R3: *Right Care, Right Place, Right Time*

Effectively Integrating Senior Care and Housing

Overview and Interim Program Update

National Home & Community Based Services Conference

August 30, 2018

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Hebrew SeniorLife

The Power to Redefine Aging.

Hebrew SeniorLife | HARVARD MEDICAL SCHOOL AFFILIATE

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

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

Rediscover Every Senior's
Potential Through Research

- Aging Brain Center
- Syncope & Falls
- Translational Research
- Center for Musculoskeletal Research
- Genetics & Geriomics
- Quality of Care/Standards

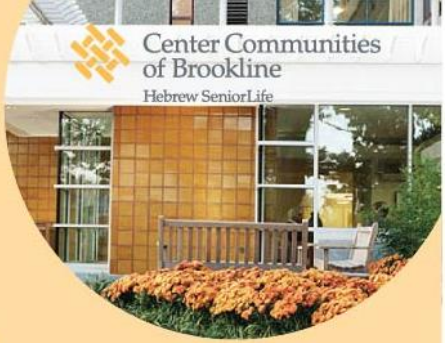
… and Teaching

- 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

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

R3: Right Care, Right Place, Right Time

Effectively Integrating Senior Care and Housing

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.

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

Total Funding, Scope, and Evaluation

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

Combined Funding Sources of $1M

* Enterprise
* Beacon Communities
* WinnCompanies

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

7 Senior Housing Sites 1,100 Residents 400 Enrollees

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

LeadingAge LTSS Center at UMass Boston *

Evaluation / Research

* Pre/Post & Control Group
* Qualitative & Quantitative

Aims and Key Performance Indicators for R3

	Health	Personal satisfaction	Cost Effective-ness
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%	Reduce transfers to hospitals, emergency rooms, and long term care by 20% for target population Reduce re-hospitalizations by 20%
Key Performance Indicators	• Falls • Wellness checks • Medication adherence support	• Wellness program attendance • Health education • Self management/care • Satisfaction with life and independence	• 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

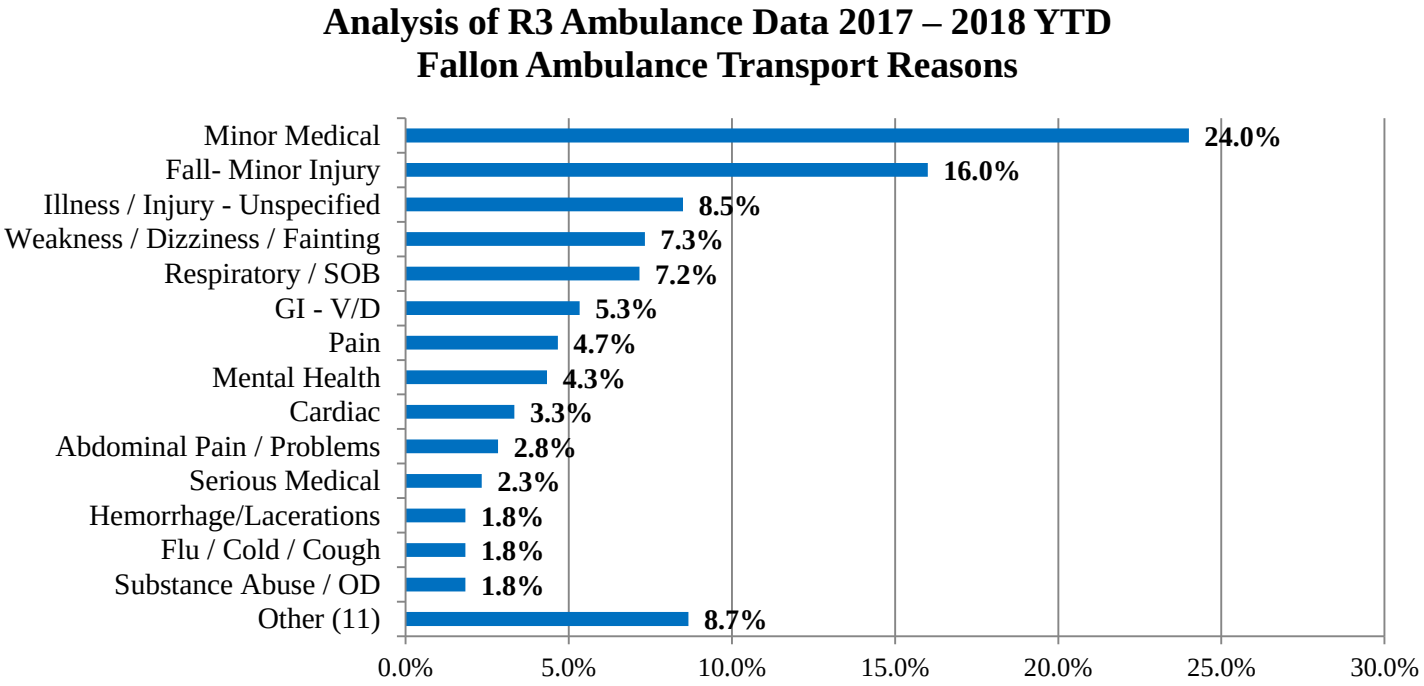
Partnerships

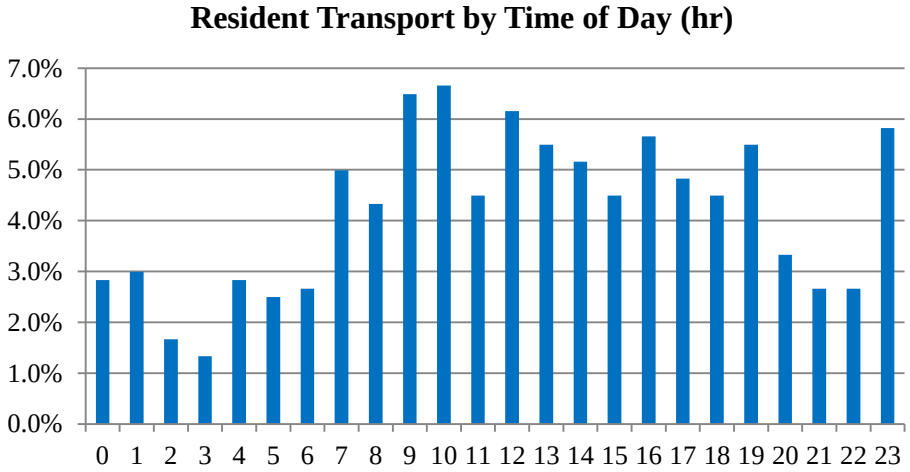
- Emergency responders: data, training
- Housing: open door, recruiting, eyes on, communication
- AAAs: care managers, evidence based programs
- Health plans: care teams, sustainability
- Mental health: referrals, awareness

Interventions

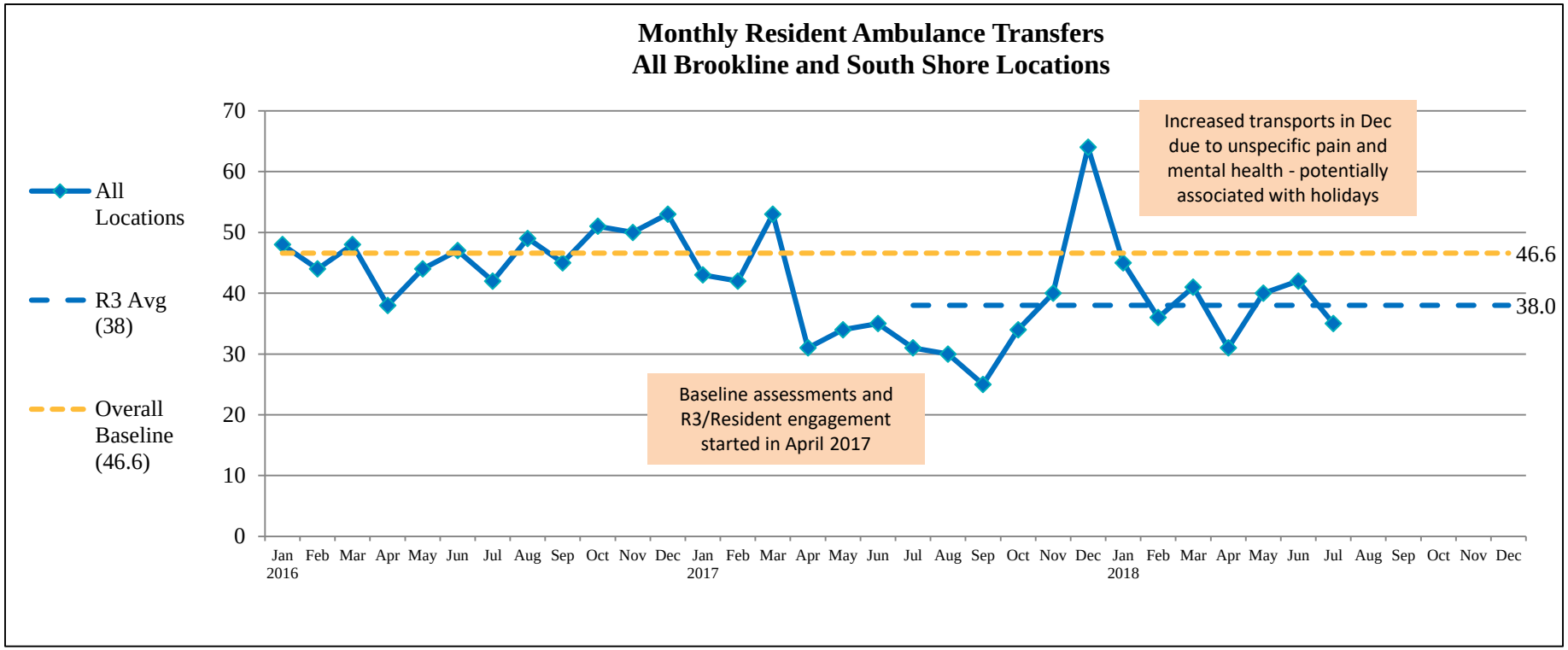
- What matters most – assessments, risk groups
- Assessments, med support, provider connection
- Monthly check in calls/data gathering
- Wellness programs (brain health, falls prevention, chronic disease mgmt.)
- Care manager collaboration and referral
- Transitions management

Key Performance Indicators: Sample Data Analysis





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**

Baseline and Interim Results
Resident Transitions to Long Term Care

2016

Site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Danesh	0	1	1	0	1	1	2	0	0	1	0	0
Cohen	0	0	0	0	0	0	0	1	0	0	0	1
Goldman	0	0	1	0	2	0	0	0	1	1	0	1
Unquity House	0	0	0	0	0	0	0	0	0	0	1	0
Winter Valley	5	0	0	0	0	0	0	0	0	0	0	0
SCFC	0	2	1	0	2	2	1	0	0	0	2	0
TVAB	0	0	0	0	1	0	0	0	1	1	0	0
Total	**5**	**3**	**3**	**0**	**6**	**3**	**3**	**1**	**2**	**3**	**3**	**2**

2017

Site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Danesh	0	1	0	1	1	0	1	1	1	0	1	1
Cohen	0	0	0	1	0	0	0	0	0	0	0	0
Goldman	0	0	1	0	1	0	0	0	0	1	0	0
Unquity House	1	0	0	0	0	0	0	0	0	1	0	1
Winter Valley	0	0	0	0	1	0	2	0	0	0	0	0
SCFC	1	1	0	3	1	0	3	2	0	0	1	0
TVAB	0	0	0	0	0	1	0	0	0	0	0	0
Total	**2**	**2**	**1**	**5**	**4**	**1**	**6**	**3**	**1**	**2**	**2**	**2**

2018

Site	Jan	Feb	Mar	Apr	May
Danesh	0	0	2	0	1
Cohen	0	1	0	0	0
Goldman	1	0	0	1	1
Unquity House	1	0	0	0	0
Winter Valley	1	0	1	0	0
SCFC	0	1	1	0	1
TVAB	0	0	0	0	0
Total	**3**	**2**	**4**	**1**	**3**

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