Wellness Collaborative Description, January 2016

West Virginia is an elderly, low income state with high healthcare needs. Since the fall of 2013, the Wellness Collaborative's[1] Healthy Home program has been engaging the elderly population living in apartment complexes in health and wellness plans and care coordination. Starting with 15 individuals, participation has grown to 34 and is planned to grow to 200. Currently 4 organizations are donating time and resources to develop a new method of caring for the elderly population in order to help them "age in place," and use health care resources effectively while and avoiding emergency hospital visits. Davis Health Systems was the co-founder along with the Randolph County Housing Authority (RCHA). The hospital is actively looking for community-based approaches to helping its patients remain healthy after a hospitalization. The housing authority, which manages 100+ rental units, is seeking ways to help residents stay in their homes as they age while experiencing wellness. Housing is increasingly understood to be a key determinant of health, economic stability, and educational attainment, and RCHA is actively seeking cross-sector partners interested in exploring the nexus of "Housing-plus" in order to help local resident achieve their life goals.

The Healthy Home program is based on a successful "service-enriched housing model" called SASH that operates in Vermont. http://www.sashvt.org/. SASH was started by a community development corporation that manages rental properties for lower-income senior residents (https://cathedralsquare.org/programs-services/sash-model/), and is now a private/public partnership supported by Medicare. The Wellness Collaborative members thought it would be valuable to replicate this model in Randolph County, starting with the First Ward School Apartments, a rental property owned by RCHA in Elkins. A report on the outcomes and lessons learned from this first phase of the demonstration project will be available in December of 2015.

Since its inception, the Wellness Collaborative has expanded its program to two additional sites—at Gateway Apartments (owned by the Elkins Housing Authority) and at Cortland Acres Housing (Pineview & The Pines), in Thomas. As of 10/31/15, the program has served 34 participants in the program, as well as providing programs and support to non-enrolled tenants at each site (similar to SASH's model).

The three goals of the Wellness Collaborative[2] are laid out below.

I. Establish measurable goals for each participant based on their input and seek to achieve 80% of these goals (aka "Identify effective solutions that help residents thrive.")
II. Reduce emergency room visits and emergency hospitalizations compared to the average number of these incidents experienced by like individuals (aka "Pursue the effective use of health care resources for residents.")
III. Seek public sector support for expansion of the program to additional sites and/or seniors (aka "Transition to a sustainable model supported by established payment sources.")

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[1] The Wellness Collaborative members include RCHA, Davis Health Systems, Randolph County Senior Center, Randolph-Elkins Health Department and Cortland Acres Housing Association.

[2] The Memorandum of Agreement goals were set out in 2013 and updated/revised in November 2015; the revisions are shown as "aka" comments in parentheses.

In 2016-17, the Wellness Collaborative proposes to do the following:

- Build on two years of demonstration project operations by creating a program supervised by an MSW, with an electronic data collection system, policies & procedures, and a strong evaluation plan.
- Expand the program to additional rental sites to reach at least 100 residents in Year One and an additional 100 residents in Year Two.
- Increase the impact of the program by focused attention to a) the barriers experienced by residents and to b) building a community resource network and volunteer corps to engage with the Healthy Home Program and its participants.
- Develop an Ad Hoc Committee to promote the model, create training and orientation materials, and capture lessons learned.
- Publish and disseminate at least one scholarly paper assessing the Healthy Home program model in terms of its benefits to seniors, to communities, and to the effective use of health care resources.
- Secure commitments from private payers and/or WV DHHR's Medicare program to support ongoing expansion and sustainability through cost reimbursement and/or subsidy.

What is the challenge or opportunity being addressed?

In 2000, 15% of Appalachians were 65 or older, compared with 12% of the overall U.S. population. Research projects that Appalachia's elderly population will continue to rise at rates higher than the national average; by 2025, there will be 5.1 million persons age 65+ in the Appalachian region. One out of every 40 Appalachians will be among the "oldest old" -- those persons 85 and older. For the states represented in this request for funding, the stakes are even higher. For instance, West Virginia already has the second largest senior population in the nation--it is expected that one out of every four West Virginians will be a senior citizen by 2030.

This project will work with low-income seniors living in rental housing in both Randolph and Tucker counties. Randolph County is a rural place--it is the largest county in the state with roughly 1,000 sq. miles and is home to just 28,000 people. The county seat of Elkins has a population of just over 7,000 and it serves as the economic hub for most of its six neighboring rural counties. Senior citizens make up 19% of the population, compared to 13% of the US population. The number of senior citizens is expected to double by 2035 (with the working age population shrinking by 22%). Currently, a little over 9% of the county's seniors live in poverty. Tucker county statistics mirror those in Randolph County in terms of both the aging population and their income levels.

Currently, care is delivered to elderly residents with low-incomes in our region through the traditional "silos" of primary care, emergency care, home-health care, and rehab or convalescent care. Our experience in the first two years of implementing the Healthy Home Program at First Ward School Apartments has shown that there is: a) little to no coordination among existing care providers, b)too little focus on education and self-care,

and c)many barriers to health for lower-income residents. A recent study shows that the largest contributors to premature death are behavioral patterns and social circumstances, both of which are established and experienced in the home setting, rather than the medical setting. As our recently retired CEO Mark Doak likes to remind us: "Only 20% of health is related to medical inputs." So far, the data shows a steep decrease in hospital visits (both ER & inpatient for the population enrolled in Healthy Home program.

In addition to an ever-increasing aging population, the region--particularly Central Appalachia--continues to lag behind the rest of the US in terms of health, well-being and economic development. West Virginia ranks in the bottom ten nationally for almost all health and well-being measures, and ranks in the bottom seven states for "overall senior health." The Appalachian Regional Commission (ARC) reports a 17.9% poverty rate within the region as a whole, but the reality for rural residents is even worse. According to "Poverty in RURAL America," published by the Housing Assistance Council (HAC) in October 2010, poverty rates are higher and incomes are lower in nonmetropolitan than metropolitan areas. The median income in Appalachia, $27,930, is 56% of the median income in the nation at $41,994. The median income in distressed Central Appalachia, $18,404, is less than half the median income of the entire country. The poverty rate in Central Appalachia is nearly double the national average and 25% of households have incomes below $15,000 versus 16% for the nation.

These distressing statistics are especially troubling when one considers that in Central Appalachia there are more than 215,000 elders living in poverty. The median income for residents over the age of 65 is only $23,400. Of residents over the age of 55, 22% are cost-burdened, paying more than 30% of their income towards housing expenses; for elders renting their home this statistic doubles to a staggering 44%. For aging adults in Appalachia, these conditions may have life-threatening consequences.

Recent research from the Department of Housing and Urban Development (HUD) provides compelling evidence for supporting aging in place in rural communities. Aging in place contributes to "cost savings for families, government, and health systems." Federal Interagency Forum on Age-Related Statistics data find that almost 95% of US elders pay for health care out-of-pocket. A recent study by the US Department of Health & Human Services showed that the senior population that receives HUD-assisted housing had Medicare costs that were 16% higher than non-assisted seniors, and that 55% of this population had 5+ chronic conditions.

Why will this project address the challenge or opportunity?

The Wellness Collaborative set out to create a program that uses affordable rental housing as the venue through which to promote self-efficacy and better coordinated care for its tenants, with a particular focus on the prevention and management of chronic health conditions, and avoidance of emergency hospitalizations. When elderly persons live in rental housing, their housing manager often sees them more often than their primary care physician or family members. In the Healthy Home model, the apartment building becomes the hub for coordination of services and activities that contribute to resident self-sufficiency. Regular screenings, health education sessions and case management take place right in the

building. Outreach to primary care physicians is established when tenants enroll in the program and ongoing communication is maintained. The program is staffed by a "Core Team" of two Wellness Nurses (staff from DHS' Davis Memorial Hospital and the Senior Center) and a Resident Coordinator (RCHA staff.) The Elkins-Randolph Health Department provides health education, screenings and immunizations, and chronic disease management programs to the participants.

The Healthy Home Program is based on the following core principles.

Engage the elderly tenant in their own health and wellness plan. The Core Team works with residents to develop a specific Health Action Plan (HAP) tailored to their health needs, which is regularly assessed and updated. Each resident has a "Wellness Companion" binder in which to organize their health information, track their progress against goals, prepare for and respond to medical visits and emergencies, and share information with caregivers. (Recently, a tenant went to the ER due to extreme dizziness and a concern about falling. The ER nurse reported later that, without the Wellness Companion, he would have admitted her as a patient. Because her medical and health information was immediately available to him, he could address her situation and safely send her home.)

Provide case management through the Core Team to ensure that the tenants have access to services and activities they need. The Core Team sees the participants regularly and can thus respond quickly to problems they are experiencing. This can include helping a tenant with newly-diagnosed diabetes adjust her diet and get her prescriptions organized to refill on a monthly basis, to assisting a tenant with AIDs to access Meals on Wheels and to socialize with other tenants at meal time in order to decrease his nutritional risk.

Share information among team members in order to improve outcomes for the residents. Twice monthly meetings of the Core Team serve to share information that can contribute to success for residents. A Community Health Action Plan (CHAP) is developed each month that includes a calendar of activities and events designed to help them achieve their health goals. For instance, the local extension office provided a seven-week nutrition and cooking program for residents over the summer.

Make it Measurable. The Wellness Collaborative members set specific goals for evaluating the Healthy Home Program. The primary goal is to enroll at least 10 of the 16 residents at FWSA, and help them to achieve at least 80% of their HAP goals. In addition, the Wellness Collaborative will set measurable economic goals for the program, a primary example of which will be reducing emergency room visits, emergency hospitalizations, and hospital re-admissions for program participants, compared to the average number of these incidents experienced by like individuals. The SASH program in Vermont is a similar model that the Healthy Home program is based upon. In its first year of operation, SASH achieved a 19% reduction in hospitalizations and no re-admits to nursing homes. The Wellness Collaborative hopes to achieve the same or better results. The Collaborative will use the evaluation results to seek public sector support for expansion of the program to additional site and/or seniors.

What are the outcomes by which we will measure success?

1. The Healthy Home Program will be a replicable model with a theory of change, a collective impact strategy and a business model that can be shared with others, and at least one housing group in WV will be committed to launching a demonstration project in collaboration with at least one health care provider. Success will be measured by the launch in 2018 of at least on new Healthy Home Program.
2. At least 200 seniors will have participated in the program and both quantitative and qualitative evaluations will show that the Healthy Home program has delivered impact in the form of helping residents to thrive, and helping residents to use health care resources most effectively. Success will be measured by a)enrollment numbers, b)data gathered from participants reflecting an improved state of wellness for at least 80% of participants, c)data collected through health assessments and medical charts that show improved health and medical outcomes for the majority of participants.
3. At least one (private or public) payer will commit to a demonstration program, or a waiver or a plan amendment that will pay for 'care navigation' for Medicaid-eligible program participants and/or Medicare-eligible participants. Success will be measured by a)DHHR adopting a reimbursement plan for care coordination that will pay for the Healthy Home Program activities, and/or b)DHHR applies for Medicare Innovation Grant to explore widespread expansion of the model across the state, and/or c) A private payor in the Medicaid marketplace includes care coordination in its reimbursement plan (helping dually-eligible participants), and/or d) A private payor in the Medicaid or Medicare market commit funds to expand the demonstration so that they can learn about the model and its impact on insured populations.

How will this project be sustained?

The project currently has the support of its four Wellness Collaborative members, with both the hospital and RCHA donating staff time to the project. In addition, the WVHCA has committed two Rural Health System Program grants to the project and has expressed interest in making future commitments. The Wellness Collaborative is also part of a regional collaborative funded by NeighborWorks America and coordinated by Fahe. There is strong commitment on the part of these stakeholders to see that this project makes a difference, both for the participants and for the state of West Virginia.

Ultimately, sustainability will depend on positive research findings that we hope to generate that attract the commitments of traditional payers for healthcare, i.e. public or private insurance entities. This is built into the Implementation Plan as an outcome that is critical to achieve in order for this project to be successful.