    

It takes a village: SCAN's three-pronged solution to older adult homelessness

May 16, 2023

Who is SCAN?

For 45 years, SCAN has been keeping seniors & older adults healthy and independent.

Through our health plan and Independence At Home (IAH) community services.

independence at home

A SCAN COMMUNITY SERVICE

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Founded by seniors, for seniors

In 1977, a group of “twelve angry seniors” in Long Beach, California got together to improve care and services for older adults. These pioneers had the simple desire to remain healthy and to age independently. So they consulted with experts in medicine and social services and formed the not-for-profit Senior Care Action Network, now known as SCAN.

Since those early days, SCAN has been a loose-knit group of activists, a federally recognized Social HMO, and an award-winning Medicare Advantage Plan. But through it all we have remained steadfastly committed to our original mission:

TO KEEP SENIORS HEALTHY AND INDEPENDENT.

About SCAN

SCAN is one of the largest not-for-profit Medicare Advantage Prescription Drug plans in the country, serving more than 285,000 members in California, Arizona, Nevada and Texas. Our mission is to keep seniors healthy and independent.

All SCAN plans build upon the strong foundation built over 45 years of senior-focused service, recognized in California with:

Recognized Brand
"Best" MAPD in CA
Five years in a row!

91% Satisfaction
(*Medicare & You, 2023*)
Member Rating of Health Plan

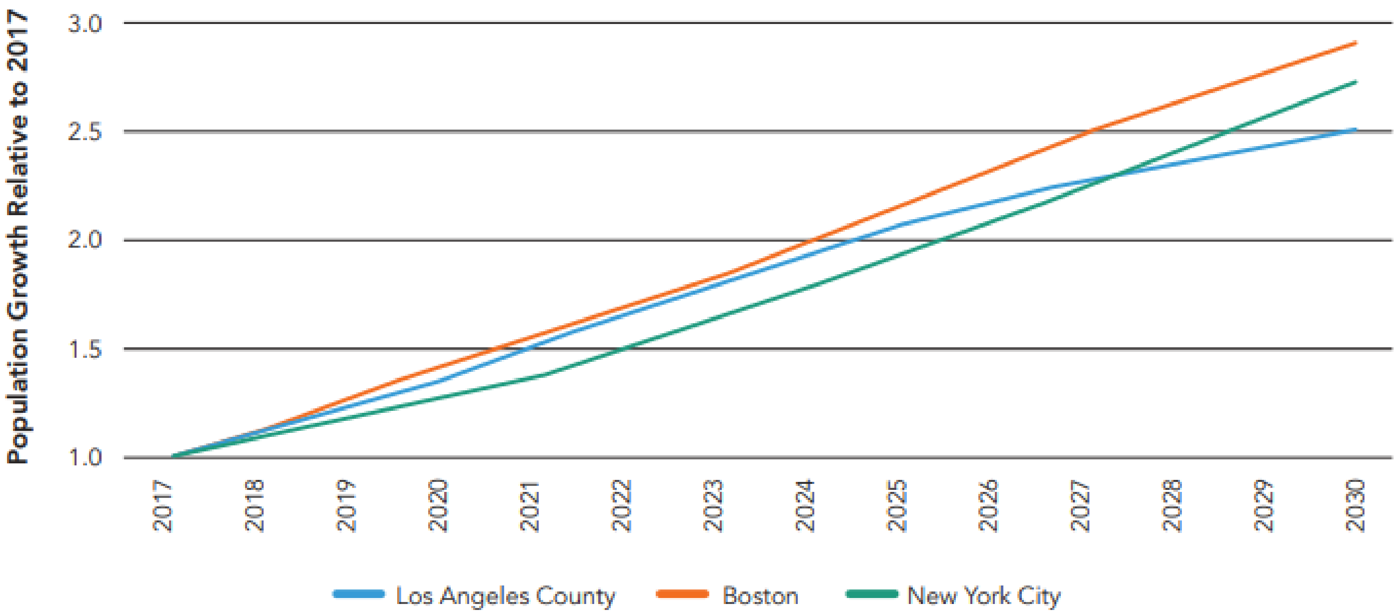
4.5 Stars
Quality care & service
Six years in a row†

Employer of Choice
Great Place to Work
Certified

†4.5 out of 5-star rating applies to all plans offered by SCAN Health Plan in California from 2018 to 2023 except SCAN Healthy at Home (HMO SNP) and VillageHealth (HMO-POS SNP) plans. Every year, Medicare evaluates plans based on a 5-star rating system.

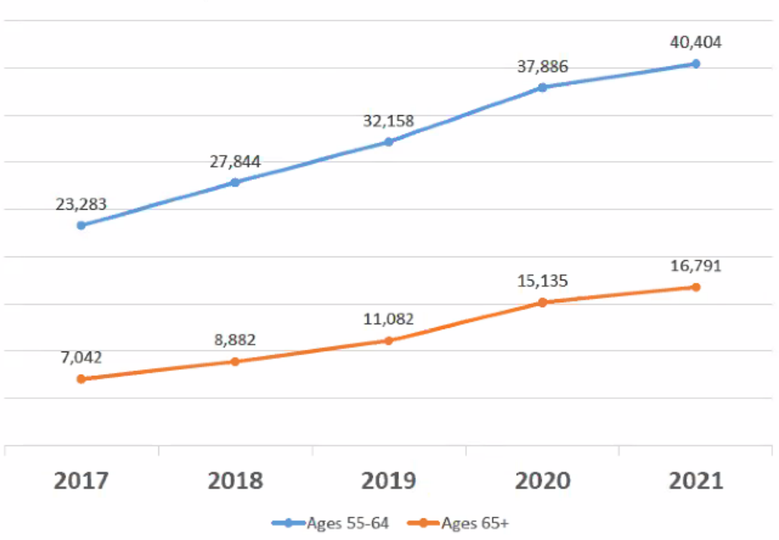
The Growing Crisis of Older Adult Homelessness

Forecasted Relative Change in the 65 and Older Homeless Population compared to 2017



[1]Culhane, D., Doran, K., Schretzman, M., Johns, E., Byrne, T., Metraux, S. & Kuhn, R. (2019). The Emerging Crisis of Aged Homelessness: Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs? International Journal for Population Data Science 4(3) DOI:10.23889/ijpds.v4i3.1185

Age of People Experiencing Homelessness in CA



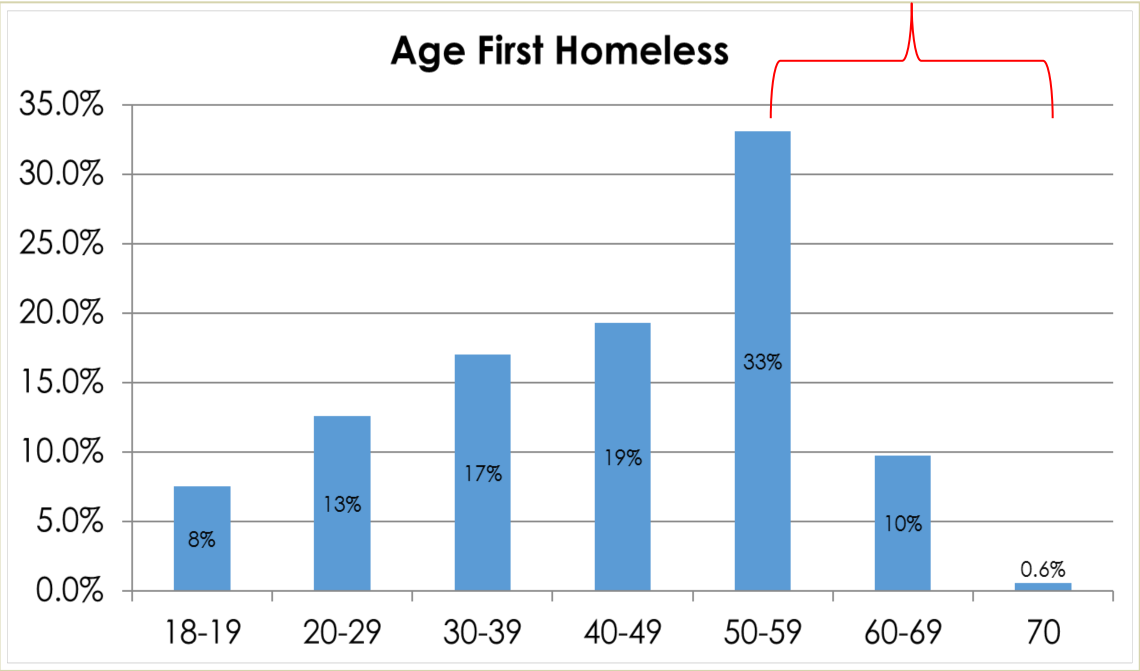
- From 2017 to 2021, the number of older adults (55 or older) that entered system **almost doubled**
- **In 2021:**
  - **15%** of people in system were ages 55 to 64
  - **6%** of people in system were 65 years or older

EMPOWERED BY United Way

- HDIS Data from 2017 to 2021 (Customized Tableau) https://public.tableau.com/app/profile/california.business.consumer.services.and.housing.agency/viz/Overall_Characteristics_V1_3-7_22_22/CharacteristicsofCAExpHomelessness
- Note: Data from HDIS includes data collected from all service providers that participate in CoC's local Homeless Management Information Systems (HMIS)

UNITED TO END HOMELESSNESS

Late Onset Homelessness



- 44% with first episode of homelessness after age 50

Causes

- Low wage work throughout life
- Crisis: Job loss, marital breakdown, illness (self, spouse), death (spouse, parent)

Brown RT, Goodman L, Guzman D, Tieu L, Ponath C, Kushel M. Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. PLoS One. 2016; 11(5):e0155065. PMID: 27163478.

The State of homelessness in older adults

Housing insecurity among this population is projected to triple in Los Angeles, costing $450M by 2026, an 80% increase since 2011. [1]

Housing insecurity and homelessness (H&H) is a significant driver of health inequities

H&H is associated with poorer self-rated physical health and an increased number of chronic conditions

[1]Culhane, D., Doran, K., Schretzman, M., Johns, E., Byrne, T., Metraux, S. & Kuhn, R. (2019). The Emerging Crisis of Aged Homelessness: Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs? International Journal for Population Data Science 4(3) DOI:10.23889/ijpds.v4i3.1185

Causes of Homelessness in Older Adults

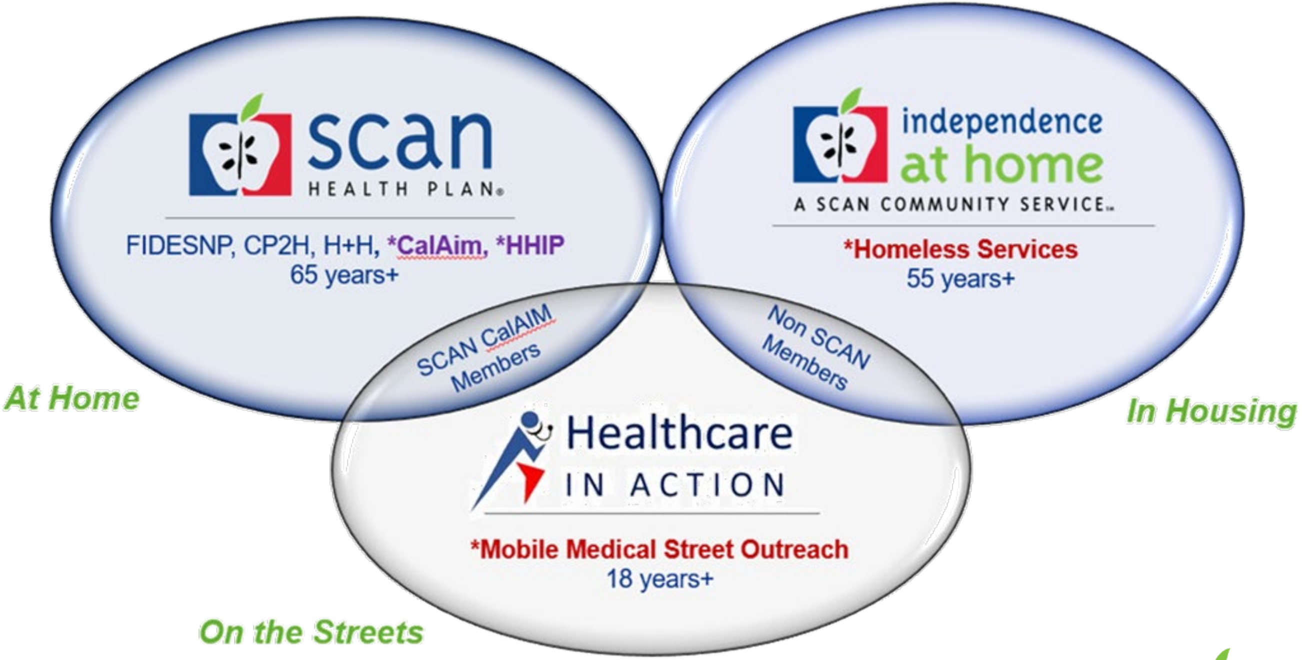
50%	Economic hardship
20%	Weak social ties
10%	Disabling health conditions

SCAN Homeless Services

Ecosystem at SCAN that supports Older Adults Experiencing Housing Insecurity (OAEH)

Bringing Services to Where They Are…

*** 2021 Launch** ***2022 Launch**



SCAN Health Plan

Our 5 Principles

1) Put the Member First

2) Build an Empowered Team

3) Build a Complete Ecosystem of Formal and Informal Partners

4) Practice Harm Reduction

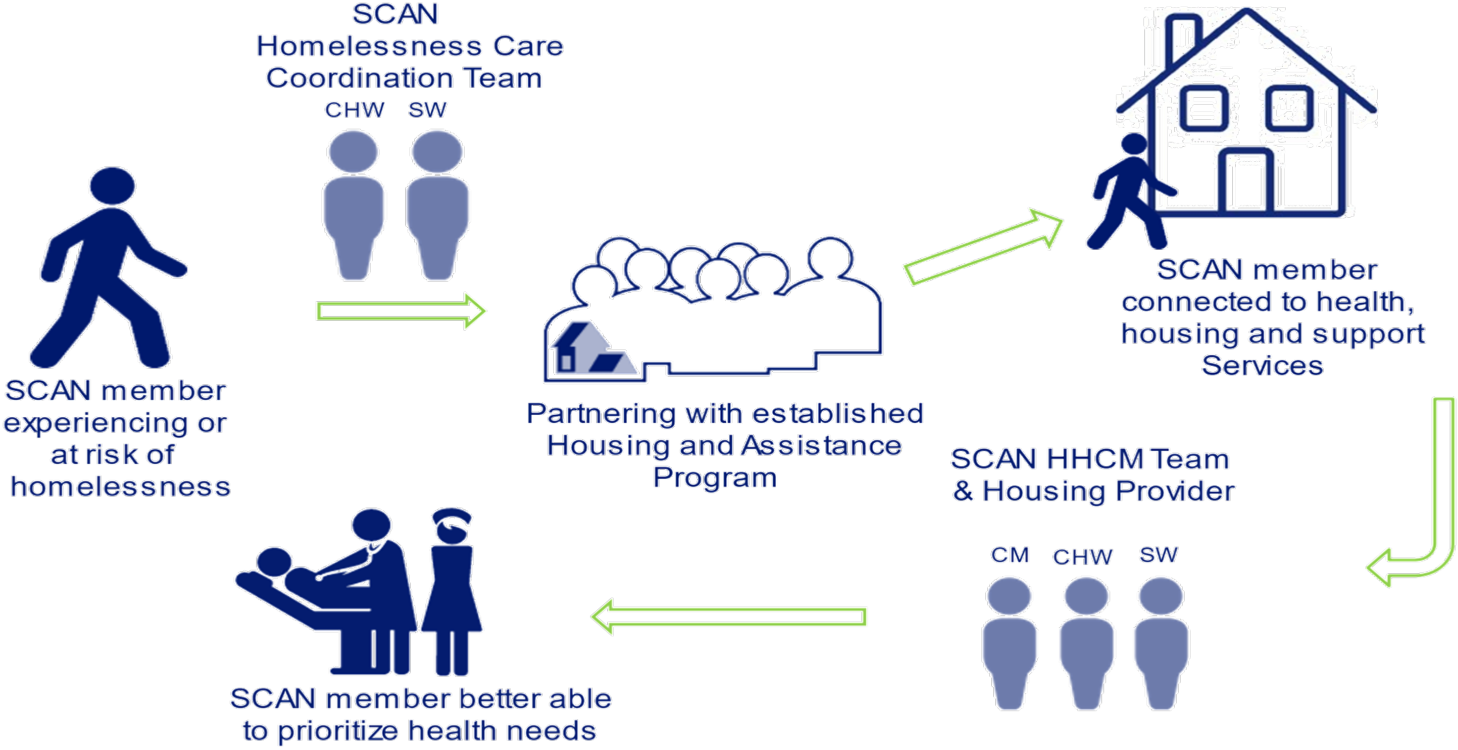
5) Take a New Approach

Member Identification

- SCAN Health Plan identified 71 members who were housing insecure in Los Angeles by referral from providers and the SCAN Personal Assistance Line.

- Inclusion criteria:
  - Members with closed cases OR
  - Members who had been in the program for 60+ days

Housing and Homelessness Care Management



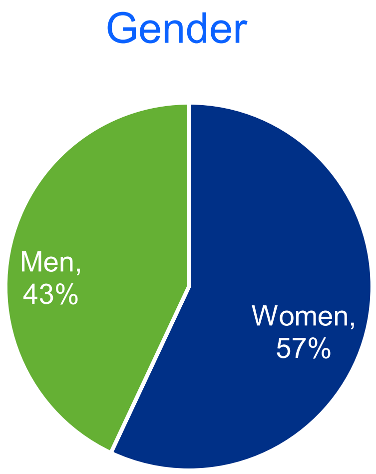
Put the Member First

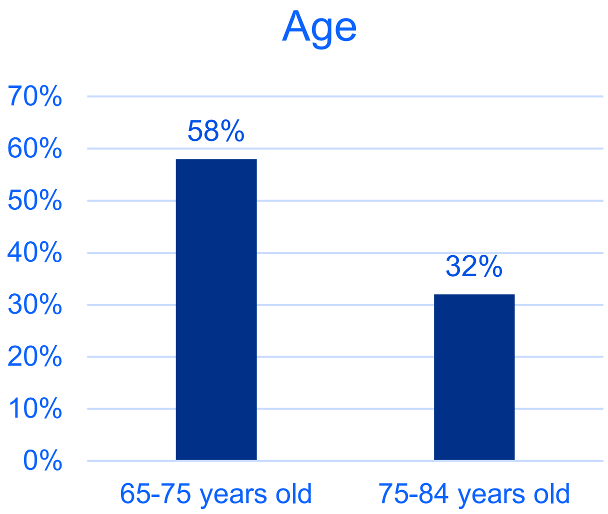
- By using a ‘What Matters to You’ approach to goals, the team was able to build rapport with members.

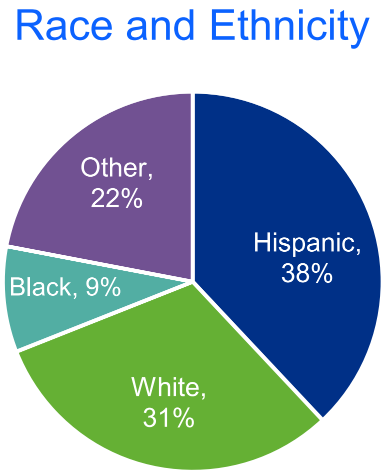
Using a whole-person care perspective, the improvement team addressed needs with the following interventions:

Areas of Focus	Interventions Deployed
Housing	• Court support (Connected to Legal Aid • Benefits advocacy • Secure available resources to assist with subsidizing rent • Arranging for supporting the details of the move • Ensuring housing is accessible (Adult Protective Services Home Safe Program
Social	• Food Insecurity (Food stamps, Meals on Wheels) • Caregiver Support (IHSS, SCAN LTSS) • Financial literacy and budgeting • Financial assistance (Supplemental Security Income) • Utility assistance (electricity grants) • Home modification programs (Habitat for Humanity) • Social isolation (social programs, connecting to existing social network)
Medical	• Health Promotion (SCAN disease management programs, Silver Sneakers) • Provider Appts (Advocacy, understanding treatment plan in layman terms, navigating referrals and the health system) • Access to Care (Enrolled members in Medi-Cal, Connecting members to PCP, Specialty Care and Care Team) • Safe discharge; addressed gaps in care and medication and adherence • ADLs and IADLs support- transitional housing is not often able to support

Demographics: Gender, Age, and Race/Ethnicity







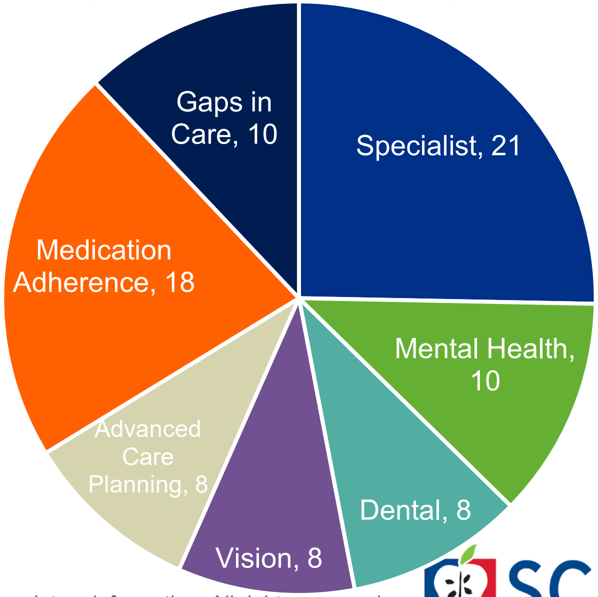
Results

Housing & Social Results

22 (31%)	• Received PSH
15 (21%)	• Connected to family or a friend
15 (21%)	• Received temporary or transitional housing
12 (17%)	• Received housing vouchers
7 (10%)	• Prevented from eviction

Medical Results

- 95% members were connected to their care team
- The team addressed access to care needs by connecting members to the following:



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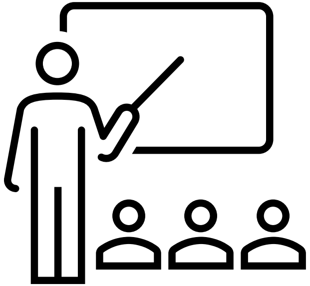
Lessons Learned

- Best practices for addressing H&H in older adults include:



1. Learning members' life stories and understanding their social needs
2. Develop patient-driven action plans
3. Robust advocacy
4. Providing personalized 1-on-1 assistance to navigate the housing support and healthcare systems
5. Working collaboratively with county housing officials and landlords to ensure housing remains accessible

CalAIM Enhanced Care Management

Enhanced Care Management (ECM)

Bridge the housing and homelessness disparity by building partnerships and relationships with community organizations and connecting members experiencing homelessness or at risk of homelessness to social and healthcare services

What Mattered Most?

Housing, Access to Food, Caregivers and Health Concerns

CalAIM Community Supports

Housing Supports

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services

Short-term Recovery Supports

- Short-term, post-hospitalization housing
- Recuperative Care (medical respite)

Independence at Home (IAH)

Housing and Care Coordination Services for Older Adults Experiencing Housing Insecurity

Independence At Home (IAH)

Provided to Older Adults (55+ and caregivers) at no cost

Long-Term Care Management

Are you 65+, eligible for Medi-Cal and want to continue to live at home? Through our **MSSP Program***, we work to help you stay safely at home for as long as possible.

* Must meet MSSP eligibility requirements

Community Health Education

Are you interested in learning about topics important to older adults and family caregivers? Our friendly Health Promotion Representatives offer a variety of classes on a weekly basis in-person, via Zoom or by phone.

Mental Health Assistance

Are you 55+ and finding it hard to cope—or a caregiver to someone who is? Our **Insights Program** will connect you with a mental health professional you can talk with from the comfort of your home.

MORE WAYS WE CAN HELP

- **Resource & Referral Line**
  Connection to community services
- **Homeless Services**
  Healthcare and housing coordination
- **Technology Support**
  Basic education on cell phones, tablets, etc.
- **Caregiver Support**
  Mental health and connection to community resources
- **Medication Education**
  Information and tools to get the most out of your medications

IAH Homeless Services

Housing Insecurity & Homelessness

- Focus: Care Coordination for Older Adults (55 years+ and caregivers) with a focus on Housing Stabilization (prevention, retention) and Social Supports
- Launched in 2022

Model 1 / 1E 1-3 Months	Model 2 6-12 Months	Model 3 Longer-term
Quick Engagement	Engagement during housing crisis	Long-term engagement Currently homeless
Gap Care	Barriers in appointments to care	Not connected to health care/coverage
Document & applications	Inconsistent Care Coordination	Not connected to other service providers
Coordinate with SP housing provider to support	Moderate HRA risk/ADL	High HRA Risk

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Outcomes

347
Unique Clients Served

7
Clients Housed

96%
Stabilized in Housing

Infrastructure & Core Competency

61
Service Agencies

7
Partnership Agreements

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Healthcare In Action (HIA)

Healthcare in Action

A MEMBER ORGANIZATION OF SCAN

Healthcare in Action Introduction

A non-profit, value-based, payer agnostic medical group with integrated primary care, mental health, substance use, and social work services. Serves patients in six counties across Northern and Southern California.

Street Medicine
Care delivered when, where and how patients want it

+

Managed Care
Financial mechanism to create a sustainable delivery system (i.e. CalAIM)

=

Sustainable Healthcare Model for Homeless Adults

What does HIA do?

- Primary Care (ex: wound care)
- Psychiatric Evaluations
- Medication Management
- Housing
- Referrals (ex: to dental)
- Documentation (ex: housing)

HIA Street Medics Help Formerly Homeless Woman Rebound

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HIA Team Structure: Delivering Care via Interdisciplinary Team

- Consulting Psychiatrist
- Supervisor, Care Management
- Coordinator
- Regional Director
- Supervising Physician

Primary Care Teamlet

1 Teamlet per 200 patients

PA/MD
1 per Teamlet

- Wound care
- Medications
- Triage
- Care planning

Clinical Support
1 per Teamlet

- Acute and chronic medical issues
- Substance use
- Mental health

Peer Navigator
6 per Teamlet

- Individual with lived experience
- Patient engagement
- Case management
- Housing navigation

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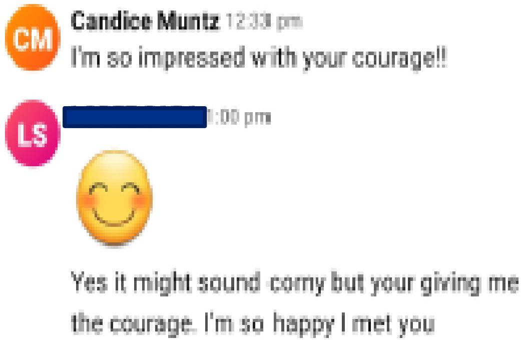
Model 1: Clinical Care + Wrap-Around Services

* HIA's wrap-around services are certified as Enhanced Care Management and Housing Transition Navigation Community Supports Service under CalAIM.

Model 2: Concierge Service

- HIA supports safe discharge from the inpatient setting and from emergency department
- 24/7 availability for patient consults
- Follow up care for **30 days** post-discharge with frequency of care based on patient needs
- Warm hand-off to PCP including HIA if patient is eligible and willing

Empathetic Peer Navigation



HIA Success

2180 Unique Patients Served

35 Patients Housed

50% reduction in 30-day hospital readmission rates

More than 90% of clients into CES for housing

2 Private Contracts

4 Health Plans

Innovations

GPS TRACKERS

SOLAR CHARGERS

24/7 ANSWERING SERVICE

Collaboration and Successes

Mr. & Mrs. F

At Risk

Carlos (CHW) & Blanca (CM)

- 82-year-old and 76-year-old couple facing eviction and now safely placed at an ALF.
- Mr. F w/c bound d/t CVA with L side paralysis & aphasial and now connected with their medical team.
- Mrs. F is cognitively impaired and has difficulty providing care to Mr. F and now receiving the appropriate level of care.

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Mr. P

Housed and Stable

- 72-year-old living in the streets of LA County and now housed.
- Experiencing Mental Health issues and cognitive impairment and now connected with BH services, housing tenancy & sustainability.
- Last seen by his PCP +2yrs and now receiving routine medical care.
- Monthly Income of $670 and now receiving rental assistance.

Erik (Peer Navigator)

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Questions

SCAN Homeless Team 2023

Keeping Older Adults Experiencing Housing Insecurity, Healthy & Independent

Onward!

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Appendix

Ms. SG's story

Housing Retention

Ms. SG is 64 years old and spent many years of her adult life living on the streets. She exited homelessness into the Downtown Women's Center permanent supportive housing program, thinking her ordeal was over. Unfortunately, over time, her unit fell into an uninhabitable state; Ms. SG was at high risk for falls due to the clutter, and the filth was affecting her lung condition. Out of compliance with her lease, Ms. SG was threatened with eviction and returning to the street. It was at this point that she was referred to IAH Homeless Services.

- Deep cleaning of her apartment to prevent eviction and readdress the health concerns associated with her living conditions. (EAF Funds)
- Reapplication for IHSS and strongly advocated for the maximum number of hours and used the Personal Assistance Services Council to identify a provider that Ms. SG has been very happy with.
- Connection to IAH Insights program to manage her depression and anxiety. Ms. SG has improved her mood and outlook
- Resolved a medication issue through advocacy with Pharmacy /LA Care PCP; Ms. SG has the medicine she needs to support her COPD

After eight months with Homeless Services, Ms. SG's housing has been stabilized, her medical and mental health conditions have been supported, and she has the tools she needs to remain independent at home.

Mr. L

Housing Stabilization

- 69-year-old living in his van since 2010 and
- BA degree in Music and 3 courses away from completing his master's program and
- Monthly income of $1028 and
- Suffering from Degenerative Disc Disease and

Jessica (Peer Navigator)

IAH Homeless Services supports clients through the whole continuum

What matters to our clients depends on where they are at…

Unsubsidized Housing		Unhoused		Interim Housing		Subsidized Housing	
Prevention	Diversion	Outreach	Non-Residential Housing Resource	Emergency Shelter	Transitional Housing	Permanent Supportive Housing	Affordable Housing
Resources Healthcare Home Safety Caregiving	Legal Advocacy Doc Readiness	Basic Needs Doc Readiness Resources	Navigation Doc Readiness	Doc Readiness Healthcare Resources	Doc Readiness Healthcare Resources	Deep Cleaning Healthcare Home Safety Caregiving	Healthcare Home Safety Caregiving