



**U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy**

**DESIGN OF A
DEMONSTRATION OF
COORDINATED HOUSING,
HEALTH AND LONG-TERM CARE
SERVICES AND SUPPORTS FOR
LOW-INCOME OLDER ADULTS**

May 2011

Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract between HHS's ASPE/DALTCP and the Lewin Group. Additional funding was provided through Interagency Agreements with the HHS Administration on Aging and the U.S. Department of Housing and Urban Development. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Emily Rosenoff, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Emily.Rosenoff@hhs.gov.

DESIGN OF A DEMONSTRATION OF COORDINATED HOUSING, HEALTH AND LONG-TERM CARE SERVICES AND SUPPORTS FOR LOW-INCOME OLDER ADULTS

The Lewin Group

May 11, 2011

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

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I. OVERVIEW

In 2011, as the baby boomers begin to reach age of 65, their preference to remain as independent for as long as possible and to “age in their communities” underpins the conceptual framework for housing with services for older adults presented here. Consistent with the U.S. Department of Health and Human Services’ (HHS’) Vision and Strategic Framework on Multiple Chronic Conditions¹ policymakers, housing and services providers, elderly consumers and their families increasingly embrace person-centered, holistic and cost-effective approaches to addressing the needs of vulnerable low and modest-income older adults. The person-centered philosophy places the elderly individual (and family where available) squarely in the center of the local health and long-term care delivery system and recognizes that the quality of the larger physical and social environment within which an individual lives (including shelter) significantly influence one’s health and quality of life.

Building on over two decades of efforts to increase access to home and community-based services (HCBS), the Patient Protection and Affordable Care Act (ACA) further expands primarily Medicaid-funded options, providing unique opportunities for exploring how housing with services models may be efficient ways of serving large numbers of lower-income older adults. The Money Follows the Person demonstration that seeks to transition nursing home residents to the community has identified the lack of service-enriched affordable housing as one of the demonstration’s major barriers (O’Malley-Watts, 2011). The U.S. Department of Housing and Urban Development (HUD) also recognizes the important role of services in helping its elderly housing residents to remain safely in their apartments. HUD’s recent policies emphasize aligning new Section 202 developments with health care reform efforts at the state and federal levels to better support elderly as they age in place in the community.

Acknowledging the lack of service coordination and integration for Medicare and Medicaid beneficiaries--particularly those with multiple chronic conditions and functional problems--the ACA established several new offices within the Centers for Medicare and Medicaid Services (CMS) to develop and oversee a range of payment and service reform demonstrations and programs (Accountable Care Organizations [ACOs]/Shared Saving Program, Medicaid Health Home) that test new approaches to reducing fragmentation and excessive costs. These new options offer unique opportunities to explore the role of affordable housing with services in achieving the goals and objectives of these initiatives. The American Recovery and Reinvestment Act provides additional sources of support for the delivery of evidence-based prevention services to low-income elderly residents of publicly subsidized housing and those living in close proximity to these properties (Stone, 2011).

¹ See http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf.

In sum, the conceptual framework offered here that will guide the design of affordable housing with services for older adults demonstration options recognizes the increasing adoption of a person-centered philosophy of service delivery and the desire of most individuals and their families to “age in place”. The models that ultimately emerge from this project should build on these trends and the federal and state policy initiatives currently underway to reform health care and housing for low-income older adults.

II. PURPOSE

The HHS Office of the Assistant Secretary for Planning and Evaluation's Office of Disability, Aging and Long-Term Care Policy, in partnership with HUD and the Administration on Aging, engaged the Lewin Group and its sub-contractors, Leading Age Center for Applied Research, The Moran Company, and Mary Harahan, to develop design options for a demonstration of targeted, coordinated housing, health and long-term care services and supports for low-income older adults. This paper presents the conceptual framework for the demonstration design, developed to guide the project by:

- Outlining the policy problem the demonstration would address.
- Describing the demonstration goals and expected outcomes.
- Describing the broad parameters of the demonstration.
- Introducing two alternative approaches to targeting demonstration interventions and their advantages and disadvantages.
- Describing current practices and anticipated components the demonstration may rely upon.
- Specifying the research and practice questions the demonstration would seek to answer.

III. DEFINITION OF THE POLICY PROBLEM

A large and rapidly expanding pool of low and modest-income seniors face the dual challenges of finding affordable and safe housing that can also accommodate changing needs as they grow older. Millions of older adults who rent or own their own homes face excessive housing costs and/or live in housing with serious physical problems. Data² from the 2009 American Housing Survey (AHS) show that about 1.8 million very low-income older adults (incomes of 50% or less of the area median income) pay more than half their income for rent and/or live in substandard housing. Another 1.3 million elderly renters live in publicly subsidized housing. As they age, an increasing proportion of these seniors experience chronic health problems and/or disabling physical, cognitive and mental health conditions (Vladeck, Segel, Oberlink, Gursen & Rudin, 2010).

The current system of multiple payers--primarily Medicare and Medicaid provide few incentives for primary, acute and chronic care providers to collaborate with each other, let alone cooperate with low-income housing or aging and long-term care services providers. As a result, when many older adults most need integrated services; they experience a highly fragmented and poorly coordinated services system with often devastating consequences. The ability of older adults with chronic conditions and/or significant disability to continue living independently may be cut short, their health and safety compromised, and public and private health and long-term care costs may skyrocket as a result of premature transfers to more expensive nursing homes and residential care facilities, repeated trips by emergency medical technicians to an individual's home, repeated trips to hospital emergency rooms (ERs), and frequent hospitalizations.

The aging of the baby boomers will increase the already high demand for affordable housing that incorporates health and long-term care supports. ***A potential policy approach to helping meet this demand involves capitalizing on independent, publicly assisted rental housing, largely unlicensed, multi-unit apartment buildings exclusively designated for seniors, or rental properties where large numbers of seniors now live. Such housing could act as a platform for purposefully organizing a system of coordinated health and long-term care services and supports for residents as well as similar poor and modest-income seniors in the surrounding community. Innovative housing providers across the country working with community agencies have, at their own initiative, developed many prototypes of affordable housing with services strategies to assist residents as they age.*** While significant research has been conducted on the benefits

² Calculations are based on U.S. Bureau of the Census and HUD. AHS National Dataset 2009. Substandard housing is defined as Moderately or Severely Substandard as measured by the AHS ZADEQ variable. Elderly is defined as 65 or older.

of supportive housing environments for vulnerable, low-income populations such as the homeless, limited research has focused on the outcomes associated with subsidized senior housing linked to services. The evidence base that has accumulated remains equivocal (Rabins, Black, Roca, et al., 2000; Ficke & Berkowitz, 1999; Harahan, Sanders & Stone 2006a; Castle, 2008; Golant, Parsons & Boling, 2010).

IV. RATIONALE FOR A NEW AFFORDABLE HOUSING WITH SERVICES DEMONSTRATION

Several converging factors might influence policymakers, housing providers, service and support providers and older adults themselves to carefully examine integrating services into an affordable housing platform. Numerous publicly assisted housing properties offer:

1. A concentration of older adults, many of whom experience multiple chronic illnesses and functional impairment, creating potential economies of scale for preventive, primary and long-term services and support providers.
2. Existing infrastructure that facilitates offering care coordination and onsite health services, such as physically accessible properties, common space available for the co-location of health services, and the presence of a service coordinator.

For a demonstration to succeed and sustain itself, each of the major stakeholders must find value in the model.

- **Federal and state health policy officials** increasingly focus on care patterns of high-cost patients who experience repeat ER visits and hospital stays as a potential avenue to battle rising health care costs. Introducing evidenced-based interventions to residents of subsidized housing may improve the health of community residents and lower health care costs.
- Anticipated Medicare payment reforms and Medicaid revenue opportunities will incentivize preventive, primary, **acute, and long-term services and supports providers** to combine forces to improve the care provided to individuals with high health care spending as a result of the current system fragmentation.
- An aging resident base and the accompanying increase in chronic illness and disability of resident may compel **sponsors and managers of publicly assisted housing** to consider greater service integration. From the perspective of the property owner or manager, partnering with health and social service providers may assist in reducing accidents, injuries and resident calls to 911; make it easier for the property to comply with fair housing rules and Olmstead requirements; improve resident transitions between the property and hospital and rehabilitation settings; improve resident and family security and satisfaction while maximizing resident autonomy; improve safety for all residents and reduce complaints about individuals “too sick” to live there; reduce housekeeping and maintenance costs; reduce turnover and evictions; and enhance the properties image in the community and, as a consequence, become an effective marketing tool.

- Affordable and accessible senior rental complexes, purposely organized to provided health and long-term care services and supports, may enable **low-income seniors** to retain the autonomy their desire in an independent living setting with care available as needed.

V. POLICY AND PRACTICE QUESTIONS

The demonstration is intended to answer the following policy and practice questions:

1. Can independent affordable senior housing (largely subsidized congregate apartment buildings) serve as an effective platform for meeting the health and long-term care services and support needs of low-income older residents (62+) as well as some proportion of similar individuals who live in the surrounding community?
2. What housing with services models result in the best outcomes?
3. Do targeting specific groups of residents maximize the chances that the above outcomes will be achieved?
4. What capacity, infrastructure and resources must be present in housing providers and their partners, and in the communities in which sites are located to maximize the demonstrations success?
5. To what extent can demonstration sites rely on existing federal and state data sources to identify potential demonstration sites and participants? What is the role of the government in making data available?
6. What rules promulgated by HUD, local housing authorities and finance agencies, and sponsors and owners (fair housing rules, restrictions on services coordinator roles and responsibilities; financing for services coordination, common space, and building/apartment accessibility features; allowing residents to have live-in help; etc.) are major barriers to implementing the proposed design and can they be accommodated? Some of these issues may be defined in the Housing Quality Standards (HQS), see: <http://www.hud.gov/offices/adm/hudclips/guidebooks/7420.10G/7420g10GUID.pdf> for the future, perhaps some of the accessibility features can be added to the HQS.
7. What federal and state health and human service policies and/or regulations are impediments to demonstration implementation and how can they be overcome (e.g., state licensing requirements for congregate settings providing health services and or serving frail residents; federal privacy rules; barriers to integrating services for dual eligible; etc.).

8. What other barriers to the demonstration must be addressed (e.g., insurance liability concerns/costs; local fire and safety ordinances). What types of properties do they impact and how can they be overcome.

VI. KEY OUTCOMES OF INTEREST

The demonstration could examine both structural/system and individual outcomes, such as the following:

A. Structural/System Outcomes

- Improve services efficiency and coordination between affordable housing and health and long-term care providers and settings, particularly for high risk, medically complex and chronically disabled elders.
- Improve physical accessibility of housing and help maintaining the physical property.
- Lower Medicare and Medicaid costs.
- Assist properties to comply with Fair Housing rules.
- Assist states in complying with Olmstead regulations and implementing health care reform and rebalancing efforts, including Money Follows the Person.
- Promote the growth of accessible affordable independent housing for lower-income older adults.

B. Resident Outcome

- Enable low-income residents of affordable independent senior housing, as well as residents in the surrounding community to remain healthy and functionally able for as long as possible.
- Improve resident (both housing property and larger community) safety, quality of life and quality of care.
- Reduce resident turnover and evictions.
- Increase and improve the types and comprehensiveness of services residents receive.

- Reduce unnecessary hospitalizations, use of ER services, and limit or reduce unnecessary transfers to facility-based models of care (e.g., assisted living, nursing homes).

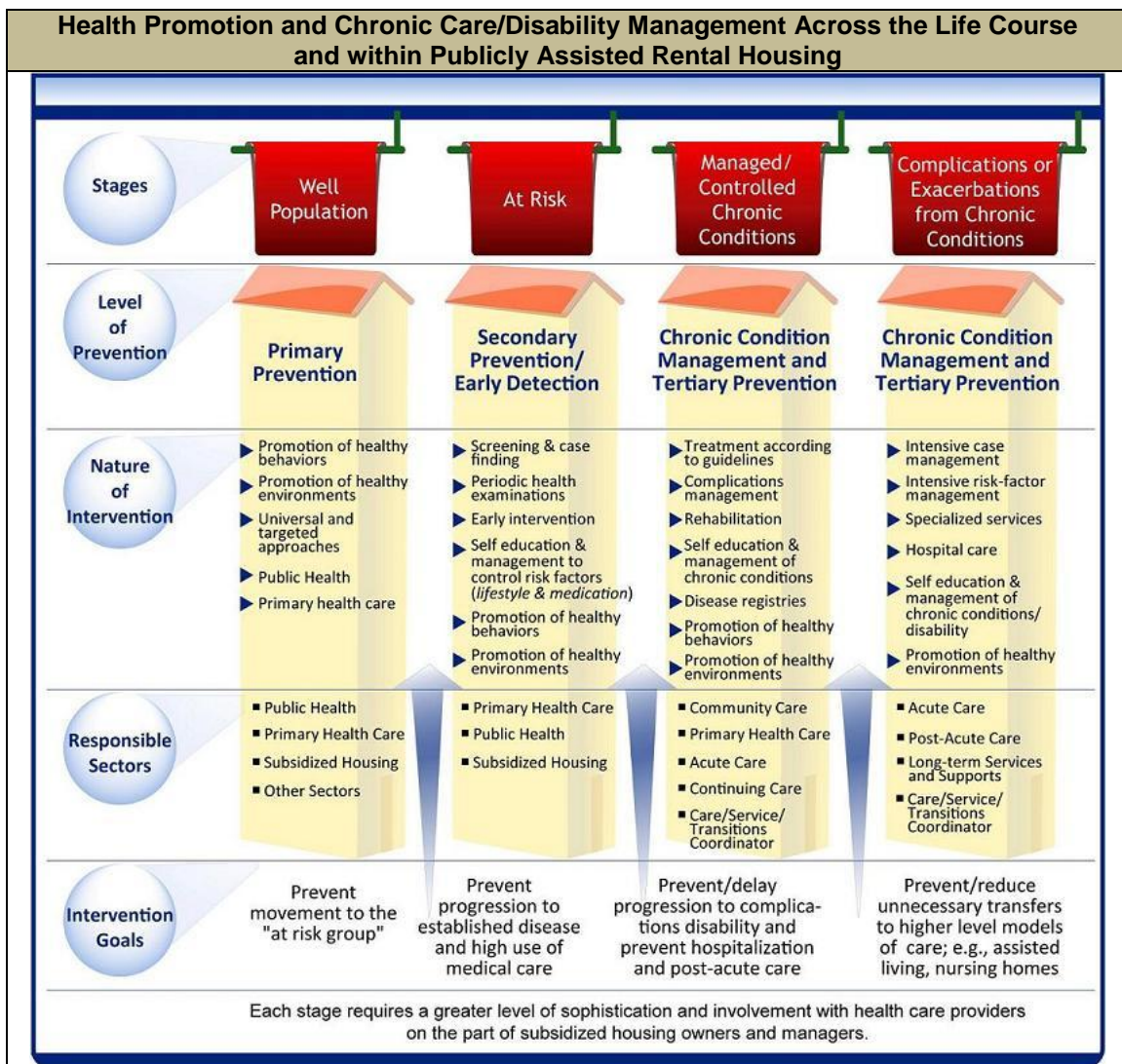
C. Target Population

The demonstration will target low and modest-income older adults who qualify for federal housing subsidies, including senior residents of Section 202 properties, public housing, seniors who obtain housing through Section 8 vouchers and older adults living in Low-Income Housing Tax Credit (LIHTC) properties. Seniors with similar income characteristics living in close proximity to participating housing properties will also be recruited into the demonstrations. Within this broad population, the design team is considering the advantages and disadvantages of targeting some or all of the following types of sub-groups, dependent upon the service delivery model selected:

- Individuals with modest activity of daily living (ADL)/instrumental activity of daily living (IADL) impairments at risk for falls, medication mismanagement, etc.
- Individuals with multiple chronic diseases and significant disability.
- High Medicare spenders.
- Healthy/well older adults who may benefit from preventative and wellness services.

VII. POTENTIAL TARGETING AND SERVICES DELIVERY MODELS

Service delivery models could take numerous forms and focus on interventions at different points in a chronic health conditions/disability stage continuum. A more public health oriented model would target all low-income older adults in participating properties and the surrounding community with the goal of improving the health and quality of life of all, while a risk-based model would target resources to a smaller subset of high risk seniors. The demonstration could examine the relative cost efficiencies, benefits, and implementation considerations of broader and narrower models.



A decision point in terms of the service delivery models for the demonstration will be the extent to which they focus on integration of services across settings and systems. While there is no consensus on the definition of “integration,” key elements typically include: (1) broad and flexible benefits; (2) far-reaching delivery systems that include community-based long-term care and care management; (3) adoption of mechanisms that really integrate care (e.g., care planning protocols, interdisciplinary care teams, integrated information systems); (4) overarching quality-control systems with a single point of accountability; and (5) flexible funding streams with incentives to integrate dollars and minimize cost shifting (Stone 2011).

A. Examples of a Public Health Model within Subsidized Housing

The public health model would incorporate a full range of primary, acute, chronic care and long-term care services and support. Services organization and delivery could be based in and managed by a single free standing housing property or the corporate owner/sponsor of multiple housing properties within a region or within a nearby community agency such as a federally qualified health center, area agency on aging (AAA), physician practice designated as a medical home, health plan or a local public health department. The housing property and property service coordinator would be an instrumental part of the partnership. The housing provider would provide space, contribute to or manage the screening and assessment of potential participants, help to negotiate agreements with community providers, facilitate onsite visits for other partners and assist in monitoring services delivery and quality.

The public health model would be anchored in communities with high concentrations of low-income seniors and subsidized senior housing properties with a sufficient volume of elderly residents to have some possibility of showing cost-effectiveness for Medicare and Medicaid programs, the service delivery system and for the payers. The model targets all low-income older adults in participating properties and the surrounding community with the goal of improving the health and quality of life of all. Participants could include:

- Healthier older adults who might benefit from preventative and wellness services such as health education, blood pressure and glucose monitoring, exercise classes, etc.
- More at risk individuals who are growing older and more frail and are therefore more subject to illness and injury.
- Special populations who have multiple chronic conditions, severe behavioral health issues and/or significant disabilities and are at high risk for repeat ER or hospital visits, falls, etc.
- While recognizing the entire elderly resident population as the target, models within the public health approach could run the gamut from modest interventions

addressing the prevention, psycho-social and chronic care needs of select individuals within the properties and adjacent community to fully integrated programs that address the entire range of medical and social needs of the resident and adjacent community population.

Examples of existing programs³ that illustrate this model include:

- **Lapham Park**, Milwaukee, WI--Lapham Park is a senior-designated public housing property that provides a continuum of onsite services through a group of community partners to address residents' preventative, acute, and long-term health care needs. St. Mary's Family Practice Clinic offers physician care to all residents. Community Care Organization, which operates a Program for All Inclusive Care for the Elderly (PACE) program, provides acute, primary, specialty and long-term care for nursing home eligible residents enrolled in its capitated program. The Milwaukee County Department on Aging provides a congregate meal site. Multiple other community partners provide additional wellness programming. S.E.T. Ministry provides case management services.
- **Seniors Aging Safely at Home (SASH)**, Burlington, VT--SASH is a care management model that helps coordinate health and long-term care services for residents in affordable senior housing properties and individuals in the surrounding communities. The core of the model is a full-time SASH coordinator employed by the housing property, who coordinates a team of community service providers including a home health agency nurse assigned to the site, an AAA case manager, a community mental health provider, representatives of other HCBS providers (such as PACE). A "health aging plan" is developed with all residents who choose to participate and the SASH coordinator assists in coordinating with the community partners to facilitate the plan.
- **Mable Howard Apartments**, Oakland, CA--A community health center and PACE program adult day health center, co-located with a low-income senior housing community, provides the opportunity for residents to age in place. Residents get benefit of a full range of services from less intensive, flexible services from the health center to full medical and long-term care benefits in a managed care plan. The health center is a federally funded Qualified Community Health Center. It provides preventative care, primary care and case management, including mental health services, podiatry, dental care, health education and screening, physical therapy, and links to home health services. The PACE program provides nursing home eligible residents access to comprehensive medical, social and long-term care services under a capitated system of reimbursement in an onsite adult day health center. PACE staff provide care in the residents own apartment as needed.

³ As part of the overall project, site visits to all of these programs are being conducted.

B. Examples of a Risk-Based Model within Subsidized Housing

The risk-based model also requires communities with high volume of low-income older adults in affordable housing properties. In this case however, community selection would take into account other criteria as well such as higher than average clusters of very old (85+) and/or chronically ill older adults. The model could target services to one or more of the following types of high risk seniors which are not mutually exclusive:

- Dual eligible who are high users of Medicaid and Medicare services.
- Individuals with three or more chronic illnesses.
- Those at risk of nursing home entry for an extended stay because of cognitive and or physical impairments (e.g., multiple ADLs).
- Individuals with significant behavioral health issues.
- The top 5% or 10% of Medicare spenders.

Services organization and delivery is more likely to be managed by an entity outside the housing property⁴ such as a health plan, primary care practice, community mental health center, medical home or ACO for three primary reasons:

1. A lack of capacity of most housing providers to manage the high level of care required.
2. Service organization and delivery and most property owners or managers are leery of the regulatory requirements of being licensed as a health care provider.
3. Properties often do not have enough volume to support the business model--they need an outside entity that has a larger population (Stone, 2011).

Examples of current strategies⁵ illustrating this model include:

- **The Marvin**, Norwalk, CT--The Marvin operates Connecticut's Congregate Housing for the Elderly Program, which is a state subsidized program for low-income elders who have temporary or periodic difficulties with one or more essential ADLs. Residents pay a minimum rent and a congregate service charge, which is based on their adjusted income. The state provides a subsidy for residents who cannot afford to pay the full cost of the service program. Services include housekeeping, emergency call systems in each room, 24-hour security, community, meals social and recreational activities, wellness/prevention

⁴ However, the service providers could be co-located within the housing property.

⁵ As part of the overall project, site visits to all of these programs are being conducted.

programs and emergency transportation. The Marvin also participates in the state's assisted living services program. Under this program, the Marvin provides an onsite nurse (hours depending on needs and number of participants; on-call nurse (24 hours/day); personal services including hands-on assistance with daily activities including, but not limited to: dressing, grooming, bathing, using the toilet, transferring, walking, and eating; and additional core services may be provided including housekeeping, personal laundry and meal preparation. Assisted living services are provided through the Connecticut Home Care Program for Elders program and paid for through either a Medicaid waiver or a state-funded component (for persons whose income exceeds the Medicaid waiver limits).

- ***Just for Us***, Durham, NC--Just for Us is collaboration between the Duke University Medical Center Division of Community Health, the Lincoln Community Health Center (Durham's federally qualified community health center), the Durham County Department of Social Services, the Durham County Health Department, the Council on Senior Citizens, and the City of Durham Housing Authority. Collaborating agencies operate under a single administrative structure managed by Duke Community Health under contract with Lincoln Community Health Center. The program targets low-income seniors and disabled adults with multiple chronic conditions who are homebound and cannot access health and medical care on their own without great difficulty. Just for Us provides patients with annual physical examinations, consistent monitoring and treatment of chronic medical conditions, treatment of acute care needs that can be treated at home, lab tests and patient health education. Patients receive routine visits from the physician or physician assistant every 6-8 weeks, or more often when their medical condition warrants. Patients with specific needs may also be seen by a nutritionist (particularly diabetic patients) or occupational therapist. A social worker provides case management and helps patient apply for benefits, such as food stamps and Medicaid, and access supportive services, such as Meals on Wheels and home health aides (most of the housing properties served by the program do not have a service coordinator). The program can also help arrange mental health services.

VIII. POTENTIAL SELECTION CRITERIA FOR DEMONSTRATION COMMUNITIES

The following could serve as potential selection criteria for demonstration communities:

- Large numbers of older adults living in subsidized housing.
- Large numbers of older adults whose incomes would qualify them to live in subsidized housing in close proximity to subsidized senior housing.
- Strong network of aging services and medical care providers with a history of working together.
- High proportion of seniors with chronic health conditions, frequent use of health care providers and disabilities/impairments.
- Communities in states with a commitment to flexible spending for HCBS.
- Communities in states where the housing and services agencies have some experience working together and/or there is evidence of a commitment to affordable senior housing.
- Communities that are taking advantage of ACA and other demonstration opportunities (e.g., ACOs, medical or health homes, transitional care demonstrations, independence at home, etc.).

IX. FUNDAMENTAL DEMONSTRATION DESIGN/RESEARCH CONSIDERATIONS

In developing a demonstration to examine the outcomes and impact of integrating a range of services into subsidized housing, a number of fundamental design considerations outlined below need to be addressed. **Appendix A** provides practical examples relevant to each of the areas below.

A. Type of Evaluation

- Should the demonstration be designed to allow for a randomized experiment? Treatment/control studies? Formative versus summative evaluation?
- Should the demonstration design aim for multiple tests of a single model or should the design allow for multiple models that could be implemented by sites with varying resources and capacities? In other words, should a standardized intervention be implemented across sites or should the demonstration build upon existing models/practices?

B. Selection of Demonstration Sites

- What volume of participants will be required in each demonstration site, within each model proposed to be tested, and in the overall demonstration to assure that it can be evaluated?
- What volume is necessary to make the design affordable and sustainable?
- Will the demonstration provide the infrastructure for data collection or will having assessment and management information systems be a requirement for site selection?

C. Identification of Target Population

- What targeting models, and associated practices, staffing and data are most likely to be effective, least costly and easily replicable for identifying the target population, enrolling them in the demonstration, and producing desired outcomes?

- What are the trade-offs between focusing exclusively on a high risk/cost group versus using a public health approach that serves a broader population with tiered interventions?
- What enrollment incentives need to exist for program participants?

D. Assessment of Participant Service Needs

- What assessment and care management functions/practices are most likely to be effective, least costly and easily replicable for determining need/preferences and for coordinating services?
- Should all demonstration participants be assessed, have a care plan and be followed up over time or only a subset?
- How frequently must participants be assessed?
- Should the demonstration aim for a standardized assessment tool or a more variable tool based the preferences and experience of participating housing providers, community partners and the state policy context?
- Should there be a core of assessment questions required of all demonstration sites and if so what are they?

E. Delivery Models for the Integration/Management/Coordination of Acute, Chronic, Primary and Long-Term Services and Supports

- What role do service coordinators/case managers need to play in order to achieve the desired outcomes?
- What qualifications and training for service coordinators/case managers are necessary?
- What services must be present and available to the demonstration participants? Will it be the same across the demonstration or will it vary and if so how?
- Are the logistical aspects of a public health approach feasible within a housing setting?
- What are the advantages and disadvantages of health or social services providers taking the lead versus housing providers taking the lead in the organization and delivery of acute, chronic, primary and long-term service and supports?

F. Resource Development/Financing Schemes

- What payment mechanism will provide proper incentives for provider participation, effective service coordination, and appropriate service provision?
- Can any of the ACA provisions be used to support such a model (e.g., health homes, ACOs)?

G. Quality Improvement/Performance Measurement and Accountability

- What monitoring/quality improvement strategies should be built into the assessment/care management/services delivery/services coordination functions? Should these be required to be the same across sites or build upon existing practices?
- How should concerns about quality and safety be addressed in light of resident rights to autonomy in their own apartments?
- What outcomes will indicate success?

BIBLIOGRAPHY

- Castle, NG. 2008. "Service enriched housing and senior living enhancement program" *Journal of Housing for the Elderly*, 22(3): 263-278.
- Cohen, R. 2010. "Connecting Residents of Subsidized Housing with Mainstream Supportive Services: Challenges and Recommendations." Washington, DC: The Urban Institute. Retrieved from: <http://www.urban.org/UploadedPDF/1001490-Subsidized-Housing.pdf>.
- Ficke, RC, and Berkowitz, S. 1999. Evaluation of the HOPE for Elderly Independence Demonstration: Final Report. Prepared for the Office of Policy Development and Research, U.S. Department of Housing and Urban Development.
- Golant, SM, Parsons, P, and Boling, PA. 2010. "Assessing the quality of care found in affordable clustered housing-care arrangements: Key to informing public policy." *Cityscape*, 12(2): 5-28.
- Harahan, M, Sanders, A, and Stone, R. 2006a. Inventory of Affordable Housing Plus Services Initiatives for Low and Modest-Income Seniors. Prepared for the Office of Disability, Aging and Long-Term Care Policy, U.S. Department of Health and Human Services. Available at: <http://aspe.hhs.gov/daltcp/reports/2006/ahpsinv.htm>.
- Harahan, M, Sanders, A, and Stone, R. 2006b. "Linking affordable housing with services: A long-term care options for low- and modest-income seniors." *Seniors Housing & Care Journal*, 14(1): 35-46.
- O'Malley-Watts, M. 2011. Money Follows the Person: A 2010 Snapshot. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Retrieved from: <http://www.kff.org/medicaid/8142.cfm>.
- Rabins, PV, Black BS, Roca, R, German, P, McGuire, M, Robbins, B, Rye, R, and Brant, L. 2000. "Effectiveness of a nurse-based outreach program for identifying and treating psychiatric illness in the elderly." *JAMA: The Journal of the American Medical Association*, 283(31): 2802-9.
- Stone, R. (in press). 2011. "Models of service delivery." Chapter 6 in *The Fundamentals of Long-Term Care*. Washington, DC: The Urban Institute Press.
- Vladeck, F, Segel, R, Oberlink, M, Gursen, MD, and Rudin, D. 2010. "Health indicators: A proactive and systematic approach to healthy aging." *Cityscape*, 12(2): 67.

APPENDIX A: EXAMPLES OF RELEVANT EXISTING PRACTICES

In order to ground the fundamental demonstration design and research considerations outlined in Chapter IX, this Appendix provides examples of relevant existing practices or other operational aspects related to the basic elements of the intervention, and how they might work to produce desired outcomes. Examples in each area were drawn from the literature and current experience.

Demonstration Design/ Research Considerations	Relevant Existing Practices
Type of Evaluation--Degree of standardization	<ul style="list-style-type: none"> • Channeling demonstration used randomized controlled design had a uniform service package, both basic and complex models, an assessment and case management approach defined by the government so there was consistency across sites. • Cash and Counseling demonstration used randomized controlled design and standard intervention frameworks, but relied upon existing practices for assessment, service packages and service coordination. • Medicare Care Coordination demonstration used randomized controlled design, but allowed each demonstration site to implement its own service coordination model. • Better Jobs Better Care demonstration targeted changes in policy and practice that focused on recruitment and retention of direct care workers. The applied research and evaluation program focused on workplace and public policy that addressed recruitment and retention of direct care workers.
Selection of Demonstration Sites	<ul style="list-style-type: none"> • Identifying candidate communities and subsidized housing--Census data could be used to identify urban areas with higher than average concentrations of older adults. HUD and State Housing Agency administrative data could then be employed to identify within these census tracts communities where there are clusters of HUD subsidized senior housing and LIHTC properties located in close proximity to one another. By combining data from HUD administrative files with data available in the CMS Chronic Condition Warehouse, which includes Medicare and Medicaid enrollment and claims, and assessment data based on Outcome and Assessment Information Set for Medicare home health recipients, the characteristics of housing residents and residents of the surrounding community can be analyzed and compared. Other tools for assessing the health status of older adults could include the use of public health surveillance strategies, public health records and other tools. • Determining necessary volume--Volume of individuals in the demonstration will be a consideration from two aspects: (1) power requirements necessary to detect a particular impact; and (2) implications for a business model in the real world.

Demonstration Design/ Research Considerations	Relevant Existing Practices
Selection of Demonstration Sites <i>(continued)</i>	<ul style="list-style-type: none"> • Existing management information systems--Most housing properties do not use electronic assessments, although a few may have electronic care management systems, but these are often not standardized. Community-based organizations have varying degrees of electronic assessment and participant tracking, which are often based on the state's Medicaid HCBS waiver system requirements. Increasingly, health care providers have adopted electronic health records and some communities are standardizing protocols for the exchange of health information across providers, some even including community-based organizations.
Identification of Target Population	<ul style="list-style-type: none"> • Soliciting referrals from community providers of individuals who meet the risk criteria. • Predictive modeling techniques could be developed based on data from public health records and or Medicare/Medicaid claims to identify high risk residents. • Residents of the housing property could be asked to complete a short assessment of their health status and services needs.
Assessment of Participant Service Needs	<ul style="list-style-type: none"> • Candidate tools for assessing participant needs include: the CARE Tool under development for CMS, state assessment tools for Medicaid HCBS, the Minimum Data Set Resident Assessment Instrument. Alternatively, the housing property could develop its own assessment tool and processes.
Potential Delivery and Financing Models	<ul style="list-style-type: none"> • Models that integrate health and long-term care services to varying degrees (e.g., PACE program, Evercare, Arizona's Medicaid Managed Care Program, Minnesota's Senior Health Options, Massachusetts's SHO program). • ACA models which attempt to link integrated care delivery with payment incentives that encourage providers to collaborate with one another to improve patient care and reduce costs--"Medicaid Health Homes," ACOs, and the Independence at Home Demonstration. • Standardized integrated care models (e.g., Guided Care developed by researchers at Johns Hopkins (Dr. Chad Boulton), the GRACE model developed by Dr. Steve Counsel, the Care Transitions Program led by Dr. Eric Coleman, and the Transitional Care Model developed by Dr. Mary Naylor). • Necessary core services--Core services might include a needs assessment, case management (at least for high risk participants); access to primary care and chronic care management (possibly onsite), transportation for medical appointments, housekeeping and social services, personal care, medication management, behavioral health services, and health and wellness services. Such services would be offered to residents on a voluntary basis and delivered in increments that meet need and maximize efficiency. Access to assistance on a 24/7 basis for emergencies may also be crucial to maintaining resident safety and reducing the revolving door between the ER and a resident's apartment (e.g., PACE or health plan help line). Whether that could be delivered by an offsite agency or must be present in-house is a question for the design team. Some integrated care models also rely on enhancing patient self-care and "health coaches"--non-professional staff who can work with individual participants on health issues.

Demonstration Design/ Research Considerations	Relevant Existing Practices
Potential Delivery and Financing Models (<i>continued</i>)	<ul style="list-style-type: none"> • Lead agency--A variety of organizations, including the housing property itself, could manage and implement the demonstration. However, there may only be handful of housing sponsors and properties which are large enough or have sufficient capacity to act as the lead agency (e.g., Good Samaritan, Presbyterian Homes and Services, Mercy Housing). All participating housing properties would at a minimum need an onsite service coordinator dedicated to recruiting and assessing residents for participation, providing information and referral, acting as an intermediary to the provider network, assisting with services planning and arrangement, monitoring implementation and providing feedback for quality improvement purposes. Other candidates for lead agency might include the local Area Agency on Aging, a community health center, a Special Needs Health Plan, and a multidisciplinary physician group (medical house calls programs, medical homes) etc. • Formal and informal strategies for service delivery--Multiple and diverse strategies have been used in the past to staff a housing with services program and to link resident to needed services. Some housing properties have onsite staff including service coordinators who help residents identify needs and locate services, and nurses who operate a wellness clinic providing health education and preventative services. Other properties negotiate informal and formal agreements with local hospitals, community health centers or physician practices so that nurses, nurse practitioners and geriatricians come to the property at regularly scheduled times. Agreements have also been formalized between the property and academic health centers so that students can carry out clinical rotations and provides needed health services. Some properties co-locate services such as a PACE site, adult day care center, senior center or physician office to bring selected services to residents. Others recruit volunteers and other trained lay people from the property or the community to assist residents with managing their health issues. In some cases, housing properties are part of a larger campus that includes an assisted living facility and/or nursing home to provide more nighttime coverage or provide additional services such as personal care. A few properties own and operate licensed home health agencies that serve residents and the broader community, while some others partner with home health agencies to negotiate more affordable rates for homemaker and personal care services. (Harahan, Sanders & Stone, 2006b; Golant, Parsons & Boling, 2010). Achieving a comprehensive and integrated system of care for property residents is likely to require stronger, more formal relationships between health care providers and the housing property than has been previously implemented in housing with services programs.
Resource Development/ Financing Schemes	<ul style="list-style-type: none"> • Program funding: (1) for program development, staffing, infrastructure and services not covered through Medicaid or Medicare because many residents are not eligible for Medicaid-funded HCBS and Medicare does not currently pay for comprehensive service coordination; (2) to augment a housing properties' services coordinator with a full-time nurse or social worker; and (3) to design, implement and manage data systems to track performance.

Demonstration Design/ Research Considerations	Relevant Existing Practices
Resource Development/ Financing Schemes (<i>continued</i>)	<ul style="list-style-type: none"> • Modifying existing policies and regulations: (1) Changing HUD rules to allow properties to identify a select number of services as a budget line item within their operating budget. Specific services could be required based on their demonstrated effectiveness to improve resident outcomes/lower cost. (2) Allowing properties under common ownership to pool residual receipts, reserves and excess cash flows (while assuring an adequate amount of reserves for all properties) and direct them to where they are most needed to strengthen resident services. (3) Making it easier to use residual receipts for resident services by clarifying HUD policy. (The Section 202 reform bill recently passed does clarify that unexpended funds from refinancing proceeds and residual receipts can be used for services). Although this may provide housing providers with more flexibility to pay for services, it is unlikely to generate enough revenue to support a services program. (Cohen, 2010). (4) Develop a new waiver that allows housing properties to combine housing and services resources as long as it is in the aggregate less costly than current practice. • Creating targeting incentives--Reward developers/sponsors for targeting older adults with services needs and insuring that needed services are available to them. For example, in cases where the developer agrees to admit a certain proportion of residents based on predictors of health risk and high health and long-term care costs, new Section 202 Housing for the Elderly awards and the allocation of LIHTC designated for seniors could include a bonus, part of which would go to the developer and part to fund services. This approach is similar to the new 811 Program under the Melville Act. • Giving preference in admissions--to high risk seniors identified by Medicaid HCBS providers, physicians groups, VA hospitals and clinics, and other community agencies in return for their willingness to guarantee an appropriate services package to the prospective resident. • Providing partnering incentives--to large housing sponsors with multiple properties to become stakeholders in the growing number of health care organization and delivery models such as medical homes, ACOs, and Medicare Special Needs Plans. Housing sponsors could be given a special bonus to be designated for gap filling services in return for their participation. Good Samaritan, Presbyterian Homes and Services and Mercy Housing likely have sufficient resident volume to be attractive to these health care delivery plans. Cathedral Square in Vermont is part of the shared savings activity in the Medicare Medical Home Demo.
Quality Improvement/ Performance Measurement and Accountability	<ul style="list-style-type: none"> • The Health Indicators in Naturally Occurring Retirement Community (NORC) Programs initiative has developed promising quality improvement strategies and tools to help NORC providers identify and manage the care of NORC residents most at risk, focusing on heart disease, diabetes and increased risk of falls. Standards of Practice which reflect best practices and clinical guidelines in self-care, medical care and community supports have been developed which include detailed measures relating to each standard (Vladeck, et al., 2010). The COLLAGE effort (Kendall and Hebrew Senior Life program) is trying to collect standardized data across participating housing properties to use for benchmarking and accountability.

DESIGN OF A DEMONSTRATION OF COORDINATED HOUSING, HEALTH AND LONG-TERM CARE SERVICES AND SUPPORTS FOR LOW INCOME OLDER ADULTS

Reports Available

Design of a Demonstration of Coordinated Housing, Health and Long-Term Care
Services and Supports for Low-Income Older Adults

HTML

<http://aspe.hhs.gov/daltcp/reports/2011/lioaDemo.shtml>

PDF

<http://aspe.hhs.gov/daltcp/reports/2011/lioaDemo.pdf>

The “Value Added” of Linking Publicly Assisted Housing for Low-Income Older Adults
with Enhanced Services: A Literature Syntheses and Environmental Scan

Executive Summary

<http://aspe.hhs.gov/daltcp/reports/2012/ValueAddes.shtml>

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<http://aspe.hhs.gov/daltcp/reports/2012/ValueAdd.shtml>

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