenges when attempting to access care.

Participating in the HWS program presented an opportunity for Providence to see what impact in-person contact could have on vulnerable plan members like those living in the HWS properties. The plan believed that a regular onsite presence could help members better understand and navigate the health system. It also offered an opportunity for the health plan to engage members with whom it might not otherwise have connected–particularly members with mental health issues.

FamilyCare believed that having care coordinated or delivered as close to a member as possible could increase the potential for more effective health management and disease prevention. Issues could be addressed in a timely manner before a health problem resulted in adverse outcomes and/or more intense intensive use of resources.

FamilyCare's care managers were already working directly with members in settings like hospitals, physician practices, and community clinics. Working with the HWS program presented the opportunity to test its approach in a different setting, allowing it get even closer to its members, and to see whether the HWS model could benefit the approximately 150 FamilyCare members and other residents living in HWS properties. HWS participation also gave FamilyCare the opportunity to explore the efficiency of purchasing a service rather than providing it directly.

Early Intervention

CareOregon was interested in testing the efficacy of investing resources in a high-risk, as opposed to a high-cost, population. The health plan had already created a Health Resilience Program focusing on the non-clinical needs of its high-cost members. That program addresses a number of factors – including prior trauma, addiction and mental health issues, and housing insecurity – which inhibits these members from properly managing their health and results in excessive use of ER and other hospital care.

CareOregon data showed that Medicare members in the HWS properties were not all high-cost. However, these residents were at high risk for becoming high-cost plan members due to their advanced ages, low incomes, and the fact that most lived alone.

Although health plans understand the impact that social determinants can have on health outcomes, those plans do not traditionally invest extensively in addressing social determinants because the return on investment is not immediate. CareOregon theorized that directing resources to this high-risk population would save the plan money in the long run.

CareOregon's investment in the HWS program represented a way to explore this theory. The HWS program also provided a laboratory for testing other CareOregon initiatives to address the social determinants of health, including the Food RX program. In addition, CareOregon was also interested in exploring the HWS program's potential to uncover undiagnosed addiction and mental health issues, address social isolation, and enhance members' perception of their ability to live independently.

As mentioned above, FamilyCare also saw the value of engaging with members in their home setting, as it presented the opportunity to identify health issues before they bloomed into health crises that resulted in a need for more intensive and costly services.

Leverage Other Resources

CareOregon knew that its efforts to address the social determinants of health would benefit its members. However, it also knew that it did not have the skills and funding to address these various concerns on its own. Getting involved with the HWS program allowed CareOregon to leverage the work of other organizations and for all the organizations to build something bigger together.

Providence Health Plan was also interested in leveraging the wraparound services provided at the HWS properties, which offered value to its members. For example, the HWS operations director and members of the navigation team were able to intervene when one Providence member faced eviction and potential homelessness. Similarly, if one of Providence's members has mental health needs, the health plan can refer the member to the onsite counselor for consultation and assistance. This referral ability helps prevent access challenges that plan members might face if they were required to make their own intake appointments and travel to a mental health agency for those appointments. The plan's care manager can also build relationships with the other participating community partners and learn about resources for plan members they might not otherwise have been aware of.

FamilyCare also noted the benefit of leveraging the services that other HWS partners provide onsite. By building relationships with other participating community partners, the plan's care manager can help its members gain access to more services than the plan could provide alone.

Plan and Payer Agnostic

Each health plan currently participating in the HWS program has committed its staff to see all residents in a HWS buildings, regardless of their plan affiliation. CareOregon and FamilyCare had previously operated programs through which care managers/navigators served non-members in either clinic or community-based settings. When Providence began sending a care manager to two of the HWS properties, it chose to follow the example of CareOregon navigators and engage with all residents who sought services from them. While open to serving all residents, the plans do want to ensure that their own members' needs are addressed.

The plans provided common reasons for their openness to serving all residents regardless of affiliation:

- The plans see the HWS program's initial few years as a time to test the model's efficacy. This assessment needs to include the full resident population, not just plan members.
- The plans have an interest in community health, which extends beyond just their members. FamilyCare wears a dual hat as a CCO and CareOregon and Providence are founding members of another CCO. CCOs are focused on prevention and helping Oregon's Medicaid population stay healthier and better manage chronic conditions.
- The plans recognized the benefit of leveraging the services of multiple organizations to serve their members.

Health Plan Funding Mechanisms

Medicaid and Medicare managed care plan premiums can be split between medical services and quality improvement activities and administrative costs and profits. In 2012, the Affordable Care Act mandated that at least 85% of Medicare Advantage premiums must go toward medical care and quality improvement activities. A final rule passed in 2015 established the same threshold for Medicaid managed care plans beginning in July 2017. Under both programs, quality improvement activities are defined as activities that:

- Improve health outcomes. These activities include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, medical home models, and accreditation fees.
- Prevent hospital readmissions. These activities include patient-centered education and counseling, comprehensive discharge planning, and post-discharge support from an appropriate health care professional.
- Improve patient safety, reduce medical errors, and lower infection and mortality rates.
- Promote wellness and health.
- Enhance the use of health care data to improve quality, transparency, and outcomes, and support meaningful use of health information technology.

The grant provided by FamilyCare and the in-kind staff provided by Providence are supported through the plans' administrative pots. The in-kind staff members provided by CareOregon are supported through both the plan's medical/quality improvement and administrative/profit pots. Initially, the care navigators were funded entirely out of CareOregon's administrative dollars because it was not clear what the navigators' role would be and what types of assistance they would provide. Some support for the navigators shifted to the medical pot as the plan gained greater experience with the navigators' roles and recognized that navigator-provided services constituted quality improvement activities.

Mental Health Funding Challenges

Two mental health agencies – Cascadia Behavioral Health and LifeWorks Northwest – joined the HWS LLC because they believed that integrating housing, health, and behavioral health services is a way to improve health and bend the Medicare and Medicaid cost curves. Both organizations had already collaborated with affordable housing organizations and operated their own housing properties.

Both organizations had relatively few existing clients in the HWS properties prior to the launch of the program, however, the resident assessment conducted by PSU indicated that there was a high level of unmet need for mental health services in the properties. As the assessment suggested, Cascadia and LifeWorks found a substantial need after the organizations started working in the communities. Depression and anxiety are common, while a surprising number of residents have serious mental illness and addiction issues.

Despite this need, however, Cascadia and LifeWorks have struggled to maintain the financially viability of their participation in the HWS program. Both organizations provide Medicaid-billable services at the property. An agency cannot bill Medicaid unless the client requires medically necessary services, signs a form acknowledging that he or she has mental health needs, and agrees to participate in developing a treatment plan. Residents have been eager to talk to the onsite clinicians, but few have been willing to sign the consent form admitting they have mental health needs. Without this step, the mental health agencies are unable to bill Medicaid and cover the cost of their onsite staff.

An inability to meet Medicaid's reimbursement standards forced Cascadia to pull its clinician from the buildings. Over the course of a year, the organization was only able to formally enroll about 10 individuals in its service program despite extensive pre-engagement work with multiple residents. The organization had hoped to enroll 40 to 50 residents.

LifeWorks Northwest is currently considering whether it will be able to remain in the program because it is only covering approximately 40% of its costs. LifeWorks staffed the position with a LCSW, which allowed the organization to also bill Medicare. However, Medicare rates for mental health services are low and only

cover individual and group therapy and psychiatric evaluation and medication management. Unlike Medicaid, Medicare does not cover outreach and case management, which the mental health agencies say are important services for the population served by the HWS program.

The mental health agencies believe that mental health services carry a stigma among older adults. Members of this population group have greater anxiety and fear about what their neighbors and others will think about their need for mental health supports. They also worry that such needs could put their housing at risk. One of the agencies noted that the residents they are targeting tend to be isolated and do not want people to know about their mental illness. It takes time and presence for these individuals to build relationships with the staff, feel comfortable with them, and see value in accepting their services.

The CCOs have developed some alternative payment models to support mental health services for special populations. For example, Asian Health & Services provides mental health services to Asian populations in a way that accommodates that population's cultural approach to mental health services. This alternative was not created specifically for the HWS program, but is allowed by the county mental health authority as a way to allow more flexibility in the provision of culturally specific services. Several additional alternative payment methodologies, including recognition of older adults and people with disabilities as a culturally specific population, have been presented to the CCOs and the county mental health authority. Thus far, no adaptations have been granted.