Washington State Medicaid Transformation Project

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Project Title	**Implementing a cluster care approach for personal care services (COPES) for people in permanent supportive housing**

Rationale for the Project

Problem statement – why this project is needed. Along with comprehensive behavioral health and primary care, in-home personal care (COPES) is a key support for individuals with complex health conditions to retain the greatest level of independence and avoid more costly interventions. The formerly chronically homeless population living in permanent supportive housing (PSH) requires highly integrated, engagement-oriented, highly flexible services in order to maintain housing and stabilize these conditions. But unlike behavioral healthcare and (to a more limited extent) primary care, personal care services are not well-integrated within PSH, and consequently are delivered inefficiently or not at all.

Research and practice in PSH has shown us that this subset of homeless adults, with serious and persistent physical and psychiatric conditions, often does not stabilize in housing without fully integrated on-site holistic support. However, the existing payment and regulatory frameworks for personal care services prevent flexible approaches, and many people living in PSH do not receive the services they are enrolled to receive due to incompatibility with the inflexible schedules of aides or the necessary communication between service providers to make use of the service. Common occurrences now include where care aides arrive at a site to find the person unavailable, or needed visits cannot be scheduled in the first place. Very often the individuals who need these services are experiencing the late-in-life effects of "aging," but the effects of chronic homelessness on life expectancy mean they are not very old chronologically. This fact combined with the significant behavioral health disorders affecting many, creates differences in how this population group deals with setting and keeping appointments as compared to the elderly population eligible for the same types of personal care.

Effectively providing in-home personal care services is essential for this sub-population to avoid more costly long-term care interventions, but the traditional home care model does not work well for them. This service gap puts this high needs group at risk for more costly long-term care interventions. To further complicate the picture, the characteristics that tend to screen them in for PSH tend to screen them out from traditional long-term care settings. Such characteristics include chronic untreated psychiatric and physical health symptoms, substance use, criminal justice involvement for minor infractions, long histories of homelessness, and reluctance to engage in any supportive or medical services. This can result in multiple hospital stays and at times, returns to homelessness.

Supporting research (evidence-based and promising practices) for the value of the proposed project. PSH is recognized as an evidence-based best practice by SAMHSA and HUD, and research has demonstrated the role of PSH in reductions in Medicaid costs for chronically homeless individuals (desc.org/research.html). Washington State Institute for Public Policy has included PSH for individuals who are chronically homeless on the inventory of identified practices of interventions and policies for the behavioral health system to implement under the direction of SB5732 (2013).

Relationship to federal objectives for Medicaid with particular attention to how project benefits Medicaid beneficiaries. This project seeks to increase health service engagement among an underserved but highly medically complex population, thus supporting retention of stable housing and reducing avoidable use of intensive services and settings like hospitals and jails. It also improves population health by connecting eligible but unengaged beneficiaries to needed health and supportive housing services through models that effectively accommodate their disabilities. This project would allow for increased efficiency and more robust and integrated personal care services with on-site housing & primary care services, as well as better care coordination with community-based primary and behavioral healthcare.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)
X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
X Accelerate transition to value-based payment
☐ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)
☐ Health Systems Capacity Building
X Care Delivery Redesign
X Population Health Improvement – prevention activities

Region(s) and sub-population(s) impacted by the project. We are ready to pilot in Seattle-King County, but it can be brought to scale in other areas through partnerships with Housing First PSH providers. There is interest in Whatcom, Snohomish and Pierce Counties. Target population is formerly chronically homeless single adult population with complex physical and behavioral health disabilities and substance use disorders now living in permanent supportive housing. Most of this group is eligible for Medicaid.

Relationship to Washington's Medicaid Transformation goals.

Domain 1—Health Systems Capacity Building. The project will direct services resources in a way that optimizes participation in the least restrictive and expensive setting, freeing up resources in more intensive settings like hospitals and jails. It will enable development of needed technology and service delivery infrastructure to effectively reach currently underserved beneficiaries.

Domain 2 - Care Delivery Redesign: Community-based model. This redesign of the in-home personal care service delivery model to a cluster care approach will significantly increase enrollment and participation these services by Medicaid recipients, decreasing use of more intensive and expensive interventions and hospitalization.

Domain 3 - Population Health Improvement—Prevention Activities. This cluster care approach will more effectively engage high needs individuals in integrated health care and housing support, which will improve health, enhance overall housing stability and reduce the frequent cycling through hospitals and jails often seen in this population, as a result of poor access to tailored, relevant health and social care. The project will also contribute to systems-level collaboration and analysis around strategies for improving health delivery to this underserved beneficiary group.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities. Cluster care provides personal care services to a group of clients living near each other by a coordinated team of aides, allowing for better outcomes by having the aides work alongside other on-site service providers in coordinating care planning and service delivery approaches. The services would be delivered by a coordinated team of home care agency aides. Their weekly schedule must be designed in a way that personal care tasks are provided for each client, achieves maximum efficiency of worker time and provides flexibility to accommodate client choice and client availability each day. The schedule might, for example, involve having one or more aide assigned to a client and may allow certain tasks to be grouped together such as shopping, laundry and transportation. The aides would be expected to be available and accessible throughout their scheduled shift to perform unscheduled tasks for cluster care clients as needed. This flexibility accommodates the challenges this population may have maintaining set schedules.

This integrated approach would dramatically improve access to home care services, prevent more costly higher level care, accommodate client choice and increase client satisfaction, increase efficiency, enhance integration with other on-site services, and provide better coordination with community-based primary and behavioral healthcare.

PSH, personal care/COPES, behavioral health treatment, and primary care services are all best used by beneficiaries when they are all mutually supportive of and integrated into one another's goals. A cluster care approach is the best way to achieve this depth of integration, by addressing the inherent challenges of the current model by design. By designing the delivery model of in-home services to best accommodate this population's behavioral health disabilities/social functioning needs, many more current Medicaid recipients will successfully participate in services, and additional eligible individuals can be appropriately engaged for the first time. Like all other services delivered in PSH, in home care services must be tailored to meet the highly individual needs of tenants: services must be flexible, access must be accommodated, and aide workers must be able to respond to client needs in non-traditional ways. A cluster care approach will likely increase participation levels, increase new enrollment, contribute to housing stabilization, and improve health outcomes for this population. Goals and outcomes anticipated:

- Test the feasibility and effectiveness of a cluster care approach to service delivery for a PSH population with complex health and social needs

- Increase participation by Medicaid recipients enrolled in in-home care services
- Increased enrollment in services among eligible but currently unengaged individuals
- Improve health outcomes and engagement in primary care by providing tailored and flexible in-home care services through a model recipients are able to participate in
- Reduce reliance on more intensive interventions
- Provide crucial element of effective PSH (in-home personal care services) to enable individuals to remain stable in their own homes as long as possible

Links to complementary transformation initiatives. DSHS ALTSA HCS – Roads to Community Living, WA Money Follows the Person Demonstration, https://www.dshs.wa.gov/altsa/home-and-community-services/roads-community-living.

Potential partners, systems, and organizations needed to be engaged to achieve the results of the proposed project. Necessary to implement this program are providers of primary healthcare services, providers of behavioral healthcare services, supportive housing providers and home care (COPES) providers. Harborview Medical Center, Neighborcare Community Health Center, DESC, Plymouth Housing Group, Catholic Housing Services, Catholic Community Services of Western Washington and Full Life Care are good examples of the types of partners needed for this to work. In addition to service providers, engagement of payors including DSHS-Aging and Long Term Supports Administration (ALTSA), the Local Area Agency on Aging / Aging and Disability Services;, the Local Homeless Continuum of Care funders, Managed Care Organizations (MCOs) and the Local Behavioral Health Organization (BHO) will be key to devising successful payment models. The model could eventually be brought to scale outside of King County into areas served by partner organizations in other counties and cities, including Tacoma, Bellingham and Spokane.

The main results of this program would be better coordination of care between physical health and behavioral health practitioners, reductions in use of emergency department and inpatient care due to conditions being managed better, as well as improvements on certain individual health indicators, including hypertension and diabetes, which are increasingly common among the adult behavioral healthcare population

Core Investment Components

Proposed activities and cost estimates ("order of magnitude") for the project. Cost of this Initiative 1 Transformation Project to be determined in collaboration with ALTSA, local AAA, and agencies contracting to provide personal care and supportive housing services for ALTSA-eligible beneficiaries.
Best estimate (or ballpark if unknown) for how many people you expect to serve, on a monthly or annual basis, when fully implemented. 50 to 200 people per month depending on implementation schedule needed to bring project to scale.
How much you expect the program to cost per person served, on a monthly or annual basis. Unknown. Cost will be informed by current cost of personal care services and opportunities to implement and track efficiencies as well as outcomes over time.
How long it will take to fully implement the project within a region where you expect it will have to be phased in. 4 months to contract/6 months to implementation after contracts completed.
The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline. ROI to be determined through RDA analysis to look specifically as healthcare costs for personal care beneficiaries living in PSH, including institution, hospital, ER usage, etc.

Project Metrics

Key process and outcome measures against which the performance of the project would be measured.

- Increased housing stability
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons
- Improved quality of life, including measures of recovery and resilience
- Improvements in client health status and wellness
- Increases in client participation in meaningful activities

What efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation? The contracting process will include in depth discussions of the necessary level of infrastructure to bring model to scale and to meet model fidelity. We will work with RDA and other partners to evaluate system utilization by project cohort against overall individuals with similar profiles.