

Support and Services At Home: A Care Management Model Utilizing Community Health Workers

The United States is expected to have a significant increase in its elderly population over the next 20 years. In 2011, people 65 years and older represented 13.3 percent of the population, and by 2040 this age group is predicted to grow to 21 percent. During this same time period, the population of people aged 85 years and older is projected to triple, from 5.7 million in 2011 to 14.1 million in 2040.¹

Concurrently, adults 65 years and older are showing an increase in preference to “age in place,” meaning a person’s ability to live in his or her own home and community safely, independently, and comfortably, regardless of age, income, or ability level.² A recent AARP survey indicated that 85 percent of baby boomers are planning to age in their current homes.³ The desire for people to age at home has led to an increase in the number of people dedicating their time and energy to caring for this population. According to the Institute of Medicine (IOM), 80 percent of care partners are family members in home settings and report spending, on average, 4.6 years caring for their family members.⁴ In the case of dementia, caregiving may span four to 20 years.⁴ The growth of the population of adults 65 and over, and the need for caregiving, highlights the urgency for communities to develop and institute policies that create environments conducive to this demographic shift.

As communities look to support adult populations while they age in place, the focus should not only be to work with primary care providers, but also to build up the community health worker (CHW) workforce. Although physicians provide great value in making diagnoses, they lack the time needed to provide care and disease management services to fully address the triple aim of improving the experience of care and health of populations, and reducing per capita costs of healthcare. Efforts to better integrate CHWs with primary- and acute-care settings will go a long way to ensure that people get the care management they need. The Support and Services at Home (SASH) program is an innovative model that supports Medicare beneficiaries and dual eligibles by utilizing CHWs and wellness nurses to streamline access to medical and nonmedical services necessary for this population to remain living safely at home.⁵

What is SASH?

SASH provides personalized, coordinated care to help Vermont's most vulnerable citizens, seniors, and individuals with special needs. SASH helps these populations access the care and support they need to stay healthy while living comfortably and safely at home. SASH is available in many communities throughout Vermont, serving primarily persons 65 and older, and persons with disabilities. Participation is voluntary and free of charge. SASH communities include a care coordinator and wellness nurse who work in partnership with a team of community providers to assist SASH participants. For more information visit <http://www.sashvt.org/> or view the [explanation of SASH benefits form](#).

SASH Coordinator (CHW)-

SASH coordinators build trusting relationships with participants in order to develop a thorough knowledge of each SASH participant's strengths or challenges related to remaining safely in his or her home. View the [SASH coordinator job description](#).

SASH Wellness Nurse – SASH

wellness nurse's provide and oversee wellness care and coaching for SASH participants and are responsible for coordinating health services with other SASH team members and community providers. View the [wellness nurse job description](#).

Background

Cathedral Square Corporation (CSC) is a nonprofit organization that owns and manages affordable housing communities for seniors and individuals with special needs, located in Vermont. CSC offers various levels of assistance, from independent senior housing and shared housing to assisted living. There are many reasons why seniors move into CSC's housing, whether they want to seek greater affordability, downsize, avoid isolation after losing a spouse, or be closer to family. CSC's goal is to provide supports so that residents can remain within CSC community housing for as long as possible, providing a "home" to their residents. Similarly, CSC converted a portion of one of its properties into an assisted living facility, for the very purpose of ensuring that residents who had called the community "home" for 30 years, were able to remain with their friends and neighbors, and avoid moving to a nursing home.

In the early 2000s, CSC recognized the increasing challenges brought on by an aging population. As an affordable housing provider in Vermont for more than 30 years, CSC found that residents have a difficult time navigating the healthcare system and a lack of structure exists for supporting seniors who want to remain at home, additionally, there is a decrease in availability of nursing home beds, all of which present challenges to healthy aging. To address this issue, CSC utilized historical relationships and its knowledge of critical partners to bring together representatives from the Program of All-Inclusive Care for the Elderly, Visiting Nurse Association and Hospice of Vermont and New Hampshire, local area agencies on aging, and the University of Vermont's Center on Aging, as well as representatives from Vermont's network of designated mental health agencies and local hospitals. The group discussed how affordable housing providers like CSC could help aging organizations extend services within the home. CSC invited executive directors from these organizations to serve on a model design team to plan the SASH pilot. An independent consultant, funded by the Vermont Health Foundation, brought the partner organizations together to develop the pilot. This consultant assisted in the development of a [memorandum of understanding \(MOU\)](#) to harness the strengths of social service agencies and providers to work together as one team in support of a group of SASH participants (known as a "panel").

In July 2009, the team piloted SASH in one of CSC's housing communities. The goal was to make SASH a scalable and replicable program across the state of Vermont, and eventually across the country.

Expansion of SASH beyond the pilot began in 2011. CSC approached Vermont's [Blueprint for Health](#) about including SASH in an application to the Centers for Medicare and Medicaid Services (CMS) to participate in a Medicare initiative called the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration. CSC argued that SASH would be a useful partner to primary care practices if they extended physician practices into the home.

Utilizing a grant through the Housing Assistance Council (HAC), a division of the U.S. Department of Housing and Urban Development, CSC brought together all of the nonprofit housing organizations in Vermont for an in-person meeting to provide an overview of SASH and make the case for adopting the program ([view the SASH Brochure](#)). CSC identified select housing organizations, coined by CSC as Designated Regional Housing Organizations (DRHOs), which were early adopters of SASH and had a keen interest in the housing and services model. The HAC grant then paid for individual peer-to-peer exchanges in which a DRHO would accompany CSC to meet with potential housing organizations, share SASH templates and job descriptions, and help them get the program started. Vermont's housing organizations are required to cover basic start-up and ongoing expenses for SASH, including office space and phone and internet service for SASH coordinators and wellness nurses. The value that SASH brings to the housing organizations' residents and properties exceeds the initial and ongoing investment.

Affordable or subsidized housing is housing that is owned and operated by private owners who receive subsidies from the government in exchange for renting to low- and moderate-income people. While originally piloted only in subsidized housing communities, a CMS condition of MAPCP funding was that SASH would serve all Medicare beneficiaries regardless of their residential setting, income, or age. As of January 2014, SASH has expanded to every county in Vermont and is in more than 90 subsidized housing properties, serving over 3,100 individuals; 647 of these participants live in single-family homes or apartments outside of the subsidized housing communities.

What Is SASH?

SASH can create an entirely new role for housing providers by developing them into advocates that monitor the health and well-being of their residents and provide or coordinate services that allow residents to remain in their own homes.⁶ In SASH, participants can enroll permanently, regardless of health needs, and services are targeted based on individual needs and goals. Panels of 100 participants are supported by a five-member team connected to the medical home. Two key members of this team are the SASH coordinator, or CHW, and the wellness nurse. The SASH coordinator and wellness nurse focus their efforts on transition support after a hospital or rehabilitation facility stay, self-management education and coaching, and care coordination.⁷

SASH coordinators are full-time employees of local housing organization's where SASH is implemented; they must possess a bachelor's degree in social work or have an equivalent combination of background and experience. Wellness nurses are quarter-time employees, either employed by the housing organization or contracted through a home health agency or hospital. Wellness nurses must be licensed

as a registered nurse in the state of Vermont and possess at least two years of clinical setting experience.

CSC works to certify and train SASH coordinators in evidence-based programming. SASH coordinators around the state are trained to lead chronic disease self-management programs, chronic pain management, diabetes, tai chi for arthritis, and tobacco cessation. To date, 25 SASH coordinators have been trained to lead chronic disease self-management programs. In addition to a SASH coordinator and wellness nurse, additional SASH team members include a homecare or skilled nurse from the local visiting nurse association, a designated case manager from the area agency on aging, and a representative from the community mental health agency.⁸ SASH teams meet on a regular basis (at least once a month) to create action plans and coordinate care for their panel of SASH participants. An Individual Healthy Living Plan is developed with each participant, in addition to a Community Healthy Living Plan. The latter is a population-level program plan driven by the panel's assessment data. The Community Healthy Living Plan focuses on panel members' collective needs and brings in evidence-based programs to address falls, medication management, control of chronic conditions, lifestyle barriers, and cognitive and mental health issues.⁹ Before the development of SASH, there were inconsistencies regarding collaboration between agencies and restrictions on the sharing of data. SASH teams are a formal partnership, and all organizations must sign an MOU, agree to form a collaborative, and send designated staff members to attend SASH team meetings. When individuals agree to participate in SASH, they sign a consent form allowing their information to be shared with members of the SASH team.

Utilizing Vermont's Integrated System

SASH staff have significantly increased participants' ability to access their primary care provider. DocSite is Vermont's statewide clinical registry used by Blueprint for Health community health teams, physicians, and hospitals. SASH coordinators and wellness nurses are the state's largest users of DocSite for primary entry. SASH staff created a large dataset that is being used by the health department, community health teams, and providers for data analytics on a population-wide level. As DocSite continues to add more clinical data to its system, SASH staff are some of the first and most robust users of its integrated health records functionality. This will enable SASH to better link with community health teams and more efficiently utilize available resources and coordinate care for participants.

Results

The following data demonstrate SASH's impact and short-term results:

- Estimates from the Medicare expenditure trend model indicate that quarterly savings accelerated during the first 15 months of the SASH program (in the fifth quarter) due to lower rates of growth in acute-care payments and post-acute-care payments.¹⁰
- The SASH pilot:
 - Resulted in a 19 percent reduction in hospitalizations.¹¹
 - Reduced the number of participants reporting three or more falls in the past year from 39 to 29 percent statewide.¹²
 - Reduced the number of participants at high nutritional risk from 35 to 24 percent statewide.¹⁴

How Is SASH funded?

To fund the original SASH pilot, CSC obtained an appropriation from the Vermont legislature and matched it with a grant from the Vermont Health Foundation; SASH also received funding from other small grants and CSC contributions. However, this was not a sustainable funding source to expand SASH state-wide. In 2010, when Vermont Blueprint for Health applied for MAPCP funding from CMS, CSC's executive director successfully demonstrated the similarity between SASH goals and those of the Blueprint (prevention, chronic disease management of panels of patients, and overall health improvement), and the Blueprint included SASH in its application.

Vermont was awarded MAPCP funding in 2011, allowing SASH to begin expanding later that year. CMS funding provides \$700 per person, per year in support of SASH. SASH also receives annual grants from the Vermont Department of Disabilities, Aging, and Independent Living, Department of Vermont Health Access (Health Information Technology Grant), Vermont Health Foundation/Fletcher Allen Health Care, and contributions from CSC and other foundations in Vermont.¹³

Throughout the initial pilot and demonstration, several organizations have been extremely supportive with funding and technical assistance, including LeadingAge, a national association of nonprofit aging services providers. Enterprise Community Partners has also provided several grants to CSC at critical points in SASH's development and expansion. The Vermont Housing and Conservation Board, as well as the MacArthur Foundation, provided capacity funding to CSC for SASH.

Role of the Partners

Cathedral Square Corporation (CSC)

CSC pioneered the SASH concept by bringing together the right partners and piloting the SASH model at one of their locations. Currently, CSC is responsible for operating the program statewide through an MOU; CSC trains SASH coordinators and wellness nurses and coordinates quarterly rollouts of new panels. Trainings last eight weeks and are conducted quarterly via in-person meetings, webinars, and videoconferencing. An operations support coordinator employed by CSC travels around the state to provide technical assistance and monitoring.

CSC is responsible for other roles, which include:

- Ensuring that staff implement the SASH model with fidelity to the original model and provide technical assistance needed to ensure that happens.
- Serving as DRHO in the four northwestern counties.
- Serving as a point of contact for legal issues and questions regarding SASH implementation.

CSC's goal is for all organizations involved in SASH to operate as one entity and focus on serving panels of people. Maintaining this goal and the partnerships involved requires a great deal of maintenance, including focused check-in times for partners' input and orientation for new staff (personnel changes require periodic trainings to review the SASH model). The growth and expansion of SASH also means an increase in the number of partners throughout the state (approximately 65).

Designated Regional Housing Organization (DRHO)

There are six DRHOs located in Vermont: RuralEdge, Central Vermont Community Land Trust, Brattleboro Housing Authority, Shires Housing, Rutland Housing Authority, and CSC. DRHOs receive a modest amount of funding (currently \$20,000/year) from the Vermont Department of Disabilities, Aging, and Independent Living grant for their regional leadership role of cultivating relationships with partner agencies essential to foster collaboration and team support of participants. DRHOs share their SASH expertise with 16 other housing organizations who are just starting the program, offering perspective from organizational peers that are also implementing SASH. DRHOs help peer organizations navigate the local table, which is the advisory group of the community, and provide technical assistance, as needed. Generally, DRHOs assist other housing organizations who are in close proximity and offer additional support when CSC is not available. Occasionally, CSC encounters people who find the model hard to understand, so regional leadership groups led by DRHOs are important to overcome these challenges. They serve as the ears to the ground to help mediate these partnerships. CSC relies on DRHOs around the state to maintain efforts with local partners and hold regular check-ins.

Vermont Department of Health

The Vermont Department of Health (VDH) became interested in SASH when VDH received a Vermont Community Transformation Grant (CTG) in 2012. CDC funds CTG grants nationally through selected state departments of health. Using CTG funds, VDH awarded several smaller grants to programs in the state and selected the SASH program to focus specifically on rural areas to develop systems that track and monitor blood pressure and cholesterol, and create smoke-free environments for low-socioeconomic-status citizens. CSC received \$257,500 in CTG funds over three years to distribute among three rural DRHO areas to add the CTG goals and populations to SASH. As part of the CTG, VDH is currently evaluating the outcomes of its work with SASH to measure the effectiveness of community-based prevention services; the evaluation will determine the effectiveness of SASH services in helping participants lower their blood pressure and improving other health measures. Program staff and participant satisfaction will also be evaluated, as will the strength of connection between SASH and local primary care practices.

VDH also provides SASH resources for participants. VDH has many smoke-free housing resources that inform and educate SASH coordinators.

Conclusion

With its growing elderly populations, the United States needs a system of care built on the reality that people want to remain in their own homes and communities as they age. A community-based system would be well suited to address the major determinants of health, social circumstances and behaviors. Long-term, rather than episodic, strategies are needed to address the social determinants of health and behaviors that are the root causes of most chronic conditions. In SASH, participants enroll permanently regardless of health needs, and services are targeted based on individual needs and goals. A population-based approach would make sense financially and operationally given the volume of need and the fact that care has moved from a centralized institutional setting to the community.

SASH has demonstrated its scalability by expanding from one pilot site to more than 90 affordable housing sites in every county in Vermont. The SASH system can be replicated in any state that has federally funded affordable housing, Older Americans Act funding of agencies on aging, Medicare and

Issue Brief



Medicaid funded home health and mental health agencies and a state commitment to healthcare reform that integrates primary care, acute care, long-term services and supports, and health promotion. States and traditional and affordable housing providers can easily find value in a program like SASH as it helps to support state residents and leads to a healthier population, while reducing costs.

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² CDC. "Healthy Places Terminology." Available at <http://www.cdc.gov/healthyplaces/terminology.htm>. Accessed 2-24-2014.

³ Governing Generations. "An Earth-Shattering Ka-Boom: The generation that changed everything it touched—including old age." 2013. Available at <http://www.governing.com/books/governing-generations.html>. Accessed 2-21-2014.

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⁵ Department of Vermont Health Access. "Vermont Blueprint for Health: 2012 Annual Report." 2013. Available at http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%202002_14_13_FINAL.pdf. Accessed 11-25-2013.

⁶ Eldridge NR. "Support and Services at Home: A Care Partnership" in *Innovative Communities: Breaking Down Barriers for the Good of Consumers and Their Family Caregivers*. Long Term Quality Alliance. Available at <http://cathedralsquare.org/files/LTQA%20-%20Innovative%20Communities%20Report.pdf>. Accessed 11-27-2013.

⁷ Department of Vermont Health Access. "Vermont Blueprint for Health: 2012 Annual Report." 2013. Available at http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%202002_14_13_FINAL.pdf. Accessed 11-25-2013.

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Issue Brief



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¹¹ Fletcher Allen Health Care aata.

¹² DocSite clinical registry data.

¹³ Cathedral Square Corporation. "SASH: Support & Services at Home Brochure." 2013.