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Aging in Place:

UTILIZING COMMUNITY LONG-TERM SERVICES & SUPPORT IN OMH RESIDENTIAL PROGRAMS

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May 2, 2018 2018 ACL Management Symposium

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Outline

- Aging in Place approach relevance to individuals living with SMI and the BH service system
- Data analysis of individuals receiving long term services and supports (LTSS) in OMH Housing
- OMH LTSS Pilot and case studies
- What we've learned so far
- Upcoming projects and opportunities
- Questions

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What do we mean by "aging in place"?

Aging in place means…

Living in a place you consider your home, with friends, neighbors, family and community-based supports creating a wrap-around of support that addresses changing mental, physical and social needs to sustain meaningful quality of life.

It does not mean

Remaining in settings that:

- exacerbate the aging process (SNF)
- cannot meet holistic needs because there are no other choices

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Aging in Place Focus: Why now?

- Alignment with OMH's strategic Plan
- Consistent with the intent of the Geriatric Mental Health Act
- A holistic approach that aligns with social determinants of health/mental health
- Better Health Outcomes

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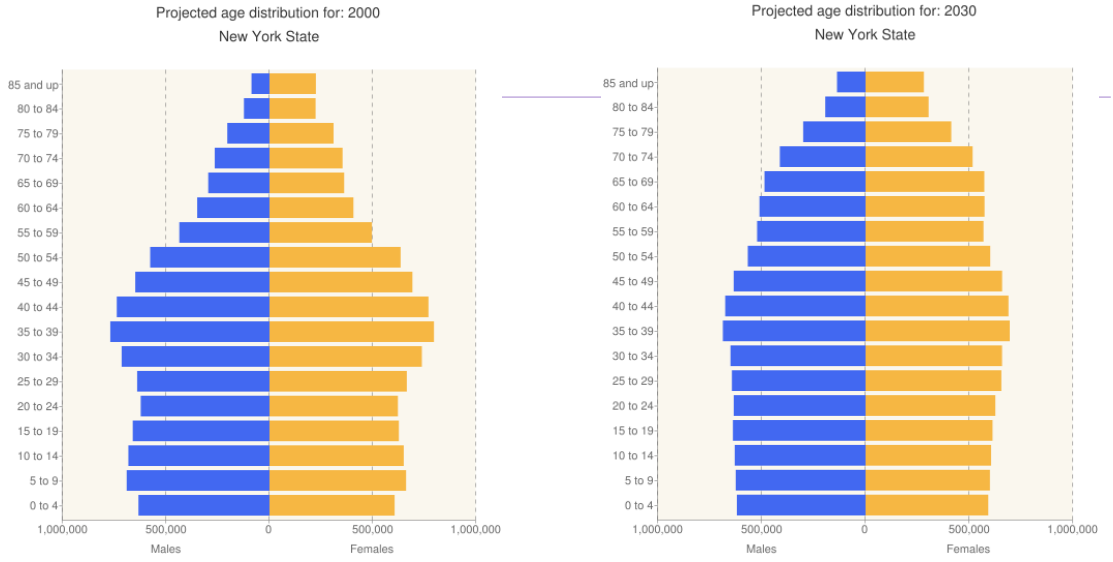
The NYS population of seniors (65+) is increasing



Cornell Program on Applied Dynamics, based on 2010 US Census

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The SMI population is "aging" prematurely

- Individuals living with SMI have a 25-30 year shorter life span than the general population
- For people with major mental illness, the average life expectancy is 53 years old: "50 is the New 80"

Why?

- Disproportionate risk of death from significantly increased cardio and metabolic risk factors (obesity, heart disease, diabetes)
  - Substandard health care for common chronic illnesses

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The "High Cost/ High Risk" Population

Mental Health and chronic health disease rank among the top ten most common and expensive conditions in Medicaid readmissions*:

1. Septicemia (except in labor) —$319 M (17,600 readmissions)
2. **Schizophrenia and other psychotic disorders** —$302 M (35,800 readmissions)
3. **Mood disorders** —$286 M (41,600 readmissions)
4. Congestive heart failure (non-hypertensive) —$273 M (18,800 readmissions)
5. **Diabetes mellitus with complications** —$251 million (23,700 readmissions)
6. **Chronic obstructive pulmonary disease and bronchiectasis**—$178 M (16,400 readmissions)
7. **Alcohol-related disorders** —$141 M (20,500 readmissions)
8. Other complications of pregnancy —$122 M (21,500 readmissions)
9. **Substance-related disorders** —$103 M (15,200 readmissions)
10. Early or threatened labor —$86 M (19,000 readmissions)

Behavioral Health conditions dramatically increase the cost per individuals in Managed Care:

- Medicare 245% higher for an individual with BH conditions
- Medicaid 341% higher for an individual with BH conditions

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"Aging in Place" Approach Aligns with The Continuum of Services Paradigm

Focus 2: Access and Engagement: Make It Easier to Get Good Care

Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization. Through partnerships at the federal, state, and local levels, build the capacity of the mental health system to provide a continuum of services that includes inpatient psychiatric care, when needed, with community-based resources also available. Ensure that people with SMI and SED receive care in the least-restrictive safe setting available that meets their mental health service needs.

Interdepartmental Serious Mental Illness Coordinating Committee, The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers, December 13, 2017

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How can data help?

A repeated frustration amongst attendees was the lack of availability of data for effective targeting of such individuals. The question was raised as to how can housing providers, care coordinators, social workers, and others at the housing gateway target high users without systematic and direct access to protected Medicaid usage data.

- The Supportive Housing Network of NY,

High Cost Medicaid Users in Supportive Housing: Best Practices/Think Tank,

December 5, 2014

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Alternative Strategy: Not individuals, but Systems

We already know who the high Medicaid users currently are or will be – individuals with co-occurring SMI and chronic medical conditions who face barriers accessing community based services

Instead analyze long term service support use within and across OMH housing to address systemic gaps

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Data Dive: Individuals receiving LTSS in OMH Housing

Goal: Analyze demographics and more detailed information about long term services and supports (LTSS) use to identify needs and gaps in accessing the full continuum of services

Sample: individuals receiving LTSS while residing in OMH housing (Congregate/Treatment, Apartment/Treatment, Supported SRO, Supported Housing Community Services)

Time Frame: LTSS received any time between admission to discharge/December 2017; totals shown are cumulative for the entire year

Approach: Claims/Service-based analysis

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What are long term services and supports (LTSS)?

Skilled Home Health Care:
- Nurse (RN or LPN), Dietician/Nutritionist, Therapist (OT, PT, RT, ST)
- Home Health Aide
- Medical Social Services
- Social and Environmental Supports

Paraprofessional Services:
- Homemaker/Housekeeper (Level 1 IADLs)
- Personal Care (Level 2 “hands on” assistance with ADLs)

Consumer Directed Personal Assistance Program (CDPAP)

Personal Emergency Response System (PERS)

Durable Medical Equipment (DME)

Home and Congregate Meals

Adult Day Programs: Social (SAD) and Medial (ADHC)

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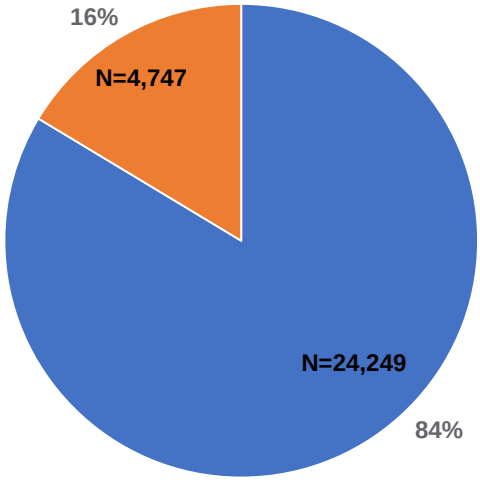
Percent and Number of Individuals (Cumulative) Who Received At Least One LTSS in OMH Housing in 2017



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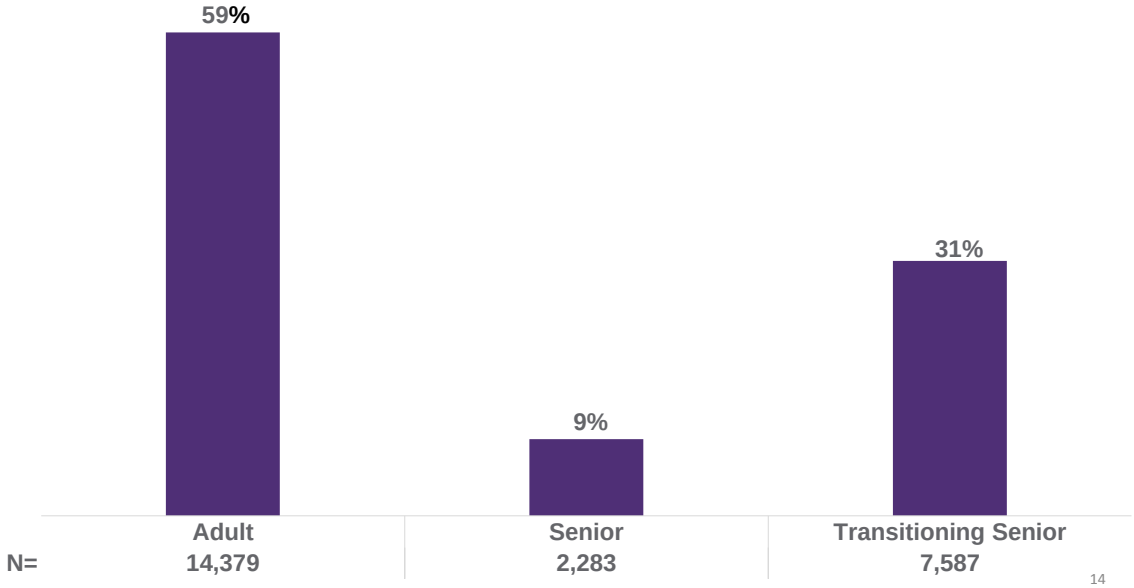
Percent and Number of Individuals by Age Category in OMH Housing



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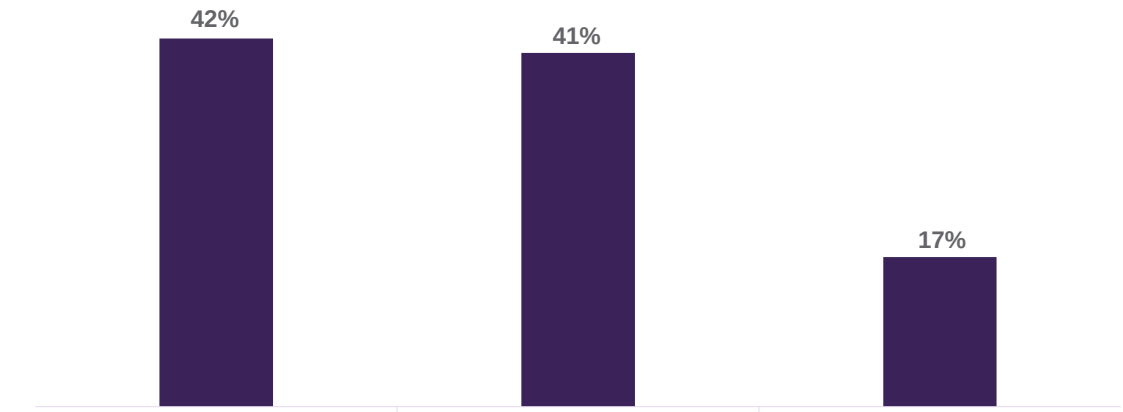
Of Those Who Received LTSS in OMH Housing in 2017, Percent and Number of Individuals by Age Category



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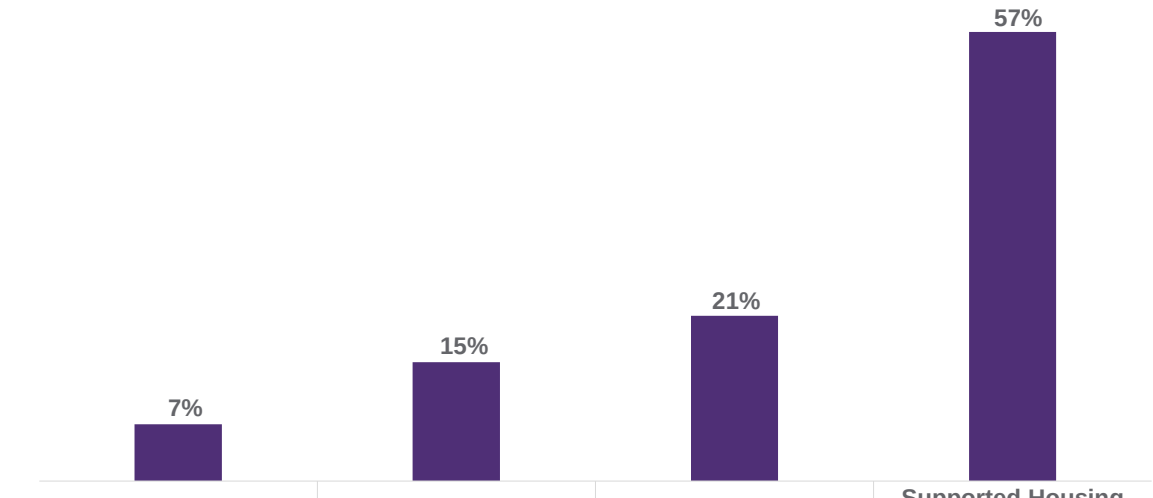
Of Those Who Received LTSS in 2017, Percent and Number (Cumulative) of LTSS Claims by OMH Housing Type



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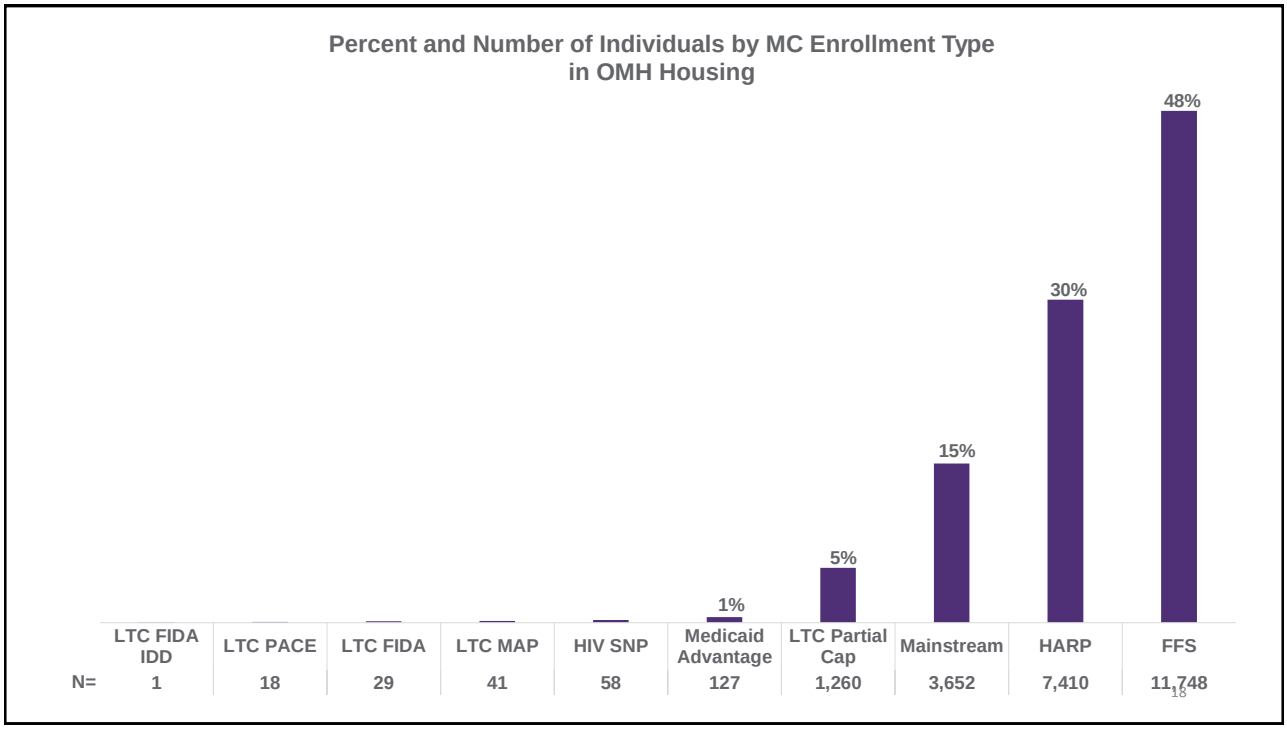
Age Trends: Individuals Who Received LTSS in OMH Housing

Over the course of 2017, approximately 1/5 of individuals living in OMH Housing received at least one LTSS

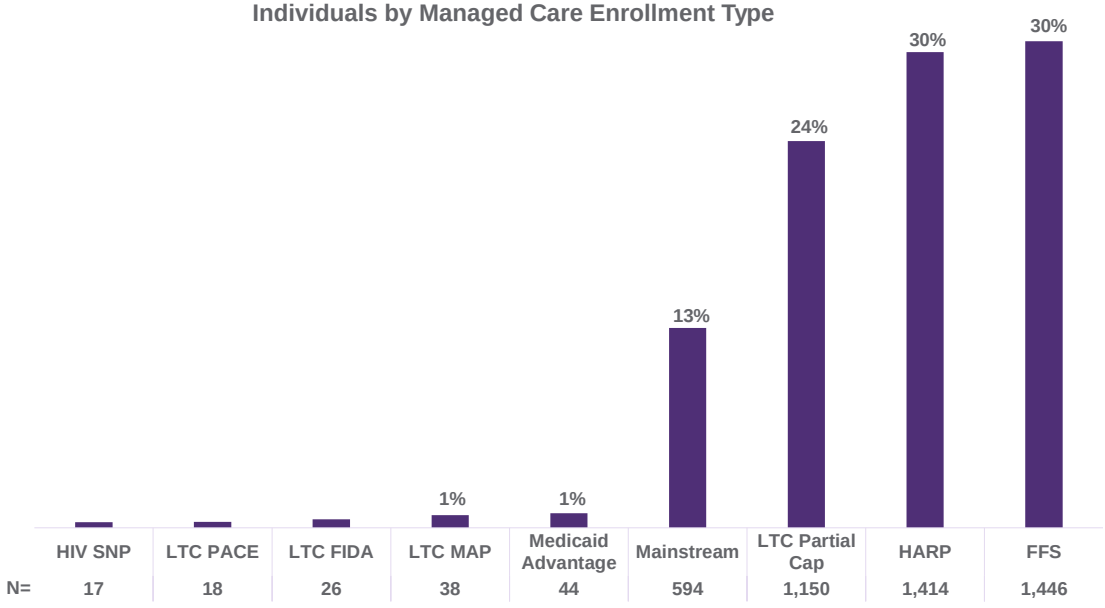
Across OMH Housing types, the percentage of individuals who received LTSS in the Adult and Transitioning Senior age categories (42%,41%) is highest followed, after a significant gap, by Senior (17%)

The greatest percentage of LTSS claims across all age categories is clearly concentrated in:

1. Supported Housing Community Services, followed (after a significant gap) by:
2. Congregate/Treatment
3. Supported (SROs)
4. Apartment/Treatment



Of Those Who Received LTSS in OMH Housing in 2017, Percent and Number of Individuals by Managed Care Enrollment Type



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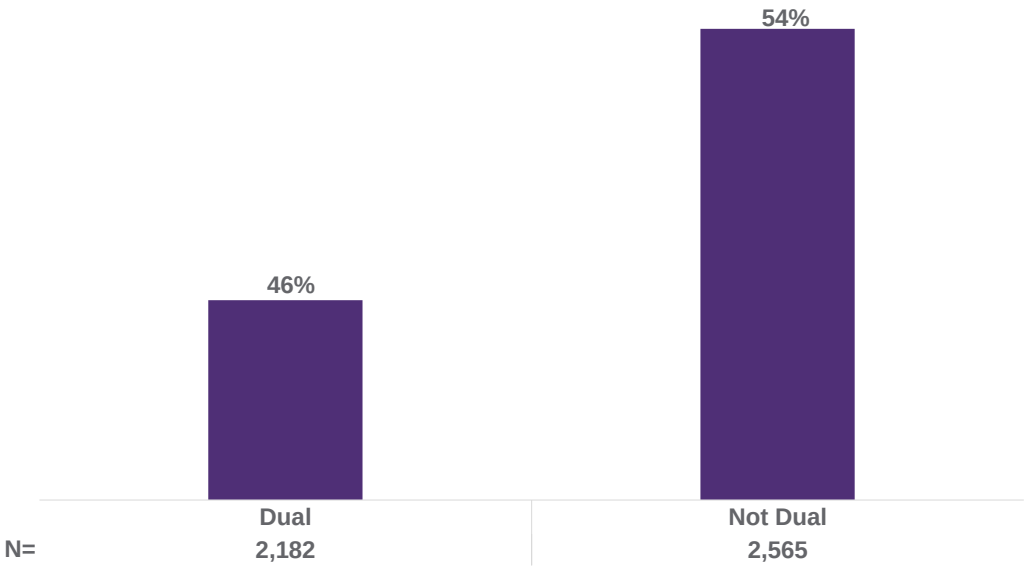
Of Those Who Received LTSS in OMH Housing in 2017, Percent and Number of Dual (Medicare & Medicaid) Eligible Individuals



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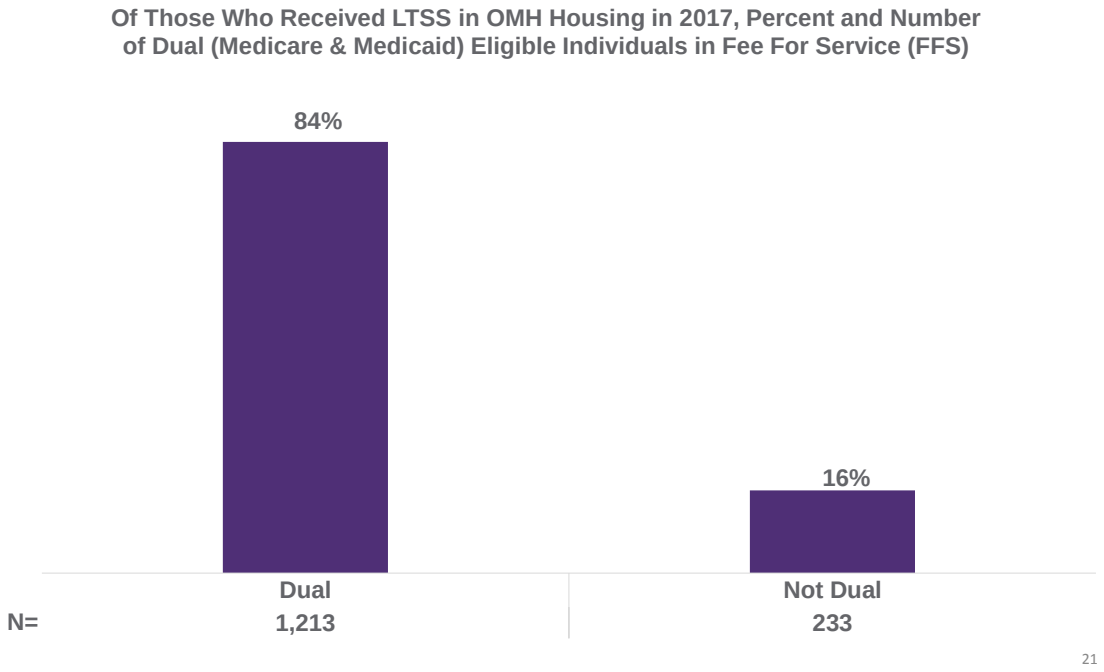

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Eligibility Trends: Individuals Who Received ≥1 LTSS in OMH Housing in 2017

Across OMH Housing Types:

- The highest percentage of individuals in OMH Housing (those receiving and not receiving LTSS) is highest in FFS and HARP; however, individuals who did not receive LTSS in 2017 have a much higher percentage in FFS (48%), whereas those who received ≥1 LTSS have an equal percentage between FFS (30%) and HARP (30%)
- Most individuals who received ≥1 LTSS in FFS are dual eligible individuals
- Individuals in HARP and Mainstream rarely access LTSS despite these services being included in the benefit package

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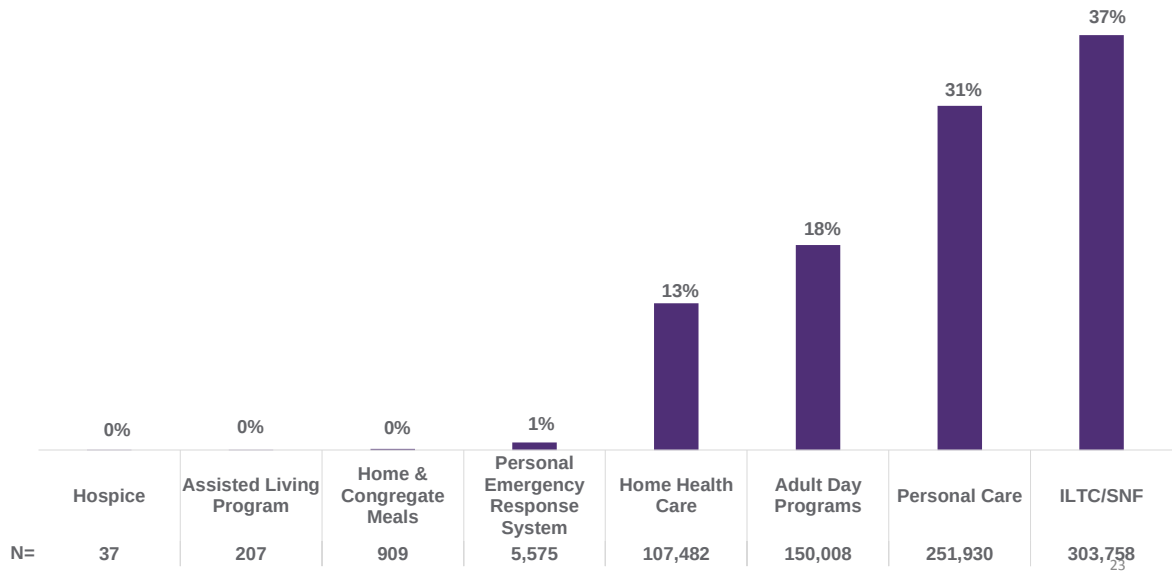
Of Those Who Received LTSS in OMH Housing in 2017, Percentage and Number of Claims by LTSS Category



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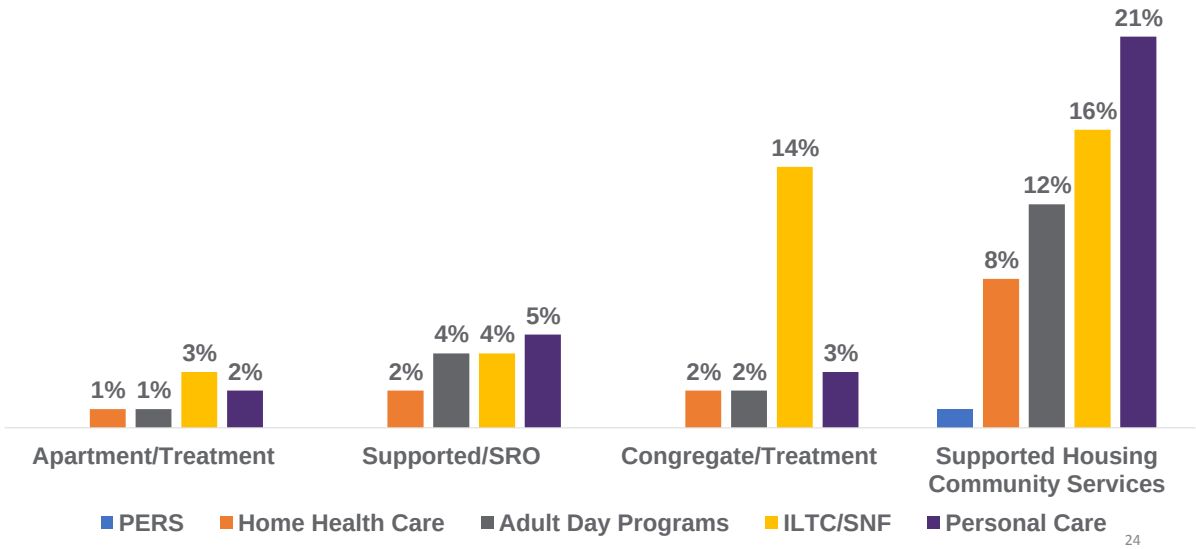
Of Those Who Received LTSS in 2017, Percent of LTSS Claim Category By OMH Housing Type



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LTSS Trends: Individuals Who Received ≥1 LTSS in 2017 OMH Housing

Across all OMH Housing types, the data suggests:

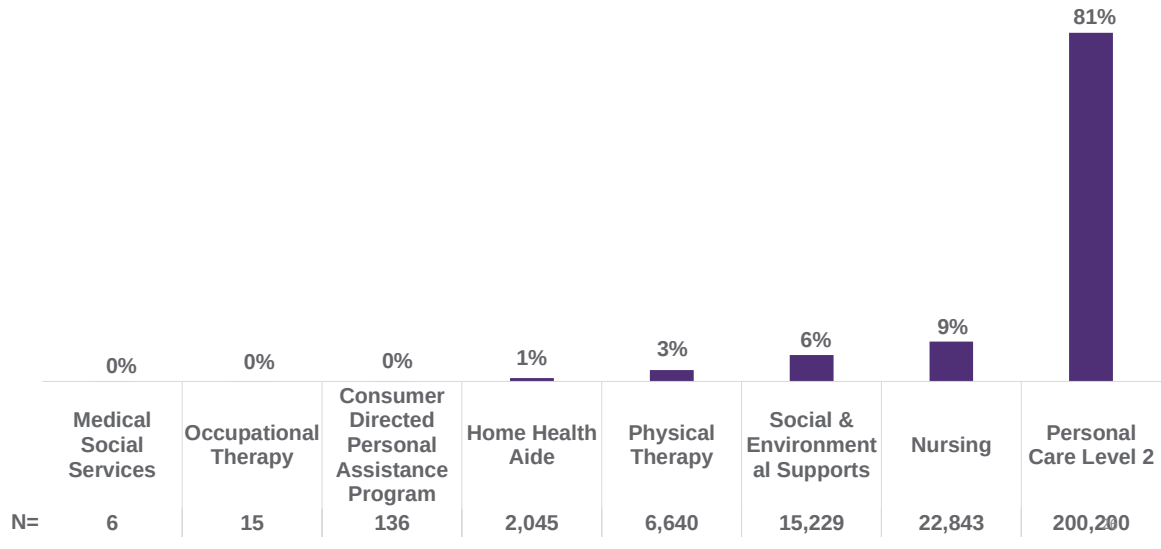
LTSS received in institutional settings, such as skilled nursing facilities, has the highest percentage, suggesting that individuals are often sent out of their home to receive needed services after the situation has become critical

People are receiving very little to no Personal Emergency Response System (PERS), Durable Medical Equipment (DME) or Home delivered or congregate meals, services that are often instrumental in enabling people to age in place

Among OMH Housing types:

In 2017, the greatest combined percentage of Personal Care and Home Health Care (29%), was received by individuals in Supported Housing Community Services but less than 10% of both service categories combined is being accessed in other OMH Housing Types

Of Those Who Received LTSS in OMH Housing in 2017, Percent and Number of Home Health Care and Personal Care Claims By Service Type



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Home Health Care Trends

Among individuals who received LTSS in Supported Housing Community Services in 2017:

- Hands-on assistance with ADLs is by far the most prominent service being received
- While individuals are receiving some nursing and social/environmental services, these are underutilized
- Home health aide, PT and OT, Consumer Directed and Personal Assistance Program (CDPAP) and Medical Social Services, that could be of great benefit for medication management, skill building and restoring functioning, are significantly lacking

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OMH LTSS Pilot Projects

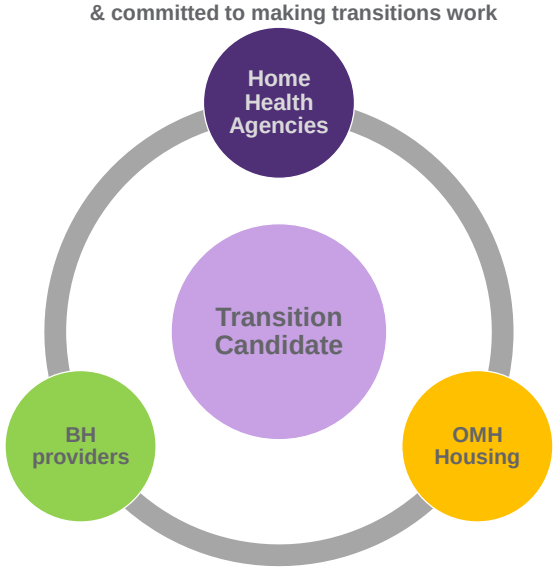
Goal: Make "Aging in place" in the most integrated setting possible a reality for individuals living with SMI by accessing wrap-around community based services, including LTSS

Populations

Transitioning	State PCs, CRs, Apt/Treatment
⬇	⬇
Aging in Place	Permanent Housing: Supported/SROs, Supportive Housing Community Services

OMH LTSS Pilot Project Partnership Model

Experience serving individuals with SMI & committed to making transitions work



Caregivers, supports and peers (within CR and community based) open to working together to make transitions work

Positive experiences serving people who have transitioned from more supervised/transitional settings & committed to making transitions work

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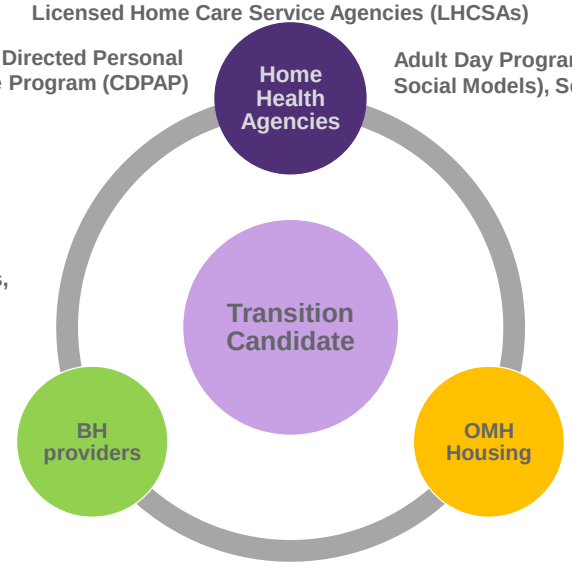
OMH LTSS Pilot Project Partnership Model

Certified Community Health Agencies (CHHAs), Licensed Home Care Service Agencies (LHCSAs)

Consumer Directed Personal Assistance Program (CDPAP)

Adult Day Programs (Health and Social Models), Senior Centers



CR Transition Service Teams, MIT Teams; Peer Specialists and Bridgers; Community Mental Health Nurses; ACT, CCBHCs; Mobile Crisis; Telepsych, including consultation with BH and Geriatric specialists; PROs, club houses and drop-in centers, HH and HH+

PCs; CRs; Apt/Treatment; Supported SROs; Supported Housing Community Services

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Long Island: Pilgrim PC Catchment Area

On and Off Campus CRs: Crooked Hill (Suffolk) and Oceanside (Nassau): start with small group of individuals

Beginning the transition process inside the CR, with home health assessments and services: Building the relationship

Matching transition candidates with housing that can meet the person's physical, mental and social needs through on-site as well as community-based wrap around services from BH providers, LTSS and peers

Establishing community Medicaid and MC benefits (if applicable) to reduce delay in service availability at new housing

Individual Cases that Support the Need for a Systemic Aging in Place Focus Across the BH service system

Individuals displaced from Family Care trying to return to community-based settings

Individuals at risk of losing housing because of increased need for assistance with ADLs and IADLs

Diabetics facing barriers to accessing integrated housing due to medication management and administration

Individuals who have successfully made the transition to integrated housing thanks to the transition team staff who regularly visit and talk with people months after they have moved

Individuals who are successfully aging in place in permanent supported housing, have reduced ER and in-patient use, and more importantly are sustained by the meaningful community created by wrap-around supports

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What have we learned so far…

Accessing LTSS is incredibly difficult, time-consuming process even for professionals more familiar with eligibility requirements

Eligibility assessments for LTSS represent a barrier to access because:

- Assessments will not be completed until an Individual is living in the new setting making transitions to more independent living more difficult as services will not be arranged until that transition is made – This is particularly difficult when transitioning from an institutional level of care
- Individual may currently be residing in setting considered an IMD and billing Medicaid is not possible
- A great deal of additional advocacy is needed to get assessment scheduled

Misunderstanding of what constitutes duplication of LTC services and those provided in a congregate level of care

New approaches and supports must be built both within and between supervised/institutional and community based settings to make aging in place a reality for individuals living with SMI

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Next Steps

Expanding projects to other PC Catchment areas: Creedmoor, South Beach, Rochester…

Invitation to Supported/SROs and Supported Housing Community Services providers to receive “aging in place” consultation and support from OMH:

- Individualized data exploration: demographics, MC enrollment status, current LTSS services being received
- Partnership building assistance: Home Health Agencies, Home Care Association of NYS, Local Department of Social Services and DOH for establishing community Medicaid

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Questions?