Community Housing Partners Healthy Communities Case Study

Introduction

Headquartered in Christiansburg, Virginia, CHP develops and manages both for sale and rental affordable housing across 6 states – Virginia, North Carolina, South Carolina, Kentucky, Maryland, and Florida. With 6,584 housing units in 112 properties, energy savings and comprehensive resident services are hallmarks of Community Housing Partner's (CHP) approach.

CHP has a lengthy history of local and national leadership in green and healthy housing, including multiple LEED certified rental properties, a NeighborWorks Network Green Designation, and an EnergySTAR Award for Excellence in Energy-Efficient Housing.

An intentional focus on *other* aspects of health came later.

At a NeighborWorks Training Institute in 2015, Vice President for Resident Services, Angie Roberts-Dobbins attended a presentation by County Health Rankings & Roadmaps Program on the social determinants of health, which led her to explore how CHP could do more to help its residents lead healthier lives.

This case study looks at CHP's most comprehensive health and housing project to date – a renovated multi-family property in Hopewell, Virginia where CHP has a contract with a local organization to provide comprehensive health services for residents. Supported in part by a NeighborWorks' Healthy Communities Innovation Grant, this included on-site monitoring and triage, health navigation, wellness programming, meal packages and other services that were easily accessible to the mostly elderly residents.

This case study examines three primary aspects of the project:

- How partnerships with a variety of stakeholders led to the development of a model for Kippax Place.
- Challenges in building a relationship with Hopewell's John Randolph hospital, a for-profit operation owned by the Health Corporation of America (HCA), including framing the benefits of collaboration.
- How the project is tracking and using outcomes.

Community Need

The oldest part of what is now Hopewell, Virginia was settled in 1613. The community was a busy seaport during the Civil War and a thriving employment center prior to World War I when Dupont invested in dynamite and guncotton manufacturing.

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More recently, Hopewell's story has been one of disinvestment and struggle. New jobs in the community have been filled by commuters and have not provided opportunities for Hopewell residents. Elementary and middle schools lack accreditation and affordable rental housing is scarce. CHP's Roberts-Dobbins describes Hopewell as "a place with layers and layers of trauma and nothing growing for the residents."

The community of 22,501 people is located directly south of Richmond. Seventy-five percent of residents are African American and 8.5% are Hispanic. Hopewell lags behind Virginia as a whole in many areas. Sixteen percent of families live in poverty compared to 8% for Virginia and only 35% of households own their home.[1]

Hopewell also falls near the bottom of Virginia communities in County Health Rankings and Roadmaps health indicators as shown in Table 1.[2] The community also has higher levels of diabetes, hypertension, and depression than the state average. And 356.6 people per 100,000 die from coronary heart disease in Hopewell, compared to 169.4 in the state of Virginia.

As Roberts-Dobbins explains, these health disparities are what led CHP to seek a more comprehensive approach to improving resident health at Kippax Place.

Table 1. Hopewell City rankings on selected health indicators

Factor	Ranking out of 133 VA counties 2018	Ranking out of 134 VA counties 2016
Health outcomes	126	118
Length of life	125	120
Quality of life	121	114
Health factors	128	128
Health behaviors	121	120
Clinical care	117	107
Social and economic factors	**127**	**131**

Source: County Health Rankings and Roadmaps 2018, 2016

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Kippax Place

CHP purchased Kippax Place in 2016. The building has 100 one-bedroom units and approximately 100 residents. A majority of residents (68%) are over age 55 and 74% are disabled. The income limit for residents is 50% of the Area Median Income (AMI), but currently a majority of the residents are considered "extremely low income" earning less than 30% AMI.

[1] American Community Survey 2008-2012, Policy Map
[2] County Health Rankings & Roadmaps, 2016, 2018

CHP completed a Rental Assistance Demonstration (RAD) conversion on the 50-year property in 2017. RAD allows public housing authorities, in this case the Hopewell Redevelopment and Housing Authority, to convert public housing to Section 8 Housing Assistance Payment contracts so that the rents are subsidized.

Kippax Place after renovation. Photo courtesy of Community Housing Partners

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CHP's construction and renovation program aspires to Viridiant Earth Craft standards for affordable multi-family properties in Virginia. The standards address energy and water savings, healthy indoor air quality, and reduced maintenance and utility costs. In addition to the direct impact of indoor air quality on resident health outcomes, reducing utility costs through weatherization, lighting, and appliance efficiencies can mean money is available in individual budgets for food, medicine, and other necessities.

Building partnerships

CHP's approach to integrating health and housing relies on local resources and opportunities. This means that strategies may vary across the communities where its properties are located. For example, in Gainesville, FL a teaching hospital provides services to residents within a CHP-led rental community. In 2015 alone, CHP had a cadre of 540 committed community partners providing over $1.6 million in resources.

In looking for local health partners in Hopewell, CHP had a unique opportunity to be part of a Hopewell community team participating in *SYNC: Transforming Healthcare Leadership,* a partnership of the Medical Society of Virginia, Virginia Hospital and Healthcare Association and the Virginia Nurses Foundation. Also on the team were the Crater Health Department, local physicians, a faith-based partner, and several other non-profit organizations.

Each local team chose a community health issue as a capstone project and developed strategies to address it. The Hopewell team chose to improve the health and wellbeing

of residents at CHP's Hopewell properties, focusing first on Kippax Place,[3] by developing a model to align medical, mental, and spiritual care with other resident services.

Collaborative Care Model™

The Collaborative Care Model™ developed by the Hopewell team leverages aspects of two existing models: the Memphis Health Care Model and the Camden Coalition of Healthcare Providers Model.

The Memphis Model draws on an established network of clergy and congregations to exemplify and promote healthy lifestyles, encourage use of community-based programs, and help people transition from hospital to home successfully.[4]

The Camden Model targets "super-users" of the health care system and "works backwards" to identify why participants are overusing the emergency department or have repeated inpatient stays. Wrap around care management strategies aim to reduce the need for repeated costly services.[5]

The Hopewell Collaborative Care Model™ identifies "super-users" and develops a community-based approach to provide care management for those individuals to avoid hospital recidivism and emergency department overuse. The model draws on collaboration and resources provided from the hospital or health system; physicians and other health care professionals; and home-based education and support, including health and medical services. (See Figure 1)

Figure 1. Hopewell Care Resources

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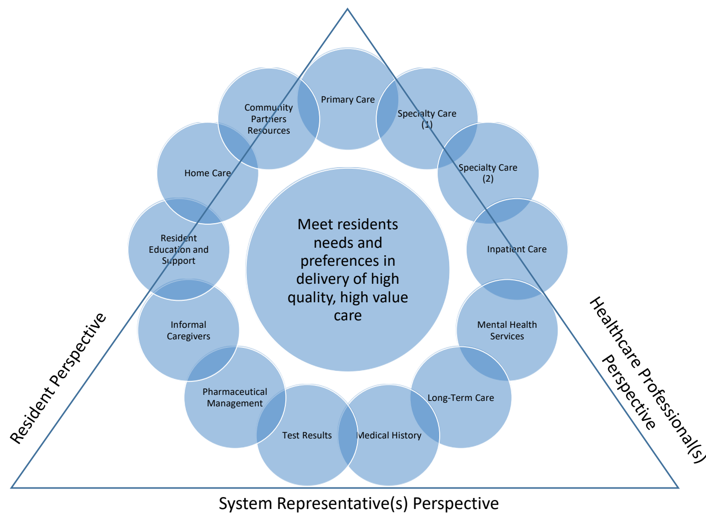
[3] CHP owns two properties in Hopewell. The second property, The Summit, has 2-bedroom units for families.

[4] Cutts, T. et al From the Memphis Model to the North Carolina Way, North Carolina Medical Journal July-August 2017 vol. 78, no. 4, 267-272 http://www.ncmedicaljournal.com/content/78/4/267.full, accessed on May 24, 2018.

[5] US Department of Health and Human Services, Agency for Healthcare Research and Quality, https://www.ahrq.gov/workingforquality/priorities-in-action/camden-coalition-of-healthcare-providers.html, accessed on May 24, 2018.



<u>Program elements</u>

The Hopewell program includes both 'lifestyle change programs' and 'health intervention programs' for residents. CHP contracted with Controlled Outcomes, a local non-profit organization with experience in community health, to manage the program.

Lifestyle change programs target healthy foods and nutrition. Residents are connected with Meals on Wheels. Initially, residents were also provided with a healthy food box option where residents can elect to receive a box of healthy ingredients for preparing specific meals. In 2017, the food box alternative was changed from a year-round option to a seasonal offering. Controlled Outcomes has also partnered with local supermarkets to offer food tours that include nutrition education as well as on-line ordering and delivery. The latter service has provided more food shopping options, with one of the markets waiving the delivery charge.

Programming also includes monthly Lunch and Learns on health-related topics.

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Kippax Place residents meet with Dr. Brian Jackson of Controlled Outcomes. Photo courtesy of Community Housing Partners.

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Initial presentation

To implement the chronic care management/health intervention portion of the program, Controlled Outcomes needed aggregate discharge information from John Randolph Hospital to pinpoint the number of Kippax residents who were overusing the emergency department. John Randolph is a for-profit hospital owned by Health Corporations of America and the only hospital located in Hopewell, just a few blocks from Kippax Place.

Brian Jackson, Managing Partner with Controlled Outcomes, met with the CEO and Board of Trustees for John Randolph and gave a detailed presentation on the care management proposal, the Collaborative Care Model and evidence supporting its success in reducing emergency department overuse.

The incentive presented to the hospital was a reduction in charity write-offs, which was a key benefit for hospitals under the Camden approach. As Jackson recalls, his audience did not seem particularly taken with the idea; they listened, but neither the incentive nor premise seemed to resonate.

"What I didn't realize at the time," says Jackson, "is that for a for-profit hospital looking at billable hours and services, visits by Medicare and Medicaid super-users are very profitable. What I was suggesting was in fact reducing their bottom line."

Back to the drawing board, Jackson found allies in two physicians, the hospital's Chief Medical Officer and a Board trustee, who believed the project had merit but needed a different approach to appeal to a for-profit hospital.

While the small group strategized an alternative approach, Controlled Outcomes negotiated a similar coordination of care program with a primary care clinic serving 60% of Kippax residents. The clinic provides Controlled Outcomes with medication schedules, diagnoses, and treatment plans for patients who have signed a release of medical information, so that those residents can be monitored at home as needed. Services also include making sure that residents keep appointments for testing and follow-up visits.

Participating physicians have been instrumental in persuading other physicians, including specialists, to work with Controlled Outcomes so that residents have a more coordinated continuum of care.

<u>Reframing the benefits</u>

Ultimately, the proposal to John Randolph was framed to avoid a reduction in Medicare payments under the Center for Medicare Services (CMS) Hospital Readmission Reduction Program. The program allows CMS to reduce payments to hospitals with 30-day readmissions in certain categories that exceed the number expected based on an average hospital with similar patients.[6] So, the question was not "How do we save the hospital money but rather, how can we reduce the number of readmissions?" says Jackson.

Jackson was able to show how navigators would help patients understand the diagnosis and discharge orders, manage medicines to improve compliance and reduce errors, make sure that patients follow-up with physician visits, and monitor patients regularly to make sure their status was stable or improving. With internal champions promoting the concept and explaining the benefits to the board, and a change in hospital leadership, John Randolph agreed to provide medical records with signed consent to Controlled Outcomes.

Under the program, Controlled Outcomes receives a copy of the discharge plan when the patient is released and Controlled Outcomes is responsible for making sure that home care services are provided. A combination of nurses, certified nursing assistants, medication aides and care aides visit those residents who elect to be a part of the program on a regular basis. Most of the providers are volunteers.

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[6] Hospital Readmissions Reduction Program, https://www.medicare.gov/hospitalcompare/readmission-reduction-program.html, accessed May 27, 2018.

Kippax residents who are not in the coordinated care program still have access to on-site health professionals for triage, blood pressure and glucose monitoring, medication questions, and advocacy services.

Outcomes

Although collaboration is certainly not a new approach for CHP, the idea of collaboration resulting in shared accountability for the wellbeing of CHP residents is a new approach, according to Roberts-Dobbins. Participation in the SYNC capstone project, and the creation of the Collaborative Care Model led to a true partnership with transparent participatory sharing of design, data, findings, processes and outcomes.[7]

Data provided by Controlled Outcomes shows a reduction in hospital readmissions and a decrease in emergency department visits since the program was introduced in November 2016.

Specifically,

- 64% of residents were participating in one or more program components as of November 2017.
- 23 residents use Meals on Wheels, an increase of 13% over participation in 2016. An average of 15 residents participated in the healthy food box program before it was limited to seasonal offerings.
- 16 residents are participating in the care management component, with Controlled Outcomes providing post-hospitalization checks on another 4 nonparticipating residents at the request of physicians. While the number of participants is small, results for participants are both promising and consistent. For example, the medication compliance rate has increased 48% since November 2016.
- Hospital readmissions within the 30-day window for Kippax residents have declined 29% since October 2016, according to information provided by John Randolph.[8]
- Emergency department visits for all Kippax residents declined 61% from November 2016 to October 2017, according to John Randolph.
- The number of Fire/Rescue calls to the building declined from 91 between November 2015 and October 2016 to 59 between November 2016 and October 2017 – a decrease of 65%.

An unintended benefit of the program according to CHP is that residents no longer feel they are a 'forgotten community'. Program staff and volunteers show a vested interest

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[7] CHP NeighborWorks America Innovation Grant Application, May 24, 2016

[8] John Randolph only provided the percentage change for both readmissions and Emergency Department visits, rather than providing the initial and final figures.

inindividual resident care, wellbeing, a path to self-sufficiency, and an improved level of healthcare advocacy that promotes trust between the residents and medical professionals and local hospitals.

<u>Lessons learned</u>

Following are several lessons learned from the project:

Understand each potential partner's business perspective before presenting an approach. In this case, a SWOT analysis as part of due diligence would have shown that the traditional Camden Model incentives would not resonate with a for-profit hospital and reframing was necessary.

When one door fails to open, find another door. For example, Controlled Outcomes initially asked John Randolph Hospital to help identify Kippax residents who were frequent emergency department visitors. When the hospital declined, Controlled Outcomes turned to the Fire Department after learning that 98% of ED visits by Kippax residents come through EMT calls.

The Fire Department initially provided the number of calls routed to the Kippax main address, and eventually provided a log with apartment numbers. Under the current agreement, the Fire Department calls Controlled Outcomes when an EMT is dispatched to a Kippax address and again if the resident is transported to the hospital. In the latter case, Controlled Outcomes sends someone to meet the resident at the hospital.

Partnerships can expand opportunities and resources. When entering a new market, CHP immediately begins looking for reliable partners with a commitment to the social determinants of health that can bring a range of services for residents. For Roberts-Dobbins, Controlled Outcomes stood out not only because it shared the underlying philosophy and brought the needed level of expertise, Managing Partner Brian Jackson is also well connected with local government, businesses, educational institutions, and other area non-profits that brought so much more to the table. A bonus advantage of contracting is that the privacy of the residents is completely protected – CHP does not have identifying information on any of the program participants, which makes residents feel more comfortable, says Roberts-Dobbins.

> *Controlled Outcomes are the specialists – they connect residents with the specialists they need, to a social worker if it is about benefits, or a psychiatrist for mental health…they are able to hone in on the specific need and there is no way that CHP could have scaled that.*
>
> Angie Roberts-Dobbins, CHP VP Resident Service

<u>Changing corporate goals</u>

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“This has not been a linear journey,” says Roberts-Dobbins. Early successes in Hopewell have shaped CHP’s thinking about service delivery in other rental communities across its footprint. Resident Services began looking at health as the umbrella for other services such as financial capability, education, and community building and engagement as an alternative to CHP’s historical ‘siloed’ approach where health and wellness was one of four focus areas for service delivery.

In 2017, CHP as an organization formally committed to the idea that every line of business could impact health by including health outcomes as one of four key goals in its 2018-2020 Strategic Plan.

The goal states that CHP will "Optimize positive health and quality of life outcomes for our customers," and will do so through the alignment of programs and services that generate positive health outcomes. This includesreal estate development, property management, resident services, asset management, energy solutions and homeownership. The next step in the journey is to define what health means for the organization and what outcomes will be measured.

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