Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

Contact Information	*Joseph Sparacio,Chief Development Officer, (206) 548-3271, josephs@neighborcare.org* *Which organizations were involved in developing this project suggestion?* *Neighborcare Health, Seattle Housing Authority, Full Life Care*
Project Title	*Aging in Place—RN Care Coordination in Low-Income Housing*

Rationale for the Project

- *Problem statement – why this project is needed.*

The proposed project addresses the services coordination gap that exists for elderly and/or disabled adults living in low-income housing that can result in the utilization of costly services including emergency department visits, hospitalizations and intensive long-term services and supports. Current low-income housing models lack the requisite coordination of onsite services between, among others, housing case managers, home care workers, primary care providers, and behavioral health providers for this population of elderly or disabled adults to safely maintain housing and age in place. An individual may be receiving multiple services from different agencies without a structure in place to coordinate and maximize services and avoid duplication or missed needs. Aging in Place RN Coordination maximizes resident functioning and supports independence in the least restrictive and most cost-effective setting. This project focuses on three specific Seattle Housing Authority locations with a higher than average of residents receiving Medicaid funded Long-Term Care services, creating an even greater need for coordination of care between existing service providers.

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*

This proposed project design builds on the strengths, successes and long-term client outcomes achieved by Neighborcare's nurse-driven Housing Health Outreach Team (HHOT) which operates in 13 Seattle Housing First sites. A well-established, interdisciplinary program, HHOT includes RNs to triage, assess and support residents' chronic health conditions and self-management goal setting to optimize health and reduce avoidable use of intensive services. The Housing First model of permanent supportive housing with interdisciplinary teams of housing staff, medical, mental health and chemical dependency providers has been studied and the effectiveness in optimizing health and improving the quality of life for individuals living in permanent supportive housing accompanied by the significant associated cost savings are well documented. As early in the implementation as 2008, the City of Seattle released a news advisory, "Housing First Approach to Homelessness Brings Hope to Hard Lives: *Two studies show once-controversial projects are helping save lives and money."* It reported that Seattle's Housing First projects had saved an estimated $3.2 million in emergency social and health services. Medical costs were reduced by a dramatic 75%--or $1.2 million--from the year prior to admission for residents at one of project partner's sites, Plymouth Housing, where Neighborcare's HHOT staff were placed and continue to provide services. In 2013 the American Journal of Public Health published a pilot study examining service use changes in 29 Seattle Housing First participants. Participants showed a significant reduction in emergency department use, hospital admission and jail bookings. Estimated cost reductions for participants were $62,504 per person per year. In addition, a 2015 LeadingAge study showed that having on-site service coordination at federally-subsidized senior housing reduced the odds of having a hospital admission among residents by 18%.

- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.*

Aging in Place is an established best practice for our elderly and/or disabled with limited financial resources. The majority of residents in SHA housing are low-income, and 88% of residents are Medicaid-eligible. Current low-income housing models lack coordinated, onsite services designed to stabilize and safely maintain overall health, thereby reducing use of high-cost care.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

- Reduce avoidable use of intensive services

Which Transformation Project Domain(s) are involved? Check box(es)

- Care Delivery Redesign
- *Region(s) and sub-population(s) impacted by the project. Include a description of the target population.*

The project will initially target older and/or disabled adults in Seattle Housing Authority's low-income housing buildings who have been identified as high-risk for long-term supportive services based on information from housing providers or other service providers. Initial three (3) housing sites are Denny Terrace, Center Park and Lake City House. Sites targeted for this project house residents with high percentages on Medicaid and receiving Medicaid-eligible services. Individuals living in these buildings have high utilization of emergency services as well as home care workers and therefore offer opportunity to reduce costs through improved on-site services and coordination.

- *Relationship to Washington's Medicaid Transformation goals.*

The project aligns with Washington's Medicaid Transformation Goals by providing onsite coordinated health care between visiting nurses, building-based case managers, behavioral health providers and Medicaid-funded home care workers to help individuals reduce or delay avoidable use of intensive services, such as acute care hospitals, nursing facilities, and psychiatric hospitals, creates better linkages within the health care system, and supports individuals to follow after-care guidance that can reduce their likelihood of re-admittance to the high cost services listed above.

- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*

1. Maximize individual health status by providing the right services at the right time;

2. Improve care coordination across agencies and systems; residents are supported to understand and agree to needed/recommended benefits of care;

3. Cost savings from avoidance of high cost or long-term services such as emergency department visits, acute care hospitalizations, rehab facilities, preventable evictions and nursing facilities.

The intervention model uses an on-site Registered Nurse (RN) to coordinate care across service providers, including primary care providers, housing case management staff, behavioral health providers, home care workers, meal programs, among others. The RN will provide outreach, relationship-building, basic health care and coordinated medical case management for residents through collaboration with above-mentioned providers. The RNs will identify, engage and assist aging and/or disabled residents in receiving the right services at the right time in order to remain in stable, permanent housing as they age. RN care coordinators will help bridge the gap between community-based providers such as home care, behavioral Health and other long-term care providers, and medical providers. The project enables individuals to receive services in the community, not in high-cost long-term care services. Providing the right services in-home at the right time to address physical and/or mental conditions accompanying the aging process is an established, cost-effective best practice for our aging populations. The comprehensive Aging in Place care plans will be coordinated to include the integrated, interdisciplinary care team and involvement of other needed community services. Outcomes of project participants will be to improve or stabilize health, even as residents continue to approach their end of life. Health equity and the reduction of health disparities will be achieved by reducing barriers to care, engaging clients in long-term care plans that include self-management goals, and establishing healthcare homes for patients where numerous measures of health can be tracked on an ongoing basis through Neighborcare's system of quality management.

- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities and/or Medicaid Transformation initiatives # 2 and 3.*

This program directly links to Medicaid Transformation Initiative 2, Component #3: Broadening the array of service options that enable individuals to stay at home and delay or avoid the need for more intensive services, and De-link Nursing Facility Level of Care (NFLOC).

- *Potential partners, systems, and organizations needed to be engaged to achieve the results of the proposed project.*

This project will leverage an array of existing partners and organizations already at work in these SHA communities--home care and service coordination providers including Full Life Care, City of Seattle Aging and Disability Services and behavioral health providers. Seattle Housing Authority staff will also play an important role in coordinating services.

Core Investment Components

- *Proposed activities and cost estimates ("order of magnitude") for the project.*

The project is proposing to employ one (1) full-time Registered Nurse per three (3) housing sites and one (1) part-time Project Coordinator. We anticipate an average annual cost of $150,000 for a total five-year cost of $750,000. The RN will engage low-income housing residents and provide care coordination across the spectrum of service. The Project Coordinator will supervise and coordinate the work of the RN and be responsible for day-to-day project logistics. Funds will be leveraged because RN will link to existing provider networks in buildings.

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
    We expect the project will serve 175 individuals annually per 1.0 RN FTE.
  - How much you expect the program to cost per person served, on a monthly or annual basis.
    We anticipate an average annual cost of $857 per person served.
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*

Because this expands on a current Neighborcare/SHA collaboration, we anticipate the project will be fully implemented within six months of initiating the project, allowing three months of recruitment and three months of ramp up to build RN caseload. Project can be quickly scalable to include other SHA and King County Housing Authority buildings in large part due to Neighborcare's 9-year history in managing RN outreach models.

- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*

Return on investment per individual client will vary, but we do know that the evidence cited above indicates significant system-wide savings when high risk clients are engaged in care coordination ($1.2 million in medical costs in one year according to the City of Seattle study, or $62,504 per individual- American Journal of Public Health). Current HHOT sites have maintained a 98% residence retention among a population of chronically homeless, reducing jail and emergency room costs significantly.

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps. Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47.*

Annual health survey and resident assessments will establish baseline date for the initial and ongoing caseload for the RN, including number and type of high-cost services and institutions used in past year, such as hospitalizations. Subsequent annual surveys and assessments will monitor improvement in health outcomes, usage rate of high-cost services, health stability and individual improvements for those residents on the RN case load. We anticipate using outcome measures set forth by the WA State HCA regarding avoidable use of institutions.

- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

Neighborcare has recently launched a project in conjunction with the Seattle Housing Authority where one RN is placed in 3 housing sites, an identical model to this project. This was launched in November 2015, so performance data will be available from that project to inform this one.