Achieving Human Potential by Aligning Resources and Improving Trust

Vermont Blueprint for Health Conference:
Supporting Healthy Communities and Addressing Social Determinants of Health

DoubleTree by Hilton Hotel and Conference Center
Burlington, VT
March 27, 2018

Connecticut Department of Social Services
Caring for Connecticut

Lambert

A Belief in Maximizing Human Potential where ALL have the opportunity to be healthy, secure, and thriving

Three Overarching Goals

Increase ACCESS to services
Increase TRUST with public
Increase use of DATA to inform change

Who we hire
Who we partner with
What they believe
Matters

Real Choice Systems Change Grants funded initial efforts to align resources

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

THE HENRY J. KAISER FAMILY FOUNDATION

01 MAIN AREAS OF ALIGNMENT

01	Housing - to support deinstitutionalization
02	Workforce - A culture of empowerment
03	Housing - to support chronic homelessness

Housing

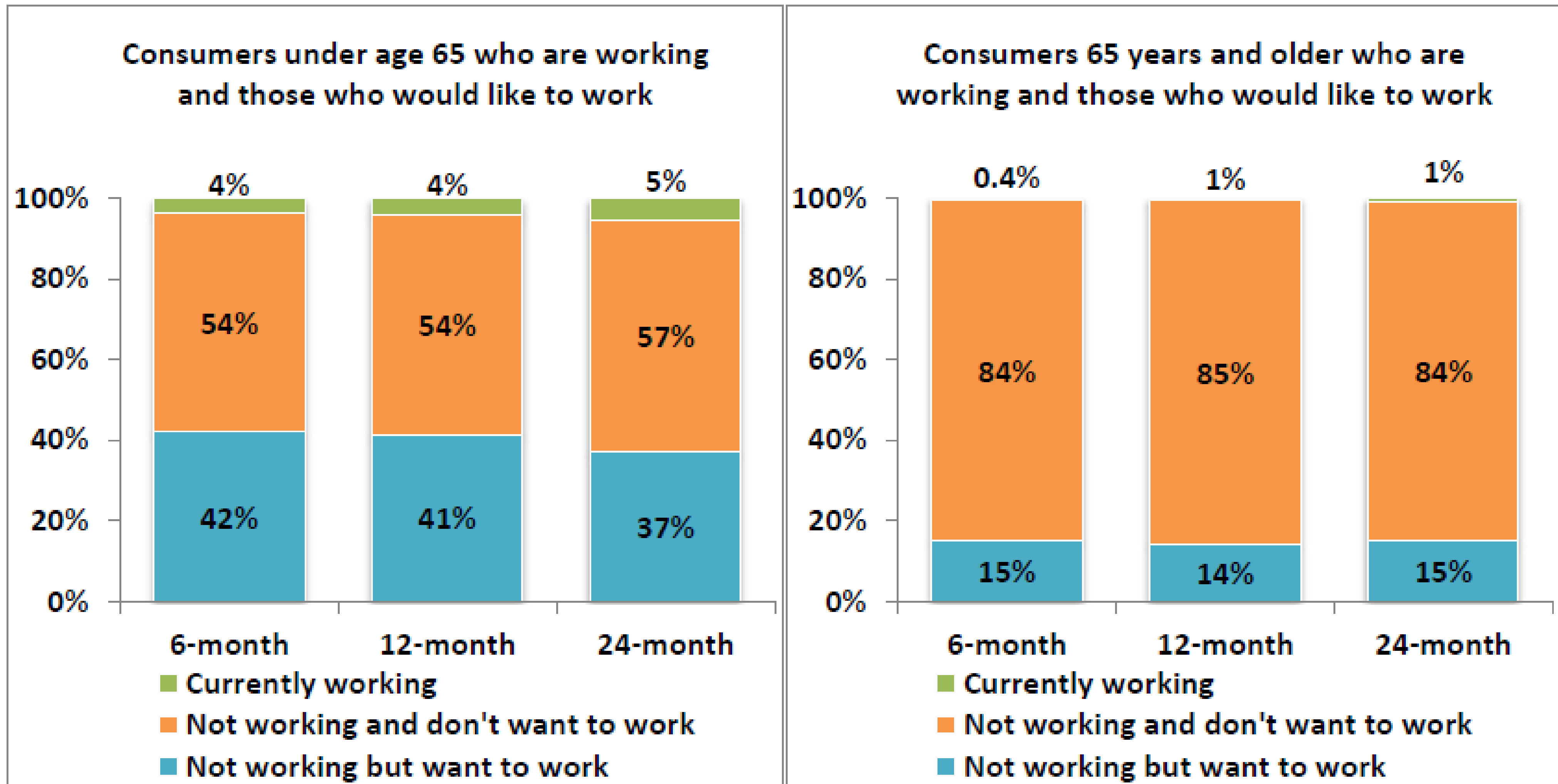
Average Return on Investment
Per Member Per Day
Institution Cost compared to Community Cost

Net Medicaid savings: $50

Cost of community housing: $26

State savings: $24

9

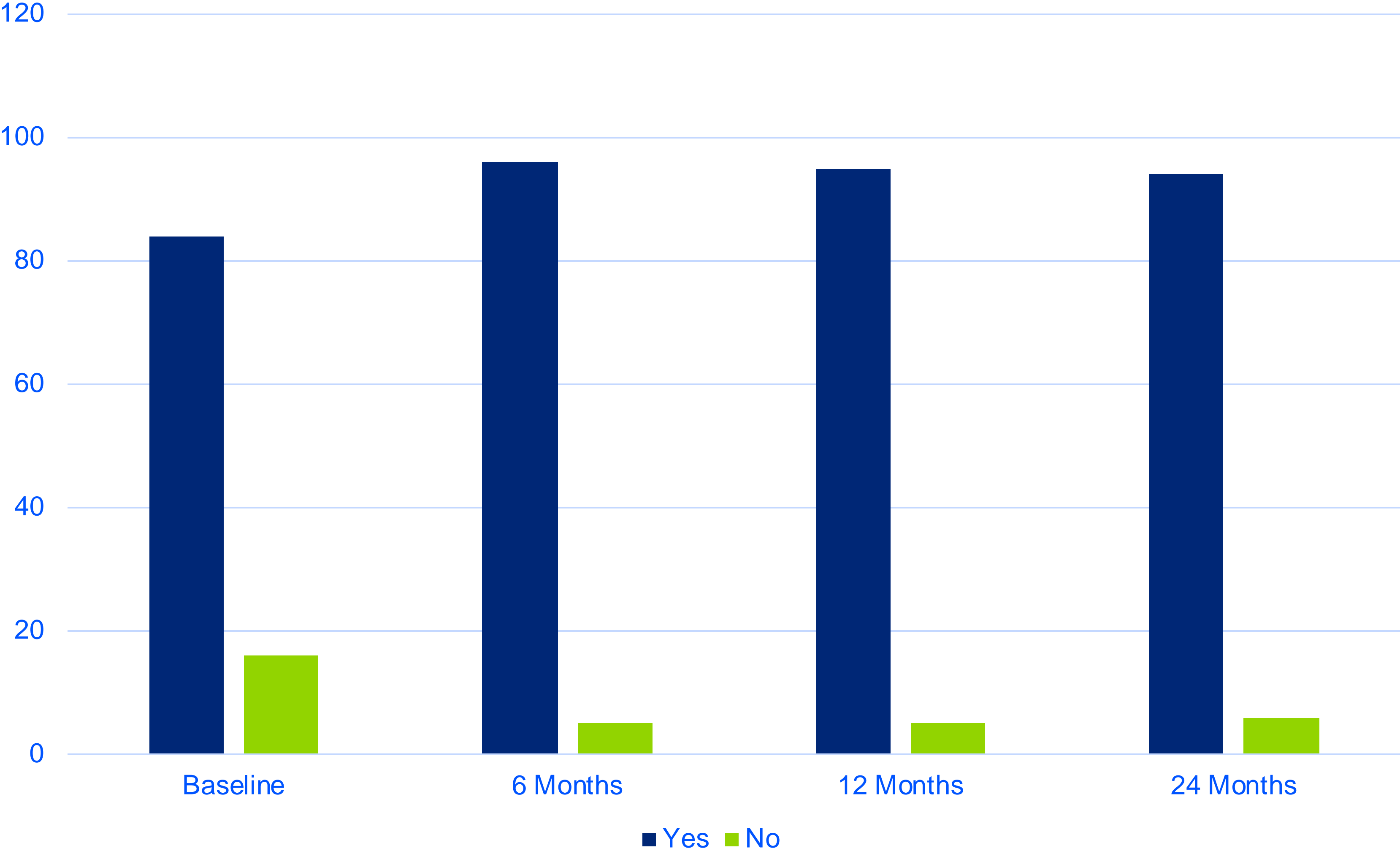


UConn Health, Center on Aging

Operating Agency: *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

Based on latest data available at the end of the quarter

Do the people who help you treat you the way you want them to?



UConn Health, Center on Aging

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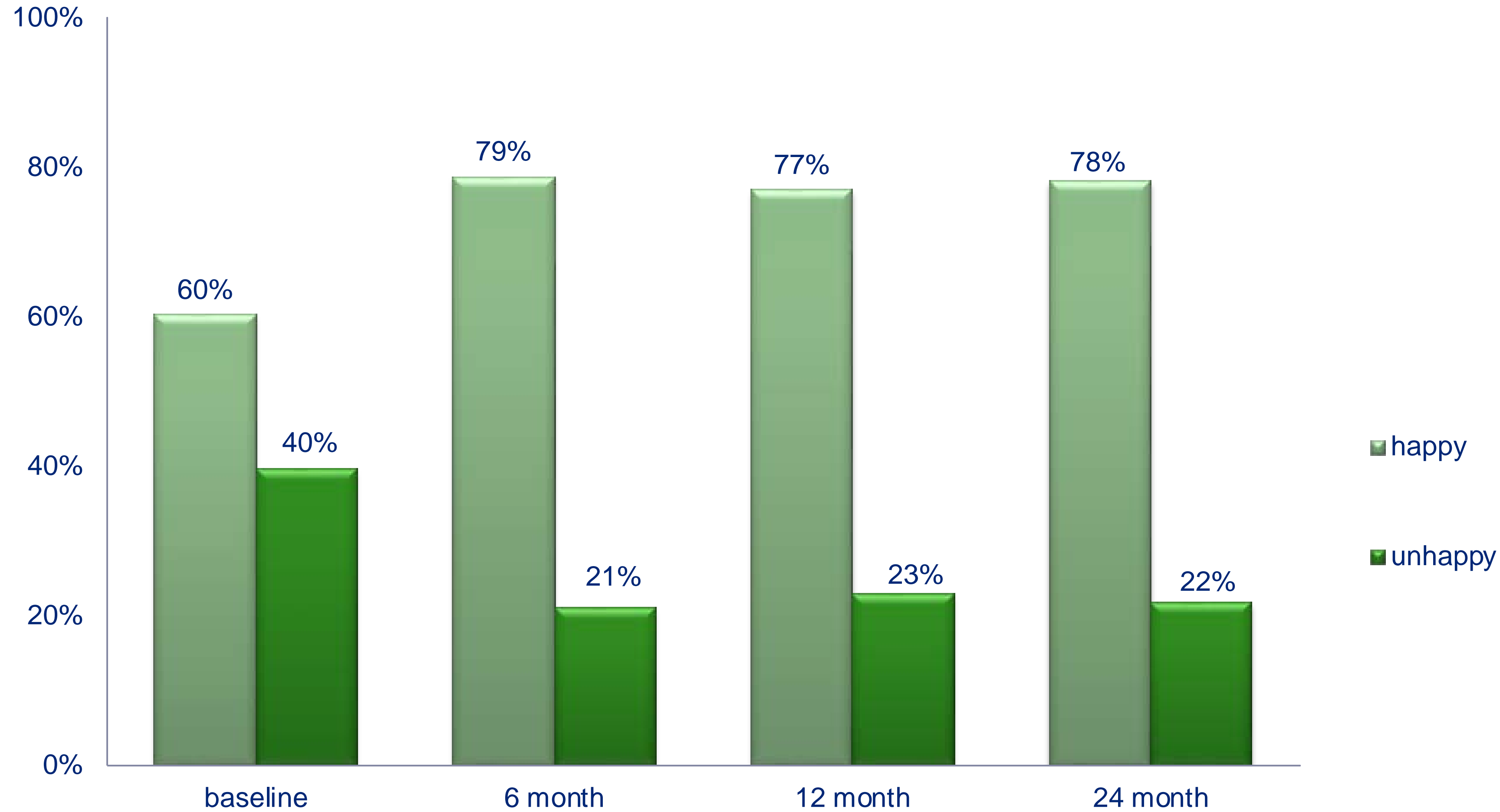
Happy or unhappy with the way you live your life*



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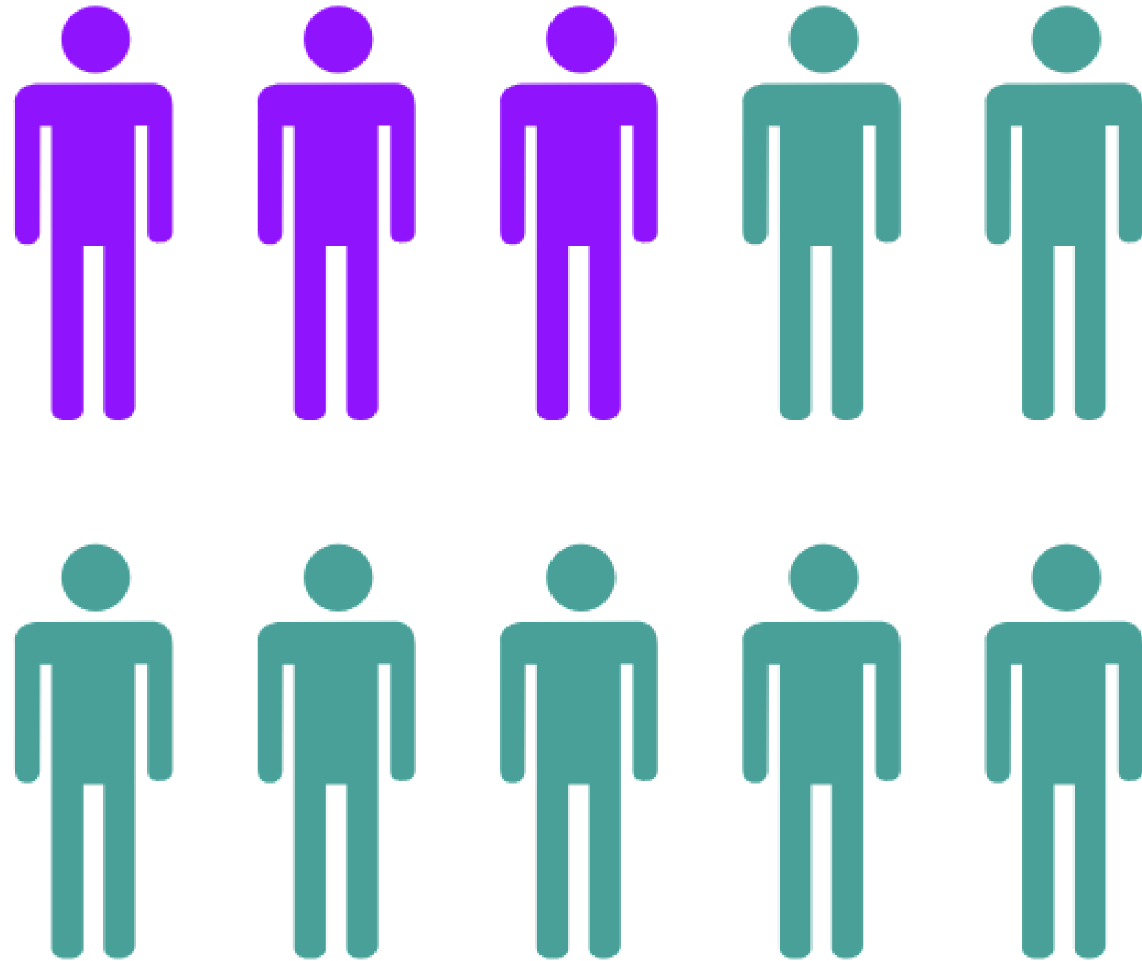
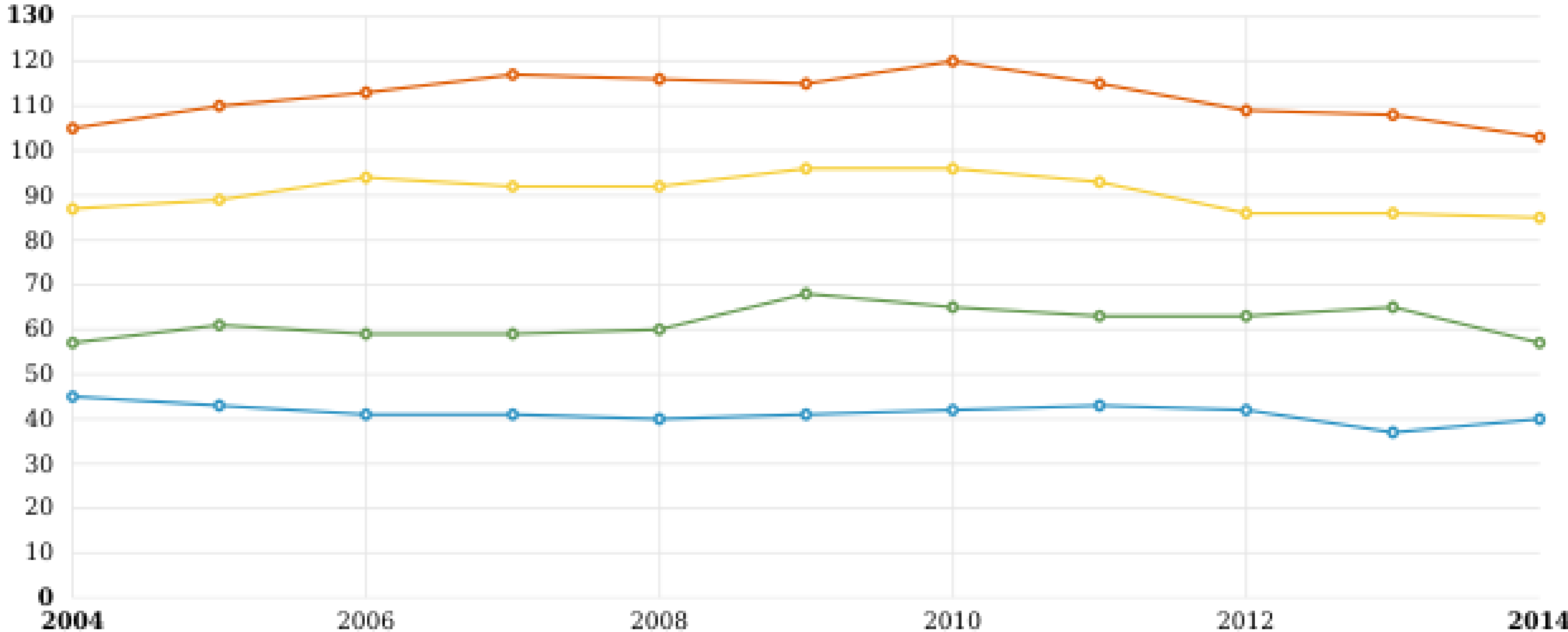
Percent of home health participants with hospital admission



Source: AARP: PICKING UP THE PACE OF CHANGE: 2017 LONG-TERM SERVICES AND SUPPORTS

Medicare Service Use: Skilled Nursing Facilities: Skilled Nursing Facility Stays per 1,000 Enrollees, 2004 - 2014



Skilled Nursing Facility Stays per 1,000 Enrollees

Connecticut **Massachusetts** **Oregon** **Vermont**

NOTES

Notes

Analysis excludes beneficiaries in Medicare Advantage and beneficiaries with zero months of Medicare Part A coverage.

Data are as of July 1 of the year indicated in each timeframe.

Sources

Kaiser Family Foundation analysis of a five percent sample of Medicare claims from the CMS Chronic Condition Data Warehouse, 2000-2014.

Challenge:

2 out of 3 people decided to stay in the institution

Engagement Education

2 days orientation for all new staff
Monthly case review meetings

83% of the Respondents Strongly Agree - Training Helped Them Learn to Guide Rather than Lead

UCONN Health, Center on Aging https://health.uconn.edu/aging/research-reports/

The relative percentage of referrals closed because the participant changed their mind dropped from 33% in 2013 to 15% in 2015

UCONN Health, Center on Aging https://health.uconn.edu/aging/research-reports/

Workforce Development

Changing culture

West Rock Nursing Home
New Haven, Connecticut

Public Health Licensing and Certification Staff

Facility Staff

Residents

Care Coordination Staff

Surprise inspections by state investigators uncovered deplorable living conditions at a New Haven nursing home. The West Rock Health Care Center is closing its doors Friday, on the heels of those findings.

May 5, 2010
NBC News

Intensive Engagement
Universal Assessment
Homelessness

25% of the people moved to the community

Housing

160 people in Connecticut nursing homes were chronically homeless upon admission

The Corporation for Supportive Housing

Social Innovation Fund Demonstration

Data Match Between Homelessness Management Information System and Medicaid Claims

Days in Shelter

Period: 12/01/2012 - 10/31/2013 (annualized)

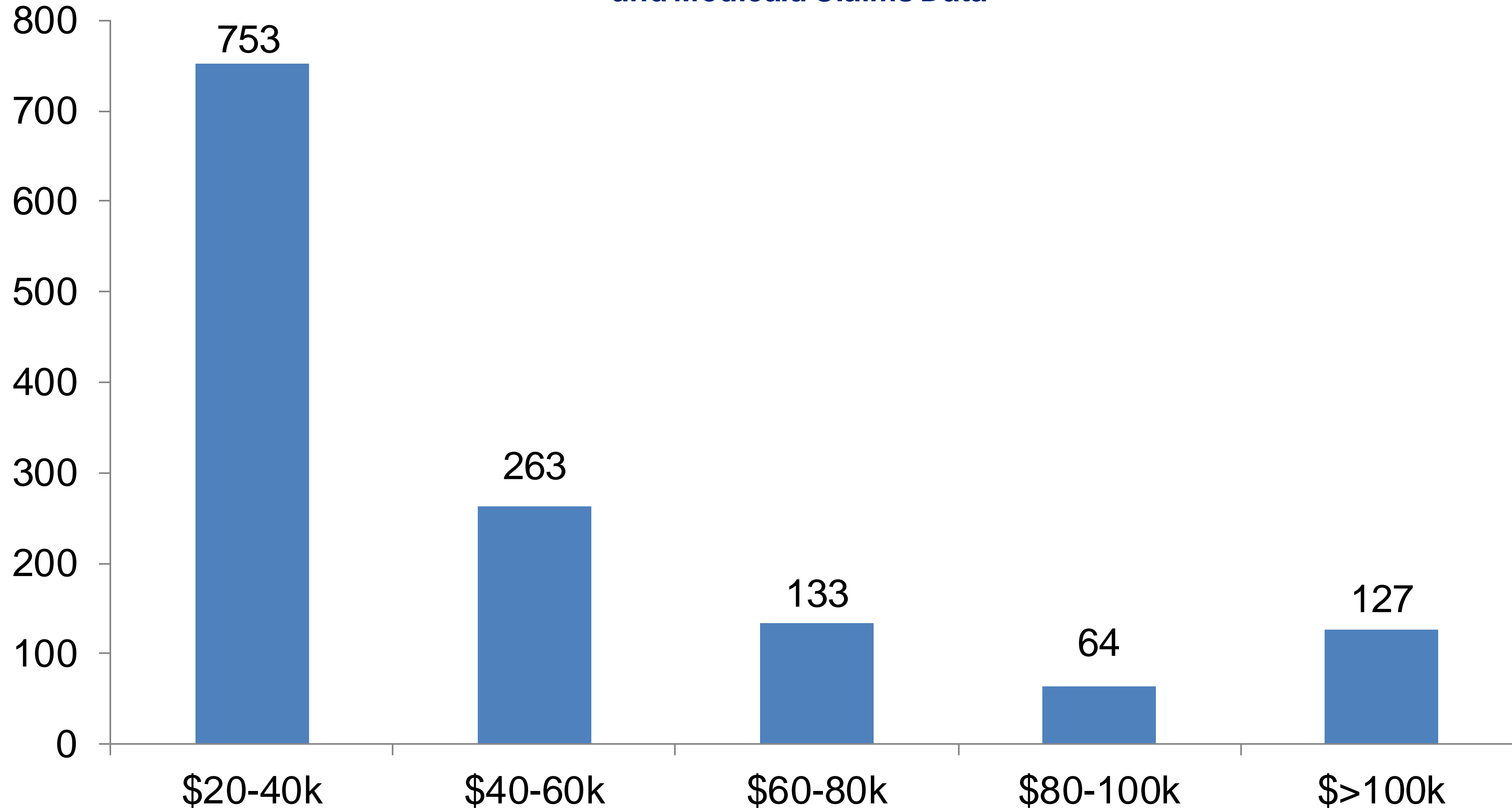
Matched Homelessness Management Information System (HMIS) and Medicaid Claims Data

Cohort Utilization	N	% of Cohort
Matched Cohort with Annualized Medicaid Claims >=$20K	1340	100%
In shelter 31+ Days	681	51%
In shelter 61+ Days	433	32%
3+ ED Visits	1048	78%
6+ ED Visits	656	49%
3+ Inpatient Visits	708	53%

Funded by Corporation for National and Community Service through Corporation for Supportive Housing

Medicaid Claims per Individual

Period: 12/01/2012 - 10/31/2013 (annualized)

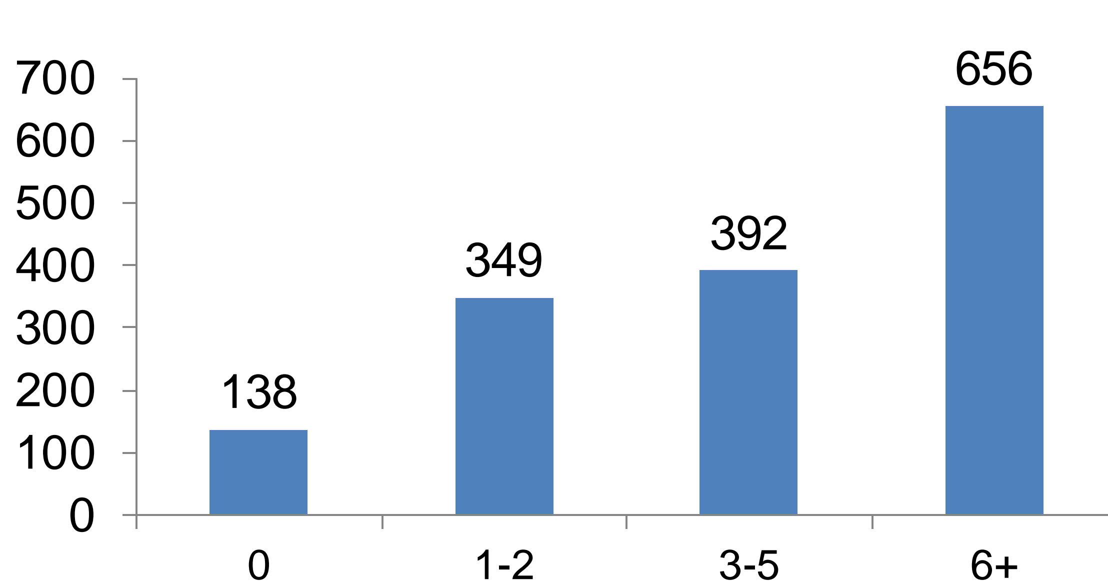


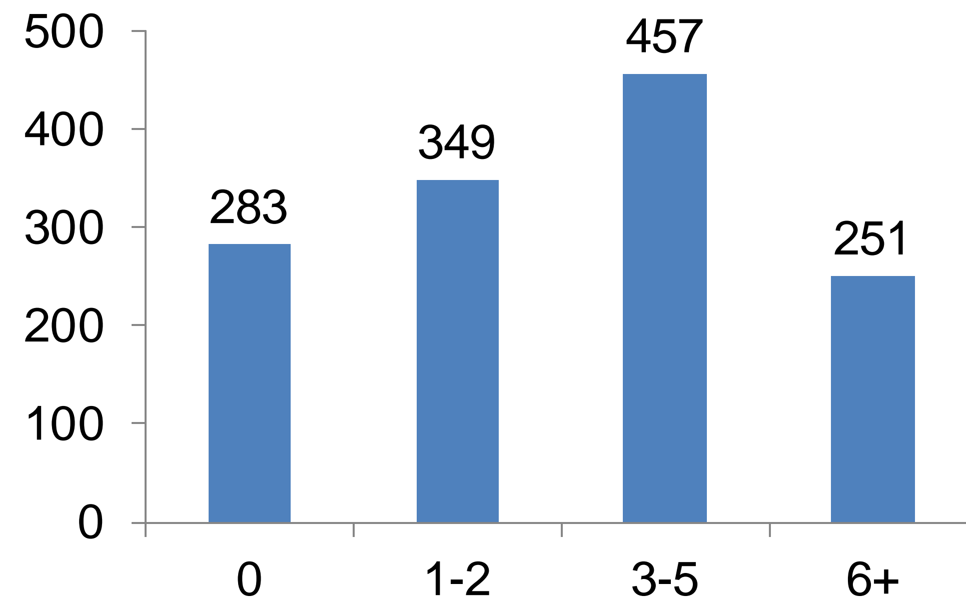
Funded by Corporation for National and Community Service through Corporation for Supportive Housing

ED and Hospital Utilization per Individual

Period: 12/01/2012 - 10/31/2013 (annualized)

Matched Homelessness Management Information System (HMIS) and Medicaid Claims Data





49% of beneficiaries visiting the ED at least six times

53% of the cohort had three or more inpatient visits

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Diagnosis

Period: 12/01/2012 - 10/31/2013 (annualized)

Matched Homelessness Management Information System (HMIS)

Diagnoses	N	% of Cohort
Any Chronic - Asthma, diabetes, CHF, other heart, stroke, liver, renal, COPD, other lung disease or Alzheimer's	1071	80%
Two or more Chronic - Asthma, diabetes, CHF, other heart, stroke, liver, renal, COPD, other lung disease or Alzheimer's	757	57%
Congestive Heart Failure	115	9%
Hypertension	671	50%
Diabetes	514	38%
Asthma	441	33%
Major Mental Health	1053	79%
Alcohol	808	60%
Drug	1185	88%

Funded by Corporation for National and Community Service through Corporation for Supportive Housing

Social Innovation Fund (SIF) Demonstration Characteristics

Data driven targeting

5 Non-profits located regionally

Assertive outreach

Rental assistance

Patient navigators

Clinical partnerships with healthcare providers

Funded by Corporation for National and Community Service through Corporation for Supportive Housing

Reductions after intervention in Treatment on the Treated Group*
N=430

Number of ED visits
Total hospital days
Number of medical hospitalizations
Number of psychiatric hospitalizations
Total cost
Number of shelter days

- *Measures the difference between those who received the treatment to a matched group within those assigned to the control condition.*

Beth C. Weitzman. PhD, Principal Investigator, New York University

CSH Social Innovation Fund Initiative, Evaluating Supportive Housing as a Solution for People with Complex Health Care Needs - Summary of Findings, November 27, 2017
http://www.csh.org/wp-content/uploads/2018/01/CSH-SIF-Evaluation-Summary-02-02-18Final.pdf

The Treatment on the Treated analysis revealed a significant cost reduction of $7,800 per person per year in Connecticut.

CSH Social Innovation Fund Initiative, Evaluating Supportive Housing as a Solution for People with Complex Health Care Needs - Summary of Findings, November 27, 2017
http://www.csh.org/wp-content/uploads/2018/01/CSH-SIF-Evaluation-Summary-02-02-18Final.pdf

SUMMARY

Engagement

Investment in ongoing education

ROI

Targeted housing saves Medicaid money

Culture

Belief in human potential

Direct Care

Who do we hire and who are our partners?

"Getting the Right People in the Right Seats on the Bus."

From Good to Great
Jim Collins

Collins, J. (2001). Good To Great. New York, NY. HarperCollins Inc

Why do you do what you do?