THE NEW YORK ACADEMY OF MEDICINE

NYS Health, Housing, and Longevity Learning Collaborative

NYS Health, Housing, and Longevity Learning Collaborative Webinar 2

May 4, 2022

THE NEW YORK ACADEMY OF MEDICINE

NYS Health, Housing, and Longevity Learning Collaborative

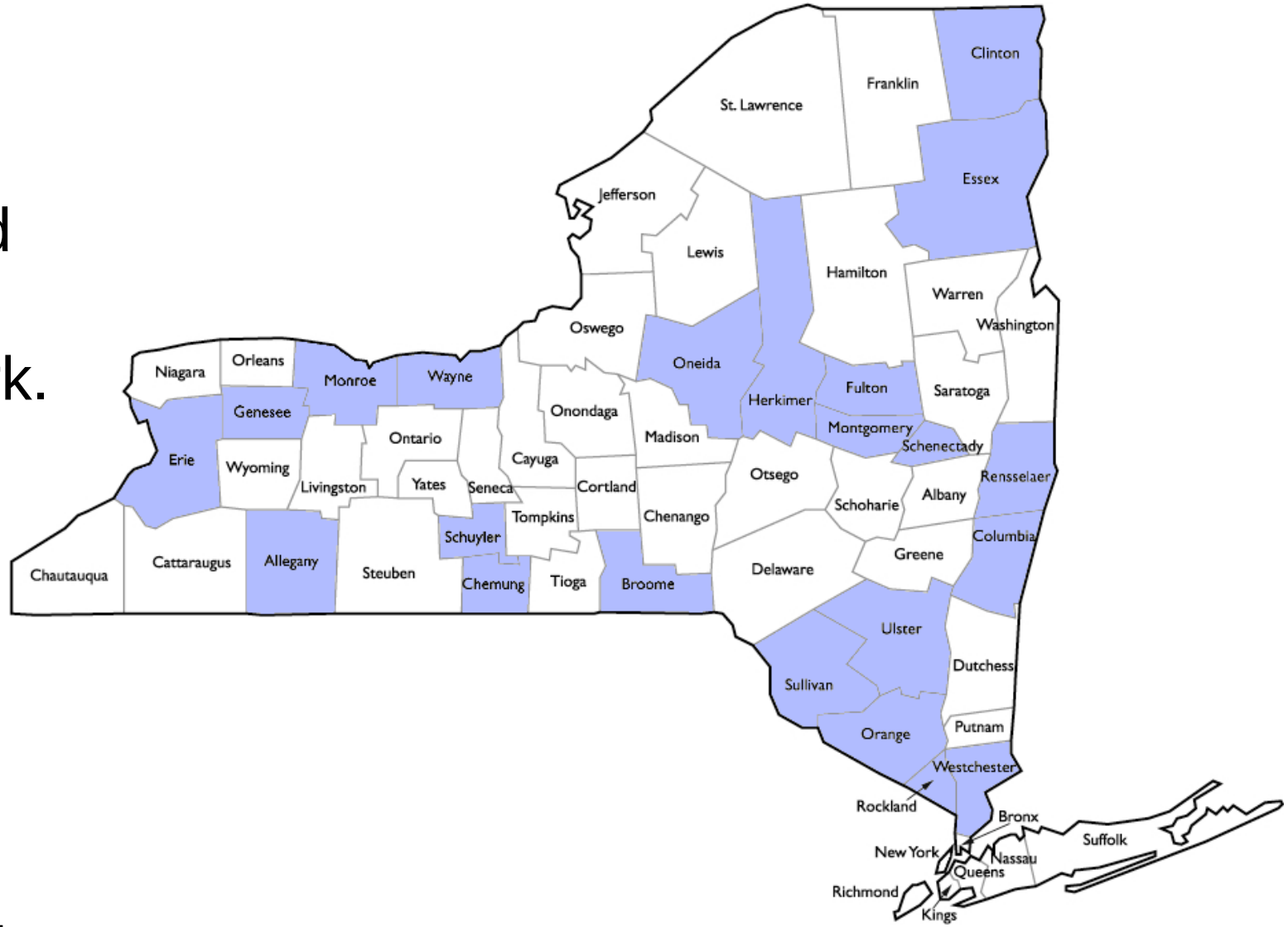
KANA TATEISHI
PROGRAM ASSOCIATE, CENTER FOR COMMUNITY PARTNERSHIPS & POLICY SOLUTIONS
NEW YORK ACADEMY OF MEDICINE
KTATEISHI@NYAM.ORG

TODAY'S AGENDA

9:00	Welcome
9:05	Introductions – Who is on the call today?
9:15	Presentation topic #1: Deep Dive on Housing Data with Epidemiologist Chris Maylahn (DOH) and Abbie Guisbond (Albany School of Public Health)
	Q & A
9:40	5-minute break
9:45	Presentation topic #2: Understanding Medicaid and Housing with Emily Engel (DOH)
	Q & A
10:10	Breakout rooms: What is something new you learned today that you can apply to your work?
	Discussion: Sharing insights
10:25	Coming attractions, closing meeting

WELCOME TO THE HOUSING, HEALTH, AND LONGEVITY LEARNING COLLABORATIVE

In the chat, please tell us your name and the county where you work.



Allegany
Broome
Chemung
Clinton
Columbia
Erie
Essex
Fulton
Genesee
Herkimer
Monroe
Montgomery
Oneida
Orange
Rensselaer
Rockland
Schenectady
Schuyler
Sullivan
Ulster
Wayne
Westchester

This map shows the health departments across NYS that registered for the Learning Collaborative.

ABOUT THE LEARNING COLLABORATIVE

Wed. April 13 - 9:00-10:30 – Webinar 1
Wed. April 27 - 1:30-2:30 – office hours 1

Wed. May 4 - 9:00-10:30 – Webinar 2
Wed. May 11 - 1:30-2:30 – office hours 2

Wed. May 18 – 9:00-10:30 – Webinar 3
Wed. May 25 - 1:30-2:30 – office hours 3

Wed. June 8 - 9:00 – 10:30 Webinar 4
Wed. June 22 - 1:30-2:30 – office hours 4

Wed. July 13 - 1:30-2:30 – office hours 5

Our **webinars** will be 90 minutes. We will have formal presentations with speakers and opportunities to engage with them and your peers.

We ask that you attend all four webinars. Recordings will be posted for those who may have a conflict.

The **office hours** sessions are also on Zoom. They will be less formal and will have a theme, but no presentations. Office Hours sessions are opportunities for peer-to-peer networking and connecting.

The office hours meetings are optional, and you can attend or not, depending on your interest and availability.

Supporting NYS Counties with Age-Friendly Principles & Housing Data

Christopher Maylahn DrPH, MPH

Office of Public Health Practice

New York State Department of Health

Purpose

- **Provide training and technical assistance to local health departments, as well as the State's Housing regulators and providers, on the adoption and incorporation of healthy aging concepts into their planning, programs and governance structures.**

Underlying Principles

Underlying Principles

- **Health In All Policies**

Underlying Principles

- New York **embraces healthy aging** to become the first age-friendly state and was identified by the Trust for America's Health as having the first age-friendly health system in the U.S.

New York State Prevention Agenda

Housing is a Health Issue

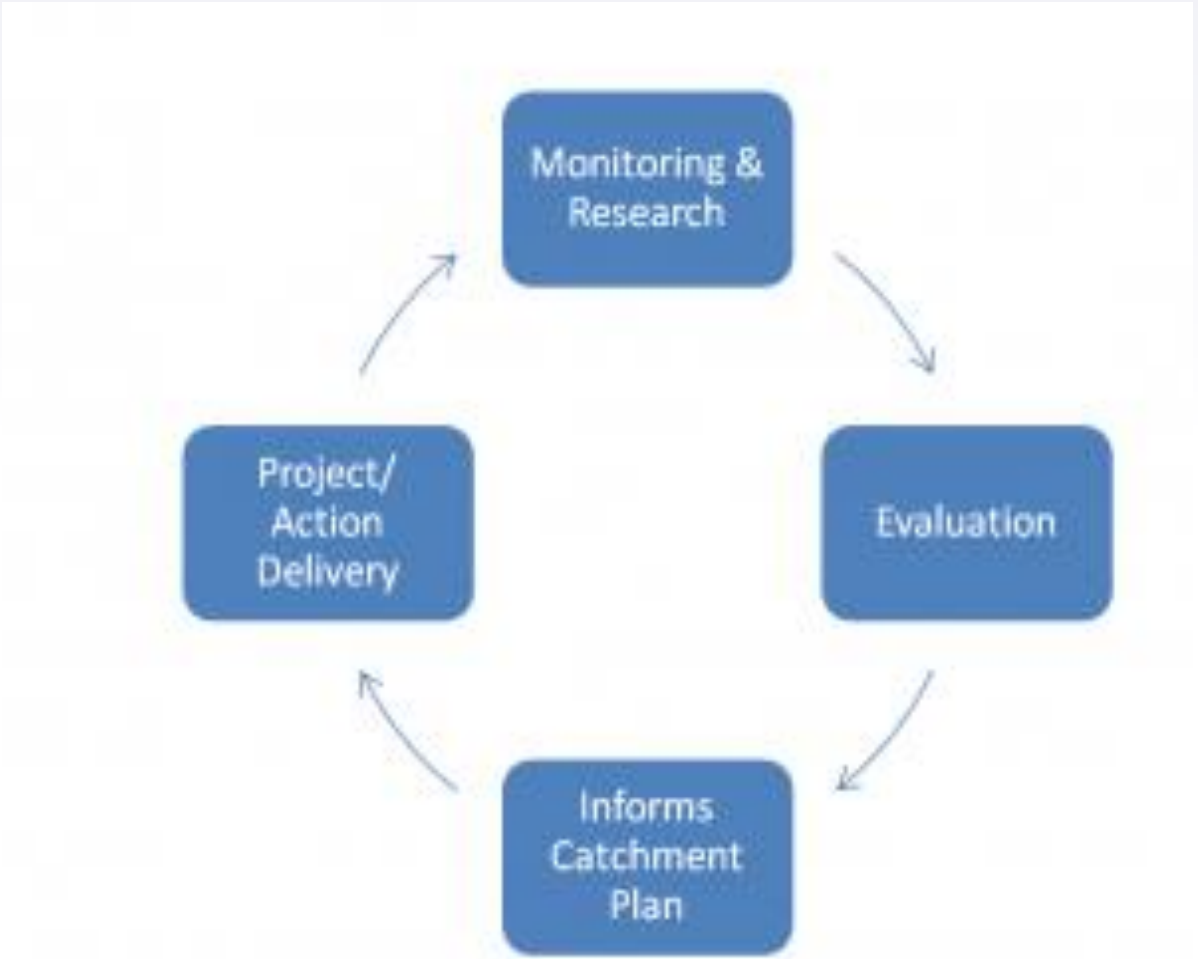
- Asthma
- Disabilities
- Communicable Diseases
- Mental Health

Assessment

- **Health hazards in the home**
- **Health risks identified**
- **Implement strategies to solve problems and abate risk**

Surveillance

- **Indicators of concern to track**
- **Dashboard to display results**
- **Actions taken**



A Deep Dive into the ‘Data Dashboard’

Abigail Guisbond

Graduate Intern, NYSDOH Office of Public Health Practice

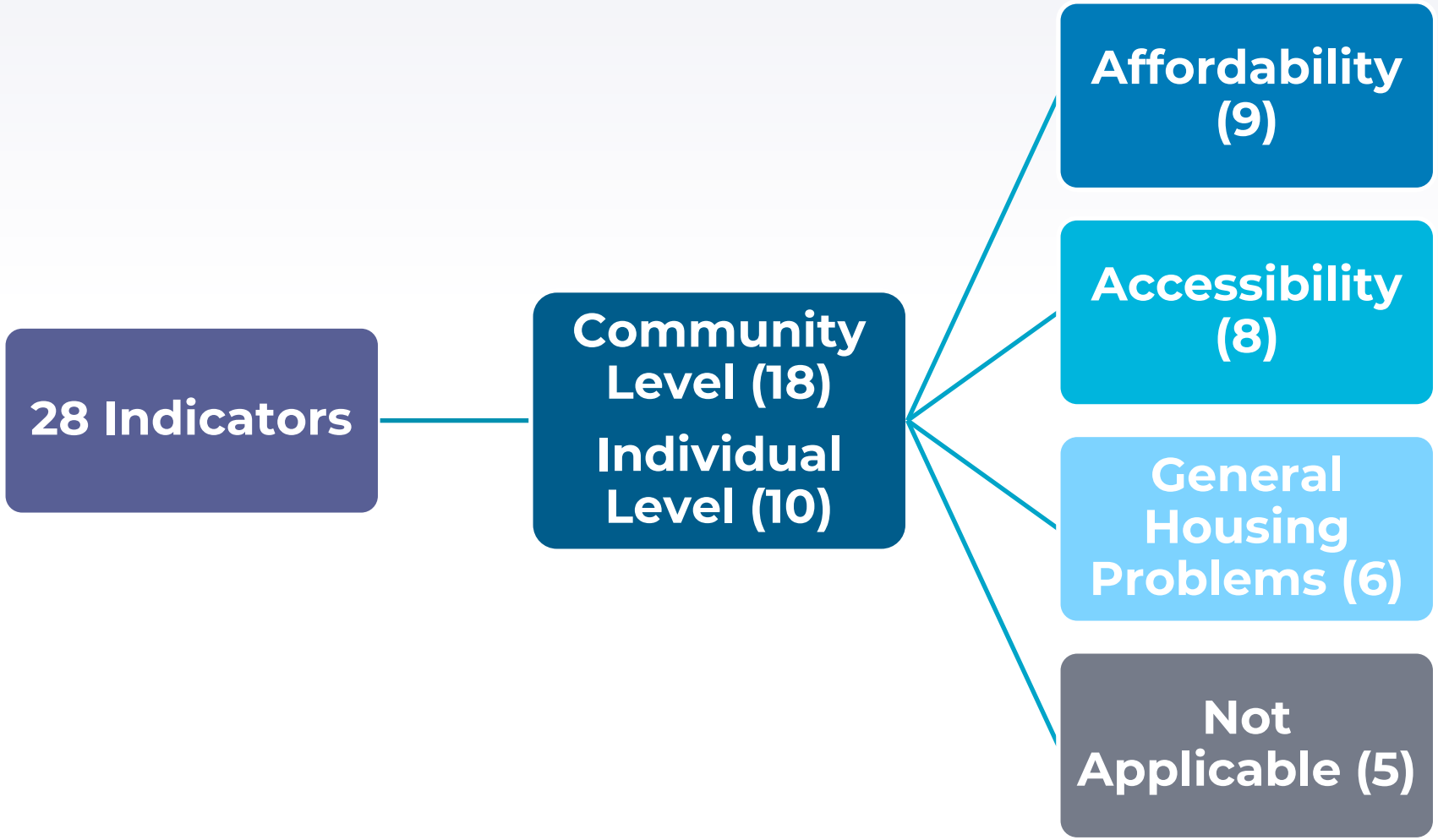
MPH Candidate, University at Albany School of Public Health

Download the Dashboard here to follow along!

Dashboard Overview

- **HOW:** Indicators and their associated data sets, links to the evidence-based health significance for each indicator.
- **WHY:** To provide LHDs with a 'one-stop shop' for data and connected resources to understand housing.
- **USES:** Data access, education, awareness, programming

Data Dashboard Structure



Indicators

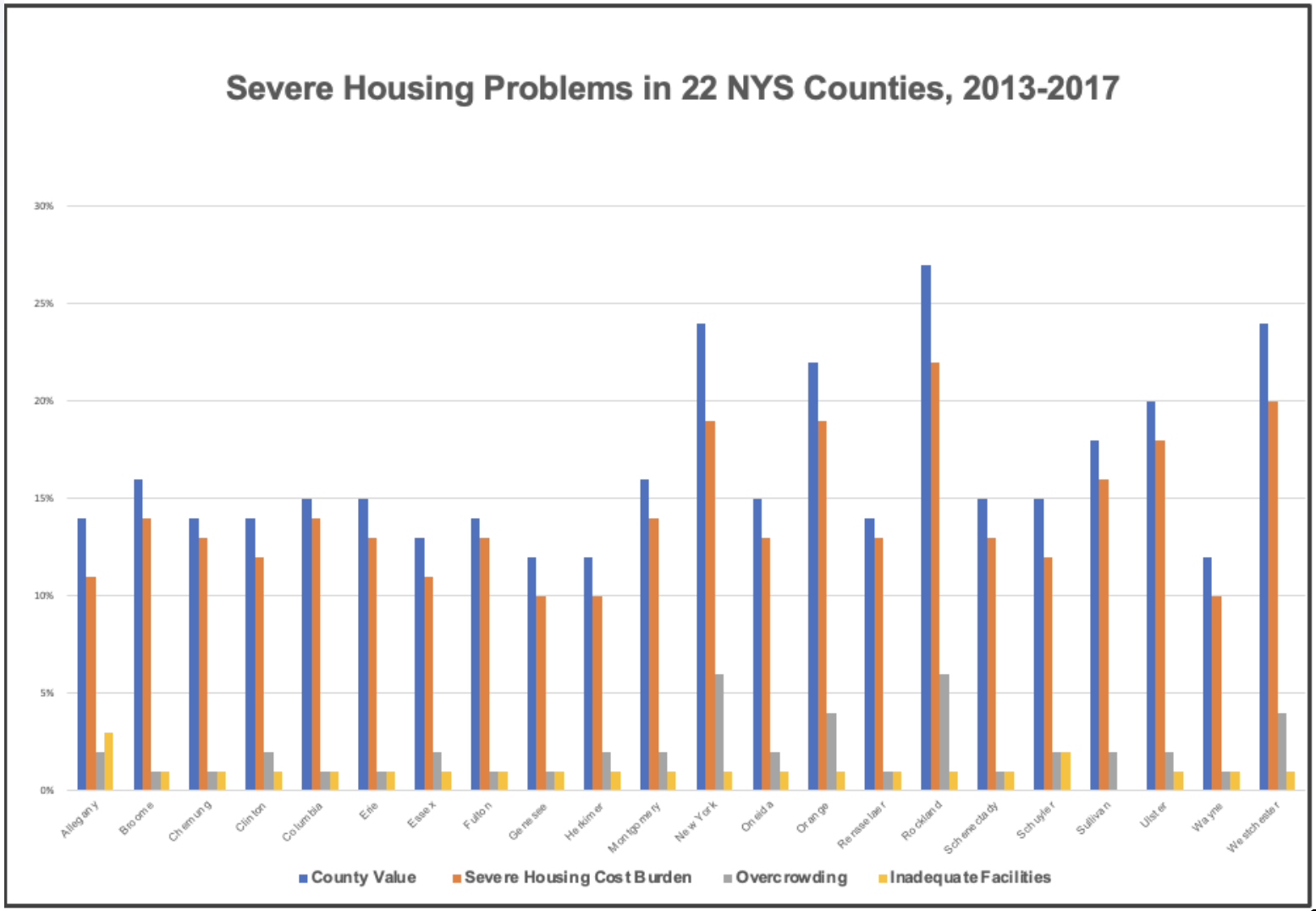
SEVERE HOUSING PROBLEMS (General Housing Problems, Community Level)

HOUSING COST BURDEN (Affordability, Individual Level)

HOUSING ACCESSIBILITY (Accessibility, Community Level)

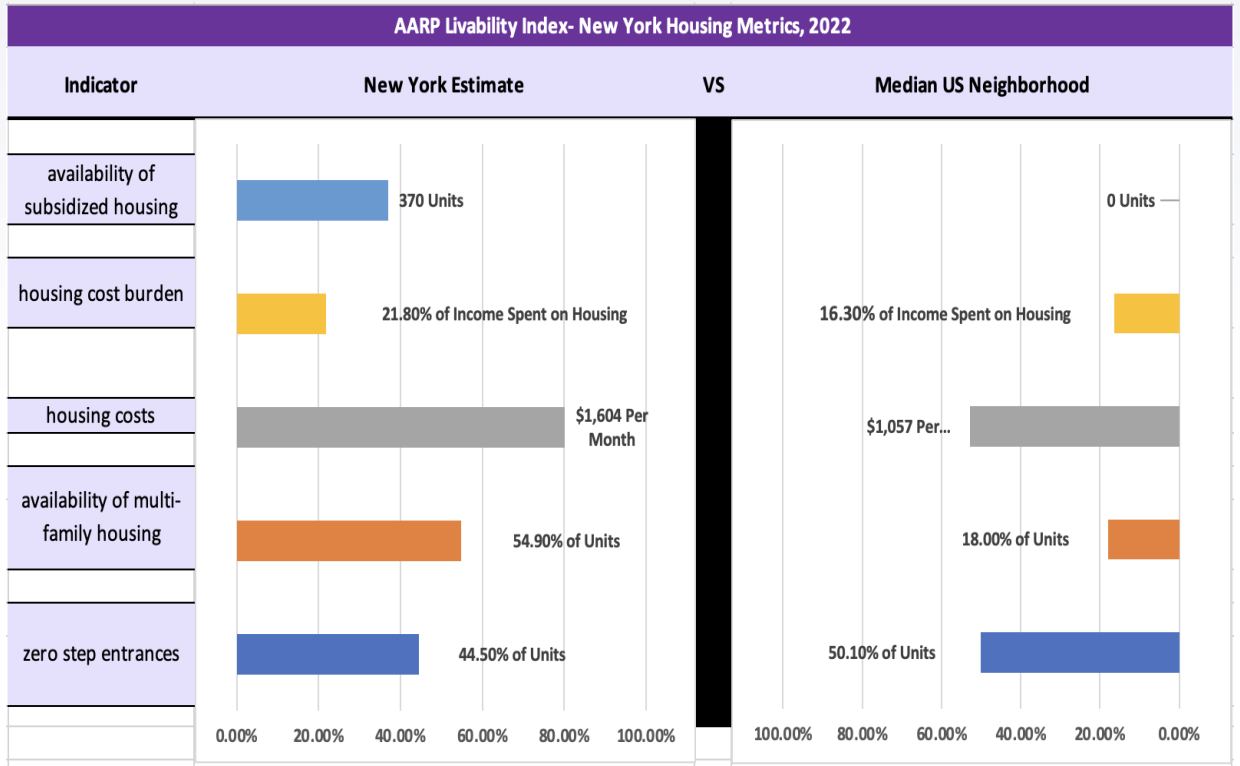
Indicator- Severe Housing Problems

- Definition
- Location: All 62 counties (data represents 22 Learning Collaborative participant counties)
- Includes sub measures of Severe Housing Cost Burden, Overcrowding, and Inadequate Facilities
- Health Significance
- Source: [County Health Rankings]



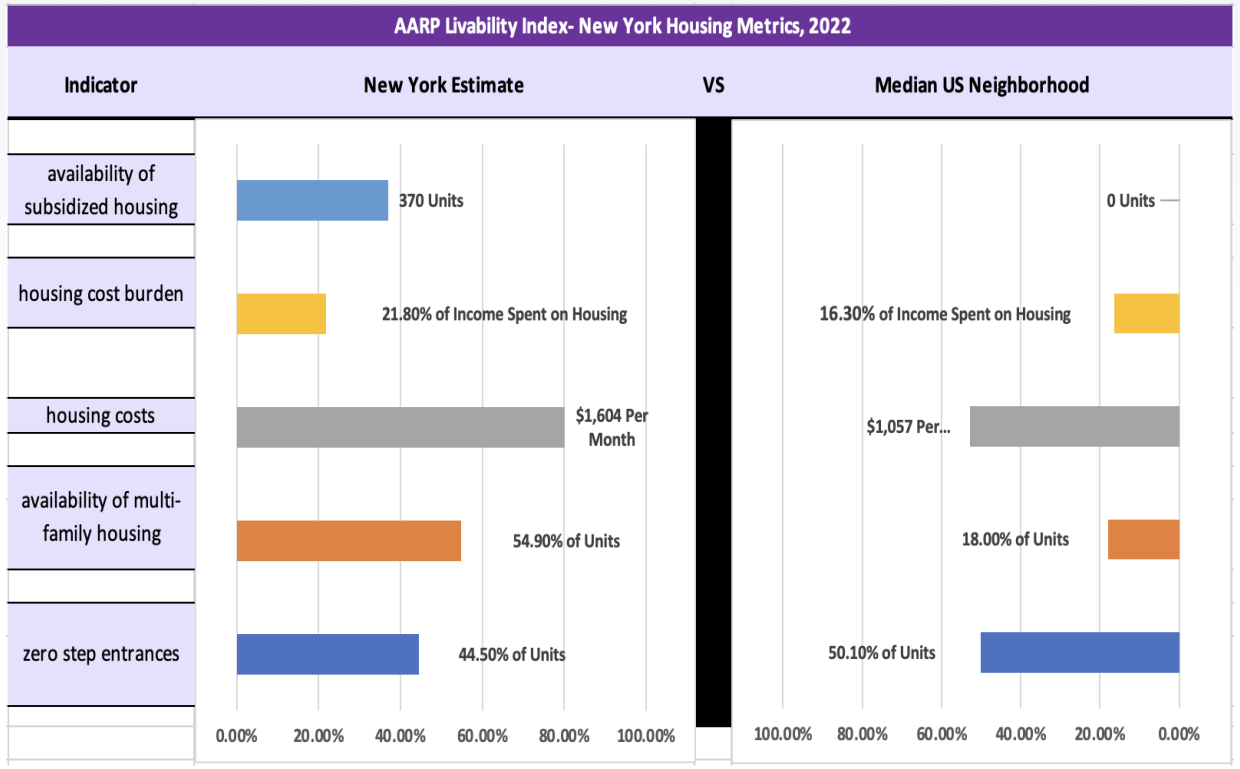
Indicator- Housing Cost Burden

- Definition
- Location: New York State
- Health Significance
- Source: [AARP Livability Index]

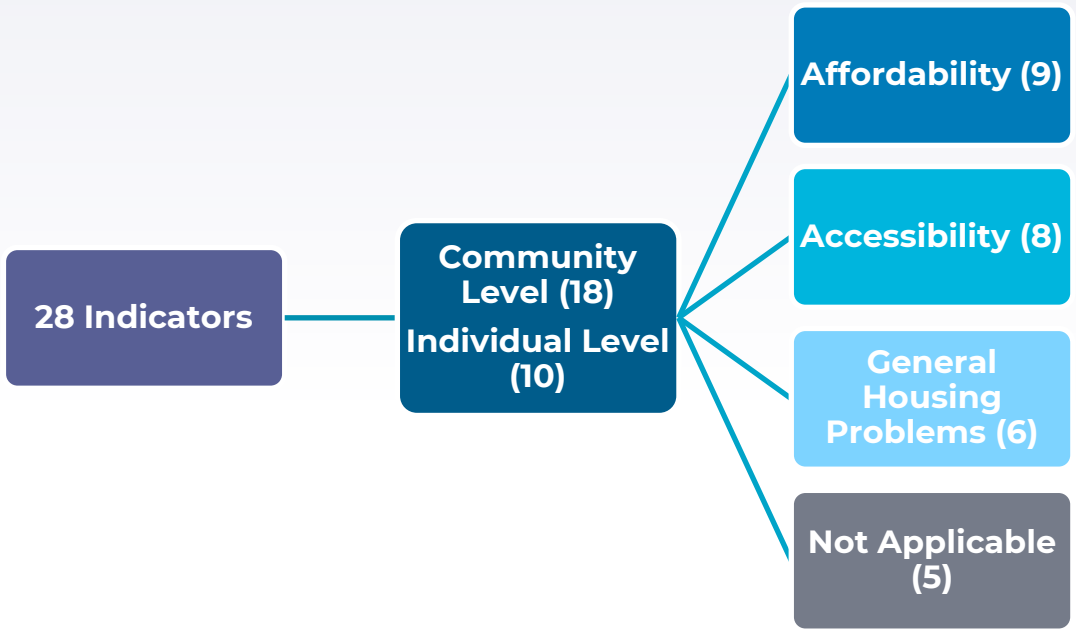


Indicator- Housing Accessibility

- Definition
- Location: New York State
- Health Significance
- Source: [AARP Livability Index]



Other Indicators



Household is severely cost burdened, Household transportation costs,

Public assisted households, Housing costs, Housing cost burden, Housing affordability, Rental affordability, Homeownership affordability, Gross rent as a percent of household income.

Total housing units, Occupied housing units, Vacant housing units, Housing accessibility, Availability of subsidized housing, Housing supply, Walkability, Access to parks and open space.

Severe Housing Problems, Housing unit lacks complete kitchen facilities, Housing unit lacks complete plumbing facilities, Housing is overcrowded, Heating Problems, Housing Insecurity.

Neighborhood Characteristics, Natural Areas, Reasons for Leaving Previous Residence, Fall within Past Year 65+, Falls Resulting in injury 65+.

THANKS!

Any questions?

Email:

- Abigail.Guisbond@health.ny.gov
- Learn more at Office Hours 2 on May 11th at 1:30 pm!

BREAK (5 MIN)

THE NEW YORK ACADEMY OF MEDICINE

NYS Health, Housing, and Longevity Learning Collaborative

EMILY ENGEL
DIRECTOR, BUREAU OF SOCIAL CARE AND COMMUNITY SUPPORTS
NYS DEPARTMENT OF HEALTH
EMILY.ENGEL@HEALTH.NY.GOV

NEW YORK STATE | Department of Health

New York Medicaid Redesign Team Supportive Housing Initiative

Emily Engel, Director
Bureau of Social Care and Community Supports

May 2022

Selecting Housing as a Focus

The Medicaid Redesign Team selected housing to address aim #2 – Improving health by addressing root causes of poor health

- National research and New York Medicaid data evidenced that higher Medicaid costs are associated with homelessness and recipients who are inappropriately placed in institutional settings
- Housing is a core social risk factor that directly affects all other social determinants of health domains and the improvement of care
- MRT cited the impact of a demonstration pilot in NYC that housed chronically ill homeless individuals
- Political will to create more supportive/affordable housing across the State

Source: A Plan to Transform the Empire State's Medicaid Program (2011).

Supportive Housing Initiative

- Created an inter-agency workgroup
- Increase availability of supportive housing
- Focus on high-utilizers Medicaid members who are:
  - ✓ Homeless (street or shelter)
  - ✓ In institutional settings

Dept. of Health/ AIDS Institute

Home and Community Renewal

Office of Mental Health

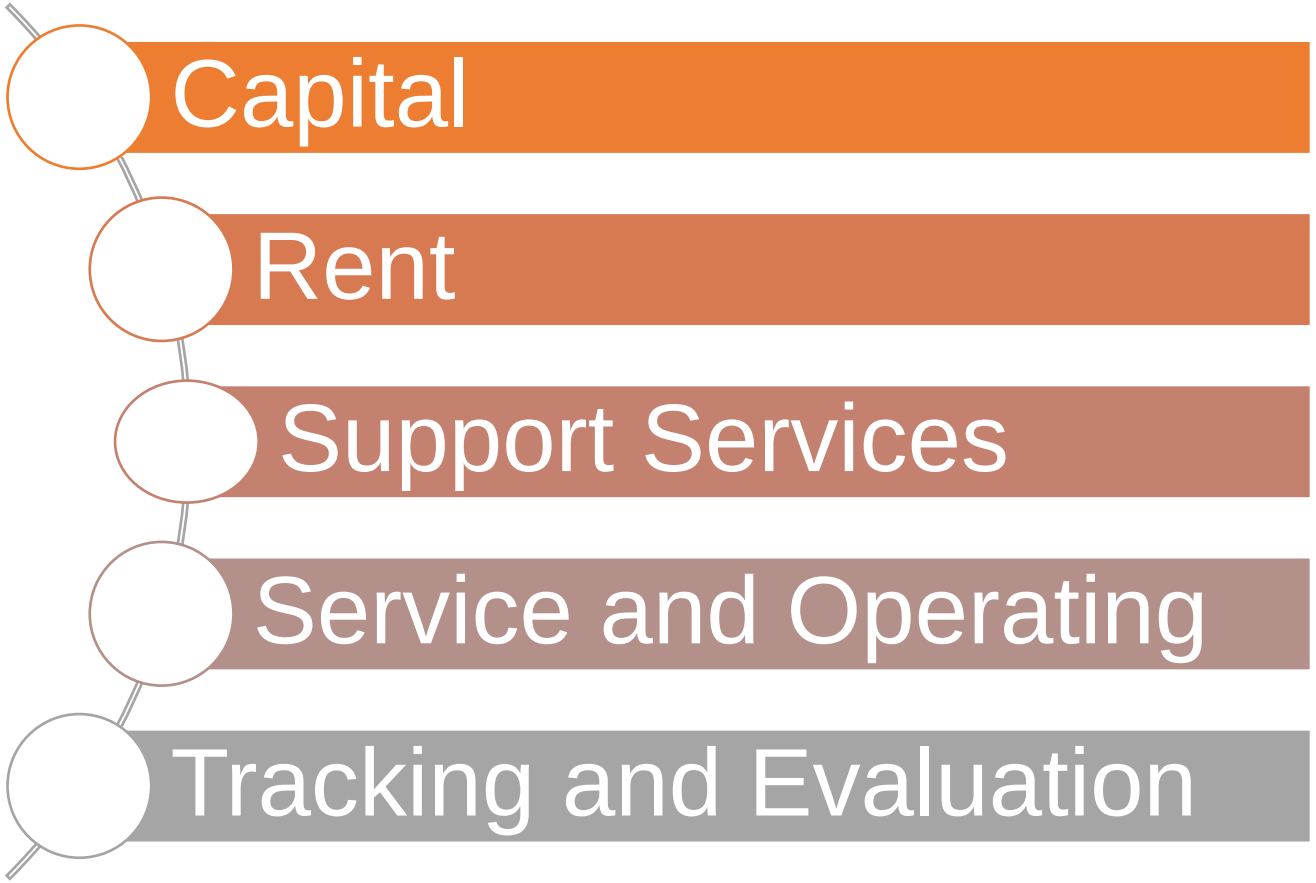
Office for People With Developmental Disabilities

Office of Alcohol and Substance Abuse Services

Office of Temporary and Disability Assistance

NEW YORK STATE | Department of Health

Investment Results



- Funding is targeted to **high utilizers of Medicaid**
- Medicaid Redesign Investment: **$800 million over the past 8 years**
- Funded **20 rental subsidy and supportive services** programs statewide
- **1,534 capital units** constructed, with 362 more units in the pipeline
- **Over 15,000** high-cost, high-need Medicaid members served to date

Note: MRT SH Investment $704 million (General Funds) and $176 million (Bonded Capital)

NEW YORK STATE | Department of Health

Independent Housing

- Tenant has their own apartment with lock and key
- Tenant can come and go and have guests over
- Transitional services
- Tenancy based services
- Socialization and wellness
- Medical needs are provided by Medicaid and Medicare

Supportive Housing Staffing

Program Manager

- Oversee case managers and programming coordinator
- Coordinate with building management/owner
- Meet with DOH on a quarterly basis

Case Manager (1:10 ratio)

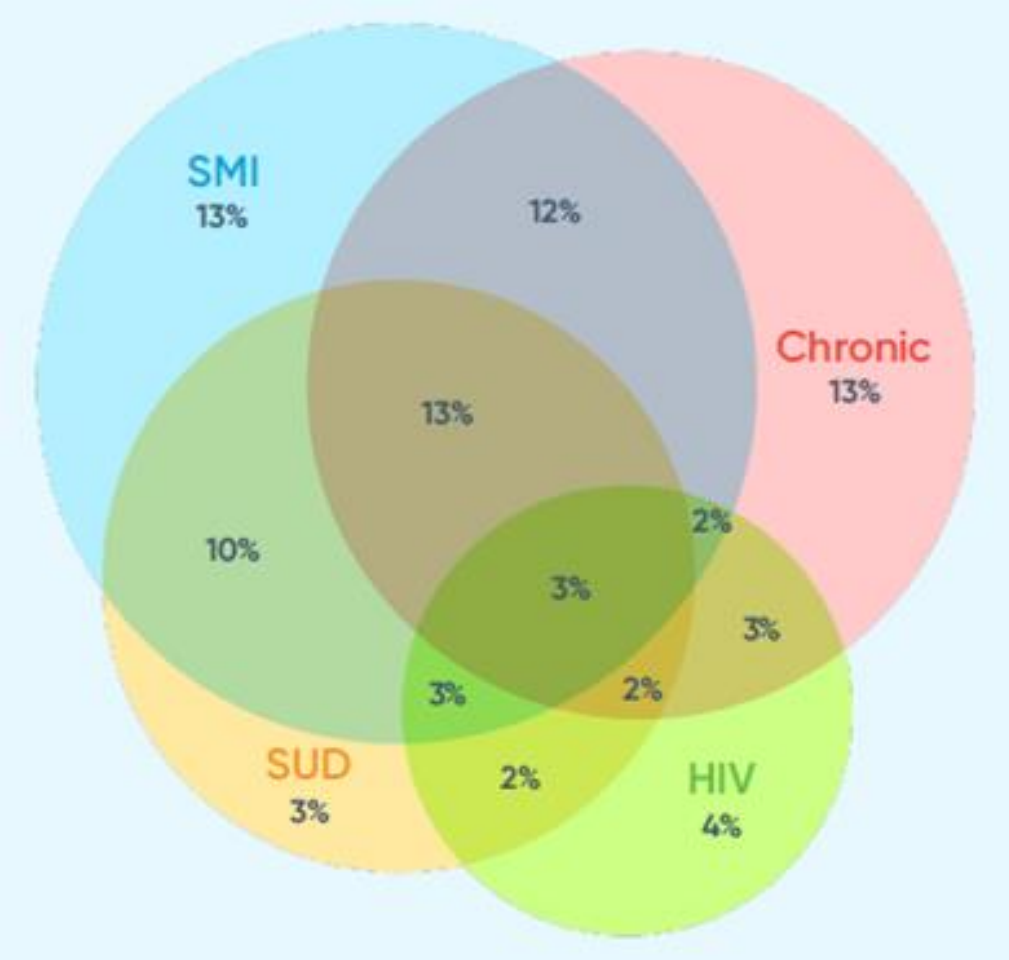
- Transportation coordination
- Transition supports
- Tenancy supports
- Service coordination
- Mitigating issues
- Works with tenants on self set goals
- Monthly check in with tenant

Programming and Wellness Coordinator

- Creates regular programming activities for tenants that target isolation
- Coordinates wellness/fitness activities and education that targets health issues for the 55+ population

Evaluation

Clinical Characteristics



Seriously ill population, high rate of comorbidities:

- 62% have at least one serious mental illness
- 41% have substance use disorder
- 33.5% have “other chronic condition”
- 5% HIV+
- Diagnoses in 3 or more of above categories: 24%

Source: McGinnis et al, “Medicaid Redesign Team Supportive Housing Evaluation: Utilization Report 1,” prepared by the SUNY Research Foundation for NYS DOH, June 2020.

.

“Other chronic condition”=12 other most common chronic conditions: hypertension, asthma, diabetes, osteoarthritis, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, cerebrovascular disease, congestive heart failure, cancer, angina, acute myocardial infarction.

NEW YORK STATE | Department of Health

MRT Supportive Housing New Evaluation Findings

On average, Medicaid claim costs declined by about $6,800 per person, However high-utilizers had an average savings of $45,600.

Clients showed lower overall mortality (8%) than the comparison group clients (15%).

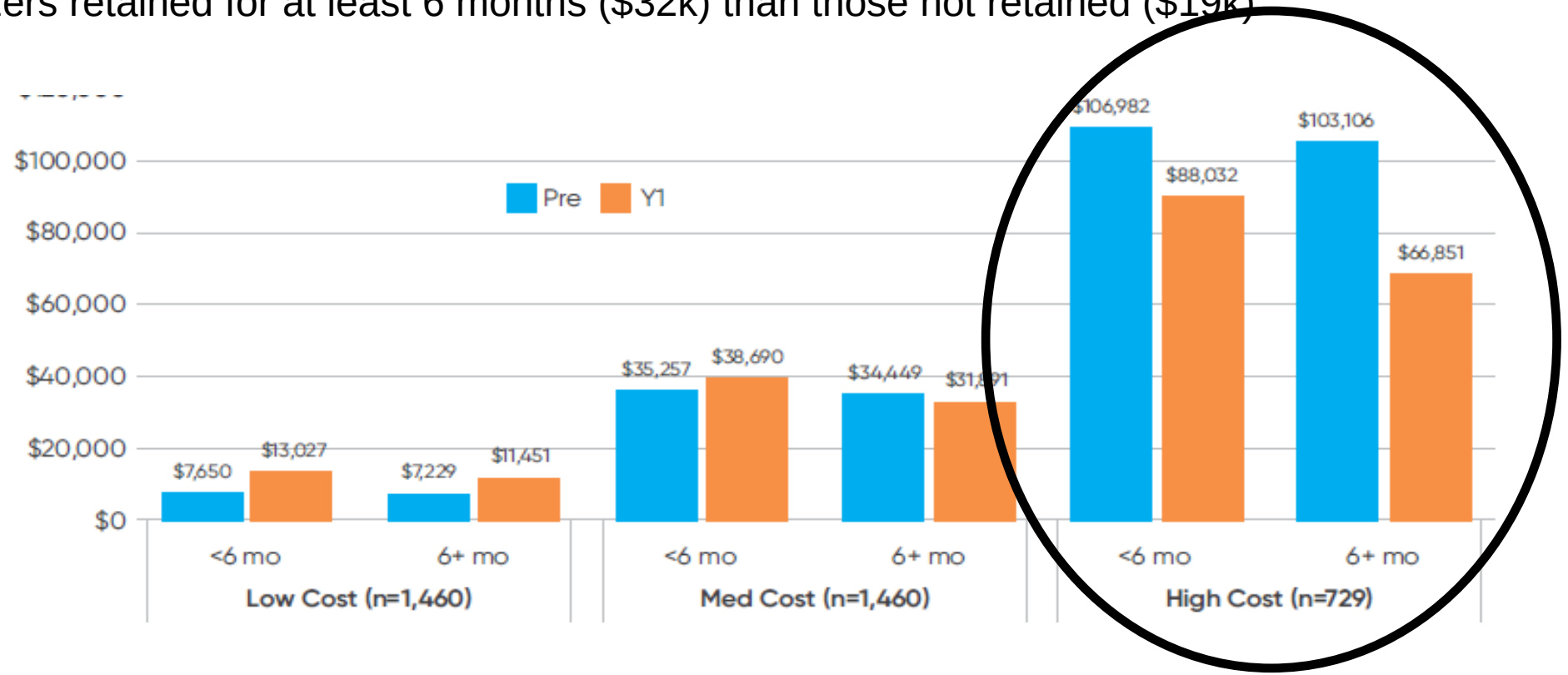
Supportive Housing decreased utilization of emergency department, nursing home, inpatient, and primary care utilization.

12-month retention in MRT-SH resulted in a 19% savings, 29% reduction in ER visits, and 48% reduction in inpatient days

NEW YORK STATE | Department of Health

Retention Effects

High utilizers show greatest impact of retention: Pre- to Post-Period drop in spending greater for high utilizers retained for at least 6 months ($32k) than those not retained ($19k)



- Medium utilizers also show retention effect, though not as large
- Similar patterns for inpatient use, ED use; retained for at least 12 months

NEW YORK STATE | Department of Health

MRT Prioritization Menu Criteria

The criteria below, used to determine whether an individual is a Medicaid high-utilizer, consider service utilization, Medicaid spending, and program enrollment.

Eligible participants are enrolled in Medicaid, or have been in the last 12 months, and meet *at least* one of the following:

Within last 12 months:

- Have had two or more inpatient stays; or
- Five or more ED visits; or
- Four or more ED visits and one or more inpatient stay

Medicaid Spending:

Be within the top 20% of adult Medicaid recipients spending relative to the county where the capital project is located and the project's target population

Residing within:

- Skilled nursing facility
- State psychiatric center
- State/Voluntary Community Residence
- Community Residence/Single Room Occupancy

Enrolled in:

- Health and Recovery Plan (HARP); or
- HIV Special Needs Plan (SNP)
- Identified by a Health Home, MCO or hospital as a high-utilizer

Programs

Olmstead Housing Subsidy

- State-wide program provides the following services to help participants live safely and independently in the community:
  - Community Transitional Services (CTS)
  - Environmental modifications
  - Rental subsidies
  - One-time assistance
- Serves adult Medicaid members who currently reside in a skilled nursing facility and have the ability to live safely in the community

Rapid Transition Housing

- Provides an array of services intended to establish independence, wellness and self-management:
  - Community Transitional Services (CTS)
  - Environmental modifications
  - Rental subsidies
  - Tenancy support services

- Located in NYC, Long Island, Syracuse, and Rochester

- Participants in the program must be on Medicaid and referred as homeless high-utilizers by a hospital, Managed Care Organization (MCO), medical respite, Performing Provider System (PPS), or skilled nursing facility (SNF).
- Individuals must have one or more documented chronic physical disabilities and have two or more chronic conditions (e.g., asthma, diabetes, substance abuse disorder (SUD)).

Health Homes Supportive Housing Program

- Provides rental subsidies and service supports
- 18 providers statewide
- Geographic areas served: Albany, Bronx, Broome, Cayuga, Chemung, Chenango, Cortland, Delaware, Eric, Kings, Madison, New York, Niagara, Queens, Rensselaer, Richmond, Onondaga, Otsego, Tioga, Tompkins, Clinton, Essex, Franklin, Herkimer, Jefferson, Lewis, Nassau, Oneida, Oswego, Schenectady, St. Lawrence, Ulster, Westchester

- This program serves single individuals or families who are enrolled in Health Home and may include a certain number of families with minors under the age of 18 years old.

- Potential clients of the program must be enrolled in Medicaid, homeless, health home enrolled or the provider must work with the Health Home to enroll the eligible member, and have one of the following within the past 12 months:

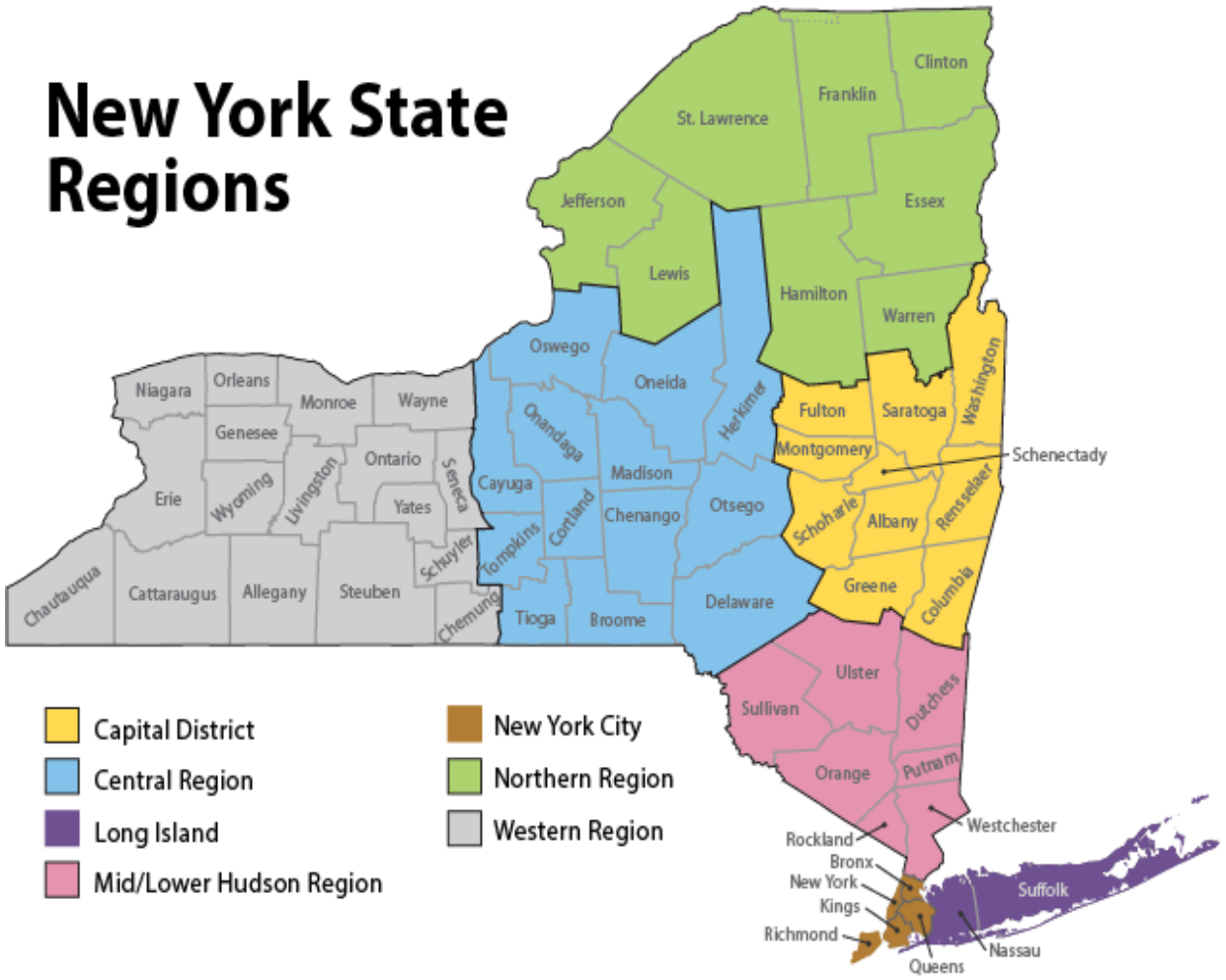
  - Have two or more inpatient stays;
  - Have five or more emergency department visits;
  - Have four or more emergency department visits and one or more inpatient stay;
  - Have base period Medicaid spending above the top 20% of Medicaid members relative to the county of fiscal responsibility and target population parameters (for example, an SMI recipient in Westchester would have to have base period spending more than 80% of the SMI population in that county).

Empire State Supportive Housing Initiative

- Multiagency program, funds the service and operation of supportive housing for persons identified as homeless with special needs, conditions, or other life challenges. New developments/ units only.
- Projects are statewide and are targeted to the following populations:

  - SMI; SUD;
  - HIV or AIDS;
  - Victims/Survivors of domestic violence;
  - Military service with disabilities (including veterans with other than honorable discharge);
  - Chronic homelessness;
  - Youth/young adults who left foster care within the prior five years and who were in foster care at or over age 16;
  - Homeless young adults between 18 and 25 years old;
  - Adults, youth or young adults reentering the community from incarceration or juvenile justice placement, particularly those with disabling conditions;
  - Frail Elderly/Senior;
  - Individuals with I/DD.

Frail/ Elderly Senior ESSHI Contracts In Contract Development:



- 126 Sackman Street, Brooklyn NY
- 100 Kings Highway South, Rochester NY
- 15 Oakwood Avenue, Blasdell NY
- 270 East Ave, Rochester NY
- 167 Lake Avenue Hilton NY
- Auburn NY
- Buffalo
- 2650 Culver Road, Irondequoit NY
- 81-83 South Bergen Place, Freeport NY
- 1746 Andrews Avenue South
- 3 Cerone Commercial Drive Colonie NY
- 475 Bay Street Staten Island, NY 10304
- 200 West Street, Utica, NY 13501

NEW YORK STATE | Department of Health

How to connect?

- All providers are listed on our website
- If you think someone may be eligible for one of the programs, you can make a direct referral to the program.

Supportive Housing Programs (ny.gov)

Other Initiatives

Value-Based Payment Arrangements

DOH has a total of **191** SDH interventions and CBO contracts:

- Mainstream Managed Care – 131 contracts
- Managed Long Term Care – 49 contracts
- Programs of All-Inclusive Care for the Elderly – 11 contracts

A list of approved interventions are posted on the SDH CBO website: www.health.ny.gov/mrt/sdh

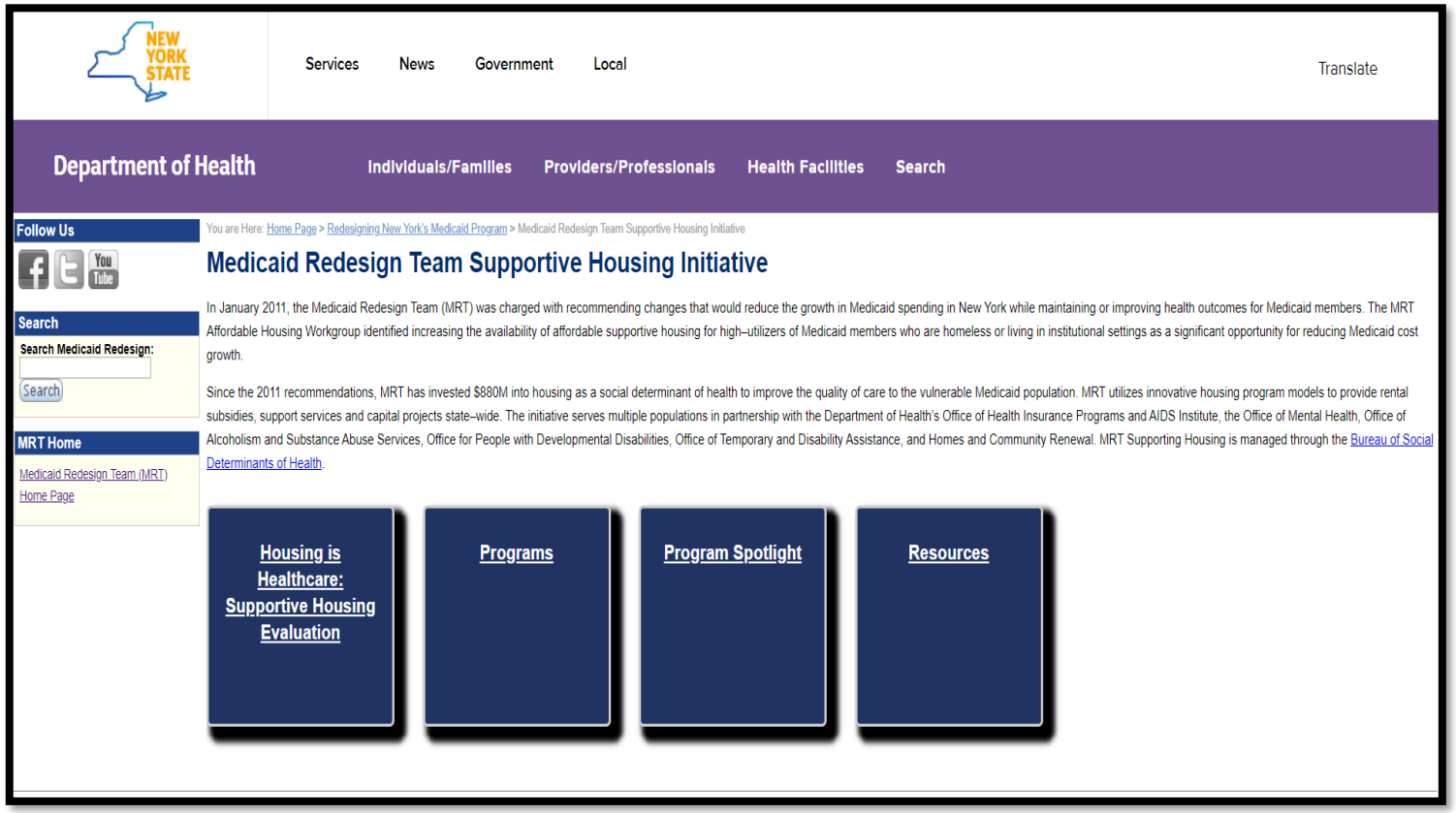
Current approved interventions:

- Food security – 47
- Housing – 24
- Transportation – 4
- Children – 5
- Social isolation – 10
- Primary care engagement – 14
- Self-management of chronic conditions – 32
- Health literacy and education – 25

Note: some interventions address multiple factors and are counted more than once in the above.

**MMC/PACE Roadmap requirement started 1/1/18 and MLTC started 4/1/19*

MRTSupportiveHousing@health.ny.gov



https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm

NEW YORK STATE | Department of Health

1115 Waiver: Strengthen Supportive Housing Services

Investing in Supportive Housing Services – $1.57 billion

- HEROs will develop an inventory of available housing resources and regional need to identify and address gaps in services.

- **SDHNs and Supportive Housing Stakeholders will implement the Enhanced Supportive Housing Initiative, which will:**
  - Encourage a coordinated and targeted effort in housing between MCOs, SDHNs, CBOs, and VBP contractors to connect high Medicaid utilizers with services.
  - Include-
    - Medical respite for recently discharged patients at risk of imminent homelessness and too sick to return to the street
    - Community transitional services for those living in institutional settings or experiencing homelessness
    - Tenancy Supports
    - Referral to and coordination of related services and benefits

Currently under public comment: New York 1115 Medicaid Waiver Information Page (ny.gov)

Q&A

THE NEW YORK ACADEMY OF MEDICINE

NYS Health, Housing, and Longevity Learning Collaborative

DISCUSSION:

What is something new you learned today that you can apply to your work?

LEARNING COLLABORATIVE PAGE

We will post webinar slides, recording, and resources from our Learning Collaborative on the NYAM Health & Age Across All Policies website, https://www.nyam.org/haaap/spring-2022-housing-lc/

THANK YOU