Testimony to House Committee on General, Housing and Military Affairs
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Brief description of the SASH model

- Partnership model with locus of support emanating from affordable housing communities.
- Part of Vermont's Blueprint for Health - considered a "community extender."
- SASH Partners include: Area Agencies on Aging, Affordable Housing Organizations, Community Mental Health and Development Services, Home Health Agencies, local hospitals, primary care practices.
- Funded as part of the Blueprint for Health's application for Medicare Demonstration funds (MAPCP Demo) in 2011. The capitated payment from Medicare MAPCP Demonstration for SASH pays for a full-time SASH "care coordinator" and part-time Wellness Nurse to work with a team of designed staff from the partner agencies to serve a panel of up to 100 SASH participants.
- The SASH staff are, with a few exceptions, embedded in subsidized affordable housing properties where some of the highest risk and most costly Vermonters reside.
- The SASH team (one team per 100 participants) meets on a monthly basis with the identified SASH participant and develops goals and action steps to help the participant stay at home, get back to home, etc.
- The SASH model is implemented around the state, in every county and Blueprint Health Service Area with MOUs in place with the applicable community providers organizations and local hospitals.
- SASH Model currently serving approximately 5,000 older adults and persons with disabilities in 54 panels.

Outcome and Indicators within the Act 186 Report Impacted by the SASH Model

<u>Outcome 2 – Vermonters are Healthy</u>

Indicator (B) – percent of adults smoking cigarettes

- SASH assessment includes questions on smoking and direct referral to Quit Line.
- SASH staff work closely with VHD Tobacco Control Program to increase tobacco cessation group programs within SASH hub sites. Several SASH Coordinators trained to lead smoking cessation groups.
- SASH partners with Tobacco Treatment Specialists from Blueprint Community Health Teams to hasten referrals for quitting assistance.

- Increasing Smoke-Free affordable housing campuses was the focus of a 2013-2014 VDH grant to Cathedral Square – implemented in 4 regions of the state through the SASH platform.

Indicator (F) – Rate of Suicide – Suicide rates increase across the age ranges and are highest among those 65 and older. Rates of suicide deaths for Vermonters over 65 has increased from 12.6 per 100,000 in 2008 to 25.5 per 100,000 in 2011.

- SASH is represented on the state's Suicide Prevention Coalition.
- SASH assessment includes validated screens on depression, anxiety and isolation.
- SASH is participating in partnership with Department of Mental Health on Zero Suicide Initiative.

Indicator (G) – Fall-related death per 100,000 adults age 65 and older – Vermont's falls related death rate for 65+ is high compared to national average (129.1 per 100,000 vs. 45.3).

- SASH assessment includes a validated falls risk screen (MACH-10).
- SASH staff track instances of falls within their panel.
- SASH focus on medication management.
- Solid partnership with CVAA - SASH Coordinators trained to lead proven programs that reduce rates of falls including: Tai Chi, Bone Builders, Matter of Balance. Proven reductions in instances of falls (see Outcomes sheet).
- Referral process set up with FallScape program- collaboration between EMS and VDH.

Outcome 7 – Vermont's Elders and People with Disabilities and Mental Conditions Live with Dignity and Independence in the Settings They Prefer

Indicator (A) – rate of reports of abuse and neglect of vulnerable adults

- SASH model provides consistent presence of staff at housing sites charged with building trusting relationships- promote early detection of abuse/neglect.
- SASH team activated for brainstorming/action planning.
- SASH focuses on reducing isolation.

Indicator (B) – percent of elders living in institutions versus home care

- SASH partnership focused squarely on keeping people living in the place they call home.
- Transition support to and from home to hospital or nursing home is a core element of the model.

Indicator (D) – Choices for Care - % in different settings

- SASH model compliments CFC program- helps to fill in gaps.

- SASH team makes referrals for CFC eligibility.
- SASH Wellness Nurse provides information on identified needs and gaps.

Indicator (E) – Number and Percent of adults with severe, persistent mental illness served in different setting.

- Community Mental Health and Developmental Services Organizations (such as Howard Center) are partners in SASH.
- Clinicians from Mental Health organizations attend monthly SASH team meetings.
- Some SASH staff and Partner agency staff are trained in Mental Health First Aid and Wellness Recovery Action Program (WRAP) - both evidence based.
- Regular training to SASH team members on mental health.