TESTIMONY TO THE HEALTH IT POLICY COMMITTEE

Advanced Health Models and Meaningful Use Workgroup

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Support And Services at Home (SASH) is an integrated, holistic care management system designed to serve individuals and promote population health simultaneously. SASH is embedded at 138 locations in communities across the state of Vermont and is operated by Cathedral Square Corporation (via a contract with the state's medical home program) in partnership with 65 health care providers and social service agencies. On the theory that all politics are local, six regional housing organizations implement the initiative locally to insure buy-in by the leadership of partner organizations.

The system is based on four well known facts:

- The demographics of this country are shifting significantly;
- People's behaviors and social circumstances are the primary determinants of health status;
- Elderly living in HUD assisted housing are more likely to have 5+ chronic conditions and spend more Medicare and Medicaid dollars; and,
- Long term care was provided primarily in centralized institutional settings and is rapidly moving out to very decentralized community settings.

These conditions beg the question of *where* a care management system should be built. The common sense answer is: where the elderly live; the place where behaviors are shaped; the place where the highest need and highest spenders are located; and in as decentralized settings as possible. And that of course describes the network of federally subsidized housing located in every state in the country. This network is already paid for, often has large community spaces, is staffed with caring and competent people that are skilled data collectors, and often has the wifi and technology needed to submit data to government agencies.

Affordable housing is the most under-utilized asset in health care reform yet it is home to the very population targeted by policy makers seeking health equity. By using each housing community as a hub, one not only reaches the highest need residents in that congregate housing, but the hub can serve individuals in the surrounding catchment area. This is a very efficient business model.

Consider this: what if the physical plant infrastructure had already existed back in the 1950s to house public schools for the baby boomers? What if all that needed to be done back then was to design the curriculum – because the school buildings already existed? That is what SASH has done for the health care industry. It has provided the setting for care management.

There are a couple of myths to debunk about SASH from the start:

#1: **SASH addresses one of the Social Determinants of Health by providing housing**. No. SASH does not provide housing. SASH is located in homes and that is where behaviors are shaped. And by virtue of living in subsidized housing the resident is likely to have lived a life of poverty - another determinant of health. Twenty-two housing nonprofits participate in SASH across the state of Vermont – and they develop housing as a primary mission – but the key to SASH is not that it provides housing. The key is that SASH is embedded in the home. Achieving health equity for the poorest is our goal.

#2: **SASH only serves Medicare beneficiaries**. No. SASH serves individuals on Medicaid, Medicare Advantage and Medicare using a variety of funding sources – including operating revenues. It is designed very intentionally to be payer agnostic. The SASH model was designed at a senior housing community, because my organization founded SASH and we are primarily a provider of housing for the elderly. After the model was designed an opportunity arose to participate in the Multi-payer Advanced Primary Care Practices (MAPCP) demonstration funded by Medicare. And therefore the majority of participants are Medicare beneficiaries at this time. However, SASH can work for families as well as it does for the elderly, and can be applied to the commercially insured.

#3 **SASH is only available to residents of congregate housing**. No. One of the smart conditions CMS placed on SASH is that we offer it to any Medicare beneficiary regardless of residential setting, income or age. At this time approximately 28% of SASH participants live in a community setting (ie single family home, mobile home park, or condominium).

#4 **A SASH participant must choose whether to be in SASH, PACE, Choices for Care, or other service program**. No. SASH is intended to be an integrator of the many services available to individuals. It is intended to be a navigator across programs and social services. SASH is intended to fill in gaps that exist due to timing, eligibility, geographic location and other factors. It is very intentionally longitudinal. Our motto is "<u>no</u> discharges". It is only over time that the root causes of chronic conditions can be addressed. And therefore it is no coincidence that we see statistically significant reductions in Medicare expenditures in the second year of participation.

#5 **SASH is a long term care program**. No. SASH integrates primary care, acute care, post acute care, long term care and prevention. SASH enhances communication across the health sectors. It is an "extender" to primary care practices that meet the NCQA medical home standards through Vermont's Blueprint for Health program.

Vermont's Blueprint for Health is a statewide network of medical homes including most primary care offices in the state. Think of the Blueprint as three tiers of support for a patient:

- the primary care practice;
- a Community Health Team supporting 20,000 medical home patients; and
- SASH teams supporting panels of 100 participants.

Each panel of 100 SASH participants is supported by a team comprised of existing agencies: a skilled nurse from the home health agency; a case manager from the Area Agency on Aging; an elder care clinician from the Designated Mental Health Agency; a SASH Coordinator from the local nonprofit

housing organization; and a Wellness Nurse hired by and located at the housing nonprofit. This team develops a shared care plan (Healthy Living Plan) with each participant and their families. The team has many functions. The team:

- Supports the participants' transitions in and out of nursing homes and hospitals;
- Coordinates physician visit planning and follow-up;
- Manages medications;
- Coaches on self management of chronic conditions;
- Offers preventive health programs; and,
- Provides wrap around supports to assist the SASH participant in meeting their self-defined health goals.

When an individual volunteers to enroll in SASH they are invited to sign a Use and Disclosure Consent form that gives the SASH team members across the agencies, their hospital, their primary care office and often times family members access to the participant's personal health information. Team members are trained thoroughly and repeatedly on HIPAA compliance.

A thorough assessment is completed in the participant's home by the SASH Wellness Nurse. The Nurse is physically located in the congregate setting so there is an ongoing relationship and trust developed between the participant and the nurse. The assessment collects 224 data elements including:

- Demographics (insurance coverage, emergency contacts, Advanced Directives);
- Managed conditions, allergies, medications;
- Problem lists (hypertension, COPD, asthma, arthritis);
- Participant's providers (Primary Care Provider, Smoking Cessation Counselor, SASH Coordinator, Case Manager);
- General Health and Wellness data;
- ADL/IADLs and vitals;
- History of Falls, Falls Risk Assessment and Mobility survey;
- Nutritional screen;
- Cognitive screen;
- PHQ-9 depression screen and alcohol/substance abuse screen;
- Patient alerts, Online Visit Planner, Encounter notes;
- The participants healthy living plan (care plan's measures and goals); and,
- Population data reports (referrals to and from social service agencies, vaccinations).

The data on each participant is entered into Vermont's CENTRAL CLINICAL REGISTRY, a web based repository with robust reporting and analytic capability. This is not Vermont's HIE. The software (DocSite) was developed by a private entity and the current owner decided to drop their health care software line. The State of Vermont is currently in the process of purchasing the DocSite source code and will migrate all data over to be housed at the HIE, Vermont Information Technology Leaders (VITL).

Cathedral Square can have access to VITL because we operate a licensed Assisted Living Residence. However, none of the other 21 housing organizations administering SASH have been given access. We believe that these housing organizations qualify as "health care operators" under 45 CFR 164.501 and should be allowed to enter into a VITL services agreement on that basis.

The original theory behind the Registry was to create an integrated health record where physicians, the Department of Health, and care management teams such as SASH could all enter and view data on their shared patient. Although technically the software enables multiple users to enter data on one patient, the biggest user of DocSite is the SASH Coordinator and SASH Wellness Nurse because they had no prior database. Physicians often have an EMR and a second and third source of data on their patients. Home health has their required databases. The primary way that data is shared is during a SASH team meeting when the assessment data is available for review by the entire team. And it is possible to print out a Visit Planner in advance of a primary care visit enabling the physician to view patient measures such as blood pressures charted since the last PCP visit. Our goal is to eliminate the information gaps that results in poor quality care and errors.

Registry data can be analyzed at the statewide, Health Service Area, or address levels. This allows us to track results with regard to access to care and improved health status. It allows us to develop "Community Healthy Living Plans". And it provides the information that drives our "Data Design" process.

(1) Increased access to care and improved health status:

Over the first three years of the MAPCP funded demonstration SASH has brought the number of participants with a primary care practitioner up to 96%. In addition we have increased the percentage of participants that have annual exams. And best of all, we know who the 4% are that do not have a PCP and we can help them find one. We have also documented improved health status in two areas in particular: reduced falls and the increase in participants with diagnosed hypertension that have brought their blood pressure under control.

(2) Community Healthy Living Plans:

Every six months each SASH panel examines their data to determine the greatest need among the panel participants. Based on that need we review the Directory of Evidence Based Practices that we have developed with the help of SASH Fellows (medical and nursing students). Based on the data driven identified community need, staff select one evidence based practice to offer the panel participants.

(3) Data Design:

As a developer of affordable housing, data on the health conditions of current and future residents is extremely valuable in the design process. Medical conditions that are sensitive to indoor air quality can be improved by the use of energy recovery units. Direct digital control systems are extremely important for a population with high rates of memory impairments. And the number of chronic conditions that can be controlled or improved due to exercise makes for a powerful argument to funders when advocating for an exercise room or a well-lit stairwell (a vertical gym as we call it!).

A participant's Healthy Living Plan (or shared care plan) is developed only after the assessment and a person centered interview. The interview is designed to identify what motivates the participant – what are their personal goals and social service needs. If the individual is not a partner in developing the plan, they will not own it. The interview often identifies motivations that are not directly related to medical care. For example, one participant was motivated by the goal of finding the son she gave up for adoption. Another with increasing memory loss was motivated by the promise that he could keep doing the recycling in the building. And another couple were motivated by their volunteer work at the elementary school – moving to a nursing home would have prohibited them from doing what they care about. This is very important data.

SASH has been brought to scale over the past four years, now embedded at 138 affordable housing sites across the state. These sites include all forms of affordable housing: HUD Section 202, USDA Section 515, tax credit financed housing, mobile home parks, and housing owned by public housing authorities. We have bridged hospitals, physicians, patients and home & community based providers through a Memorandum of Understanding that has been signed onto by 65 organizations.

Our next steps are to:

- Offer e-Visits as an alternative to primary care in-person office visits. The barrier to using telehealth technology to conduct primary care office visits at home has been lack of reimbursement for telehealth unless the originating site is a licensed setting, and reimbursement only in the most rural settings. We were successful in seeking legislation this session directing Medicaid to reimburse for e-Visits outside of licensed settings. This will be a huge benefit to Vermonters that cannot or should not have to travel to the doctor's office when affordable technology exists to diagnose the flu, examine a post-surgical wound, or adjust a prescription in the home setting.

- Seek Medicaid reimbursement for SASH participants, particularly in public housing for families often occupied by a refugee population with many barriers to obtaining services. By embedding a SASH Coordinator in this housing, familiar with the culture and native languages of the resident populations, Vermont can make great strides in meeting the basic public health goals of our state particularly in the area of childhood immunizations.

- Replicate SASH in other states. The barrier to replication has been twofold: lack of a permanent source of the capitated payment, and lack of a common assessment tool and database. We seek to work with states that have MAPCP funding in place to expand this offering to their Medicare population and to work with SIM states that are seeking value based reimbursement for new delivery models. And now that DocSite is being acquired by the State of Vermont, it opens up the potential for multiple states to use a shared database and analyze results on a multi-state basis.

- Continue to evaluate our triple aim results. HUD and ASPE joined forces to fund an evaluation of SASH. The first Memorandum showed a statistically significant reduction in the rate of Medicare expenditures for both overall Medicare spending and post-acute care. The business case for SASH combined with the Blueprint for Health is clear: we are reducing costs while increasing access and improving health status.

Thank you for your very important work.

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