CARING FOR OUR AGING HOMELESS POPULATION: CHALLENGES AND SOLUTIONS

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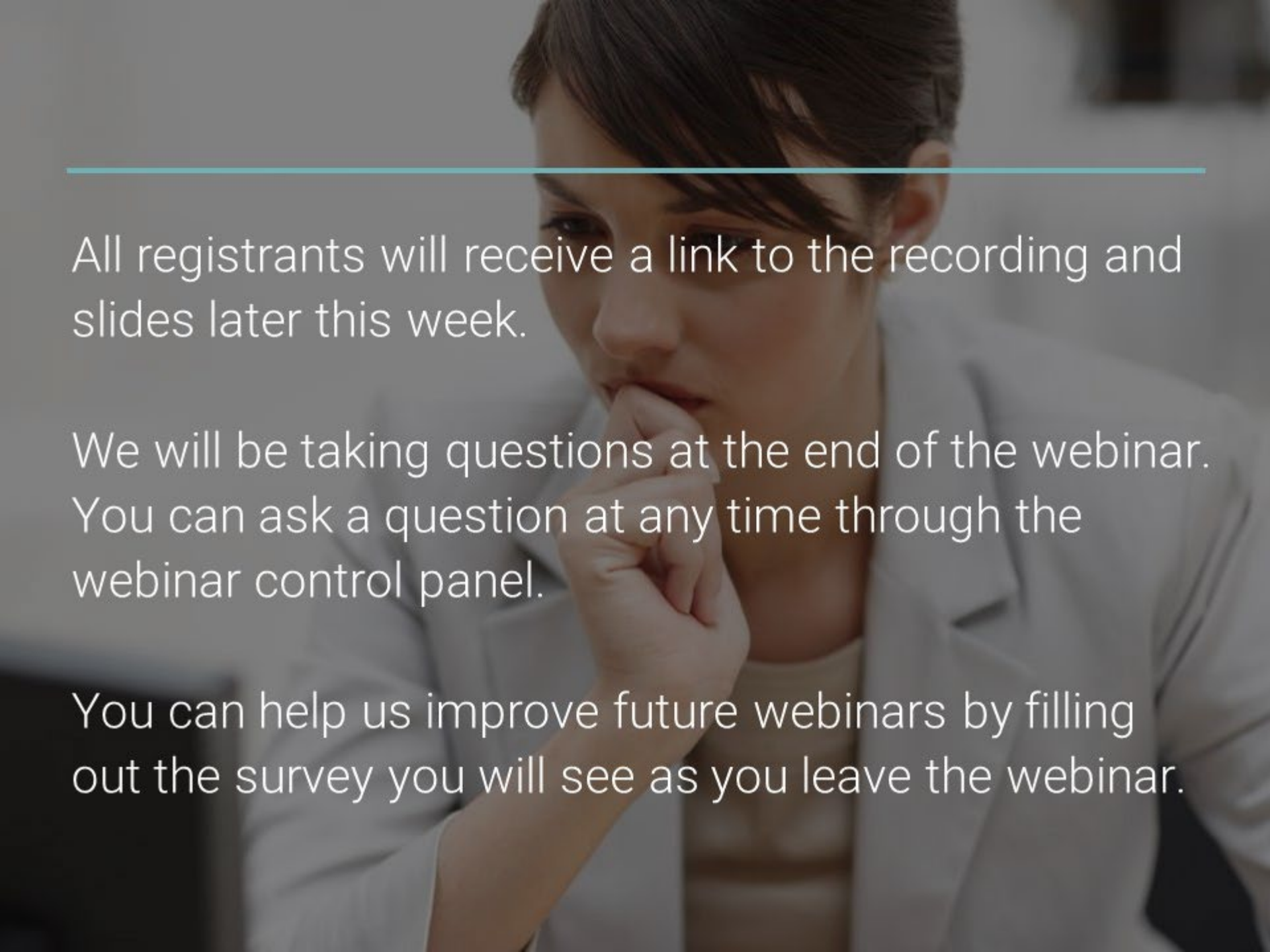

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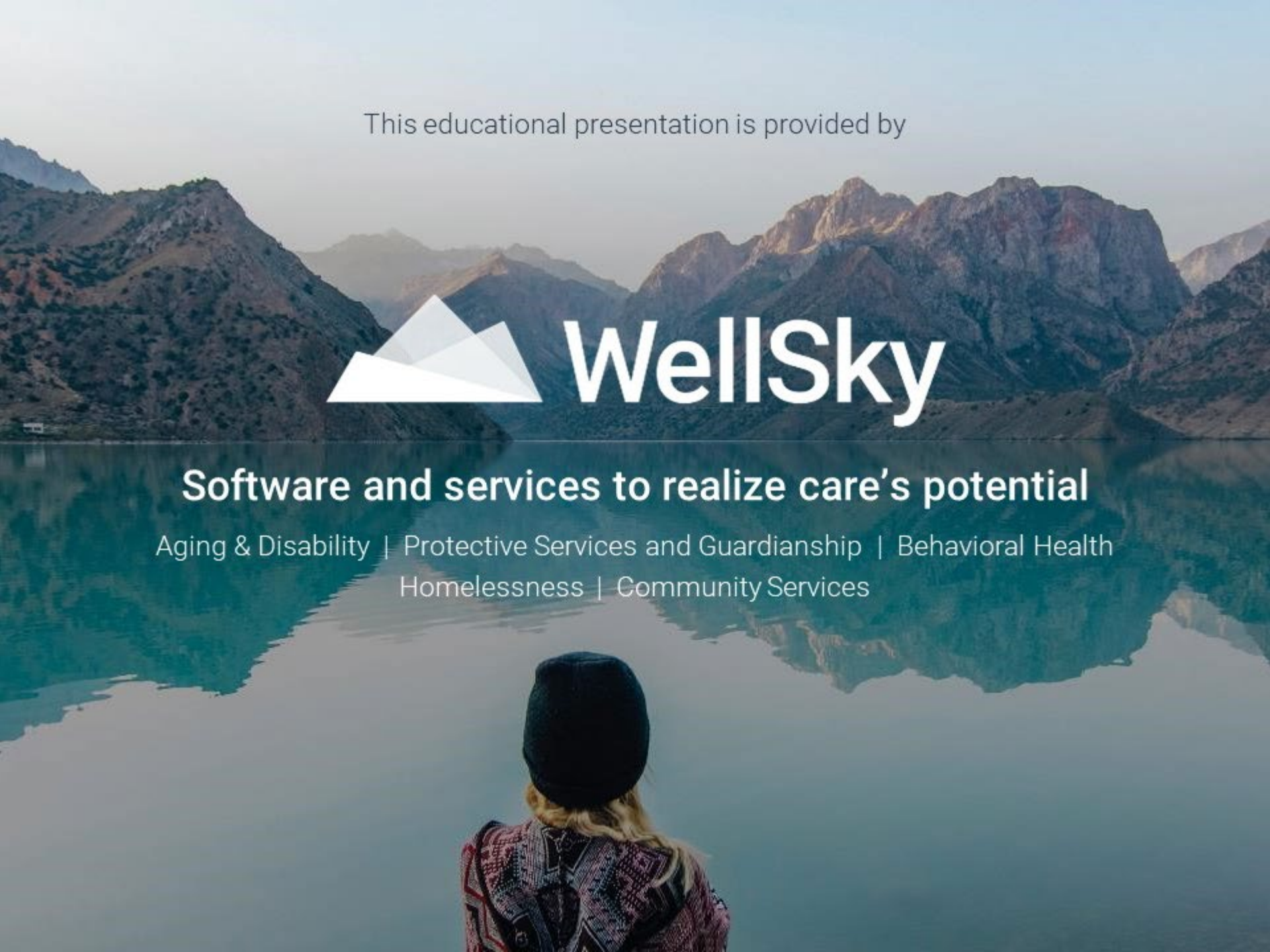
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78% states use our LTSS solutions
60% HUD continuums of care
50% area agencies on aging

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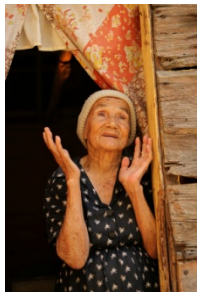

Preparing for The Changing Face of Aging in America

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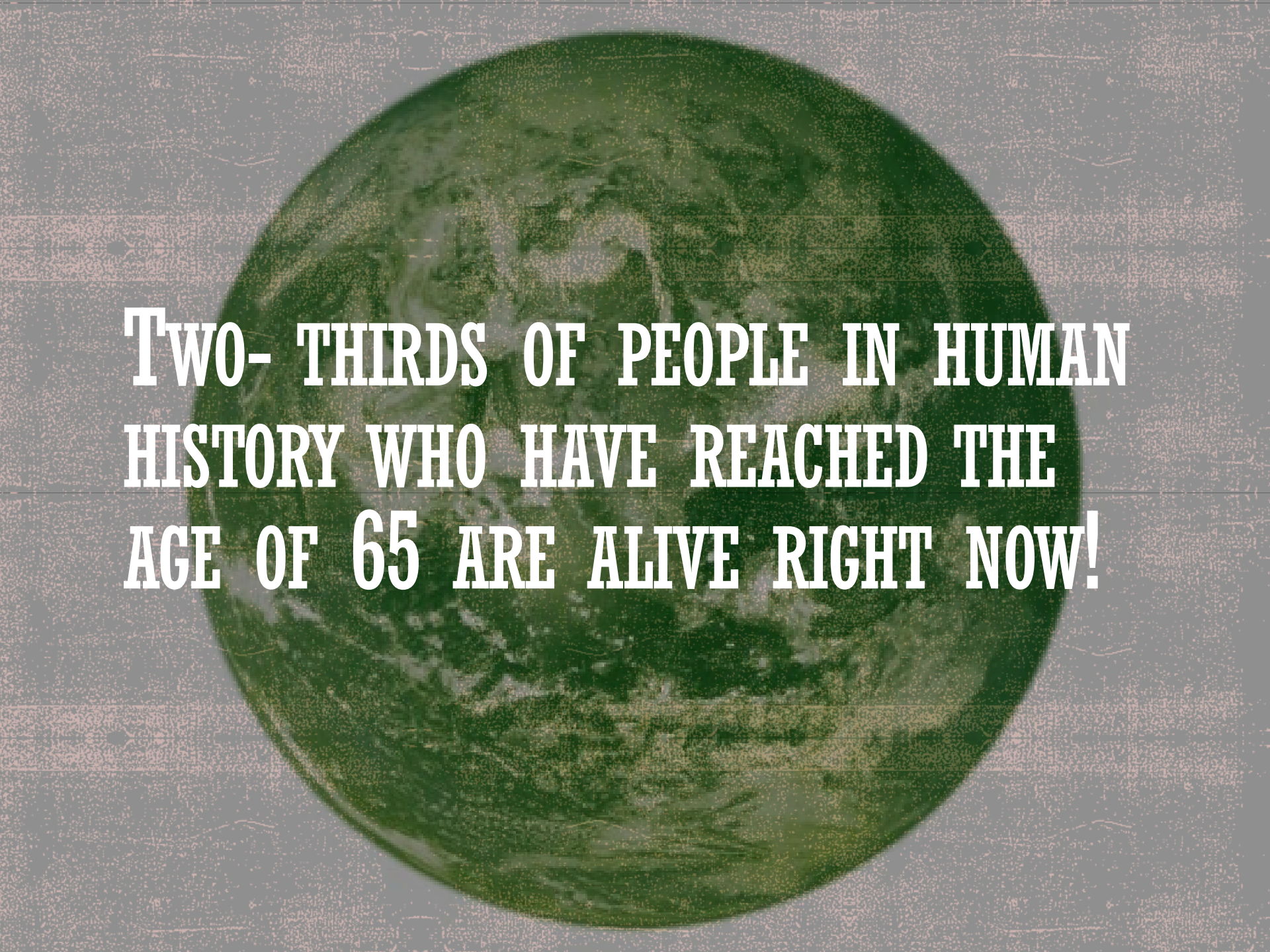
Two- thirds of people in human history who have reached the age of 65 are alive right now!

REALITIES OF AGING IN COMMUNITY

Consistent preference for remaining at home

Challenges of "aging in place"

Physical barriers	**Financial barriers**	**Loss of social connectedness and engagement**

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HOMELESSNESS AMONG THE ELDERLY

Current homeless older population

Increasing potential for homelessness among 65+ population

Solution is service enriched housing options

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WHO ARE THE OLDER HOMELESS?

50-64 year olds—younger than typical elderly population

History of homelessness, poverty, drug abuse, mental illness

More comorbidities, ER and hospital use

Lower life expectancy (avg. 64 years)

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GROWTH IN OLDER HOMELESS POPULATION

- **2007-2010 increased from 18.9% to 22.3% of all sheltered individuals**
- **Average age 53**
- **Older adults comprise 50% of housing programs for the homeless**
- **% of total homeless population who are older—almost 50%**
- **Increase in % cognitively impaired**

POTENTIAL FOR INCREASED HOMELESSNESS AMONG 65+

- **Increase in elderly living in substandard housing**
- **Lack of resources to maintain current housing post-retirement**
- **High housing cost burden not sustainable with greater live expectancy post 65 years**
- **Increased risk for housing-related injuries; increased costs to Medicare and Medicaid**
- **Lack of safe, affordable options (particularly rental)**

SOLUTIONS TO HOMELESSNESS AMONG 54-64 YEAR OLDS

- **Expansion of permanent supportive housing options**
- **Deep rental subsidies—congregate settings or vouchers**
- **Significant care management**
- **Evidence-based wrap-around service models rooted in cognitive behavioral and family system approaches**

PUBLICLY SUBSIDIZED HOUSING PLUS SERVICES FOR 65+ POPULATION

- **Currently housing over 2 million low and modest income older adults**
- **Typical property with limited or no service coordination**
- **Aging of residents requires new strategies and partnerships**

DEMOGRAPHICS
(Section 202 residents)

Poor	Aging	Diverse
Average income (2015) = $13,238[1]	Average age = 79[1]	Hispanic = 13%[2] Black = 19% White = 56% Other = 19%

Chronic conditions and functional limitations more prevalent among lower incomes, advanced ages, minorities

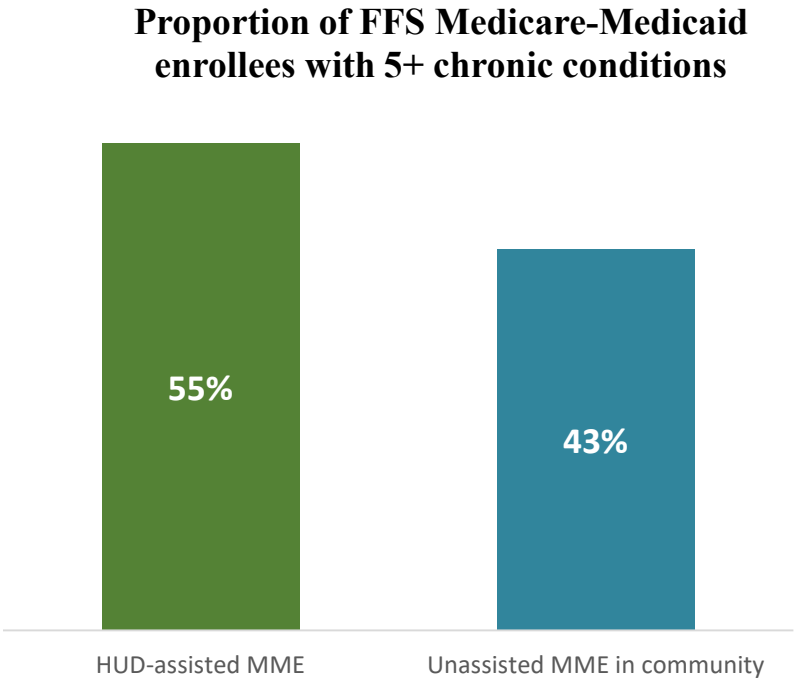
[1] http://nlihc.org/sites/default/files/AG-2017/2017AG_Ch04-S07_Section-202.pdf

[2] *Section 202 Supportive Housing for the Elderly Program Status & Performance Measurement;* Data is for residents of Section 202 housing properties, 2006

High Level of Chronic Illness

Approximately **68%** of HUD-assisted beneficiaries age 65+ are dually enrolled in Medicare and Medicaid[1,2]

[1] Of those who matched to Medicare
[2] Number who matched to Medicare and Medicaid, not number eligible



Source: A Picture of Housing & Health, found at http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.pdf

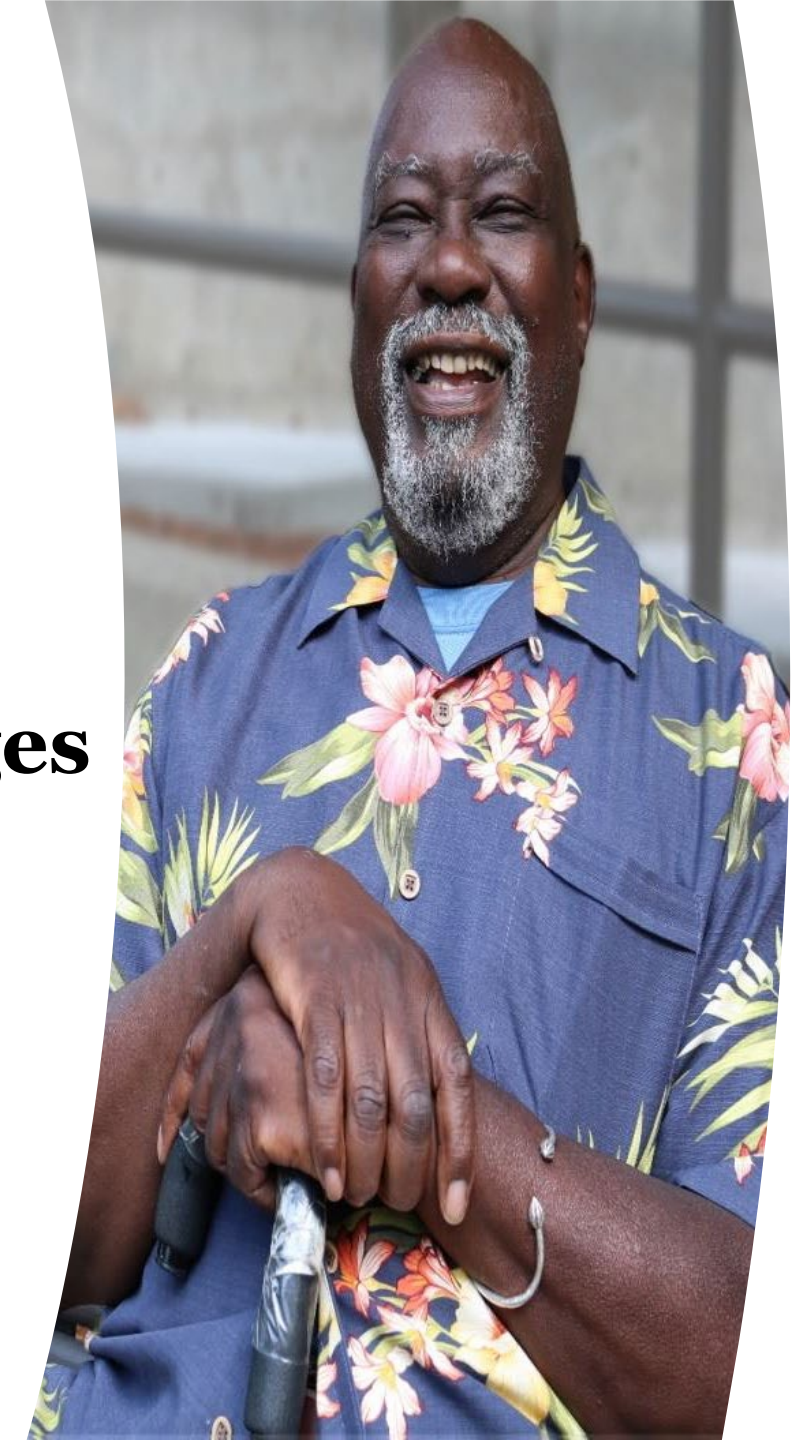
Model Components

- Independent, affordable senior housing
- Onsite staffing
  - Service coordinator
  - Wellness nurse
- Services
  - Assessment
  - “Care coordination”
  - Wellness/prevention
  - Transitional care

Model Principles

- Population health approach
- Senior population focus
- Low-income population focus
- Place-based

Model Advantages



- **Reach concentration of at-risk individuals, including duals**
- **Delivery efficiencies**
- **Leverage existing service coordinator role and presence of other housing staff**
- **Trusting relationships with residents; know their preferences, needs and capacities**

Model Advantages

- Observe residents living circumstances
- Monitor residents and notice potential emerging health issues before become a crisis
- Help remind and encourage residents to participate in activities and appointments
- Identify and help residents overcome barriers preventing following through on appointments and needed self-care management

Promising Research

- **Residents in properties with an onsite service coordinator had 18% lower odds of having a hospital stay during the year**

  Source: *Affordable Senior Housing: What's the Value?,* found at: http://bit.ly/1QqMvpo

- **Participants in urban panels of the Supports and Services at Home (Vermont) program had $1,437 lower growth in annual total Medicare expenditures than beneficiaries in comparison group**

  Source: *The Impact of the Vermont Support and Services at Home program on healthcare expenditures,* found at: https://www.huduser.gov/portal/periodicals/cityscpe/vol20num2/ch1.pdf

Promising Research

- **Participants in Staying at Home program (Pittsburgh, PA) significantly**

Less likely to

- Visit the ER
- Have unscheduled hospital stays
- Report negative health conditions
- Move to a nursing home

More likely to

- Visit the dentist
- Use health care services
- Use health services outside of hospital
- Report health improvements

Source: *Service-enriched housing: The Staying at Home program,* Journal of Applied Gerontology, July 9, 2014.

- **Residents participating in Selfhelp's Active Services for Aging Model (Queens, NY), compared to control group, experienced:**
  - 32% lower hospitalizations
  - 1-day shorter length of hospital stay

Source: *Medicare beneficiaries living in hosing with supportive services experienced lower hospital use than others*, found at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0070

Exploring Financing Options for Services in Affordable Senior Communities

Potential Financing Options

1. **Create a housing-based service coordination benefit under Medicare Part B.**
   - 1a. **Create an alternative payment model for place-based service coordination (e.g. CPC+) that could be paid through an umbrella entity (e.g. like a "mini-IPA").**
2. **Create a mechanism that aggregates volume of attributed beneficiaries in housing properties for ACOs.**
   - 2a. **Create an intermediary network similar to that described for managed care plans (see potential solution 4) or allow ACOs to also purchase services from intermediary.**
   - 2b. **Assign buildings and the FFS beneficiaries to a specific ACO based on geography.**

Potential Financing Options

3. **Allow housing-based service coordination to be a MA supplemental benefit. (Single-plan approach)**
   - **3a. Plans work one-on-one with individual housing properties (or organizations with multiple properties).**
   - **3b. Plans work one-on-one with a network of housing providers (single organization or multiple organizations).**
4. **Create intermediary entities that serve network of housing properties through which MA plans purchase housing-based service coordination as a supplemental benefit. (Multi-plan, multi-property approach)**

Potential Financing Options

5. **Create a housing-based service coordination benefit under Medicaid.**
6. **Define service coordinators as allowable providers under Medicaid.**
7. **Allow establishment of some type of preferred provider relationship between managed care plan and housing property (e.g. housing buildings are assigned to Medicaid plans allowing for equitable distribution).**

Vetting Solutions

- Need multiple solutions
- FFS and managed care
- Market based and regulatory/policy
- Pooling mechanism to address volume challenge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