CEDAR SINAI PARK

love. honor. respect.

Testimony of David Fuks, CEO Cedar Sinai Park
Re: HB 2547
April 6, 2015

Madam Chair and members of the committee, my name is David Fuks, and I am the CEO of Cedar Sinai Park and the current president of the Housing with Services LLC. I'm here to express my support for the effort to amend the original version of HB 2547 and to recommend improvements to the proposed amendments that will more accurately reflect what the Oregon Housing with Services model is.

In order to provide a context for my remarks I will describe very quickly what Cedar Sinai Park is and what the current Housing with Services project in which we are engaged is.

Cedar Sinai Park has been a provider of services to elders and people with disabilities since 1920. We provide a full range of services including nursing home care, residential care, adult day services, assisted living, and affordable housing. In addition, we are affiliated with providers that are engaged in home care and case management. We initiated the Housing with Services pilot project as a participant in an 11 state learning collaborative focused on providing home and community-based services to low income elders living independently in affordable housing across the country. This innovation was born from an understanding that residents in affordable housing have higher levels of service need than same-age residents living in unsubsidized housing. The models that have been developed across our

nation also recognize the remarkable independence and resiliency of the residents in affordable housing.

We've been fortunate to receive the assistance of the Oregon Department of Human Services, the Oregon Health Authority, the Oregon Department of Housing and Community Services, Multnomah County, Health Share, Care Oregon, Providence Elder Place, the Portland Housing Bureau and both HUD and CMS as we moved forward in our planning effort. We've also participated in a local learning collaborative involving nine providers of affordable housing with the support of Enterprise Community Partners. We been able to launch an LLC which includes three housing providers: ourselves, Home Forward, and Reach Community Housing and health and social services providers including Cascadia Behavioral Health, Life Works Northwest, the Asian Health and Service Ctr., Jewish Family and Child Service, Sinai In-Home Care, and Care Oregon.

We came together in order to develop a coordinated approach to accessing healthcare and social services for the low income residents in Section 8 Housing. We did so in order to: improve the quality of life and the independence of the individuals served, to reduce institutionalization and inappropriate hospital use, to reduce healthcare costs, and to develop a replicable model for this non-institutional mode of services. We seek to improve health outcomes by coordinating the work of licensed providers, to reduce healthcare costs, and allow people to age at home.

At this point over 400 individuals of the 1,400 living in the 11 HUD subsidized participating buildings are receiving services. The service model is an opt-in model. In other words, only individuals desiring services and choosing to participate receive services or participate in the pilot project. Receipt of services while focused on the residents of 11 buildings in the pilot is not a condition of their leases and their landlords are not the services providers.

While providers are affiliated with the project, a participant's Bill of Rights and an actively engaged client advisory council assures that individual choice and ongoing provider relationships are honored. Services provided by health navigators employed by Care Oregon are available in the participating buildings. In addition, referrals are made to a wide range of community-based nonprofits. Portland State University is conducting the pilot project's evaluation and all of our work products are in the public domain.

HB 2547 as amended raises important questions: How is housing with services to be defined? To what degree should it be regulated beyond the existing regulations

within which all of the participating providers already operate? To what degree does Oregon wish to continue to be seen as an innovator and thought leader in service to elders and people with disabilities?

As our state created assisted living and was the first state to receive a Medicaid waiver for home and community-based services, Oregon has a lot to of which it can be proud. While we are not the first to develop housing with services we can follow our friends in Vermont, Massachusetts, New York, Pennsylvania, California and Michigan in this innovative arena. What we are doing in Oregon is receiving national attention and recognition because of the creative nature of how our project has come together. We should not lose the opportunity to continue to lead and innovate. Certainly, we should not create barriers to innovation.

While the current amendments are good start to improving HB 2547, they need further work.

First, the amendments are written with the presumption of an institutional base for services. We are not creating a new institutional model. The use of this institutional language in the amendments is a reflection of the regulatory model built into the current silos of service in which nursing home care, residential care and assisted living are provided. While these are important service elements, we should not make the mistake of defining a community innovation within the frame of an old paradigm. The proposed changes to the amendment reflect an approach to housing with services that is not caught up in this traditional institutional model. We should do all we can to avoid this sort of thinking in public policy as we seek to innovate at the community level.

Second, while we applaud the development of a Bill of Rights for recipients of service and, in fact, have a model Bill of Rights which has already been adopted, we should not cast that Bill of Rights as institutionally-based. (HUD already provides a tenant Bill of Rights in its buildings.) Further, we need to recognize that recipients of service while having significant needs are also resilient adults living independently in their own apartments. Imposing additional regulation on publicly subsidized housing and its tenants may be implied to be discriminatory on the basis of income.

Third, the roster of potential representatives on the proposed task force needs to be more effectively balanced. Increasing the number of housing providers, community-based social service providers, and County leaders will help to overcome any potential institutional bias and result in a more balanced process and outcomes. The addition of a few tenants residing in affordable housing to the task

force might also be useful and respectful and would doubtless make a significant contribution to the process.

Finally, any attempt to impose a moratorium on developing housing with services should be abandoned. It will stifle innovation. The number of low income elders and individuals with disabilities is continuing to grow. The time for innovation is now. We shouldn't waste a single day. Oregon must continue to be to be a leader in developing this new paradigm and service model. A diligent study and task force process may be useful but let's not hamper innovation as we undertake that work.

Jewish Federation®
OF GREATER PORTLAND

THE **STRENGTH** OF A PEOPLE.
THE **POWER** OF COMMUNITY.

April 3, 2015

To: Members of the Committee on Human Services and Housing:

Since 1920, the Jewish Federation of Greater Portland has been the center of planning, philanthropy and service program development for Oregon's Jewish community and its neighbors. Like many faith-based organizations, every year we commit ourselves to raising resources in order to promote community well-being for our families, elders, people with disabilities, new Americans struggling to find their way, and people facing economic hardship. Our resources and our affiliated agencies serve to strengthen the human services fabric of our city and state.

The Federation wishes to express its support for the intent of the amended version of HB 2547 to create a task force to explore the state's approach to Housing with Services and to recommend support for revision of the amendments in a manner that will more clearly focus the work of the task force on the emerging programs. Our concern with the current amendments are twofold: first, the effort to look at affordable housing as an institutional approach to meeting the needs of the elders and disabled is inaccurate; second, we feel that the development of regulatory standards should be developed after the budding housing with services model has matured. In short, we are concerned that such legislation could inadvertently stifle innovation.

We are very pleased to see our community engaged in the development of the Housing with Services model. Three of our community's nonprofit agencies Jewish Family and Child Service, Sinai In-home Care, and Cedar Sinai Park have joined with a variety of community agencies and organizations to develop a pilot project which seeks to develop a coordinated approach to home and community-based services for residents in affordable housing. We are proud of our community's partnership with Care Oregon, Home Forward, the Asian Health and Service Center, Cascadia Behavioral Health and many others. These licensed providers have come together to develop a coordinated approach that is showing great promise in the effort to increase access to services and to provide those services before individuals need institutional care.

By recognizing the higher level of healthcare demand and by supporting the resiliency of elders and disabled individuals living independently in Section 8 HUD housing, this unique coalition is focusing on prevention of institutionalization. The perception of Housing with Services as an

institutional approach to care is incorrect. This model is intended to prevent institutional care whenever possible. As we consider an approach to regulating a new model for community-based services, we should be focused on the provision of services that will continue to serve our citizens in their homes. By using institutional language to describe Housing with Services, we are simply using the language of the current silos.

The Jewish Federation of Greater Portland recognizes that we must innovate in order to address the needs of a growing population of elders in this community. We support the development of a rights document for program participants but, again, feel that the nomenclature of that document needs to reflect the non-institutional approach of the new model being developed. Resident rights are already a factor of the HUD housing world.

Finally, we should not place a moratorium on the development of these services. The fact is, such services have been in development for decades and many housing and healthcare advocates are looking for ways to further serve the community in a manner that reduces institutionalization and empowers individuals to live successfully on their own. Given the fast growth of elders and disabled citizens in our community, we should seek to foster rather than inhibit innovation.

Thank you for your consideration.

Sincerely,

Marc N. Blattner
President and CEO

Bob Horenstein
Director of Community Relations

Housing with Services

YEAR 1 EVALUATION, OCTOBER 2014

Paula C. Carder, PhD, Institute on Aging

This report describes the initial findings of an evaluation of the Housing with Services project in Portland, OR. Support was provided by Oregon's State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI).

Portland State
UNIVERSITY

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The Portland State University Bridges to Baccalaureate Program provided two student interns (Maximilian West and Ana Serrato) who assisted with data collection and entry. In addition, PSU's Institute on Aging supported a portion of Dr. Carder's time and the School of Community Health supported graduate student Jack Phillips, who assisted with data collection.

Thank you to Alyssa Adcock, MSW, Housing with Services Project Manager and Howard Klink, Project Director.

Housing with Services, LLC is a collaborative model of supportive services delivered or made available to low-income residents of affordable housing.

The Oregon Health Authority's State Innovation Model grant helped to establish the project and funded the evaluation of the program implementation and resident- and system-level outcomes.

The Housing with Services program goals include reducing hospital and long-term care service use, improving health outcomes among building residents, addressing social determinants of health, increasing member engagement in preventive health care, and saving health-related costs by coordinating services to low-income tenants of affordable housing.

EVALUATION PLAN

The evaluation includes several components:

- a process and implementation evaluation of the consortium model based on interviews with stakeholders and review of Housing with Services progress reports;
- a self-administered survey of residents in the 11 partner buildings that included questions about health status and health service use, satisfaction, social integration, and demographic information;
- tracking health service utilization, based on administrative data provided by the Housing with Services LLC and partner organizations; and
- a cost analysis of services delivered through the consortium.

YEAR 1 EVALUATION

During the first year of the Housing with Services project, the scope grew from four properties owned by one non-profit organization to 11 properties owned by three organizations. A Limited Liability Corporation was created, Housing with Services, LLC, representing 10 partner agencies that are in the process of creating a new model of housing with services delivered to low-income older adults and persons with disabilities.

CONSORTIUM MODEL

Cedar Sinai Park (CSP) is an Oregon non-profit agency that provides housing and community-based care to elders and adults with special needs. CSP chose to create a limited liability corporation (LLC) with a group of local health, housing, and social service providers in order to create a formal structure for making decisions and delivering services. Many of these providers had participated in nearly two years of program planning meetings. Some providers chose not to participate in the LLC but continue to serve residents in the 11 affordable housing properties and/or serve new referrals. For some stakeholders, such as trade organizations and government agencies, participation in an LLC was not an option, though these stakeholders remained interested in and supportive of the project. Other agencies determined that buying into an LLC did not match their financial needs. Once the LLC was formed and the demonstration project began, the program planning meetings were discontinued.

Limited Liability Corporation Members, 2014

Cedar Sinai Park
CareOregon
Home Forward
REACH CDC
Asian Health & Service Center
Jewish Family & Child Service
Sinai Family Home Services
LifeWorks NW
Cascadia Behavioral Healthcare

LESSONS

- A consortium model needs to provide clear and on-going communication and opportunities for feedback to project partners.
- Recognizing and incorporating the expertise of local organizations is vital during program planning.
- The stakeholders who participated in program planning efforts appear to have established a strong sense of project ownership and motivation to make the demonstration project a success.

BUSINESS MODEL LESSONS

Cedar Sinai Park, as the originator of the Housing with Services project and owner of four affordable apartment buildings, is the largest financial partner in the LLC, at 51%. The LLC equity contributions totaled just over $335,000. After Cedar Sinai Park contributed 51%, the remaining organizations each paid a relative share of these costs as their equity contribution. Each percentage of equity was worth $3,000, allowing smaller non-profit agencies to afford participation.

LESSONS

- Because non-profit organizations must receive board approval in order to enter financial agreements, and board meeting schedules and agendas can take months to align and permit agreement or discussion.
- Questions and answers about the legal and financial expectations of an LLC must be prepared in advance of program implementation and presented in language that is accessible to community members who serve on boards.
- Because many non-profit social service organizations operate on a modest budget, they are cautious about committing limited resources to a project that might not allow them to recoup their costs.
- Setting a relatively low equity contribution rate allowed non-profit agencies with limited resources to participate in the LLC.
- Program success relies on fundraising for program implementation and evaluation.

SERVICE PLANNING

A services sub-committee, including Resident Advisory Council members, identified the types of services most needed and wanted by residents. After several workgroup meetings, the draft set of services was shared with service providers, the LLC members, and CareOregon staff. How services would be delivered and paid for remained a topic of discussion even as the service plan was being implemented. Providers agreed to be flexible and to

provide services as resident needs and preferences were better understood over time.

CAREOREGON

As the healthcare provider/payer with the largest number of clients in the 11 buildings, CareOregon (a coordinated care organization) was a key decision-maker in terms of services, staffing, and reimbursement of services available to the residents of the buildings. As part of their support of the program, CareOregon committed in-kind staff and began offering health-related services and education to all residents (rather than to CareOregon members only). As of October 2014, CareOregon provided:

- **Two part-time registered nurses** (1.5 FTE total), serving as a Health Navigator and a Care Coordinator, screen residents and provide advice and referrals
- A **medication therapy management** program called MedChart
- A Health Resilience Program for **identifying high-risk patients**
- **Benefits enrollment** - assistance Medicaid clients with a providers of choice

ON-SITE PRIMARY CARE PHYSICIAN

A primary care physician who accepts CareOregon and Family Care insurance is now available twice weekly in the clinic attached to one of the downtown buildings. This arrangement allows Medicaid clients to choose this provider rather than the one they were randomly assigned to visit through Medicaid enrollment that occurred as part of the State's response to the Affordable Care Act. However, residents may choose to retain their own provider.

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

Providence operates the only PACE program in Oregon, serving dual-eligible individuals who are age 55+ and who meet health-related eligibility criteria defined by Oregon Department of Human Services. Providence is in the process of implementing an on-site PACE program in one of the participating apartment buildings located in downtown Portland.

CONSUMER PARTICIPATION

Consumer choice was a key concern to stakeholders. Residents may choose whether or not to accept services without affecting their housing status or their relationship with current or future health and social service providers.

A consumer advisory group attended planning meetings and sub-committee meetings. Community organizations who represent diverse client groups, including immigrants from China, Korea, Vietnam, Russia, and Iran attended program planning meetings in order to provide feedback on culturally appropriate services.

- Although this program seeks to provide services to residents who need or want them, both housing and service agency staff must protect the privacy of their clients. This makes sharing information and tracking service use over time a challenge.
- Residents value their privacy and independence and may choose whether or not to enroll in offered health services.
- Resident services staff in some buildings have for many years organized the types of services, such as health fairs and clinics, the program is now offering. It is important to understand and clarify roles and to avoid duplication of services and best use program resources to support residents.

RESIDENT SURVEY

A survey of all residents was done in order to collect baseline information before the services were to start (summer 2014). The questionnaire included questions about social isolation, food access, medication adherence, and perceived need for supports, as well as information about health service use and diagnosis.

A total of **1401 questionnaires** were distributed to all units in the 11 apartment buildings. The final response rate, based on **546 respondents**, was 39%. In-person interviews were conducted in six languages other than English and with visually impaired tenants.

DEMOGRAPHIC PROFILE

The residents include slightly more women than men; just over half were over age 65; there majority were White (63%) and others identified as Asian (18%), other (11%), African American (6%), or Hispanic (3%).

The population is low income, with **17% reporting no income**, 59% reporting less than $11,000 and 24% more than $$11,000 annual income.

Many residents reported significant chronic diseases, especially mental health conditions—**43% reported depression; 37% reported anxiety; and 21% post-traumatic stress disorder.**

The reported conditions include both those that are silent (**high blood pressure**) and those that might cause acute symptoms that could result in hospital emergency department use (**sleep apnea, acid reflux, asthma, heart problems**). Nearly one-fourth reported **diabetes** (Table 1).

A different set of questions considered how health affects daily activities. A very large percentage of residents reported **pain—75%** and over 50% reported limitations in daily activities, mobility problems, and anxiety and depression (Fig. 1). Differences by age and gender were minimal (Fig. 2).

Self-reported Health Conditions

Table 1. Tenant Health Characteristics

	N	%
High blood pressure, hypertension	272	49.8
Depression	236	43.2
Anxiety	202	37
Sleep disorder, sleep apnea	167	30.6
Acid reflux	157	28.8
Diabetes or sugar diabetes	129	23.6
Heart trouble or heart disease	117	21.4
Post-traumatic stress disorder	116	21.2
Asthma	109	20
Severe vision problems	94	17.2
COPD, emphysema, chronic bronchitis	88	16.1
Schizophrenia, bipolar disorder, other mental illness	85	15.6
Kidney problems	61	11.2
Liver disease	57	10.4
Addiction to alcohol or drugs	50	9.2
Developmental or intellectual disability	47	8.6
Severe hearing problems	44	8.1
Dementia (such as Alzheimer's Disease)	13	2.4

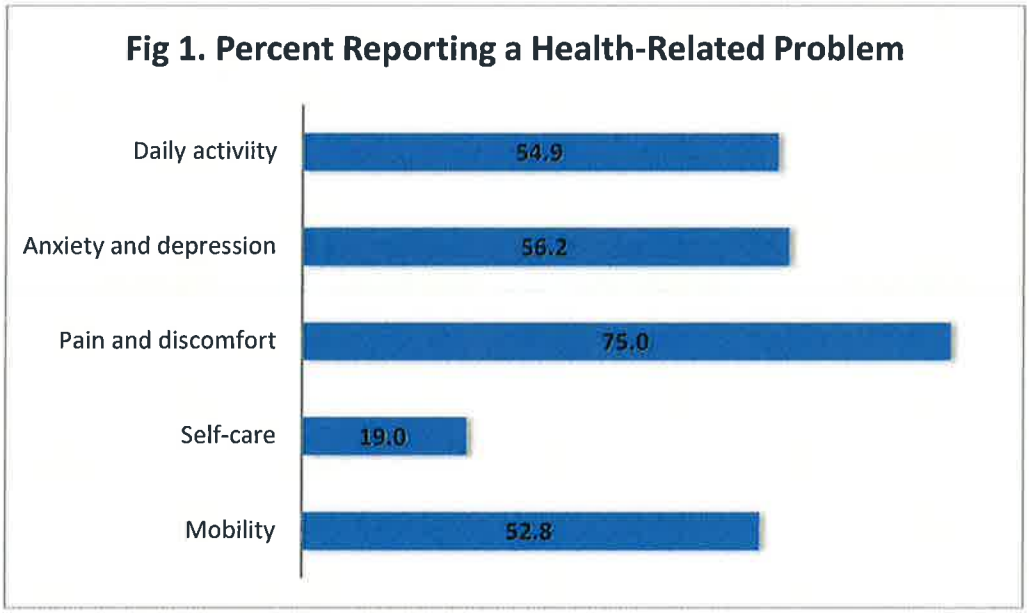
Fig 1. Percent Reporting a Health-Related Problem
Daily activiity
54.9
Anxiety and depression
56.2
Pain and discomfort
75.0
Self-care
19.0
Mobility
52.8

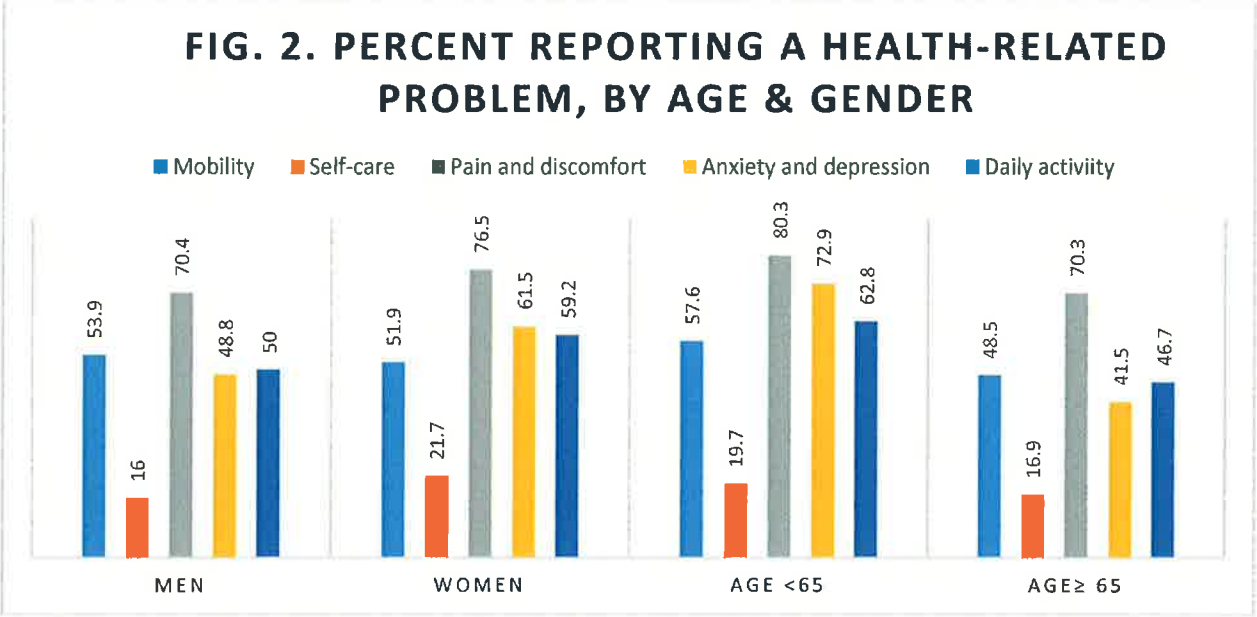
FIG. 2. PERCENT REPORTING A HEALTH-RELATED PROBLEM, BY AGE & GENDER
Mobility
Self-care
Pain and discomfort
Anxiety and depression
Daily activiity
53.9
16
70.4
48.8
50
51.9
21.7
76.5
61.5
59.2
57.6
19.7
80.3
72.9
62.8
48.5
16.9
70.3
41.5
46.7
MEN
WOMEN
AGE <65
AGE≥ 65

HEALTH-RELATED RISK FACTORS

Residents were asked about health-related risks, including those that could result in health service use, negative health outcomes, and disability.

- **63% reported problems remembering or concentrating;**
  - 24% reported that this occurs often/all the time;
- **46% had low adherence to taking medications as prescribed** (only 11% of residents reported not using prescription medicine);
  - **15% reported that they would like help taking medication**;
  - **17% reported receiving help taking medication**;
- **40% reported falling in the past year**;
  - **49% reported feeling unsteady** when walking
  - **47% worry about falling;** and
  - **32% reported a loss of some feeling in their feet**.
- **26% reported food access concerns**;
  - **19% reported hunger due to mobility issues**.

Community involvement supports health. Nearly **46%** of residents scored as having a **high level of social isolation**. More residents reported feeling a medium to high level of involvement with their building community (49.4%) compared to those who felt a medium to high level of involvement with their neighborhood community (38.7%).

Health Service Use

In the prior six months:

- **34.7% visited an emergency department** (ED);
- **50% saw a doctor at least 3 times**; and
- **17% were admitted to a hospital** overnight.

Residents who reported a mental health diagnosis were significantly more likely than those who did not to:

- have low medication adherence,
- be food insecure,
- visit a doctor in the prior six months,
- visit the emergency department in the prior 6 months, and
- have an overnight hospital stay in the prior 6 months

SUMMARY

Many residents of the 11 apartment buildings participating in the demonstration project have significant physical and mental health conditions and health-related risk factors. The project goals include increasing access to services, improving health outcomes, and reducing risk factors while decreasing health service costs, especially hospital and long-term care use.

The services package is being implemented during 2014-2015. During that time, the evaluation project includes tracking referrals and services delivered to residents and interviews with LLC partners and stakeholders. Residents will again be surveyed during the Fall of 2015 and their responses compared to the survey results described in this report.

Housing with Services, LLC, represents an experiment in coordinating and financing culturally relevant, high quality health and social services for older adults and persons with disabilities who live in subsidized housing. The project is an example of coordinated care in action, with health providers and payers working with housing- and community-based organization to coordinate care on behalf of low-income persons. The Housing with Services project is also exploring the sustainability and replicability of a model of a consortium of diverse providers with a limited liability corporation structure addressing social determinants of health.