CAST CASE STUDY

Cathedral Square Corporation

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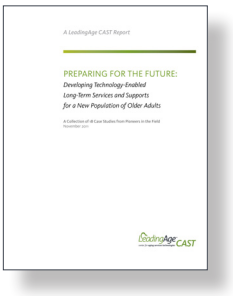

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How one housing provider earned a seat at the table to influence state health care policy

The fifth in a series of case studies from the Preparing for the Future Report

- A collaborative Support And Services at Home (SASH) pilot now integrated into Vermont's health reform initiative and supported with Medicare funding
- One-year of the collaborative model already showing a 22% reduction in falls, 19% reduction in hospital admissions with no readmissions and a 10% reduction in physically inactive residents
- As part of the health reform initiative, Vermont projects the SASH pilot to save the state $40 million in Medicare costs
- The collaboration between the multi-disciplinary teams and coordination of care is predicated on data and exchange of information, which will be enhanced with technology

The Organization

Cathedral Square Corporation (CSC) is a nonprofit organization in Burlington, Vt. that owns and manages 24 affordable housing communities for seniors and individuals with special needs. Founded as a ministry of the Cathedral Church of St. Paul, CSC opened its first building in downtown Burlington in 1979.

Over the years, CSC has worked hard to raise awareness about the important role that affordable housing communities can play in helping their residents age in place. The organization developed the Support And Services at Home (SASH) model, through which an interdisciplinary team of health professionals and service providers works at a housing site to help residents remain independent. The team is comprised of a full-time SASH coordinator and a wellness nurse, both of whom are employed or subcontracted by the housing development, as well as nurses, caseworkers, mental health professionals and service providers from community-based organizations.

When residents join the SASH program, they receive various assessments to gauge their cognition, mental health status and ability to live independently. Using these assessments and information gathered during resident interviews, the SASH team works with each resident to develop an Individual Healthy Aging Plan designed to help that resident meet his or her health and wellness goals. The team also develops a Community Healthy Aging Plan that addresses health issues affecting the entire congregate setting.

Using funds from the Vermont legislature, the Vermont Health Foundation and the MacArthur Foundation—as well as its own funds—CSC developed and piloted SASH at one of its apartment buildings from August 2009 to August 2010. Since July 2011, SASH has been integrated into the Blueprint for Health, Vermont's new health reform initiative. Organized around a medical home model, the initiative involves the creation of interdisciplinary community health teams that provide coordinated care and support patients' primary care physicians. A Medicare-funded SASH program will extend the capacity of those community health teams in 112 housing developments throughout the state.

Technology-Enabled Model or Service

CSC is currently exploring several technology-enabled services with the help of its full-time SASH Health Information Technology (HIT) Coordinator, who has significant experience in telemedicine and other methods of linking with seniors in their homes. CSC plans to deploy an electronic emergency call system in individual apartments. In addition, it would like to launch a low-cost CyberSeniors initiative that will bring local high school students to Cathedral Square buildings to teach residents how to use computers and to help them communicate with distant family and friends using the Skype communications platform. The organization's most ambitious technology initiative, however, involves its efforts to connect SASH sites to Vermont's Health Information Exchange (HIE).

HIE Implementation Approach

The SASH pilot study convinced CSC and its partners that having accurate and up-to-date information about the health status of each SASH participant would help the teams respond quickly and appropriately to emergencies or intervene early before a subtle health change becomes a major health crisis. As SASH looks to the future, it recognizes that the efficiency of information sharing will be maximized by access to the state's HIE.

The State of Vermont has already made a formal commitment to connect each SASH site to the HIE, and an active SASH HIT Work Group has been formed with the state's contractor to develop the SASH module. This reflects Vermont's full commitment to what state officials call "systemness." While SASH works to be fully integrated into the HIE, it has created a database of its health assessment data using Microsoft's Access software. This database is modeled on a database that will be used by the community health teams that will be established under the state's Blueprint for Health initiative. When those community health teams and the SASH sites are connected to the state's HIE, the databases created by SASH and the teams should be interoperable.

Interoperability will allow SASH to enrich the community health team database with additional information about individual SASH participants, including their nutritional status and history of falls. Interoperability will also allow SASH sites to access the community health teams' clinical tracking system and the electronic health record system that the state's hospitals are now implementing. Finally, SASH participants will gain access to a personal health record that will be provided to all of the state's health care consumers as part of Vermont's health reform initiative.

SASH is particularly interested in using the HIE to gain access to aggregated data about its participants' health and functional status so it can develop community-wide programs aimed at changing disturbing trends. The aggregated data will also allow SASH to identify demographic factors that could possibly influence variability in health outcomes from one SASH site to another. In particular, the SASH teams are interested in collecting accurate data on the number of prescription drugs being taken by residents of SASH sites and the number of SASH participants who have chronic diseases, have experienced multiple falls or have been transported to the emergency room as a result of a fall.

Outcomes

During its one-year testing stage, SASH interventions helped reduce hospital admissions by 19 percent among housing residents at the test site. In addition, not one SASH participant who was discharged from nursing homes during the test period experienced a readmission. In addition, falls have been reduced by 22 percent, residents at moderate nutritional risk fell by 19 percent, and the percentage of physically inactive residents was reduced by 10 percent.

SASH has also proven that it represents a wise use of resources. The State of Vermont recently projected that its health reform initiative, combined with SASH, will save Medicare $40 million by reducing older consumers' use of inpatient hospital and physician services, hospital outpatient and emergency room services, pharmacies and nursing home days.

These outcomes have helped to cement SASH's credibility with sometimes skeptical housing providers, who have signed up to participate in its statewide rollout in mid-2011. In addition, service providers who work at the SASH test site now endorse the program because SASH has demonstrated that it can help them carry out their missions more effectively.

Having CSC and SASH involved in discussions of Vermont's health care reform initiative has also helped health care providers see housing providers in a new light. Until recently, it was not generally accepted that housing providers like CSC play a role in coordinating a resident's services and supports, or have access to residents' health information. Now, a growing number of state policy makers, health providers and community-based service providers understand the benefits they can reap by sharing information with SASH sites and receiving information from those sites.

Challenges

Outdated infrastructure: Like many owners of older housing communities, SASH sites face a challenge as they attempt to upgrade their buildings to support technology innovations. Wireless technology is virtually nonexistent in these buildings, but will become increasingly important in helping these sites share information with other practitioners and eventually institute more sophisticated methods of monitoring resident behavior and tracking health outcomes. CSC hopes to be included in the state's broadband initiative. If it is successful, all housing sites would be "community anchors" earmarked for broadband.

User-friendliness: The technology used on the front lines to input assessment data must be user friendly while not diminishing the quality of the interaction between the assessor and the participant. In the most rural areas of Vermont, this may require a greater number of laptops or tablets due to the geographic dispersion of SASH sites.

The Business Case

When the State of Vermont's Blueprint for Health applied to the Centers for Medicare and Medicaid Services (CMS) in August 2010 for the Multi-Payer Advanced Primary Care Practice (MAPCP) Medicare Demonstration program, it projected that SASH would help the initiative achieve a cumulative savings in Medicare expenditures. That business case helped SASH obtain $10.2 million in Medicare funds—which represents a capitated amount of $700 per participant per year—to roll out its team-based model to 112 housing sites beginning in July 2011. One stipulation of Medicare funding was that SASH enroll Medicare beneficiaries regardless of age, income or residential setting.

An aggressive and effective rollout of SASH also required an Implementation Grant. The state has provided funding for that purpose through the Medicaid Global Commitment. Cathedral Square is currently seeking additional funds from other sources so it can add dollars to Medicare's per-participant cap.

CSC is currently developing information materials and participant selection criteria for serving consumers living in communities that surround SASH sites.

Advice for Others

Make systems change your goal. Housing providers need to view themselves as valuable community resources. These providers should not be satisfied with creating "boutique" programs that serve only a small number of older consumers and often disappear when their short-term funding has been exhausted. Instead, housing communities need to become actively involved in efforts aimed at changing the entire health care system.

Get a seat at the table. The ability of housing providers to participate in systems change will depend on their willingness to get involved when states and local stakeholders are creating health information exchanges and telehealth networks, instituting payment reforms, and establishing Accountable Care Organizations. It is essential for housing providers to become educated about their state's plans in these areas and seek ways to become involved in the process.

Sell yourself to your HIE. The burden is on housing providers to convince state officials that they have valuable information about older residents that could help improve the care provided by local health providers, particularly emergency room physicians.

Look to the future. Like all providers of long-term services and supports, housing providers need to start thinking about the kinds of services and supports consumers will be demanding in 10-20 years and the kind of technology necessary to provide those services efficiently and effectively. Providers need to begin taking steps today to upgrade their buildings so that they are ready to support that technology. ■

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