Expanding the world of possibilities for aging.

Partnering with Aging Services in the Community

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LeadingAge

inspire. serve. advocate.

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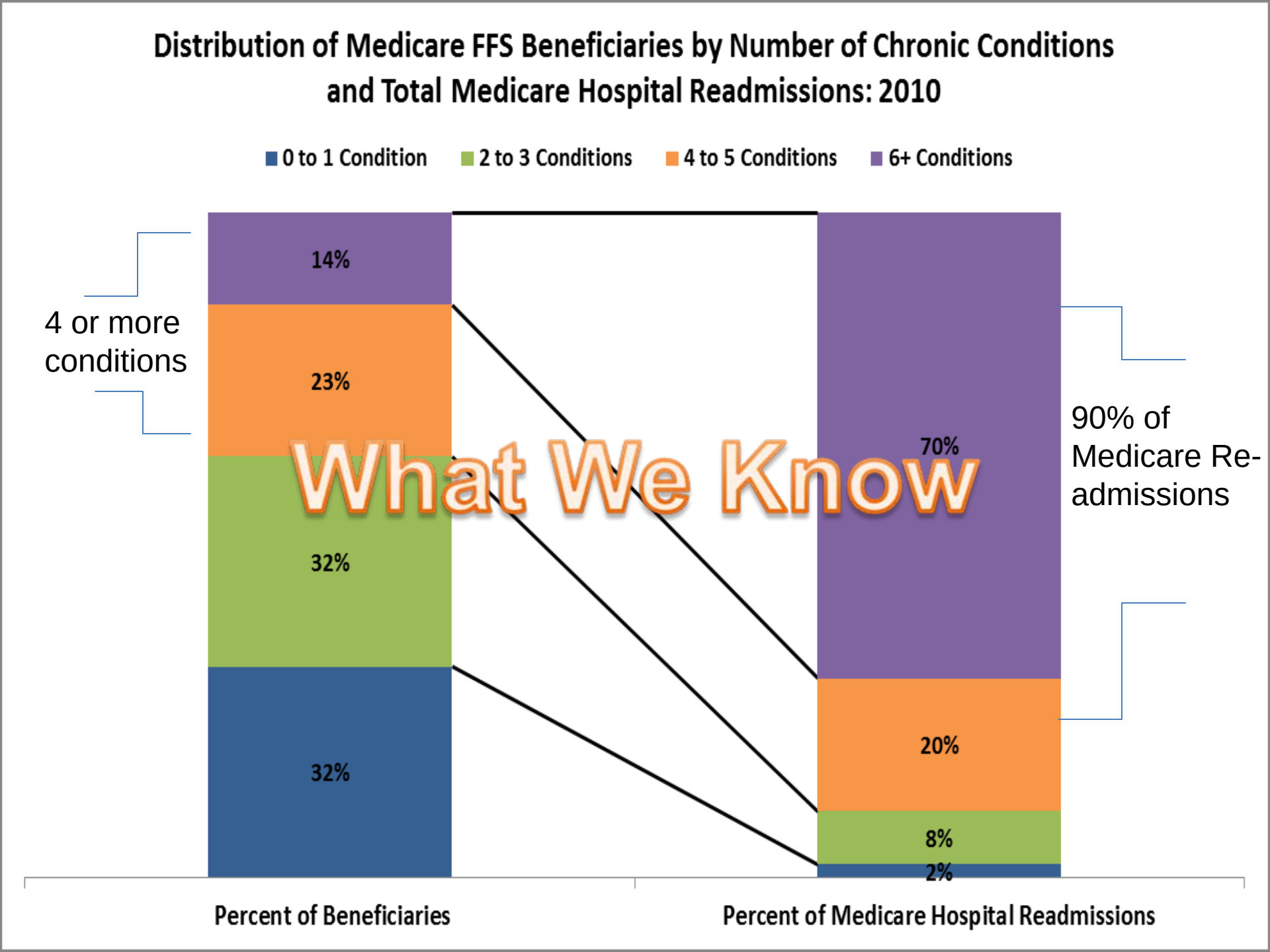
Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Hospital Readmissions: 2010
0 to 1 Condition
2 to 3 Conditions
4 to 5 Conditions
6+ Conditions
14%
23%
32%
32%
70%
20%
8%
2%
4 or more conditions
90% of Medicare Re-admissions
What We Know
Percent of Beneficiaries
Percent of Medicare Hospital Readmissions

Natural Points of Aggregation – Coordinating Services where People Live

	% > 65 population	% Medicare Costs	Where do they live?
Frail Elderly	5%	43%	NHs, assisted living, affordable housing, community-dwelling
Chronically Ill (multiple co-morbid)	20%	42%	Affordable housing, CCRCs, ALFs, community-dwelling,

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Aging Services linked to Reduced Hospital admission

Nutrition Programs

Adult Day Services

Med Management

In-home Monitoring and Tele-health

Care Coordination

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Examples of LeadingAge Members Participating in CCTP Demos

Brewster Place, Topeka, KS

CJE SeniorLife, Chicago, IL

Eddy Visiting Nurse Association, Troy, NY

All use a combination of nurse coaches, social services, tele-health and coordination with primary care within a community, aging services organization

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Pulling it all Together

Getting to our Goal

Present world of health care reform:

- Hospital and physician practice focused
- Playing with payment system
- HCBS are seen as "purchased services"

Incremental process change

Activated communities:

- "System" is identified more broadly
- Services are linked and integrated
- Focus is on broad measures of "health"

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Health Measures and Payment must Focus on Populations

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Using Supportive Affordable Housing as the Platform

Affordable Housing for the Elderly Characteristics

- Affordable Housing is a natural aggregator of high risk individuals
  - >90% are on Medicare
  - 1/2 of those are Medicare/Medicaid beneficiaries and 1/3 of residents are rated as vulnerable on the VES scale
- Average age= 82, with multiple chronic illnesses
- For many it where they will spend the rest of their life
- Residents have a trusting relationship with housing management and service coordinators

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What it Could Look Like

Expanded role of Wellness and Homecare Nurse

Medical Homes

Med Assistance

Service Coordinators linked to Care Managers and Primary Care Teams

New Partnerships with Health Plans

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Successful Housing/Medical Models

- SASH – VT (affordable housing, Medicare/Medicaid, patient-centered medical homes)
  - 19% reduction in hospitalizations
  - Reduced falls by 22%
  - Costs $700/person/yr
- Mercy Care Plan
  - 43% fewer hospital days and 31% fewer admissions
  - 9% reduction in ED visits
- National Church Residences
  - Working with Ohio “duals” integration demo

SASH
SUPPORT & SERVICES at HOME
a caring partnership

mercy HOUSING
Live in Hope

National Church Residences
CENTER FOR SENIOR HEALTH

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Challenges

- Evidence is still local – how do these program scale?
- Resistance for payors and “traditional health care systems” to look to housing and community-based services
- Resistance by community-based service providers to understand *risk*
- Limited inventory of affordable housing and limited capital options to invest in more

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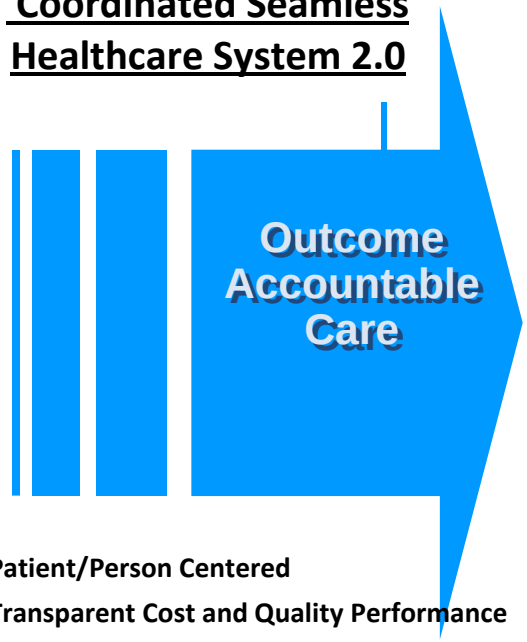
US Health Care Delivery System Evolution

Acute Care System 1.0

- Episodic Health Care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Coordinated Seamless Healthcare System 2.0



- Patient/Person Centered
- Transparent Cost and Quality Performance
- Accountable Provider Networks Designed Around the patient
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

Healthy Population Centered
Population Health Focused Strategies

Integrated networks linked to community resources capable of addressing psycho social/economic needs
Population based reimbursement
Learning Organization: capable of rapid deployment of best practices

Community Health Integrated
E-health and telehealth capable

Neal Halfon, UCLA Center for Healthier Children, Families & Communities

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