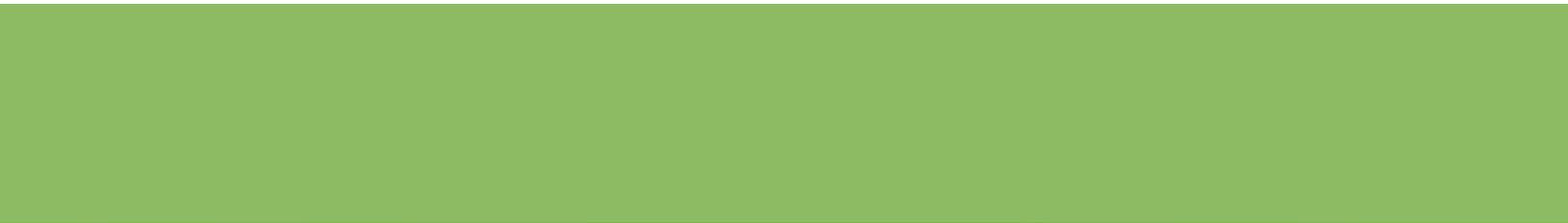




Stewards of Affordable Housing for the Future

The Path to Partnership

Lessons Learned in the Pursuit of Joint Initiatives between
Affordable Housing Providers and Medicaid Managed Care
Programs



Executive Summary

Introduction/ Project Background

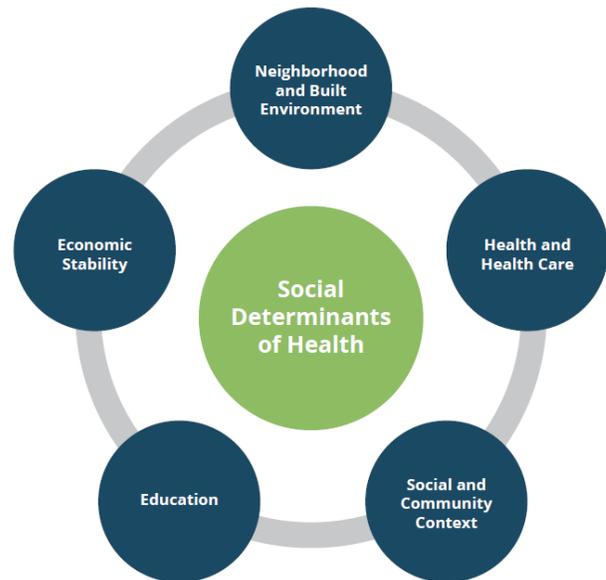
A growing body of literature emanating from the public health sector teaches that traditional medical care alone has a limited impact on overall health outcomes; while the structural determinants and conditions in which people are born, grow, live, work and age, collectively known as the Social Determinants of Health, have a greater impact on health status^{i, ii}. However, investments made in addressing social determinants of health lag far behind the public resources devoted to medical care through programs such as Medicaid, Medicare and the Children’s Health Insurance Program (CHIP). Housing, in particular, has a tremendous impact on health, bringing the intersectionality of health and housing to the forefront of the social determinants of health conversation.

Stewards of Affordable Housing for the Future (SAHF) is a nonprofit collaborative of thirteen exemplary multi-state nonprofit affordable housing providers who own and manage more than 130,000 affordable rental homes across the country. With a mission to lead policy innovation and advance excellence in the delivery of affordable rental homes that expand opportunity and promote dignity for residents, SAHF’s members are poised to address the social determinants of health, specifically through service enriched housing, in ways that can result in real health outcome improvements and cost savings to traditional medical care programs.

A 2016 study done by the Center for Outcomes Research and Education and Enterprise

Community Partners Inc. found that pairing affordable housing with health care services increases access to primary care and reduces emergency room utilization (20% increase in primary care visits and a 18% decrease in emergency room visits during the first year in affordable housing). This improved access and decreased utilization translates to reduced costs to public healthcare programs including Medicaid.ⁱⁱⁱ

Despite an increased recognition of the importance of the social determinants of health, including stable, affordable housing, there are still few examples of close collaboration between affordable housing providers and stakeholders from the healthcare system to leverage housing as a platform for improved health outcomes. As the divide between affordable housing and healthcare is bridged, there are many opportunities to demonstrate the value of affordable housing while improving the health of our communities.



Source: From *Healthy People 2020*, Office of Disease Prevention and Health Promotion, Department of Health and Human Services.

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

Beginning in 2014, with the support of the Kresge Foundation, SAHF engaged its members in efforts to build collaborative relationships with partners from the healthcare sector, in order to implement joint initiatives to demonstrate the contributions of service-enriched housing to the healthcare system. Although many of our members have established work with healthcare stakeholders, few have direct partnerships with insurers. Subsequently, this endeavor focused on collaboration with Medicaid payers. In partnership with Health Management Associates (HMA), target markets and potential Medicaid health plan partners were identified and paired with SAHF members to facilitate conversation and identify points of synergy. SAHF members who participated in this matchmaking activity included Mercy Housing, Volunteers of America (VOA) and National Church Residences.

To move forward with this cross-sector collaboration, a set of essential tasks had to be addressed.

Essential Tasks to Foster Collaboration:

- 1. Speak the same language:** Healthcare and affordable housing are both heavily regulated sectors which over time have developed their own jargon. Understanding the languages of housing and health (the programs, agencies, regulations, and mission) facilitates productive collaboration.
- 2. Confront diverse, sometimes conflicting, objectives:** Affordable housing providers and health plans have diverse interests which sometimes overlap and sometimes conflict. For example, health plans focused on cost containment may target complex, high-cost high-risk beneficiaries while an affordable housing provider may serve primarily families and children many of whom have relatively low healthcare costs. Identifying common and complimentary objectives improves the impact of collaborative initiatives. In this case, focusing on properties that serve seniors and the disabled may present greater opportunities for health plans looking to reduce healthcare costs in the near term, while properties that serve families may be good locations for initiatives targeted towards improving preventive healthcare to avoid healthcare costs in the long term.
- 3. Dedicate the necessary resources:** One of the objectives of enhancing collaboration with health plans is to identify and secure stable sources of revenue to support services delivered by affordable housing providers that positively impact health. Many housing providers lack the stable resources needed to focus on healthcare related support services, while potential healthcare partners are also resource constrained and need to incorporate return on investment calculations into any funding decisions. Finding a solution that ensures sufficient resources are dedicated will support the effectiveness of collaborative interventions.

Purpose/Goals

In recognition of the positive impacts that stable affordable housing, especially service-enriched housing, has on health outcomes, the purpose of this matchmaking activity was to connect affordable housing providers and health plans to demonstrate these outcomes and encourage financial support from health plans towards the sustainability of housing-based services. While many have identified the availability of affordable housing as a critical issue, attracting investment from health plans for the development of additional affordable housing inventory was not a primary goal of these efforts. Our hypothesis is that establishing meaningful connections between housing providers and Medicaid health plans, specifically around services, would result in relationships that could later be leveraged to address

the need to increase the amount of affordable housing stock.

Matchmaking Process

HMA used housing inventory data provided by SAHF to identify markets with significant numbers of affordable housing units operated by SAHF members. Preference was given to opportunities for multiple SAHF members to work together on joint initiatives with potential healthcare partners. SAHF members were consulted to identify their high priority markets as well as those properties with existing infrastructure to support potential collaborative initiatives with healthcare partners.

Next, HMA conducted environmental scans of each identified market to determine the likely health plan partners. Medicaid health plans were identified as the best candidates for partnership given the demographics of the residents served by affordable housing providers. Medicaid health plans that served the region were identified and enrollment information was gathered to determine which health plans had the largest market share. Additionally, SAHF and HMA identified state and local healthcare initiatives that would present specific opportunities for collaboration. Some markets that were initially identified were eliminated from consideration prior to performing market scans due to the complexity of the Medicaid managed care landscape, and the number of health plans operating in the market which presented difficulty in achieving scale (critical mass of residents being served by a particular health plan). This was the case in Florida and Illinois. Other identified markets were eliminated after initial outreach to health plans was unsuccessful, as was the case in Detroit, MI and Rhode Island. The market scans for each of the markets identified are attached to this report as Appendix 1.

After an assessment of the market scans, and initial outreach to potential health plan partners, joint initiatives were pursued in the following markets:

Target Markets and SAHF Members

Market	SAHF Members	Potential Healthcare Partners
Atlanta	Mercy Housing, National Church Residences	Amerigroup Wellcare Peach State Health Plan (Centene)
Denver	Mercy Housing, Volunteers of America	Colorado Access
Pittsburgh	National Church Residences	UPMC Health Plan Gateway Health Plan

HMA used its contacts within the Medicaid health plans in the target markets to set up initial meetings between the affordable housing providers and appropriate health plan leadership. The purpose of these initial meetings was to introduce the health plans to the housing provider, educate the health plan about the support services being delivered, as well as those that could be delivered to residents, and identify opportunities for collaboration. Based on feedback from Medicaid managed care organizations collected earlier during a SAHF convening held in May of 2014, another objective of these initial meetings was to determine the priorities and needs of the health plans so that targeted proposals for collaborative initiatives could be developed to align to those needs.

Joint Initiatives

Atlanta:

The State of Georgia currently operates a Medicaid managed care program that focuses on mothers and children, creating an opportunity to partner with family properties in that region. Through conversations with Peach State Health Plan (Centene) and Amerigroup, partnerships were established with Mercy Housing in Atlanta.

Cultivating Healthy Communities Initiative

Mercy Housing's focus on wellness provided a point of synergy in fostering a partnership with this health plan. In bringing these two sectors together, Peach State Health Plan became the lead sponsor of Mercy Housing's "Cultivating Healthy Communities" initiative (see Appendix 2). This initiative addresses health and wellness by providing nutrition education, including healthy cooking classes, linkage to community resources to address food security issues, and enhancing opportunities for exercise and physical activity. This collaboration also resulted in the establishment of a community garden at the Hills at Fairington, a property with over 400 apartments, and the expansion of an existing community garden at the Terraces at Parkview, which houses 90 low income families. Both properties are in Lithonia, GA outside of Atlanta.



Photo of the community gardens at Mercy's property, the Hills at Fairington in Lithonia, GA.

The initiative launched on April 30, 2016. Mercy Housing will be working with the University of Georgia and the Atlanta Community Food Bank to measure the success of the program after its first year. The Cultivating Healthy Communities initiatives are funded through a grant from Peach State Health Plan.

Amerigroup and Mercy Housing Partner on Telemedicine Pilot

Discussions with Amerigroup in Georgia took a different direction. Amerigroup was interested in leveraging the Resident Services offered by Mercy Housing. In response to a focus by the Georgia Department of Community Health (DCH) on the use of telemedicine to improve access to healthcare services, Fran Gary, President of Amerigroup GA, proposed a pilot project in conjunction with Mercy Housing that will improve access to essential healthcare services -- primary, specialty and behavioral healthcare services -- for all residents, by creating a telemedicine presenting site in a dedicated space at The Hills of Fairington community building. Approximately 30 percent of the residents at this property are Amerigroup beneficiaries, creating a strong business case for Amerigroup's interest in this partnership. When properly implemented, the broad adoption of telemedicine has the potential to

extend care across populations of both acute and chronically ill patients and help achieve the important policy goals of improving access to high-quality and efficient health care.^{iv} For Mercy's residents, this means they can now access health care right where they live, with the potential to increase primary care visits and reduce emergency care use. Providing this convenience also helps to overcome transportation barriers as well as mitigate the need for missed work or school days due to an illness.

Amerigroup funded the purchase of the telemedicine equipment from the Georgia Partnership for Telehealth and is underwriting the monthly subscription fee for one year. Even though Amerigroup offered funding for the set-up of the telemedicine presenting site, the equipment and services being offered will be available to all residents (including residents not covered by Amerigroup) and billable to all Medicaid managed care health plans. This unique initiative demonstrates the innovation that spurs from cross-sector engagement, providing mutually beneficial services that aims to increase access and reduce unnecessary utilization, in addition to improving the outcomes of the residents served in this affordable housing property.

In June 2016, Mercy Housing and Amerigroup met with DCH to tell them about the pilot and explore options for enrolling Mercy Housing as a Medicaid Provider so that they could bill for the service of hosting the telemedicine presenting site. DCH leaders were receptive to the pilot concept and defined a series of requirements for a site visit that would be necessary before Mercy Housing could bill for telemedicine services.

In the design phase of the initiative it became clear that the operation of the telemedicine presenting site would require the handling of Protected Health Information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) governs the appropriate handling of an individual's confidential health information and often poses a barrier in cross-sector engagement with health entities. Since Mercy Housing did not possess the infrastructure (systems, training and staff) to ensure compliance with HIPAA requirements, Amerigroup identified a local Urgent Care Center that would assume responsibility for staffing the telemedicine site. The Center's staff has the appropriate clinical and HIPAA-related training to operate the service in compliance with relevant laws, helping to overcome this specific barrier.

Denver:

Mercy Housing, Volunteers of America and Colorado Access Embedded Care Coordinators

The State of Colorado delivers Medicaid services through Regional Care Collaborative Organizations (RCCOs), which are similar to Managed Care Organizations. One advantage of the Colorado market as a location for collaboration between affordable housing providers and healthcare partners is that there is a single RCCO per region. This means that there is a single entity providing healthcare coverage to the majority of residents of a given property. Mercy Housing, Volunteers of America and Colorado Access, the RCCO covering the Denver metropolitan area, held a series of meetings to design and plan for the implementation of a joint initiative to bring embedded care coordinators to affordable housing properties. Care Coordinators play an important role in achieving healthcare improvement through face to face patient engagement and education. Locating these resources where people live, particularly in a service-enriched housing environment such as that which is provided by Mercy Housing and Volunteers

of America, presents a great opportunity for collaboration. The role of the Care Coordinator will complement rather than duplicate existing resident services and will include:

- ❖ Coordinating with Colorado Access
 - Participating as part of a multi-disciplinary team that supports the residents
 - Facilitating access to a care team for residents
 - Facilitating access to residents for care team members
- ❖ Connecting to Resident Services Coordinators
 - Scheduling periodic meetings with on-site staff
 - Participating as part of the residence team
 - Helping Resident Service Coordinators with health-related questions and issues for all residents
- ❖ Connecting to Residents
 - Conducting “open door,” sessions on-site, with offices hours for residents
 - Hosting and organizing healthcare related educational events for groups of residents
 - Providing one-on-one support to residents (e.g., benefits, education, follow-up after a medical appointment or service, etc.)
 - Providing information about Medicaid basics and access to other sources of care
 - Addressing issues of residents’ health literacy with enrollment and care
 - Providing information about and the benefits of having a medical home (a specific and consistent place to receive primary care services)
 - Providing information about access to other community resources (behavioral health, long-term services and supports, etc.)
 - Providing self-management support education for certain chronic conditions

One key decision confronted by the group was determining which entity would employ the Care Coordinator. Initially, Mercy Housing indicated that they preferred a model where it would employ the Care Coordinator while Colorado Access would provide funding to support the position. Volunteers of America preferred a model where the Care Coordinator was employed by Colorado Access and would be granted special access/space to operate at the VOA property. Colorado Access also preferred a model where it employed the Care Coordinator so that the position could be better aligned with the other components of its care management program including greater access to the management supports from Colorado Access (i.e. direct linkage to clinical resources and more intensive care management functions). Ultimately, it was decided that Colorado Access would act as the employer of the Care Coordinators.

Discussions between Mercy Housing, VOA and Colorado Access have benefitted from Colorado Access’ experience launching a similar project with the Denver Housing Authority (DHA). The group used that experience as a model as they discussed an agreement framework to support the initiative. Currently, VOA, Mercy Housing and Colorado Access are finalizing agreements to implement the initiative.

Additional external resources, including potential local foundation support, are being identified to support program evaluation. The evaluation will include an assessment of the effectiveness of embedded Care Coordinators at an affordable housing property as compared to the effectiveness of

other community-based Care Coordinators and telephonic Care Coordinators in working with residents of affordable housing properties.

Pittsburgh:

National Church Residences and University of Pittsburgh Medical Center (UPMC) Health Plan Enhanced Service Coordination Initiative



Bruce Mills (pictured left) suffered from complete hearing loss for 26 years until National Church Residences' Home for Life Program, connected him to services that helped restore his hearing. (Source: Columbus Dispatch, April 2, 2017)

Pennsylvania is in the process of implementing managed care for its Medicaid-funded Long Term Services and Supports (LTSS). In preparation for this shift, and in recognition of the fact that many managed care organizations have limited local experience working with beneficiaries who need home and community based services, National Church Residences approached several health plans who were bidding on state managed LTSS contracts and proposed enhanced service coordination services through its "Home for Life" program. Potential partnerships with National Church Residences were incorporated into the health plan proposals of Gateway Health and UPMC Health Plan. Contract awards were announced by the state in August of 2016 - UPMC Health plan was selected as

one of three plans to implement statewide, while Gateway Health did not receive a contract.

Under Home for Life, National Church Residences provides a progressive plan for helping seniors remain healthy in their homes rather than moving to nursing facility based care. The program components:

1. **Provide an Enhanced Service Coordinator to each identified member of UPMC Health Plan.** UPMC and/or National Church Residences may identify these members as in need of additional social supports to better manage their chronic diseases. This can happen either before or after an acute care episode (pre- and post-acute).
2. **Assess each resident.** The Enhanced Service Coordinator meets individually with each resident to complete an assessment using an evidence based tool that National Church Residences customized, called Care Guide, which helps to assess and identify the most vulnerable elderly populations in a community, and allows them to target their needs and design interventions based on diagnosis, health status, social supports and primary care utilization. Since Care Guide is customizable, it can be adapted to meet the needs of UPMC and Community Health Choices program requirements as necessary.
3. **Identify and engage preferred providers.** Using the assessment data and information, the Enhanced Service Coordinator works with preferred health care providers to provide health care or wellness services, to address the specific health care needs of an individual senior or the larger community.
4. **Promote health and socialization.** The Enhanced Service Coordinator also promotes senior residents' health and socialization through engagement and social activities that combat

isolation and depression, also contributing to better health outcomes for residents and “Home for Life” participants.

National Church Residences benefitted from its own experience in delivering home health services as it designed this offering. Unlike some other affordable housing providers, it is experienced in partnering with health plans and billing for healthcare services. The Home for Life program takes that experience and applies it to a non-clinical intervention designed to improve quality of life and health outcomes. The Home for Life intervention, while available to residents of senior housing managed by National Church Residences, will not be limited to those living at National Church Residences properties.

Due to a challenge to the results of the procurement awarding the contracts for managed LTSS in Pennsylvania, implementation has been delayed. UPMC and National Church Residences are currently planning to implement this program in the Spring of 2017.

Lessons Learned

Through discussions between affordable housing providers and potential healthcare partners it was discovered that a recognition of opportunity was not enough to drive meaningful collaboration. In addition to addressing the essential tasks for effective collaboration listed in the introduction to this report, housing providers and potential healthcare partners need to be flexible and motivated to craft joint initiatives that will improve outcomes. This section of the report outlines five major lessons learned from these efforts.

Lesson 1: Joint initiatives must address the problem of scale.

After engaging a potential healthcare partner, one of the initial steps was to determine how many of the healthcare partner’s members/patients were residents of service-enriched affordable housing properties. Several attempts at establishing partnerships failed when it was discovered that due to the mix of health plans/coverage types among residents the number of residents at a given property connected to a given health plan was too small to justify a targeted initiative. This problem was especially acute at family properties where the small number of “clients in common” did not represent high costs/high risk to the health plan.

Learning

- ❖ Affordable housing providers should make the case to health plans that the value of “community benefit” will accrue to the partner even when all of the people who receive services are not current members of the health plan. This case was made successfully in the Atlanta telemedicine initiative as Amerigroup recognized the community benefit of setting up a telemedicine site at the Mercy Housing property even though residents who were members of other health plans would also be using the services. Health plans would also see enhanced value from initiatives that include service to individuals in the communities that surround the affordable housing property. By leveraging an affordable housing property as a community gathering place, the reach of collaborative initiatives could be amplified.
- ❖ Properties where most residents have the same source of coverage provide ideal opportunities for collaboration with health plans. This is the case with the Denver Care Coordinator initiative where virtually all residents of the targeted properties receive health coverage from Colorado Access. In markets where residents receive coverage from multiple health plans, collaboration

with neighboring affordable housing providers or multi-payer initiatives may be necessary to achieve scale. While the Denver initiative does include more than one affordable housing provider, so far, none of the initiatives that have begun from these matchmaking activities include multiple health plans. This should be a focus area going forward.

Lesson 2: Housing providers must be willing to adapt services to meet the requirements of the healthcare system.

Finding the right collaborative opportunity requires flexibility, which may include re-focusing existing staff on new tasks. Health plans reacted positively to the potential impact resident services could have on health outcomes, and the opportunity to incorporate resident service coordinators in a community based care team structure, but they also were focused on specific objectives (such as ensuring beneficiary connection to primary care) that were outside of the scope of current resident services. Additionally, affordable housing providers need to be careful not to jeopardize existing resident services as they seek ways to address healthcare partner needs.

Learning

- ❖ Housing providers need to identify ways to directly address healthcare while not diverting too many resources from other essential resident services.
- ❖ Financial models need to be developed for initiatives that may include housing providers billing their healthcare partners for services, as new revenue streams are needed to offset the cost of new health-related services being provided by resident service coordinators. Ideally these funding sources can also be used to preserve or partially offset the cost of existing non-health related services already being provided at the property that have an impact on healthcare outcomes (i.e. job training or educational programming).

Lesson 3: Housing providers must present a business case to potential health plan partners that includes primary and secondary benefits.

Health plans recognize housing as a social determinant of health, but joint initiatives need to provide a clear benefit to justify the health plan's dedication of resources. Health plan prioritization of resources, even for non-profit health plans, is strongly tied to financial metrics and cost savings is the most compelling business case. Secondly, health plans are increasingly accountable financially for improved health outcomes. Health improvements that help health plans achieve incentive payments/bonuses also provide a good foundation for a strong business case. Lastly, health plans are trying to demonstrate more holistic models of care in response to direction from their state Medicaid Directors. Partnerships with affordable housing providers contribute to this holistic approach, even if direct impacts are less evident in the near term.

Learning

- ❖ A clear, written program design should be developed once a potential health plan's needs/priorities are identified. The National Church Residences Enhanced Service Coordination Proposal is a good example of laying out a business case. (See attachment 2).

- ❖ If the goal is to attract funding that can also support resident services generally, the benefits of those services must also be articulated, making the case using existing studies that document the impact of addressing the social determinants of health.

Lesson 4: HIPAA compliance needs to be addressed as a potential barrier.

HIPAA privacy regulations set forth standards for handling Protected Health Information (PHI), reporting requirement for privacy breaches, and sanctions for non-compliance. These requirements drive health plan compliance programs and affect all entities that partner with health plans and may have access to PHI. At the same time, the most meaningful opportunities to leverage services delivered by affordable housing providers will require some use of PHI to achieve the greatest impact. Affordable Housing Providers need to address HIPAA compliance as a potential barrier to more meaningful collaboration with health plans.

Learning:

- ❖ Complete a true accounting of the costs (time and expense) associated with HIPAA compliance. Current assumptions as to the level of effort associated with HIPAA compliance have been discouraging for affordable housing providers.
- ❖ Explore creative collaborations that do not include exchange of PHI. Initiatives designed for community benefit rather than a targeted intervention with an identified group of residents may be needed.
- ❖ In addition to HIPAA-specific compliance issues, affordable housing providers should discuss other state regulatory and program requirements with potential Medicaid health plan partners. Compliance with these requirements may be a pre-requisite for partnership.

Lesson 5: Healthcare partners and Housing providers need to be realistic about joint initiative resource requirements.

Partnership with healthcare partners does not represent access to a “pot of gold.” Despite the vast government resources dedicated to healthcare (through Medicare and Medicaid) the amount of money available for initiatives not related to direct clinical care remains limited. In the early stages of the program design, housing providers and their potential healthcare partners need to complete an honest assessment of the resources each is prepared to devote to a joint initiative as well as the outcome expectations.

Learning

- ❖ Housing partners need to be upfront about their desire to achieve stable revenue streams from their healthcare partners, and healthcare partners should be asked to outline their requirements/willingness to provide such funding.
- ❖ Housing providers may need to make upfront investments to develop capabilities required for effective partnerships that include new revenue streams which should allow for recoupment on those investments.
- ❖ Initiatives take time to develop, and the pace of collaboration may be slowed by health plan priorities and other factors such as health plan internal budgeting processes, and contracting

cycles with state Medicaid programs. Housing providers may need to commit staff time and attention to development of initiatives over a long period; maintaining engagement with health plan partners requires persistence.

Next Steps

The collaborative initiatives outlined above represent an initial step towards better collaboration between affordable housing providers and health plans that serve low-income families and seniors. The experience gained through these initiatives will help inform affordable housing providers as they seek collaborative relationships with the healthcare sector to encourage additional investments in housing-based support services that have an impact on health outcomes. The initiatives also highlight challenges and limitations associated with collaboration focused on services rendered by an affordable housing provider. Below are additional findings that supplement the aforementioned lessons learned.

Changing healthcare landscape means new potential partners

A national movement towards value-based payment models and accountable care delivered locally by providers who assume financial risk may offer additional potential partners. As integrated health systems, Accountable Care Organizations, Patient-Centered Medical Homes and other delivery system arrangements assume greater financial risk for health outcomes, they are increasingly looking for collaboration with community-based social service providers. These models that push traditional managed care functions are becoming more prevalent in the healthcare sector, including state Medicaid programs. Going forward, affordable housing providers should evaluate opportunities to work with these entities in addition to the publicly sponsored health plans that serve Medicaid enrollees.

Addressing Policy Barriers that Prevent Medicaid Investments in Housing

While service-focused collaborations are important to building strong relationships between the healthcare sector and affordable housing providers, the most meaningful housing-related need for high cost consumers of publicly funded healthcare is adequate affordable housing supply. Despite recent guidance from the Centers for Medicaid and Medicare Services about the use of Medicaid funds for housing-related services^v, current federal law prohibits Medicaid funding from being used to pay for direct housing costs (e.g., monthly rent). Enhanced systems and processes to connect Medicaid beneficiaries to housing resources are only effective if there are housing resources that can serve those beneficiaries.

Potential approaches for addressing these barriers include:

- ❖ Developing a joint advocacy agenda between the health and housing sectors for additional federal housing resources to stimulate new production of affordable housing and additional rental assistance;
- ❖ Encouraging the innovative use of unrestricted state funding including developing strategies to encourage states to use potential future Medicaid funding flexibility to address affordable housing inventory needs; and
- ❖ Encouraging policy support for investments in housing that deliver healthcare return on investment

Pursue new approaches for the direct investment by Healthcare stakeholders to increase affordable housing capacity

Establishing collaborative relationships between healthcare stakeholders and affordable housing providers around services is a first step towards more meaningful integration of these important social service sectors. These relationships can lead to investments from the healthcare sector in affordable housing to begin to re-balance spending priorities in a way that lowers costs across the system. Affordable housing providers should continue to promote opportunities to leverage investments from healthcare stakeholders to improve access to stable affordable housing. Examples of models to pursue include:

❖ ***Direct investments by Health Plans in the construction of Housing:*** By leveraging the Low- Income Housing Tax Credits program, UnitedHealthcare's Affordable Housing Investment Program has provided over \$240M in equity to community development programs nationwide, including a \$34M investment in the State of New Mexico where UnitedHealthcare Community Plan serves Medicaid beneficiaries.

❖ ***Non-Profit Hospital Community Benefits Programs:*** To preserve their tax-exempt status, non-profit hospitals are required to engage in activities that benefit the communities they serve. Traditionally, this has meant providing low cost or free care to patients who lack the ability to pay. As health insurance coverage has expanded, charity care programs are shrinking and hospitals are becoming more creative in how they meet the community benefit standard. Investments in the construction of affordable housing may be an innovative and compelling way for non-profit hospitals to demonstrate community benefit. This is especially true as hospitals and health systems are increasingly operating under financial models that incentivize positive health outcomes over high utilization. As described in the introduction to this report, stable affordable housing can, among other positive outcomes, decrease emergency room utilization and hospital readmissions. Controlling this kind of utilization is increasingly financially beneficial to hospitals.



Chris Baca, CEO, YES Housing (left) and Charles Milligan, CEO of UnitedHealthcare Community Plan of New Mexico tour the Imperial Building, a new 74-unit mixed-use apartment community in downtown Albuquerque.
Source: Business Wire August 29, 2016. Photo: Jessica Quinn
<http://www.businesswire.com/news/home/20160829006022/en/12-Million-Investment-UnitedHealthcare-Helps-Bring-Affordable-Housing>

SAHF is planning to advance this work by holding a series of roundtables with payers, health systems, public health leaders and other crucial stakeholders.

Conclusion

Despite the challenges of bringing together two heavily-regulated social service sectors -- housing and healthcare -- the opportunity and enthusiasm for cross-sector collaboration are strong. Breaking through the silos that prevent collaboration requires flexibility from both parties and a willingness to devote resources to develop joint solutions. SAHF and its member organizations are committed to continuing this work so that low income individuals and families in communities across our nation have a stable, safe, and affordable place to live and be healthy. We hope that the lessons learned through this housing and healthcare matchmaking will be useful to affordable housing providers and policy makers, as well as health and healthcare stakeholders who are eager to create innovative solutions and participate in unique partnerships that improve the lives of vulnerable populations across the nation.

ⁱ Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*. 2014;129(Suppl 2):19-31. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/>.

ⁱⁱ Heiman H, Artiga S. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. *The Kaiser Commission on Medicaid and the Uninsured*. November 2015. Available at: <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

ⁱⁱⁱ Center for Outcomes Research and Education (CORE) (2016). "Health in Housing: Exploring the Intersection between Housing and Health Care." Available at: https://s3.amazonaws.com/KSPProd/ERC_Upload/0100981.pdf

^{iv} Kvedar J, Coye MJ, Everett W. Connected Health: A Review of Technologies and Strategies to Improve Patient Care with Telemedicine and Telehealth. *Health Aff*. 2014; 33(2): 194-199.

^v Wachino, V. Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Department of Health and Human Services, Centers for Medicare and Medicaid Services. June 26, 2015. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>

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Colorado – Denver

Medicaid Expansion: Yes

Dual Demo Project: Yes. Managed Fee-For-Service Model, launched September 1, 2014

Managed Care Plans and Enrollment

Regional Care Collaborative Organization – Denver, February 2013

Health Plan	Total Enrollment
Colorado Access	19,314*

**An additional 12,300 dual eligibles in Denver have begun enrollment into Colorado Access as of September 1, 2014 under the MFFS duals demonstration.*

Notes: RCCO enrollment has continued to grow, up nearly 100,000 enrollees since the February 2013 data (up to more than 352,000 from the 255,000 statewide total in February 2013) as of July 2013. However, the February 2013 data is the most recent publicly available with a breakdown by region.

[Colorado RCCO Map](#)

Managed Care Populations:

Colorado launched the ACC Program in 2011, enrolling Medicaid children, families, and certain ABD beneficiaries. Under the ACC model, beneficiaries are linked with a primary care medical provider (PCMP), which serves as a medical home. PCMPs are supported by the Regional Care Collaborative Organizations (RCCOs), which provide care coordination, medical management, and provider network development and support. Under the ACC Program structure, PCMPs and the RCCOs receive per member per month payments to support care coordination and are also eligible for incentive payments based on key performance indicators.

Managed Care Procurement Activity:

RCCOs are expected to be reprocured in Summer 2015, with new contracts beginning and transitioning the first half of 2016. A RFI is expected late-Summer 2014.

Georgia – Atlanta (Atlanta Region) and Savannah (Southeast Region)

Medicaid Expansion: No.

Dual Demo Project: No.

Managed Care Plans and Enrollment

Care Management Organization (CMO) Enrollment – Atlanta Region, May 2014

Health Plan	Total Enrollment
Amerigroup (WellPoint)	180,345
Peach State Health Plan (Centene)	199,786
WellCare	247,084

Care Management Organization (CMO) Enrollment – Southeast Region, May 2014

Health Plan	Total Enrollment
Amerigroup (WellPoint)	36,331
Peach State Health Plan (Centene)	4,662
WellCare	71,327

[Georgia Medicaid Managed Care regions](#)

Note: Enrollment data is available by CMO at the regional level only. The Atlanta Region (includes City of Atlanta) and Southeast Region (includes city of Savannah) each include around 20 counties.

Managed Care Populations:

Georgia's Medicaid managed care program currently serves the children and families populations only. However, the state is expected to expand managed care to the non-dual, non-LTC ABD populations in the next few years.

Managed Care Procurement Activity:

A RFP to re-procure existing CMO contracts is expected in December 2014.

Pennsylvania– Pittsburgh (Allegheny County)

Medicaid Expansion: Yes.
Dual Demo Project: No.

Managed Care Plans and Enrollment

HealthChoices Southwest Region, January 2015

Health Plan	Total Enrollment
UPMC Health Plan	68,321
Gateway Health	51,040
United HealthCare	14,862
Aetna	3,186

Managed Care Populations:

The HealthChoices program provides managed Medicaid services to Children and Families as well as Adults in the Medicaid Expansion population. Community Health Choices is the Long Term Services and Supports Managed Care Program which will serve Dually eligible beneficiaries and adults who are nursing home clinically eligible whether they are reside in a nursing facility

Managed Care Procurement Activity:

HealthChoices contracts will be re-procured in September of 2015, and an initial procurement for the Community HealthChoices program is expected in March of 2016.

Michigan – Wayne, Oakland, Macomb, and Washtenaw Counties

Medicaid Expansion: Yes.

Dual Demo Project: Yes (Wayne and Macomb counties). Launched 2015.

Managed Care Plans and Enrollment

Wayne County (Detroit)– January 2016

Health Plan	Total Enrollment
Aetna Better Health of MI	33,996
Blue Cross Complete	65,214
Harbor Health	7,034
McLaren Health Plan	380
Meridian Health Plan	70,340
Molina Healthcare	163,727
Total Health Care	38,370
United Healthcare	85,413

Oakland County – January 2016

Health Plan	Total Enrollment
Aetna Better Health of MI	3,484
Blue Cross Complete	705
Harbor Health Plan	27
McLaren Health Plan	12,013
Meridian Health Plan	30,143
Molina Healthcare	28,746
Total Health Care	7,065
UnitedHealthcare	42,648

Macomb County – January 2016

Health Plan	Total Enrollment
Aetna Better Health of MI	367
Blue Cross Complete	504
Harbor Health Plan	28
McLaren Health Plan	11,136
Meridian Health Plan	31,090
Molina Healthcare	24,291
Total Health Care	12,783
UnitedHealthcare	47,387

Washtenaw County – January 2016

Appendix 1

SAHF Matchmaking MARKET SCANS

Health Plan	Total Enrollment
Aetna Better Health of MI	40
Blue Cross Complete of MI	19,830
McLaren Health Plan	24
Meridian Health Plan	6,321
Molina Healthcare	7,746
UnitedHealthcare	279

Note: Enrollment totals above include all Medicaid managed care enrollment, both mandatory and voluntary, in each of the four counties.

Managed Care Populations:

Medicaid managed care program in Michigan includes children and families, ABD, and dual eligible enrollees.

Managed Care Procurement Activity:

Current contracts are expected to be rebid in late 2014 or 2015.

Rhode Island (Statewide)

Medicaid Expansion: Yes.

Dual Demo Project: Yes.

Managed Care Plans and Enrollment

RlteCare (Children and Families, Expansion) – Statewide, February 2014

Health Plan	Total Enrollment
Neighborhood HP of RI	100,357
United Healthcare	51,252

Rhody Health Partners (ABD) – Statewide, February 2014

Health Plan	Total Enrollment
Neighborhood HP of RI	6,524
United Healthcare	7,477

Rhody Health Options (MLTSS) – Statewide, February 2014

Health Plan	Total Enrollment
Neighborhood HP of RI	12,801

Note: Enrollment totals above provided by state as of February 2014. RlteCare enrollment likely increased since February due to Medicaid expansion.

Managed Care Populations:

Rlte Care is the state's Medicaid managed care program for children and families, and also serves children with special health care needs.

Rhody Health Partners, launched in 2009, provides a voluntary Medicaid managed care option for aged, blind, and disabled (ABD) recipients.

Rhody Health Options, launched in 2013, provides Medicaid managed care, including LTSS to Medicaid-only and dual eligible beneficiaries.

Managed Care Procurement Activity:

No scheduled procurement activity



Cultivating Healthy Communities

Sponsorship Proposal
Presented To:



February 1, 2016

Cultivating Healthy Communities

Program Overview

Mercy Housing Southeast provides service-enriched affordable housing for low-income families, linking residents to supports that allow them to maintain self-sufficiency in their homes. Residents work with knowledgeable Resident Services Coordinators who bring social service delivery on-site, refer residents to appropriate off-site services, and organize social and community-building opportunities. By combining affordable housing and Resident Services programs, we are able to create supportive community environments where at-risk families can thrive instead of struggling in isolation; the blend of affordable housing and Resident Services creates *service-enriched housing*, which is the foundation of Mercy Housing’s work.

Mercy Housing Southeast’s *Cultivating Healthy Communities* initiative advances the objectives of our Health and Wellness programs by helping vulnerable families improve their overall health by providing activities focused on nutrition and access to healthy foods. Components of the program include:

- Community Gardens
- Nutrition Education and Healthy Cooking Classes
- Food Security Initiatives
 - Food Pantries
 - Georgia Organics Mobile Food Truck
 - Food distribution in partnership with the Atlanta Community Food Bank
 - Out-of-School Time programs, providing additional food security with healthy afterschool snacks during the school year and a free lunch program during the summer months
- Exercise and Physical Activity

According to the US Department of Agriculture, 30 Census tracts in DeKalb County – including the city of Lithonia – qualify as “food deserts” where low-income populations have low access to quality foods. With fewer healthy foods available, many families must rely on those which contribute to unhealthy diets, resulting in poor overall health. Other challenges related to food insecurity include:

- Lack of easy access to fresh produce and other nutritious foods: Low-income neighborhoods in food deserts cause residents to shop at stores with a limited selection, or eat fast food.

- Lack of nutritious foods prepared at home: Households with limited access to fresh foods tend to prepare food that is unhealthy and/or lacks variety.
- Lack of food diversity for complete meals: With few choices of ingredients, families may be unable to prepare a balanced variety of healthy foods, or discover new recipes that contribute to a healthy diet.
- Lack of time to prepare healthy meals: Low-income parents often work multiple jobs with erratic schedules in order to make ends meet, leaving little time to shop for and prepare healthy meals and making cheap fast food a convenient alternative.

While unhealthy eating may be economical in the short-term, long-term limited access to healthy foods is one of the main reasons that ethnic minority and low-income populations suffer from statistically higher rates of chronic diseases than the general population. For individuals on medication, an adequate diet of nutritious food will allow them to respond better to their medication and improve strength for better chances of recovery. Changing unhealthy behaviors is necessary to enable residents to live longer, higher-quality lives. They need greater support for nutrition education and resources to access fresh, sustainable produce. Eating is one of the most routine health behaviors, and changing that behavior is one crucial way to achieve better health outcomes. With nutritional assistance and education, we seek to improve indicators like chronic diseases, hospitalizations, and emergency room visits. Ultimately, access to healthy food leads to improved health outcomes and lower healthcare costs. Using nutrition as a focal point, residents of our affordable housing communities can utilize programs that improve health and wellness, and increase opportunities for education, community service, and volunteering.

Program Components

- **Community Gardens**

Plans are underway to build a community garden at the Hills of Fairington, a 406-unit affordable housing community located in Lithonia. The gardens will be designed so that they can produce crops during cold weather months. The Terraces at Parkview, which is home to 90 low-income families in Lithonia, currently has a small community garden on-site that is maintained by the residents. Plans are also in progress to upgrade and expand the gardens at the Terraces. Beginning in 2016, residents of both properties will participate in workshops to teach the basics of gardening and growing food, offered by University of Georgia Extension service and the Atlanta Community Food Bank.

- **Food Security**

Both Hills of Fairington and Terrace at Parkview plan to implement emergency food pantries that families can access when needed. Both sites will offer weekly or bi-weekly food distribution, in partnership with the Atlanta Community Food Bank and Georgia

Organics mobile food truck program. Residents are also working with the Atlanta Community Food Bank to establish food co-ops at each of these properties. Both properties offer Out-of-School Time programs, providing additional food security with healthy afterschool snacks during the school year and a free lunch program during the summer months in partnership with the City of Lithonia and DeKalb County Schools.

- **Nutrition Education**

This component is anchored by our popular Dinners Made Easy program, which combines nutrition education, cooking instruction, cost-conscious shopping and food support into a fun, hands-on class for families. Each session focuses on a specific healthy main-dish recipe that can be easily prepared from nutritious and low-cost ingredients – often using what is available to families from local food banks and/or the community garden. Participants practice making the dish and then enjoy a meal together at the end of the class. We also offer diet and nutrition classes, smoking cessation, diabetes management and education, and daily cardio health activities.

- **Leadership and Life Skills Development**

Youth participating in Out-of-School Time are encouraged to perform community service, especially for elderly and/or frail residents. The *Cultivating Healthy Communities* initiative creates opportunities for youth to serve the community by stocking food pantries, assembling lunch bags, working in the community garden and food co-op and distributing food to neighbors in their community. The Community Garden will also provide opportunities for residents to develop entrepreneurial and marketing skills by selling fresh produce and plants. Approximately 575 adults and 450+ youth, ranging in age from infancy to 18, will participate in these programs.

- **Corporate and Community Engagement**

Mercy Housing Southeast will host a “hands-on” day with corporate and community volunteers on **April 16, 2016** (or April 23) to clean, till and plant the gardens and “officially kick-off” the *Cultivating Healthy Communities* initiative at its metro-Atlanta multi-family properties.

Sponsorship

We invite Peach State Health Plan to join Mercy Housing Southeast as a sponsor of *Cultivating Healthy Communities* with an investment of **\$25,000**. Sponsorship will provide Peach State Health Plan with an outstanding opportunity to enhance brand/corporate identity, community outreach, and local/regional marketing efforts. As a sponsor, Peach State Health Plan will receive

- prominent recognition on *Cultivating Healthy Communities* print, promotional and educational materials, media releases, publicity, “hands-on day” banners and other signage, annual report and website;
- recognition of your support at resident and public events, including opportunity to speak at the “hands-on day”
- opportunities for meaningful access to residents to deliver and/or promote health education programming and services
- opportunities for Peach State Health Plan staff and partners to engage with residents and members to advance health and wellness through *Cultivating Healthy Community* activities

We look forward to working with you to develop a package of deliverables, promotional and educational opportunities in which advance Peach State Health Plan marketing and member acquisition objectives and engage Peach State Health Plan employees in supporting the *Cultivating Healthy Communities* project.

About Mercy Housing

Founded in 1981 by the Sisters of Mercy in Omaha, Nebraska, Mercy Housing Inc. has become one of the largest nonprofit affordable housing organizations in the country. Our mission is to create stable, vibrant and healthy communities by developing, financing and operating affordable, program-enriched housing for families, seniors and people with special needs who lack the economic resources to access quality, safe housing opportunities. Our vision is working to create a more humane world where poverty is alleviated, communities are healthy and all people can develop their full potential. We believe that affordable housing and supportive programs improve the economic status of residents, transform neighborhoods and stabilize lives. Our national work spans 41 states and includes a number of subsidiaries that contribute to the financing and development of affordable housing. We have been involved in the development and/or financing of more than 45,000 affordable homes, serving approximately 152,000 people on a given day.

Mercy Housing Southeast (MHSE) is the youngest regional office of Mercy Housing Inc. Headquartered in Atlanta, MHSE has developed or preserved 43 projects delivering over 3,100

affordable rental homes since 1996. Over two-thirds of our portfolio is in Georgia, with 1,184 homes in the Atlanta metro area.

Hills of Fairington, with 406 units, is the largest multi-family property in Mercy Housing Inc.'s nationwide portfolio. It currently houses 465 adults and 366 youth under age 18. All residents are low- or very low-income, typically earning between 30% and 50% of Area Media Income (AMI). Families report an average annual income of about \$18,465. Seventy-eight percent of the Hills of Fairington's adult residents are female, and the most typical household is comprised of a single mother with multiple children. More than 50% of the heads of the households are un- or under-employed and lack a high school diploma or GED. Many of the families served by MHSE have experienced homelessness, domestic violence or other major life traumas. Ninety-two percent are African-American. More than eighty percent are on Medicaid or Medicaid eligible. Terraces of Parkview, our neighboring multi-family property in Lithonia, has 90 units with 110 adults and 158 youth under age 18. The demographic profile is the same as that of the Hills of Fairington.

OVERVIEW

National Church Residences provides housing and supportive services to nearly 29,000 seniors in 28 states. Our services are designed to help individuals achieve and maintain the highest possible level of health and wellbeing. Sometimes referred to as a pre-acute model, our engagement with our seniors is proactive rather than reactive. We understand that health outcomes are affected by more than an individual's encounter with formal health care services. A key to our success is the role of Enhanced Service Coordinators, who work with individuals where they live to identify and address all of their needs and barriers to living at home at the highest level of functional independence. As a result, those we serve can avoid unnecessary hospitalizations and delay or avoid transitions to higher levels of care such as assisted living and skilled nursing care. Our Enhanced Service Coordinators do not just enter the homes of those we serve, they seek to enter into a helping relationship—a relationship that helps those we serve stay **HOME FOR LIFE**.

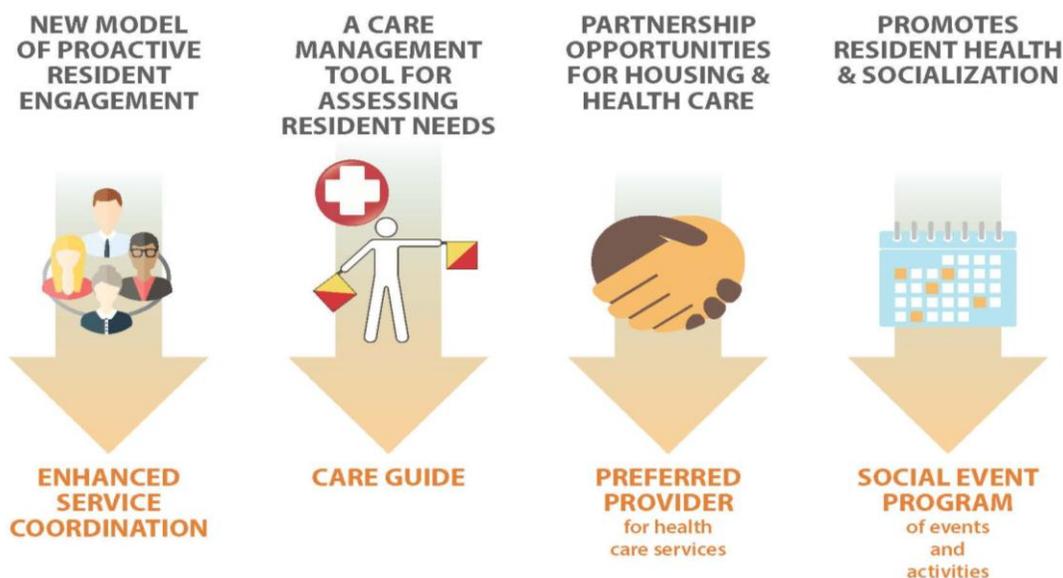
Our expertise in Enhanced Service Coordination across the country includes:

- **Proactively engaging** residents in their care through 371 Enhanced Service Coordinators (ESC);
- **Providing clinical oversight** of our ESCs through an internal team of Quality Assurance professionals (Licensed Social Workers) to 520 Service Coordinators (which includes our 371, plus an additional 149 in outside-owned affordable housing buildings);
- **Providing Enhanced Service Coordination** to over 30,000 seniors.

We are pleased to submit this proposal to UPMC Health Plan to provide National Church Residences' **HOME FOR LIFE** program to UPMC Health Plan members. National Church Residences' **HOME FOR LIFE** program is a proactive, outcomes-focused service model that uses evidence-based assessment and evaluation tools to identify an individual's needs and risk factors. We currently employ this model in our senior affordable housing buildings throughout the country. As an extension of UPMC Health Plan's case management team, our community-based Enhanced Service Coordination will effectively and efficiently provide support to the most vulnerable seniors wherever they call home which includes our Southwestern Pennsylvania properties and also those in the surrounding community. By engaging those we serve where they live, Home for Life can identify and overcome social determinant factors that might impact an individual's ability to best manage their chronic diseases, leading to higher satisfaction and engagement, better health, and cost savings.

What is HOME FOR LIFE?

HOME FOR LIFE is National Church Residences' progressive plan for helping seniors remain healthy and happy wherever they call home.



The program:

- (1) **Provides an Enhanced Service Coordinator to each identified patient of UPMC Health Plan.** UPMC and/or National Church Residences may identify these members as in need of additional social supports to better manage their chronic diseases. This can happen either before or after an acute care episode (pre- and post-acute).
- (2) **Assess each resident.** The Enhanced Service Coordinator meets individually with each patient to complete assessments that will help identify the most highly vulnerable within this population using an evidence based assessment tool that we have customized, called Care Guide, which helps us assess and identify the most vulnerable elderly populations in a community, and allows us to target their needs and design interventions based on diagnosis, health status, social supports and primary care utilization. Care Guide is customizable, and can be adapted to meet the needs of UPMC and Community Health Choices program requirements, as necessary.
- (3) **Identifies and engages preferred providers.** Using the assessment data and information, the Enhanced Service Coordinator works with preferred health care providers to provide health care or wellness services, to address the specific health care needs of an individual senior or the larger community.
- (4) **Promotes health and socialization.** The Enhanced Service Coordinator also promotes our senior residents' health and socialization through engagement and social activities that combat isolation and depression, also contributing to better health outcomes for our residents and Home for Life participants.

The Objectives

HOME FOR LIFE improves wellness for the most vulnerable seniors in a community with a lower-cost, highly effective supportive program. Working hand in hand with UPMC's care management team, the program will:

- **Increase UPMC members' access to keeping affordable, accessible housing** by providing pre-acute services under the **HOME FOR LIFE** umbrella to keep members living healthier and longer in their own homes.
- **Proactively identify members at risk of entering or returning to acute or long term care facilities** using evidence based tools through a 7-step assessment process including the Vulnerable Elder Scale, Depression Scale, and Chronic Disease status.
- **Provide Person-Centered Care Planning** that identifies the members' comprehensive level of care needs and recommended interventions, including home- and community-based services that reduce avoidable nursing facility, hospital and emergency department admissions. This Planning will create treatment/action plans endorsed by members to address members' needs and preferences and promoting optimal health and continued independence.
- **Identify and address social determinants of health** using the Care Guide tool which provides reports on activities of daily living, chronic disease management, and primary care utilization.
- **Assist the Transition of Care process** through an interdisciplinary team approach including the **HOME FOR LIFE** Enhanced Service Coordinator, National Church Residences' onsite Service Coordinators in our buildings, preferred health care providers such as home health and hospice, and UPMC's care management team.
- **Assist members in managing chronic disease** issues and other social determinants which put them at risk for health crises and unplanned hospitalizations.
- **Improve overall wellness and socialization, and reduce risk for isolation with health and wellness programs** in partnership with existing service coordinators in National Church Residences' existing network of communities in Southwest Pennsylvania.

OUR PROPOSAL

Developing effective ways of supporting and engaging members is critical to success in the new healthcare paradigm. As an innovative leader in housing, supportive services and healthcare, National Church Residences is a strategic partner for any entity poised to create positive impact. With our footprint in the continuum of housing, assisted living and skilled nursing homes, National Church Residences is experienced in both pre- and post-acute settings of care.

Proactive Approach

National Church Residences' **HOME FOR LIFE** program is a proactive, outcomes-focused service model that uses evidence-based assessment and evaluation tools to identify an individual's needs and risk factors. We currently employ this model in our senior affordable housing buildings throughout the country, and also propose to take this model outside of our National Church Residences owned affordable buildings, and employ our model for your most vulnerable members in other senior buildings or in the community. The per-member per-month **HOME FOR LIFE** fee includes:

(1) Enhanced Service Coordination

National Church Residences is an innovator in the field of Service Coordination and has worked to enhance the program to include preventative outreach and proactive strategies. Through our **HOME FOR LIFE** program for UPMC, we will rely on our proven model of enhanced service coordination, and employ one (1) Enhanced Service Coordinator per 100 identified UPMC members. This individual will be dedicated to provide in-home services to only these 100 UPMC members, and work in tandem with existing National Church Residences Service Coordinators, where trust is already established, to integrate service coordination into UPMC's care management team. Our experience working alongside our residents assists us in gaining trust in the surrounding community as well.

(2) Evidence Based Assessments

To successfully enhance the Service Coordinator program, National Church Residences launched a new electronic decision-making tool, Care Guide. It enables Enhanced Service Coordinators to track our residents' health and outcome data on our residents in order to catch potential risk factors. Service Coordinators use evidenced-based assessments that are housed in Care Guide to identify and analyze the health, emotional, and social needs of the residents and integrate needed services for the patient. The National Church Residences' Service Coordinator will become a part of your care team involved in all aspects of care planning and providing home-based assessments and support. The assessments we can provide include:

- Rand's Vulnerable Elder Survey
- Activities of Daily Living assessments
- Fall risk assessments
- Isolation screening
- Depression screening

Once a resident or member needs are identified using these assessments, the Enhanced Service Coordinator is able to create an Individualized Care Plan. The plans vary depending on the needs and vulnerability of the resident or member. For example, the care plan for a member experiencing chronic health conditions and identified as isolated would contain some of the following interventions:

- Linking the member with a Chronic Disease Self-Management Program;
- Linking and monitoring the delivery of a Home Health Service;
- Referring member and encouraging him or her to maintain relationship with primary care practitioner
- Providing educational materials to the member to help support the member's self-management of his chronic condition;
- Assisting member in identifying reasons for isolation;

- Encouraging visits and contacts with others;
- Assisting member with becoming a volunteer in his community.

The Enhanced Service Coordinator and member will implement the care plan. Care Guide tracks the interventions and outcomes over time to be able to know which interventions are most effective for a member.

(3) Engagement with Preferred Providers

Once we have identified your members who are at the highest risk and integrated needed home and community-based services into their care management plans, we need to partner with excellent providers. In Ohio, National Church Residences has excelled in directly providing these services to our affordable senior housing residents. In Pittsburgh, we can assist the UPMC care management team in identifying and working with preferred in-network home health providers, including adult day care, home health, and hospice.

(4) Health and Socialization

Finally, the Service Coordinator will not only support health related goals but will also help address social needs.

National Church Residences' Home and Community Services leadership will work with your leadership to determine desired population, outcomes and target goals for the collaboration. Leadership of both organizations will meet regularly to review data and process.

HOME FOR LIFE Project Deliverables

Deliverable	Description
Enhanced Service Coordination: Care Guide Assessments to determine At-Risk/Vulnerable Status of Members	<p>One (1) Enhanced Service Coordinator per 100 identified UPMC plan members in the community, including National Church Residences senior housing, other senior housing, or in community. Care Guide is an electronic decision making tool for service coordinators that identifies risk factors for individuals and guides interventions to ameliorate those issues. Assessments include:</p> <ul style="list-style-type: none"> • Vulnerable Elder Survey • Activities of Daily Living assessments • Fall risk assessments • Isolation screening • Depression screening
Enhanced Service Coordination: Assess, identify and address issues with social determinants as barriers to healthcare	<p>Provides Members with linkage to various key services and benefits to assist in overcoming the impact of any negative social determinant, such as:</p> <ul style="list-style-type: none"> • Education for chronic disease management • Home management services • Homemaker services • Isolation interventions • Legal assistance • Meals • Mental health services • Substance abuse services • Transportation
Outcomes Reporting: Provided to UPMC on	<ul style="list-style-type: none"> • Primary Care Utilization Reports, including <i>why</i> members are not seeing PCP

<p>defined schedule</p>	<ul style="list-style-type: none"> • Chronic Disease Management Impact Reports • Activities of Daily Living Impact Reports • Depression, Isolation Impact Reports • Reports to evaluate outcomes and impact on health care costs, including: <ul style="list-style-type: none"> ➤ Reduction in moves to assisted living and nursing homes ➤ Increased access to physician care ➤ Improved quality of care for patients with chronic diseases ➤ Reduction of emergency room visits and unplanned hospitalizations ➤ Reduction in readmissions to hospital
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Fees

Our **HOME FOR LIFE** program will provide all of the above deliverables utilizing one (1) Enhanced Service Coordinator per 100 identified UPMC members covered by per-member per-month fees. In addition, **HOME FOR LIFE** will generate savings, and we propose an additional shared savings payment if certain agreed-upon value measures are met.

Additional Services

1. Delegated Assessments: We have experience in Ohio performing delegated assessments for dual eligible populations, utilizing plan-prescribed tools with National Church Residences' personnel.
2. Delegated Waiver Service Coordination: We have a proven track record of locating and providing successful waiver coordination to 100% of our assigned members by a health plan if that member had not moved out of the service county or into a skilled nursing facility.
3. Money Follows the Person Transition Coordination: We have provided MFP transition coordination to 771 Ohioans since 2010. We are contracted with the State to provide this service in 66 out of 88 counties. Under Money Follows the Person, we have assisted 392 clients transition from Long Term Care to housing with supports in their communities.

CONCLUSION

It is National Church Residences' vision to continually improve communities by transforming the way seniors and vulnerable populations live and thrive. The **HOME FOR LIFE** program is an effective way to support individuals who face aging challenges such as chronic conditions, lack of health care understanding and dwindling social support. National Church Residences has a proven track record in providing excellent housing with vital services to allow individuals to age in place safely and successfully. We will be an excellent partner in providing the same supportive services to your members both in and outside of the walls of our housing environment. For any questions, please contact:

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