National WELL HOME NETWORK

HOUSING-BASED SERVICE MODELS

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Housing-Based Service Models (HBSMs) are a voluntary population-based approach to integrating health and social services and support as needed to help all individuals in low income communities thrive, living the lives they choose while maintaining the best health and independence possible. HBSMs combine existing resources with comprehensive care management to support person directed care in the most efficient way possible so that constrained public resources may serve as many people as possible.

HBSMs are person-directed service delivery systems that use housing as a platform to integrate health and social services. Participants benefit from a seamless set of services that include care management, care coordination, transitional care, and facilitated self-management of chronic conditions, medication management, health education, and wellness services. These services are coordinated by a housing-based Care Coordinator and Wellness Nurse team that formally partner with health care providers and community organizations including those providing home health, behavioral health, social services, and medical care.

> *By care coordination we mean "a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence based standards of care" (National Coalition on Care Coordination).*

The goal of the Well-Home Network is to aggressively advocate for replication of proven HBSMs in every state. As a starting point, the Well-Home Network will work to meet the needs and preferences of the growing elderly population – especially the lowest income living in congregate housing. In the long term, we are committed to weaving the principles of HBSMs into the fabric of our nation's health care delivery system, making supports and services the norm for every resident of publicly subsidized housing regardless of age or household composition.

The primary goal of HBSMs is to create a new *system* of care. Effective programs such as PACE (the Program for the All-inclusive Care of the Elderly) have served seniors the meet specific clinical criteria. Assisted Living residences have also been a solution for seniors with specific care needs. HBSMs are a system available to an entire population just as the public education system is available to all school age children. HBSMs are centered in low income housing communities, thereby reaching the highest need populations, while also inviting participation in the HBSM to the residents in the surrounding neighborhood. HBSMs create a new layer of support and coordination between individuals and the traditional health care system.

The key components of a Housing Based Service Model are:

(1) HOUSING IS THE PLATFORM

Publicly subsidized housing is where a large proportion of the health care system's highest need population lives. Mission-driven, affordable housing providers are stepping up to insure that their residents can remain in their homes for as long as possible regardless of health status, protecting residents' Fair Housing rights.

A primary goal of HBSMs is to increase the capacity of housing organizations to provide and/or improve access to supportive services to their residents and be part of their state's health care delivery system.

HBSMs are highly effective because the care management team is embedded at the housing site and is an integral part of the housing team developing a trusting relationship with residents. Most HBSMs involve all housing provider employees, from the CEO to maintenance technicians, are a part of the HBSM team. Some HBSMs separate the roles of the property management staff and the care coordination staff.

For example, in an HBSM:

- HBSMs require the full support of the housing organization's Board of Directors and key leadership.
- The organizing entity, or backbone organization of HBSMs are housing nonprofits.
- The participating housing nonprofits build their capacity to provide and sustain supportive services to their residents.
- The Care Coordinator (as defined above) is employed by the housing organization, or an affiliate when direct employment is not an option.
- The housing organization provides day to day oversight to the on-site Wellness Nurse and other members of the Care Coordination Team regardless of whether the Nurse is employed by the housing organization or is under contract through a certified provider. Clinical supervision will be the responsibility of the certified provider.
- As a core mission, the housing provider's practices and policies promote resident wellness and function.

(2) PARTICIPANTS ARE IN THE DRIVER'S SEAT

HBSMs are built on the fundamental concept that individuals must be fully engaged in their health in order to improve it. Engagement requires ownership and participation in the design of the model, continuous improvement of the model, control over their individual care plan, and the power to make decisions about the services, care, and medications they receive. Having control over one's own care plan can motivate participants to change behaviors that are significant determinants of their health. To that end:

- Participation in the HBSM is completely voluntary including determining who has access to personal health care information.

- Participants determine their care plan and set their own goals.
- Participants determine what health care services they elect to receive.
- Participants have access to a wide variety of prevention services and interventions that have proven to be effective.

(3) HOUSING IS A PARTNER IN HEALTH CARE REFORM

HBSMs share the health care reform goals of improving health, increasing access to care, and reducing growth in spending. By linking primary, acute, post-acute and behavioral health care, HBSMs improve transitions, care coordination, and chronic care management, and allow seniors to age in place. Consumer preferences to age in place, or in their community, will require that this country's long-term care system transitions from a centralized to a decentralized system of care. The network of publicly subsidized housing across this country provides a perfect decentralized platform to deliver health care and social supports. As an integral part of health delivery system reforms, HBSMs partner with health care providers and share their goals. For example:

- HBSMs typically have written agreements with hospitals on admission and discharge protocols.
- HBSMs coordinate with primary care providers (PCPs) and communicate with the PCPs before and after primary care visits as possible and when needed.
- HBSMs collect data on many of the Accountable Care Organizations' performance measures and state 2020 Health goals entering the data into one data platform utilized by all HBSMs.
- HBSMs have established relationships with area nursing homes and assisted living residences to coordinate smooth admissions and discharges.

(4) A POPULATION BASED SYSTEM

The residents of senior housing communities represent a broad and diverse population: ages can run from 55 to over 100; health status ranges from the very healthy to nursing home level of care; residents come from a variety of cultures and often speak multiple languages; cognitive health ranges from excellent to Alzheimers; some residents are employed and others are retired; and most senior housing includes younger persons with a physical or mental health disabilities. And because those individuals live in the senior housing community for as long as they choose, HBSMs must provide continuous support to all residents as their needs change over time. As a result, HBSMs are not episodic and are not exclusively targeted to only the high need individual. The amount of services a participant receives changes over time based on needs and preferences, however, participants remain enrolled in the HBSM and in some models a participant continues to receive services even after permanently moving from one housing setting to another within the HBSM's geographic service area. For example:

- HBSMS serve all residents in a residential setting, multiple residential settings or a geographic area.
- HBSMs include anyone within that population regardless of health status.
- HBSMs utilize data to determine the population needs of participants on a local, regional or statewide basis and develop population health plans accordingly.
- HBSMs do not discharge participants.

(5) TEAM APPROACH

HBSMs bring social service organizations and health care providers together with housing providers as a team. These cross-sector teams foster efficiency and effectiveness, avoiding duplication of services in the best interest of the person and the population the HBSM serves. Teams operate within the framework of a written agreement that spell out payment methods, information sharing protocols, and delivery of care procedures. The housing partner

does not provide health care services. It collaborates with licensed providers and social service agencies through written agreements that may include formal contracts, Interagency Agreements or Memoranda of Agreements. New administrative structures, governance and operation agreements may also be developed to manage these collaborations. For example:

- HBSMs enter into written agreements with one or more mental health agencies.
- HBSMs enter into written agreements with one or more Area Agencies on Aging.
- HBSMs enter into a written agreement with one or more home health agencies.
- HBSMs enter into written agreements with other organizations providing essential services to the participant population such as Refugee Resettlement Centers, sheriffs' offices, emergency medical services, Community Action Agencies and Food Insecurity Intervention programs.
- HBSM teams meet regularly and communicate about participant needs on a routine basis.

(6) OUTCOME MEASURES

HBSMs routinely assess participants, collect uniform data, and measure outcomes in full compliance with HIPAA. HBSMs measure access to health and social services, health and functional status, and costs. HBSMs practice evidence-based service coordination and wellness activities. These models are measured by independent, third-party evaluators using a combination of claims data, assessment data, and participant surveys. For example:

- Uniform assessments include demographic data, Activities of Daily Living, Instrumental Activities of Daily Living, and screenings for cognition, nutrition, depression, falls, substance abuse, and other items as appropriate for the population.
- Data are entered into HIPAA compliant, secure data platforms.
- HBSMs utilize data to develop individual health plans as well as population wide health plans.

(7) EXTENDING THE CARE TEAM AND CAPACITY

HBSMs engage peers, neighbors and family caregivers thereby extending the health care workforce and engaging family members in care planning and care delivery – if the participant wants their involvement. At the same time, HBSMs provide critical support, respite and relief to family caregivers. The HBSM care team embedded in the housing are trained to perform functions traditionally performed by physicians, nurses and social workers such as care management, assessments, and transitions planning. The care team serves as an extender to health care providers, thereby allowing them to practice at the top of their license. In a time of high demand and short supply of primary care physicians and nurses, HBSMs extend the health care workforce. For example:

- Care management and other functions that are more effectively and efficiently performed at home rather than in a medical setting, are delegated to "extenders" in the home setting thereby increasing the reach and effectiveness of physicians and hospitals into their patient's homes.
- Family members are part of the care team, but are no longer the sole caregiver.
- Person-centered interview techniques are used to identify a participant's key relationships and what family, friends or neighbors may be able to serve as a larger support network especially during transitions.
- Volunteers are enlisted within the housing and in the larger community, such as churches and colleges.

(8) EVIDENCE-BASED PRACTICES

Dozens of interventions have been designed to reduce falls, improve medication management, enhance self-management of chronic conditions, manage mental and cognitive health conditions, and support healthy lifestyles

(nutrition, exercise, and socialization). When these practices have been proven to reduce costs, increase access to care or improve health status, the interventions are considered evidence-based practices. Rather than designing interventions or duplicating the research, HBSMs utilize all existing resources. Some evidence-based practices focus on individuals and others are group programs. Selection of evidence-based practices or programs is driven by the data collected on individual participants as well as the aggregate data on the population a HBSM serves. For example:

- At HBSM sites with a high rate of falls the following evidence-based programs may be brought to the community: Matter of Balance, Tai Chi, and Stepping On.
- Programs proven to improve healthy lifestyles include Eat Better and Move More, and Geriatric Resources for Assessment and Care of Elders (GRACE).
- Proven practices in cognitive impairment and mental health.
- Existing programs such as PACE have proven to extend aging in place for high-needs individuals and complement HBSMs by keeping participants in their homes.
- Evidence is emerging on short-term interventions such as CAPABLE (Community Aging in Place – Advancing Better Living For Elders) aimed at improving the functionality of seniors and their homes.
- And HBSMs can develop their own promising practices, adding to the evidence base in ways that use the residential setting to improve access to care such as the use of telehealth in congregate housing.

The Well-Home Network will use this HBSM definition and key components as a compass or guidepost to identify the housing based service models the Well-Home Network will seek to replicate nationally. The end goal of the Well-home movement is to bring services and supports to the vast majority of low income seniors living in publicly assisted housing across this country. Please contact the Well-Home Network about models your organization is developing or your interest in becoming a part of the Well-Home movement.

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