Overview and Interim Program Update

National Home & Community Based Services Conference

August 30, 2018

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Hebrew SeniorLife
Our DNA: One Commitment – Redefine the Experience of Aging

Reimagine Senior Living

Continuing Care Communities
• NewBridge on the Charles
• Orchard Cove

Supportive Housing Sites
• Center Communities of Brookline
• Jack Satter House
• Simon C. Fireman Community

Rediscover Every Senior’s Potential Through Research
• Aging Brain Center
• Syncope & Falls
• Translational Research
• Center for Musculoskeletal Research
• Genetics & Geriomics
• Quality of Care/Standards

Redefine Senior Health Care

Home & Community Based
• Home Care
• Geriatric Primary Care
• Outpatient Care
• Hospice

Facility Based
• Medical Acute Care
• Rehabilitative Care
• Long-term Care

... and Teaching
• Medical Students
• Residents & Fellows
• Nursing & Therapies
• Interns

Recognize the Power of Partnerships
Reach out for Philanthropic Support
Supportive Housing
“A Day in The Life”

8:30PM: Receives call from daughter asking how her day was and wishing her goodnight

8:00AM: Resident starts her morning with a Tai Chi Class

6:45PM: Listens to local symphony orchestra’s live performance of Shahrazad

9:15AM: Meets with Wellness Coach: Discusses goal to attend and dance at granddaughter’s wedding in 6 months

4:00PM: Learns from local high school students how to connect with family on Skype

10:00AM: Has Well-Check with Nurse Practitioner who eliminates medication due to improved health

3:30PM: Enjoys visit with Depression Care Manager who supports her increased community involvement

10:45AM: Amends File of Life with updated family contact

2:30PM: Social Worker updates daughter on mom’s improved sense of well-being

11:00AM: Is greeted by Front Desk Receptionist who asks about her grandson’s graduation

2:00PM: Meets with Chaplain to continue conversation on finding meaning in her life experiences

11:15AM: Is asked by Facilities Technician how she likes her new tub cut

1:30PM: Works with Physical Therapist on balance in the Fitness Center

11:45AM: Is reminded to take her medications before lunch

12:00PM: Enjoys a nutritious meal with other residents

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The Current Challenge: A Housing and Healthcare Disconnect

### Opportunity

- **Effectively Deliver on Better Care, Better Outcomes, and Lower Cost**
  - Population health approach to caring for frail seniors living in a congregate setting
  - Low cost, service enriched environment with eyes on approach by staff in all departments
  - One place-based team with intimate knowledge and strong relationships with residents serving as the link to providers and plans
  - Pooled resources by payers to efficiently deploy resources for preventative services

### Challenge

- **Fragmentation:**
  - Multiple payers without critical mass in each building
  - Separate care managers for each plan, language, and frailty level – inefficient and infrequent visits

- **Systemic Issues:**
  - No system for communication between housing staff and health plans/providers
  - Eligibility gaps for services needed to remain in independent setting
  - Lack of evidence supporting outcomes
R3 Vision: Sustainable Model of Housing with Services

**POOLED FUNDS**
- Pooled funds cover cost of wellness teams
  - Insurers
  - Housing Providers
  - State & Federal agencies
  - ACOs
  - PMPM, shared cost, or convener model

**ENHANCED SUPPORTIVE HOUSING WITH SERVICES**
- Eyes on
- Emergency Response
- Care Coordination
- Community Services
- Assessment
- Wellness Programming
- Mental Health
- Nutrition

**BETTER OUTCOMES**
- Decreased hospitalizations
- Decreased Emergency Room visits
- Decreased Long Term Care Placements
- Decreased Falls
- Increased Medication Adherence
- Increased Self Care
- Increased use of Home and Community Based Services

**SAVINGS**
- Place based services result in savings to healthcare system
**Goals**
Create a platform for housing and healthcare collaboration & measure effectiveness

**Wellness Teams**
Wellness Coordinator and Wellness Nurse

**Partners**
Payers, hospitals, AAAs, emergency service providers, mental health, housing

**Timing**
6 months preparation, 18 months implementation
Implementation Period: July 2017-Dec 2018

**Our vision** is to create a replicable, scalable, and sustainable model of housing with supportive services to enable seniors to live independently as long as possible, receiving the right care in the right place at the right time, while reducing healthcare cost and long term care costs for this growing population.
Total Funding, Scope, and Evaluation

Combined Funding Sources of $1M

7 Senior Housing Sites
1,100 Residents
400 Enrollees

Evaluation / Research

LeadingAge LTSS Center at UMass Boston *

Health Policy Commission *
MassHousing *
Dept. Hsg & Comm Development *

HSL CCB Danesh *
HSL CCB Cohen *
HSL CCB Goldman *
Winn – TVAB *

* Enterprise
* Beacon Communities
* WinnCompanies

* HSL - Fireman
* MRE – Unquity House
* MRE – Winter Valley

Pre/Post & Control Group
* Qualitative & Quantitative
Aims and Key Performance Indicators for R3

**Aims**

- Increase utilization of wellness programs by 20%
- Increase linkages to mental health services by 20%
- Improve quality of life and ability to live independently by 10%

**Key Performance Indicators**

- Falls
- Wellness checks
- Medication adherence support
- Wellness program attendance
- Health education
- Self management/care
- Satisfaction with life and independence

**Cost Effectiveness**

- Reduce transfers to hospitals, emergency rooms, and long term care by 20% for target population
- Reduce re-hospitalizations by 20%
- Transfers to long term care
- Transports to hospitals and emergency rooms
- Hospital readmissions within 30 days of discharge
Key Components of R3 Model

Resident Engagement

- 400+ residents enrolled across 7 sites in two regions
- Baseline assessments completed with Vitalize 360 tool
- 250 control site assessments completed
- Monthly member newsletter

Partnerships

- Emergency responders: data, training
- Housing: open door, recruiting, eyes on, communication
- AAAs: care managers, evidence based programs
- Health plans: care teams, sustainability
- Mental health: referrals, awareness

Interventions

- What matters most – assessments, risk groups
- Assessments, med support, provider connection
- Monthly check in calls/data gathering
- Wellness programs (brain health, falls prevention, chronic disease mgmt.)
- Care manager collaboration and referral
- Transitions management
Key Performance Indicators: Sample Data Analysis

Analysis of R3 Ambulance Data 2017 – 2018 YTD
Fallon Ambulance Transport Reasons

- Minor Medical: 16.0%
- Fall - Minor Injury: 24.0%
- Illness / Injury - Unspecified: 8.5%
- Weakness / Dizziness / Fainting: 7.3%
- Respiratory / SOB: 7.2%
- GI - V/D: 5.3%
- Pain: 4.7%
- Mental Health: 4.3%
- Cardiac: 3.3%
- Abdominal Pain / Problems: 2.8%
- Serious Medical: 2.3%
- Hemorrhage/Lacerations: 1.8%
- Flu / Cold / Cough: 1.8%
- Substance Abuse / OD: 1.8%
- Other (11): 8.7%

Resident Transport by Time of Day (hr)
Baseline and Interim Results
Resident Trips to Hospital via Ambulance

Baseline Annual Total: 559 transfers
Annualized Total R3 to date: 456 transfers
Difference: 18.4% reduction

Increased transports in Dec due to unspecific pain and mental health - potentially associated with holidays

Baseline assessments and R3/Resident engagement started in April 2017
# Baseline and Interim Results
## Resident Transitions to Long Term Care

### Baseline Annual Total: 34
### Annlzd Total R3 to date: 31.6
### Difference: 7% reduction