Housing and the Relationship with Healthcare

Housing is Healthcare

8/30/2016 | Presented by: Susan Tucker – AVP MLTSS Plan Support
Objectives

Understand:

• The Connection Between Health and Housing
• Transition Needs
  – Institutionalized: From Nursing Home to Community
    o Vickie’s Story
  – Chronically Homeless: From Homeless to Home
    o Bob’s Story
• Solutions: One Size Doesn’t Fit All
• Q&A
Molina Healthcare

Founded in 1980 by Dr. C. David Molina with a single clinic

Provide quality healthcare to those most in need and least able to afford it

More than 20,000 employees

Serves more than 8 million Medicaid and Medicare beneficiaries

16 states and two territories

More than 4.2 million managed care members
The Molina Healthcare Story

Taking care of kids, adults, seniors and families for over 35 years

Molina Healthcare was founded by emergency room physician Dr. C. David Molina in 1980. After having treated patients with everyday ailments in the ER because they had no primary care physicians, Dr. Molina opened a clinic especially for them. Today Molina Healthcare continues his mission, serving millions of people through Medicaid, Medicare and the Marketplace, as well as other government-sponsored programs for low-income families and individuals.

9 of 12 Molina plans are NCQA accredited
National Committee for Quality Assurance (NCQA)

11 of 12 Molina Health Plans have earned NCQA's Multicultural Health Care Distinction

Molina Health Plans
Medicaid, Medicare, Marketplace and other government-sponsored programs®

Molina Medicaid Solutions
Medicaid Management Information Systems

Molina Medical Clinics
Primary care clinics
- California: 19
- Florida: 2
- New Mexico: 1
- Utah: 2
- Washington: 1
Clinics managed and operated by Molina
- Virginia: 3

Current MLTSS Programs
California, New Mexico, Texas, Illinois, Michigan
Ohio, South Carolina, Florida

MolinaHealthcare.com

~227k MLTSS Members
6 of 10 Medicare-Medicaid Programs
Social Determinants of Health

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health.

Social determinants of health including housing and neighborhoods, are responsible for up to 40 percent of individual health outcomes.
<table>
<thead>
<tr>
<th>Housing Needs</th>
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<tbody>
<tr>
<td><strong>Extremely Low Income Households</strong></td>
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<td>• 10.3 million renter households in U.S.</td>
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<td><strong>Homeless</strong></td>
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<td>• over 500,000 on any given night</td>
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<td><strong>“Couch Surfing” or “Doubled Up”</strong></td>
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<td>• 7.7 million living temporarily with friends or family</td>
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<td><strong>Residents of Institutions</strong></td>
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<tr>
<td>• Excluded from most federal reports on housing need, difficult to quantify</td>
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<td><strong>Individuals with Disabilities</strong></td>
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<td>• 14.4 million cannot afford their housing</td>
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Shortage of Affordable Housing

**Key Facts**

- **8.3 million people** receive Supplemental Security Income (SSI);
- **Not a single county** in the U.S. has affordable housing for those dependent on SSI

Source: National Low Income Housing Coalition

| 2015 Fair Market Rent for one-bedroom apartment: | $806 |
| Number of hours at minimum wage needed to afford rent: | 86 |

Source: National Low Income Housing Coalition
Vickie’s Story

- Retired, with pension
- Home paid
- Savings
- Knee Operation
- MRSA
- Spent savings
- Sold home
- Six different nursing facilities
- Jerry, Case Manager
- Terrance, LTSS Support Manager
- Amber, Transition Coordinator
- Out of nursing facility
- Living Independently
- Reduction of prescription pills from 30 to 10 per day
- No ER
- Part-time job working with persons with disabilities

https://www.youtube.com/watch?v=oPFB0Sxq_IA
Housing and Health Care Value - Vickie’s Experience
MLTSS: Adding Value

- Diagnosed with diabetes, cancer in remission
- Nursing home resident
- Transitioned home
- Continues to improve
A Solution for Chronically Homeless - Intensive Care Management and Housing First Model

<table>
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<tr>
<th>Members</th>
<th>Care managers</th>
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<td>• Serious mental illness</td>
<td>• Ability to handle crisis situations</td>
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<td>• High utilizers of crisis services</td>
<td>• Receive alerts of hospitalizations to engage in discharge planning</td>
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<th>Life skills coaches</th>
<th>Housing locators</th>
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<tr>
<td>• Assist with accessing health care</td>
<td>• Care managers and life skills coaches are cross-trained</td>
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<tr>
<td>• Help make house a home</td>
<td>• Engagement in the community at the grass-roots level</td>
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<td>• Landlord mediation</td>
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Members have serious mental illness and are high utilizers of crisis services. Care managers have the ability to handle crisis situations and receive alerts of hospitalizations to engage in discharge planning. Life skills coaches assist with accessing health care, help make house a home, and provide landlord mediation. Housing locators ensure that care managers and life skills coaches are cross-trained and engage in the community at the grass-roots level.
Molina Partnered with Local Organization

Project 25 – San Diego

- The program targets those who are the most frequent users of crisis services
- Housing and medical care, delivered in concert, reduced costs and improved health outcomes
- Molina care managers support ongoing successful community living for the member

Source: Corporation for Supportive Housing
Project 25 - User Frequency

Source: Project 25 Data, through 1st quarter 2016
Bob’s Story

• Transient, street-based life
• Chronically homeless
• Poor self-management

• Episodic incarceration
• Behavioral health issues
• Physical ailments

• Intensive Case Management
• Life skills coach
• Cross-trained as housing locators

• Living in his own apartment since June 2015
• Interest in culinary arts and vocational opportunities
• Internalized value of self-management skill development, harm reduction and sobriety
• Strong support from his medical home and care team

Note: Image for illustration purposes only. Not actual member.
Housing and Health Care Value - Bob’s Experience

**Frequency of Use**

- **ER Visits**: PreEnrollment: 12, Post Enrollment: 1
- **SNF**: PreEnrollment: 4, Post Enrollment: 0
- **Inpatient**: PreEnrollment: 2, Post Enrollment: 0

**Costs**

- **ER**: PreEnrollment: $5,000, Post Enrollment: $30,000
- **SNF**: PreEnrollment: $10,000, Post Enrollment: $25,000
- **IP**: PreEnrollment: $15,000, Post Enrollment: $20,000

Source: Project 25 Data, through 1st quarter 2016