Keeping Elders Home

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Massachusetts Health Policy Forum
a collaboration of the Schneider Institute for Health Policy at Brandeis University's Heller School, Health Care For All and Citizens Program Corporation
Frail elders: dimensions of the problem

- Over the next 25 years:
  - The number of MA residents age <65 will remain relatively stable at a little over 5.5 million
  - The number of MA residents age 65+ will increase by 46% from 860,000 to over 1.25 million
- In 2002 elderly MassHealth recipients accounted for:
  - 8% of the MA budget
  - LTC for those elderly account for 75% of these expenditures (6% of the state budget)
- The Commonwealth Fund predicts almost doubling of LTC demand as the full impact of the baby boom is felt
Successful aging: what do elders want?

• Not just a matter of objective physical health.

• Elders say:
  – “Keep on living in my home”
  – “Not be a burden to others”
  – “Do for myself”
  – “Not be disabled or really ill”
  – “Not be in pain”
Successful aging: what do elders need?

- Successful aging requires integrated supports
- MA elders with means have shown strong willingness to pay for those supports
- 500% growth in MA assisted living in the past ten years
- Nationally, less than 15% of elders have income necessary for private assisted living
Public supports: What do frail elders get?

• Social Security
  – Federal

• Medical Supports
  – Medicare and Medicaid

• Behavioral Supports
  – Medicare/Medicaid/DMH

• Social Supports
  (Meals, adult day care, homemaking)
  – EOEA, Medicaid

• Housing
How to serve most complex and frail elders in the community?

- In spite of services, gaps still exist
- Default locus of care when gaps occur is LTC
- CEEH established as experimental model to integrate services and target highest risk elders
CEEH Accomplishments

Bishop Street House
- 1992 in Jamaica Plain  9 Units (Congregate)

Symphony Shared Living
- 1995 in Boston  10 Units (DMH)

Anna Bissonnette House
- 1997 South End  40 Units

Ruth Cowin House
- 2000 Brookline  9 Units

Ruggles Street Assisted Living Facility
- 2001 Roxbury  43 Units

Elder House
- 2002 Dorchester  14 Units
CEEH Interdisciplinary Team Model

- Housing
- Mental Health
- Activity
- Health

Case Management

Case Management
CEEH Population Description

- 48.2% female
- 51.8% male
- 65-74 years (38.3%)
- Race/Ethnicity
  - 51% Black
  - 41% Caucasian
  - 4% Hispanic
  - 4% Other
Common Chronic Illnesses

Percent of Residents With Condition

MH/Dement, Hypertn, Cardiac, Diabetes, COPD, Arthritis, Asthma, GI/Incon, Stroke
Indicators of Frailty

Percent of CEEH Residents with Special Needs

- DMH Client
- Under Psych Care
- Asst'd. Walking
- Asst'd ADLs
**Research Process**

**Process**
- 110 Respondents
- Longitudinal Study: Inception, 6 months, 1 Year
- Use of a “Blind Recorder”
- Use of Survey Instruments with Proven Efficacy

**Measurements**
- Physical & Mental Functional Status
  - *SF36 Health Survey*
- Social Integration
  - *OARS Resource and Services Scale*
- Mental/Cognitive Functioning
  - *Mini Mental Status Exam (Folstein)*
- Well-being/Successful Aging
  - *Life Satisfaction Index (LSIA)*
- Health Care Utilization
  - *Record Mining*
Research Outcomes: Functional Status

SF-36 Outcomes for CEEH Residents at First and Second Collection Points and Benchmark for Average US Population Elders Age 65-74
## Research Outcomes: Social Integration and Well-Being

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<tr>
<th>Social Integration</th>
<th>Well-Being</th>
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<td>• Lower social integration scores compared with norms</td>
<td>• Low scores compared with average</td>
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<td>• Continued improvement in well-being over time</td>
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Research Outcomes: Cognitive Functioning

- Respondents score in the top quartile for cognitive functioning
- Greatest improvement within the first year of tenancy
- Statistically significant improvement in scores over time
Findings:
CEEH utilization by former LTC users

- 22 elder residents of LTC moved into Ruggles Asstd. Living
- Estimated Medicaid savings of approximately $300K annually
- 59 referrals from LTC to Ruggles in 10 months
Findings: Utilization of acute inpatient care by CEEH residents

- CEEH residents have very high degree of frailty on all scales
- CEEH residents have fairly normative acute hospital use
- One model (NCCC) predicts top 20% frailty use 66% of services
- NCCC model suggests CEEH residents should have as much as 38 more hospitalizations than were experienced
- Annual savings to Medicare and Medicaid estimated at $500K
Other models for frail elders

- Medical system is most frequent “default payer” for frail elders
- Most care management programs for frail elders have originated in medical system
- Managed care systems overall have failed to control costs and improve outcomes for frail elders
Other models of care for frail elders: 
**PACE and SCOs**

- **PACE- Program of All Inclusive Care for the Elderly**
  - Founded in 1979
  - Federal waiver
  - 36 sites nationally (8,500 enrollees)
  - 6 sites in MA (1,150 enrollees)
- **SCOs- new MA plan**
Key components for successful program for frail elders

- Target high risk (high utilizer) population
- Keep elders in community
- Administratively simple for providers and payers
- Integrate housing, medical, behavioral, social supports
- Be cost efficient and clinically effective
- Be easily replicable and scaleable
Policy Recommendation: Supported Housing/Assisted Living

- Expand existing GAFC program (possible pilot)
- Create reimbursement scale $1150-$2000/mo based on elder acuity and services required (1-3 hours of medical, social, behavioral supports/day)
- Evaluate outcomes and utilization
Final Points

- “Woodwork effect”
- Congressional Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century
- Other states’ pilots