SPECIAL  SECTION

INTEGRATING HOUSING AND HEALTHCARE

Management Issues Organizations Should Consider before Establishing Formal Relationships

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Housing and healthcare organizations across the nation have succeeded in collaborating for the benefit of their clients and their organizations. Examples include:

- A Housing and Urban Development (HUD)-sponsored public housing building that has a Program of All-Inclusive Care for the Elderly (PACE) program sponsored by a hospital
- A residential AIDS facility that uses the home care agency and acute care services of a nearby hospital
- A multilevel skilled nursing, assisted living, and independent senior housing complex that houses a physical therapy clinic operated by a healthcare organization sponsored by the same order
- A hospital whose chief of geriatrics serves as medical director for a public housing facility for seniors, a private assisted-living facility, and a home care agency that serves both housing units
- A parish and hospital that have developed a parish-nurse program to facilitate local residents' access to health services

But collaboration is not simple. The housing and healthcare fields have different services, means of funding, and clients (See **Box**, p. 42). Coordinating needs and resources can be challenging.

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Housing and healthcare organizations that have successfully integrated their activities have followed fundamental principles of good management. This article highlights the management issues that housing and healthcare organizations should consider prior to establishing formal relationships.*

Articulate Goals and Objectives

Common goals and objectives are essential for any successful relationship. Working with other Catholic organizations assumes a shared mission: the benefit of the individual client and family. However, even among Catholic organizations operating goals and objectives may differ. Healthcare organizations might want to collaborate to:

- Increase referrals
- Increase the number of health plan participants
- Improve efficiency in providing services to many people in one location
- Improve patient flow, so discharge bottlenecks do not occur
- Gain access to capital and/or space to house ancillary programs, such as adult day care

Housing facilities might want to collaborate to:

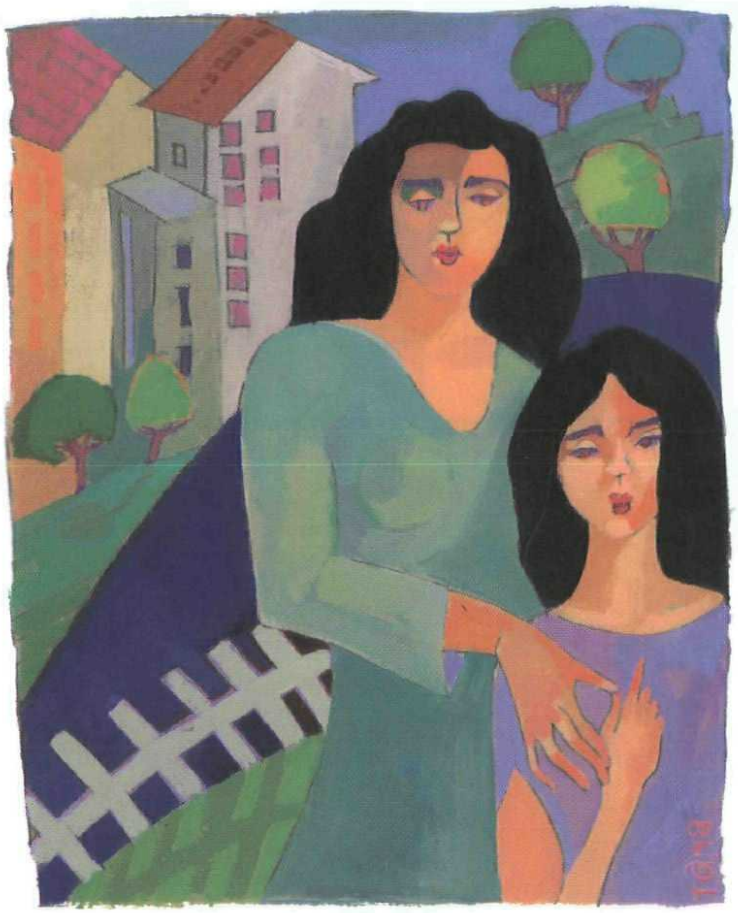
- Increase referrals
- Enable frail residents to remain longer by having health services available
- Achieve differentiation in the marketplace

*Housing facilities, even those providing sheltered or assisted living, refer to their occupants as residents. Hospitals refer to their clients as patients. Home care agencies refer to those they serve as clients. Marketing departments of all services may refer to customers. This article uses the generic term "client" to refer to those cared for by any type of housing or healthcare provider.

• Improve admissions by having health assessments

• Gain access to management resources and expertise

Although each of these reasons is valid, these goals are not necessarily compatible. For example, a Catholic healthcare system in the West had acquired a senior housing complex that the archdiocese felt it did not have the expertise to manage. The housing facility had evolved over the years, and at the time of the management transition was occupied by middle- to low-income seniors. The healthcare system viewed the facility as a source of referrals and, as a private-pay entity, a supplemental source of revenue. The archdiocese saw it as a residential facility for low-income seniors who were not wealthy but not so poor that they qualified for government-supported low-income housing. The housing complex was not full, so marketing to new residents was a priority. In planning for its future, the complex could decide to either add only higher-income residents who would remain private payers, or accept low-income people who might exhaust their resources and then be dependent upon the organization's goodwill to remain as residents. Long-term physical plant renovations could be tailored to the expected target population.



The initial agreement between the archdiocese and the healthcare system had been based on their evaluation of management expertise, but the organizations realized that, for the arrangement to continue, they needed to agree upon long-range goals. Beyond the general agreement for management functions, quantifiable objectives pertaining to both operations and outcomes needed to be specified.

Before entering into a formal collaborative arrangement, each organization should specify its detailed goals and the quantifiable indicators it will use to measure success. The goals of the organizations need not be identical, but they must be compatible.

Focus on a Specific Population

Most healthcare organizations have the capacity to serve a wide array of patients, but residential facilities tend to be more limited in whom they can serve by the physical constraints of their plant (see **Box**, p. 43, for types of housing residents). Thus, in dealing with health service providers, the housing facility operator, who knows his physical plant and governs admission criteria, should specify the characteristics of residents, admissions criteria, and the type of healthcare services the residents are most likely to need. Criteria such as "anyone over the age of 65" are probably too broad.

A healthcare system in the Midwest, given an unoccupied school dormitory, evaluated community needs and resources before aligning with any community-based agencies. After considering several options, including using the dormitory for senior housing, as a mental-health facility, or as a women's shelter, the healthcare system decided that the most appropriate use for the facility would be as a multiservice residential center for people with AIDS. At that point, the healthcare system approached the community agencies serving the AIDS population.

When considering collaboration, the organizations involved should specify the target audience in enough detail so that all the participating organizations can understand and measure the client involvement criteria.

Educate and Involve Staff

Housing, acute care, and long-term care are distinct services. Those who work in each service tend to have different orientations. Moreover,

due to the United States' fragmented approach to care, the staff of each service work under different regulations, procedures, and financial arrangements. To achieve true integration for clients, the staff of the services involved must get to know the operating characteristics of all the service partners.

The Friday afternoon discharge is the classic example. The hospital may want to discharge a patient before the weekend. The assisted-living complex may be pleased to have its resident return, but not be able to provide extra care, particularly on the weekend. The assisted-living complex may expect home health to initiate service, but home health agencies can't always arrange to start new cases late on Friday or over the weekend. Organizations that are committed to working together understand these kinds of constraints and develop routine operating procedures that accommodate the needs of each organization.

Moreover, personal relationships among the staff of the separate organizations often make it possible to overcome functional barriers that can otherwise impede care. When staff become friends, establish trust, and know that a favor on one Friday afternoon will be returned on another Friday afternoon, client care is often facilitated.

As an example, a large housing system in the upper Midwest entered into a two-step merger process with a large healthcare system. In addition to formal staff education and information presentations about the merger, the two systems' human relations departments held staff baseball games and family picnics. The informal friendships that developed around recreational activities helped develop collaboration in the workplace.

The cross-education of the staffs included guided tours of the respective facilities, joint luncheons, formal presentations explaining the relationship at staff meetings, joint continuing-education programs, cross-distribution of newsletters, and regular columns or articles in newsletters. Staff performance in collaborating can be recognized by a variety of means, ranging from formal additions to job performance criteria to staff recognition awards.

Staff also need time to meet. This may be a monthly meeting between administrators or a weekly case conference among clinicians. Collaboration requires communication, and all of the organizations participating must realize that they need to budget time for the staff to meet on a regular basis to ensure smooth, ongoing interaction. In any formal collaboration agreement, drawing up a communications plan for both initial information and ongoing education can help staff implement the operational details of the relationship.

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HOUSING AND HEALTHCARE SERVICES

HOUSING SERVICES

Independent Apartments

Congregate Living
- Meals, transportation, laundry, housekeeping

Assisted Living
- Meals, medications monitoring
- Socialization, assistance with ADLs
- Housekeeping, laundry, transportation

Group Homes
- Supervision

Half-Way Houses

HEALTHCARE SERVICES APPROPRIATE FOR HOUSING FACILITIES

Assessment

Screenings

Satellite clinics

Home healthcare

Case management

Wellness programs

Health education

Adult day care

SHARE CLIENT INFORMATION

Collaborating housing and healthcare providers can share vital information that will enhance a person's care. However, fulfilling this potential requires careful thought and deliberate action—it doesn't happen automatically.

Shared client information can be extremely valuable. Particularly in frail populations whose needs focus around independence in functioning rather than treatment for disease, how clients manage at home is intertwined with their physical and mental condition.

Unfortunately, housing and healthcare providers have different information systems for administrative and clinical data. The legal requirements differ; the financial and billing systems differ; the clinical data and the systems in which they are maintained differ. Housing providers, who are not required by law to have the detailed level of information required of healthcare providers,

do not want to incur the expense of elaborate information systems and may have difficulty persuading residents to provide what may be perceived as confidential information. The differences in information systems, as well as the fragmentation of internal information systems, make it difficult for providers to achieve the information exchange that would benefit the client's care.

Despite these challenges, there are ways to share useful information. Upon initiating a collaborative relationship, managers and clinicians from housing and healthcare organizations should evaluate how and what information each obtains and determine the most effective ways to share pertinent information. One triad of organizations, a hospital, community-based clinic, and housing complex, all of whom served an overlapping population of seniors, began with a task force of those responsible for records. Although each organization had a different client identification system already in place, the task force developed a way to cross-reference identity. This enabled the providers to track a single person across settings with confidence that this was the same individual. The healthcare providers also coded the names of clients who were residents of the housing complex to add the facility coordinators to the list of people to be informed in an emergency or on admission. The housing complex obtained permission from its residents to add information about hospital preference to its records. The total number of people involved was too small to justify the cost of a new computer system, but, by consensus, small changes were made to each entity's existing system that fostered communication among caregivers on the clients' behalf.

Marketing

When housing and healthcare organizations agree to work together, they need to help the public understand how the relationship will add value for the consumer. This may mean some changes in marketing strategy. If both organizations already have marketing programs in place, the new relationship(s) must be added. If one or more are new, the marketing plan may have more flexibility. The question then arises about what to say and what terminology to use. The organizations should agree on the general approach to marketing and on the resources each will contribute before signing a formal arrangement to collaborate. Misguided public perceptions can cause otherwise good partnerships to fail.

A HUD-sponsored senior housing complex invited a geriatric assessment team based at a local Catholic hospital to have a nurse on site one day a week to check blood pressures and identify those for whom a complete assessment or case management might be appropriate. Initially, the nurse felt that the pilot project should not continue because very few residents came. After several months, the housing managers and healthcare organization learned from the residents that the reason for the lack of use was the misperception that only residents affiliated with the nurse's base hospital or other Catholic services were welcome. Once it was made clear that the program was available to everyone, the nurse had more participants than the half-day clinic could accommodate.

The organizations should agree on a general approach to marketing—misguided public perceptions can cause otherwise good partnerships to fail.

Exercise caution in marketing. One Catholic senior housing complex developed a relationship with a nearby hospital for case management and easy discharge of the facility's residents. The hospital staff were accommodating, and staff from both organizations spent a lot of time and energy developing the collaborative processes and explaining the case management model to families. It turned out, however, that, despite the proximity of the hospital, most of the housing residents used the Catholic hospital in town, even though it was further away. Over a year or two, the housing facility implemented its case management model at the Catholic hospital and discontinued the program at the nearby hospital. Residents using the community hospital who had grown accustomed to the case management program had to be informed that it was no longer available unless they used a different hospital. The change was made by the housing complex for pragmatic reasons, but it was difficult to explain to both the hospital staff and the residents and families. Fortunately, aggressive communitywide marketing had been deferred, so neither the housing complex nor the local hospital was too embarrassed, but a few awkward moments did occur.

Jointly plan with all organizations involved how the relationships will be marketed to the

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TYPES OF RESIDENTS AT HIGH RISK FOR NEEDING HEALTHCARE

- Seniors (independent)
- Seniors (functionally dependent)
- Substance abuse recoverers
- Persons with AIDS
- Battered women and families
- Developmentally disabled
- Mentally ill
- Low-income families

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public, as well as to internal staff. Don't spend a lot of money on expensive marketing until the implementation has been tested.

Determine Financial Arrangements

When two or more organizations decide to collaborate, for client service or marketing purposes, the organizations must decide how services will be paid for. Housing and healthcare services are paid for by different sources and different systems (see **Box**), so aligning service payment can be challenging.

A wide array of payment arrangements have been used. One organization can pay the other, either for services or for management functions. Each organization can arrange for clients to bill their insurers directly for services. Clients may pay personally for services. Whatever the terms of the relationship, these should be clearly understood by the staff involved from all organizations, and charges and payment methods must be clearly explained to clients and their families.

Organizations also must be careful to consider regulatory and licensing parameters. For example, under the laws of most states, housing facilities are not permitted to provide health services. An assisted living facility might perceive that its residents need easy access to healthcare, and desire to establish an on-site clinic. In most states, the housing facility's license would prevent it from offering the service directly, including contracting with a hospital or medical group. The housing facilities could offer free space to a hospital to open an outpatient clinic on site. However, in order to be able to bill Medicare or other insurers, the clinic would need to be licensed, and it would need to meet physical plant requirements for health facility clinics in order to obtain the license.

When organizations agree that working together is in the best interests of their clients, financing should not be a deterrent. The way to pay for requisite resources can almost always be found. However, it may take creativity, patience, and persistence to do so. Before implementing a collaborative relationship, itemize the costs of services and payment sources, and analyze the regulatory constraints of each payor. Services should be affordable to the organizations or clients, and billing and payment methods should be kept simple, to promote rather than discourage use. □

MAJOR FUNDING SOURCES FOR HOUSING AND HEALTHCARE SERVICES

Housing	Healthcare
Private Pay	Medicare
HUD Section 8	Medicaid
HUD Section 2	Commercial Insurance
State and county mental health funds	Health Plans
Local public housing authority funds	Workers' Compensation
Ryan White funds	
Medicaid (for assisted living, and limited to a few states)	