U.S. Department of Housing and Urban Development
Office of Policy Development and Research

Report to Congress

Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program

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Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program

Prepared for:
U.S. Department of Housing and Urban Development
Office of Policy Development and Research

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Foreword

HUD serves the low- and very-low income frail elderly in assisted housing. The increase in the number of elderly as well as the aging in place has significant implications for HUD, from the allocation of housing units and services to the formulation of policy that efficiently caters to elderly needs. In response to a Congressional request, HUD studied housing programs which are alternatives to institutionalization or other more restrictive environments.

This report, mandated by the 1990 Cranston-Gonzalez National Affordable Housing Act, summarizes and compares the results of two long-term evaluations of HUD housing programs for seniors: the New Congregate Housing Services Program (CHSP) and the HOPE for Elderly Independence Demonstration Program (HOPE IV). Both these programs, combined rental assistance with case management and supportive services to help low- and very low-income, frail elderly renters enhance their quality of life and remain independent.

A key feature of both programs was the provision of a Service Coordinator who was responsible for designing and implementing case management, coordinating Section 8 and building management activities, and forging relationships with other agencies and community organizations to arrange for the provision of services.

The programs targeted those at risk of being institutionalized, who could be served by delivery of home care or services in a community setting. Both programs served very frail elderly persons - those that are much frailer than non-institutionalized elderly persons in the general population. Despite their frail condition and chronic health problems, the majority of the HOPE IV and CHSP participants took part in activities and enjoyed social contact. Most participants in both programs were satisfied with the services they receive and many credited the programs with making it possible for them to live independently. Both programs were equally successful in prolonging life and forestalling institutionalization.

This research will help the Department develop cost-effective policies to address the complex issues in helping America's growing frail elderly population to live independently outside institutions.

Susan M. Wachter
Assistant Secretary for Policy
Development and Research

Acknowledgements

This report compares the findings from two HUD program evaluations: The HOPE for Elderly Independence Demonstration Program (HOPE IV) and the New Congregate Housing Services Program (CHSP). Westat conducted the HOPE IV evaluation, and Robert Ficke and Susan Berkowitz served as Co-Principal Investigators. The CHSP evaluation was conducted by the Research Triangle Institute, and we acknowledge the considerable effort that Janet Griffith, Project Director, Leslie Stewart, and Angela Green provided in conducting this research.

The two program evaluations and this *Report to Congress* were sponsored by the Office of Policy Development and Research, U.S. Department of Housing and Urban Development. All of these studies benefited greatly from the thoughtful guidance of Priscila Prunella, the Government's Technical Representative, and we appreciate her stewardship throughout the course of these research projects.

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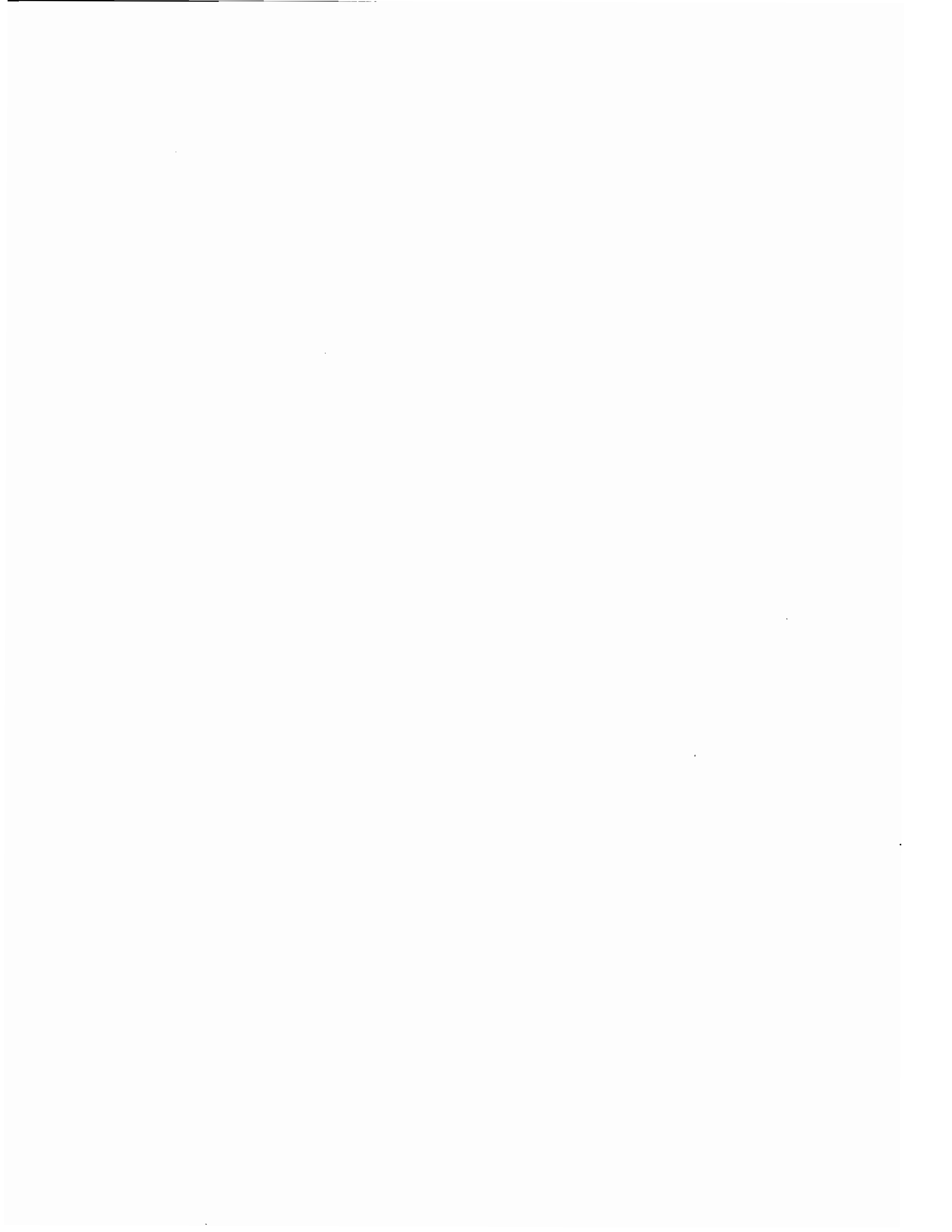

EXECUTIVE SUMMARY

This report compares the effectiveness of providing assistance under the Congregate Housing Services program (CHSP) and the HOPE for Elderly Independence Demonstration (HOPE IV) program as requested in the 1990 Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625). HOPE IV and CHSP combined HUD housing assistance with case management and supportive services for low-income elderly persons (62 and older) with limitations in personal care and home management activities, such as bathing, dressing, and housekeeping.

The purpose of HOPE IV and CHSP was to expand existing housing assistance programs to an elderly population often deprived of access to them due to frailty and to help these participants avoid nursing home placement or other restrictive settings when home and community-based options were appropriate. In addition to the housing assistance, HUD paid 40 percent of the supportive services costs, the grantees paid 50 percent, and participants, except for those with very low incomes, paid 10 percent of total program costs.

HOPE IV funding initially went to 16 public housing agencies in 1993 for projects ranging in size from 25 to 150 persons for a five-year demonstration period. The focus of this evaluation was the first round of HOPE IV awards that HUD made in February 1993 to these agencies. The grants collectively totaled $9.9 million for the supportive services component and an additional $29.6 million for rental assistance. Services were linked to the rental housing Voucher and provided to elderly participants who lived in housing units throughout the grantee's service area. For CHSP, HUD awarded 39 grants in 1993 to fund services in 45 subsidized housing developments. The number of CHSP residents served in these developments ranged from fewer than 10 to more than 100. CHSP services were subsidized through grants to public housing authority buildings, Section 202 projects, and other developments that served frail elderly and disabled residents.

HOPE IV and CHSP were targeted to similar populations of frail elderly, provided many of the same services, offered service coordination, and shared the goal of helping frail elderly persons live independently as long as possible. The major difference between the two programs was that HOPE IV was tenant-based, whereas CHSP was project-based. That is, HOPE IV combined supportive services with rental assistance (Section 8 Vouchers), and the services were provided in the tenants' homes or other community locations. CHSP services were provided in apartment housing developments designated for residency by frail elderly and persons with disabilities and were available to residents who met the program's eligibility requirements. The services were typically delivered in the resident's apartment or in the public areas, such as a dining room or activity area of the development.

Another important difference between the two programs was that HOPE IV participants could not have been receiving HUD housing assistance when they applied, and grantees had to recruit applicants from outside their current programs. CHSP participants, however, came from within existing HUD-assisted congregated housing, and they had often lived there for many years. As this report shows, these differences had a substantial impact on program design and implementation.

A key feature of HOPE IV and CHSP was the establishment of a Service Coordinator position with responsibilities for the design and implementation of a system of case management, personal care, and home management services for the frail elderly tenants and residents. Of particular importance was the coordination of the traditional Section 8 and building management staff activities with the new case management and services components of HOPE IV and CHSP. In addition, the Service Coordinator was

responsible for forging relationships with other agencies and organization in the community, including purchase-of-services arrangements with existing service providers. Supporting the Service Coordinator was a Professional Assessment Committee (PAC) responsible for screening applicants for frailty and ascertaining need for services, in accordance with the HUD HOPE IV and CHSP regulations. The PAC must have included at least one medical professional and others with various health or social services backgrounds.

The following section provides highlights from the HOPE IV and CHSP evaluations and shows the major similarities and differences between the two programs. Throughout this report, various terms are used to describe the housing environments and HUD subsidy programs within which HOPE IV and CHSP operated. These include tenant-based Section 8 and scattered-site rental housing, both of which refer to the HUD Voucher program that pays a portion of the rent and related expenses in private market housing. The terminology also includes congregate housing projects, properties, and developments, all of which refer to HUD-subsidized apartment buildings where CHSP offered case management and supportive services.

Overview of Findings from the Evaluations

Benefits and Outcomes

- For Public Housing Agencies and congregate housing developments, application for and participation in HOPE IV and CHSP had a noticeable impact on the grantees' orientation toward a frail elderly population. For HOPE IV, the internal culture of PHAs and the Section 8 program changed radically from one focusing almost exclusively on housing assistance to acknowledging and accepting responsibility for a range of service needs among frail elderly applicants and tenants in HUD rental assistance programs. Under CHSP, building management was able to broaden its attention beyond the physical structure and accommodate the service needs of the residents in HUD subsidized congregate housing.

- Overall, HOPE IV and CHSP were complementary and helped meet the needs of low-income frail elderly community residents. They served people who lived in different settings — Section 8 subsidized housing units versus apartment developments with a number of other elderly residents. Grantees that operated both programs saw each as being valuable in meeting the needs of elderly community residents who — by choice or for other reasons — lived in different kinds of settings within the community.

- A key component of HOPE IV and CHSP was that each program fostered the development of partnerships with other service delivery agencies in the community that helped meet tenant and resident needs. Such partnerships were essential to effectively use HUD supportive services funding, and this confirmed the importance of linkages between housing and other community agencies when assistance moved beyond the traditional boundaries of subsidized housing.

- HOPE IV and CHSP represented an important opportunity to link housing and service delivery for low-income, frail elderly persons in a far more systematic and coordinated fashion than had existed in the past. The Service Coordinators from both programs reported that HOPE IV and CHSP increased collaboration between housing and service providers to serve the needs of their elderly residents.

- Partner agencies that provided services to program participants included: State Agencies on Aging and programs for persons with disabilities, Area Agencies on Aging, home health agencies, mental health agencies, Visiting Nurse Associations, the United Way, Meals on Wheels programs, adult day care providers, and religious organizations. These agencies and organizations not only delivered services under contract with HOPE IV and CHSP grantees, but also used their own funds to serve program participants. In this way, HOPE IV and CHSP leveraged other community resources to benefit older persons.

- In order to determine what these levels of service might have been without the program, the HOPE IV evaluation included a similarly frail elderly comparison group receiving Section 8 rental assistance but not enrolled HOPE IV. The HOPE IV participant and comparison groups were interviewed during a baseline and follow-up survey two years apart to show changes over time between these two groups. Among persons in these two groups, the evaluation found that HOPE IV participants received a significantly higher level of supportive services than the comparison group and this disparity in access to services increased over time. For example, at follow-up, nearly one-third (32 percent) of the HOPE IV comparison group reported receiving no services at all despite high levels of frailty, versus 7 percent of the participants.

- For HOPE IV, receipt of services was significantly related to a range of positive outcomes. In particular, service recipients scored significantly higher in four major mental health dimensions (anxiety, depression, loss of behavioral/emotional control, and psychological well-being), social functioning (quantity and quality of social activities), vitality (energy level and fatigue), and other measure of social well-being.[1]

- However, despite enhanced availability of services, there were no statistically significant differences between the HOPE IV participants and comparison group members in the rates of nursing home placement, mortality, or exiting Section 8 for other reasons. In a similar vein, there was no separate effect of receiving specific individual CHSP services on continued participation in that program. These findings are consistent with the assumptions in the research designs and the results of prior studies that show the impacts of similar programs address quality of life and care, rather than changing such overt outcomes as institutionalization or otherwise having to leave one's home due to frailty.

- For both CHSP and HOPE IV, half the residents studied were still in their respective program 24 months after the baseline survey and about 9 percent had left the program (but remained in their subsidized housing) because they were no longer eligible, were dissatisfied, or obtained services from another source. About 14 percent of the HOPE IV and CHSP participants had died during the two-year period.

- However, more CHSP than HOPE IV participants had moved to a nursing home, group home, or other higher level of care (25 percent versus 9 percent) over the two-year period. While frailty levels were comparable between the two groups of participants, the higher median age for CHSP relative to HOPE IV (82 years versus 74 years) may provide one explanation for this difference.

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[1] Ware, J.E., SF-36 Health Survey, Manual and Interpretation Guide. The Health Institute, New England Medical Center, Boston, MA, 1993.

Program Implementation

- It took considerably longer to recruit and place participants into the HOPE IV program than it did for CHSP, largely because of who was eligible to participate in each program. To expand Section 8 participation beyond its current scope, HUD regulations required that HOPE IV applicants had to come from outside existing HUD housing assistance programs. CHSP applicants, by comparison, came from among current residents of HUD-assisted congregate housing.

- Because they were serving an entirely new constituency, virtually all the HOPE IV grantees reported substantial difficulty recruiting and placing eligible applicants in appropriate rental housing. Most of the HOPE IV participants (60 percent) already lived in rental apartments that met HUD Housing Quality Standards, and they did not have to move to quality for participation. The remaining 40 percent, however, had to relocate to a qualifying apartment from either substandard housing or from other ineligible settings. For many HOPE IV participants, therefore, the need was for the basic Section 8 rental assistance, as well as for the case management and in-home services the program provided.

- In addition, effective implementation of HOPE IV often required the PHAs to make substantial changes to their existing Section 8 application and placement policies and procedures. These changes were required to address the realities of a frail elderly population that needed considerable assistance in applying for the program and locating suitable rental housing. Furthermore, as implementation continued, HOPE IV grantees then had to balance these initial activities with the intensive case management and supportive services requirements for those placed in the program.

- By contrast, CHSP Service Coordinators did not experience the same challenges with recruitment and enrollment, in large part because residents were already living in the congregate facilities. Although they employed a variety of outreach methods, such as fliers and brochures, newsletters, CHSP Service Coordinators could rely mostly on "word-of-mouth" and the help of the resident services staff in identifying individuals who might benefit from the Program.

- Largely because of these heavy HOPE IV implementation requirements, recruiting and enrolling participants continued far into the 5-year demonstration period, and the HOPE IV Service Coordinator role developed differently than in the CHSP program. HOPE IV Service Coordinators had to continue to devote significant time and energy to "front end" tasks, whereas Service Coordinators in the CHSP projects were able to focus more exclusively on case management functions after the initial start-up period.

- Concerning consumer satisfaction with program implementation, HOPE IV and CHSP participants were very satisfied with their Service Coordinators. All emphasized the Service Coordinator's help in linking them to, and providing information about, services. HOPE IV participants also gave primacy to their Service Coordinator's help in obtaining housing and rental assistance, whereas CHSP residents tended to highlight the more personal, interactive aspects of the relationship.

- During the initial implementation of the two programs, CHSP participants saw their Service Coordinators much more frequently than did HOPE IV participants on a day-to-day basis, but actually met less often to discuss their service plans with their Service Coordinators. However, the frequency of the HOPE IV participants' in-person contacts with their Service Coordinators declined

considerably between baseline and follow-up as the initial labor-intensive activities gave way to periodic reassessment of needs and monitoring.

Participant Characteristics

- The evaluations found that the vast majority of HOPE IV and CHSP participants were widowed, white females who were living alone, consistent with the profile of frail elderly Americans, overall. Over half of the participants were at least 75 years old; however, CHSP participants were markedly older, with a median age of 82 years, versus 74 years for HOPE IV.

- Moving can be a traumatic experience for a frail elderly population, and changing residence was often a requirement for HOPE IV participation. Nearly half of the HOPE IV participants had moved into their current home within one year of enrollment, either to meet HUD housing quality standards or for other reasons. In contrast, only 12 percent of the CHSP participants had lived in their current apartments for less than one year. This was a function of design differences in the two programs. All HOPE IV participants were new to HUD housing assistance, per the program requirements. In contrast, CHSP participants were drawn from current residents of HUD assisted congregate housing.

- HOPE IV and CHSP participants were considerably more frail than the elderly population as a whole, in terms of activity of daily living (ADL) limitations. For example, among all non-institutionalized elderly age 65 and over, only 11 percent reported a limitation in at least one ADL, ranging from about 9 percent for dressing to approximately 1 percent for feeding oneself. In contrast, nearly three-quarters of HOPE IV participants and nearly 80 percent of CHSP participants reported difficulty performing at least one ADL.

- While HOPE IV and CHSP participants were considerably more frail than the elderly population overall, they were much less frail than persons who receive, or are eligible for, nursing home care. Approximately 92 percent of nursing home residents age 65 and older had at least one ADL dependency, in this case involving the assistance of another person.

- When asking participants about their ADL limitations according to HUD's eligibility criteria, however, about 19 percent of the HOPE IV and 24 percent of the CHSP participants had fewer than three ADL difficulties, contrary to the HOPE IV and CHSP program regulations. As one possible explanation for this disparity, prior research in measuring ADL difficulties shows that frail elderly persons, especially women, self-report fewer difficulties than do professionals when assessing them.

- Consistent with their functional limitation status, HOPE IV and CHSP participants reported having many chronic health conditions. About one-half of HOPE IV and CHSP participants reported having high blood pressure, and 39 and 45 percent of these participants, respectively, indicated having a heart condition. Fourteen and 20 percent of HOPE IV and CHSP participants, respectively, reported having diabetes, arteriosclerosis, or having had a stroke.

- Even with case management and personal assistance, HOPE IV and CHSP participants spent considerable time alone in their homes. For a frail elderly population, the risk of falls is always present and a potential source of injury. Twenty-two percent of persons in HOPE IV and 12 percent of CHSP participants said they sought medical care as a result of falling during the past year; and 9

percent and 7 percent, respectively, were hospitalized for more than 1 day due to a fall during that period.

- Despite their high level of frailty and prevalence of chronic health conditions, the majority of the HOPE IV and CHSP participants had not been confined to bed or a chair at all during the month prior to the baseline interview and had not stayed in a hospital overnight at all during the prior 12 months. However, more than a third of both groups of participants had stayed overnight as a hospital in-patient over the prior year, which is twice the rate for the elderly household population as a whole.

- In spite of their poor health and frailty, most of the HOPE IV participants reported the quality of their lives to be relatively high, although this was not the case for all. Over one-third of the HOPE IV participants responded at baseline that they were, in general, very satisfied with the way their life is going, and 45 percent indicated they were somewhat satisfied with life. Almost one-fifth, however, said they were not satisfied with the quality of their lives according to these criteria.

Informal Assistance, Social Support, and Service Utilization

- Informal assistance, social support, and social interaction are important aspects of an older person's quality of life that also tend to correlate with measures of mental health and life satisfaction. In addition, the quality and level of social support received, independent of other factors, can affect a frail elderly person's risk of institutionalization. Many HOPE IV and CHSP participants reported low levels of loneliness, and almost all had at least one confidante. However, 20 percent of HOPE IV participants and 21 percent of CHSP participants said they felt lonely quite often, and 41 percent and 43 percent, respectively, said they felt this way sometimes.

- Most HOPE IV participants showed a bimodal pattern of in-person or telephone contact with others: either less than once a month or several times a week or more. For example, 47 percent of HOPE IV participants saw a child less than once a month. At the other end of the spectrum, 26 percent of HOPE IV participants saw a child more than three times a week and 12 percent saw a child every day.

- However, the pattern of contact with family and friends for CHSP participants was not similarly bimodal; the distribution of in-person and telephone contact with family members and others is much more even across the different categories. For example, only about half as many (25 percent) of CHSP participants as HOPE IV participants reported seeing a family member (a child or any other family member) only once a month or less. At the same time, considerably fewer CHSP participants (6 percent) reported daily contact with family members.

- A higher percentage of CHSP participants than HOPE IV participants had received comparable formal services prior to entering their respective Programs. These findings are not surprising given that CHSP participants were already living in congregate housing prior to entering the CHSP, which gave them some access to services and a stable environment where service linkages may have had a chance to develop. By contrast, many HOPE IV participants had to relocate to enter HOPE IV and were selected into the Program partly on the basis of their demonstrated need for supportive services and distance from family members who might have been able to assist them.

- Under HOPE IV and CHSP, the core services received by participants were much the same across these two programs, with about four-fifths of both groups reporting they got housekeeping, slightly under one-half indicating receipt of transportation services, and just under one third saying they got personal care services.

- Satisfaction is generally high with both HOPE IV and CHSP; almost all the participants in both programs said they were very satisfied or at least somewhat satisfied with the program. In addition, the vast majority of HOPE IV and CHSP participants were happy with the amounts and types of services they were receiving. For example, 82 percent of HOPE IV participants said they did not need any more of their current services. Of those indicating they would have liked more of their current services, the greatest number of participants expressed a desire for more housekeeping. Data for CHSP participants show a broadly similar pattern of overall satisfaction with services received. When asked about the specific services they received from both formal and informal sources the vast majority of CHSP participants (75 percent or more) indicated that these services adequately met their needs.

- One important conclusion from the evaluations is that the HOPE IV and CHSP program models are complementary, and each responds to an important but distinct need. Concerning HOPE IV, many frail elderly live in scattered-site rental housing that meets HUD housing quality standards, and a tenant-based model responds to this reality by allowing persons to remain in their current homes and receive the rental assistance, case management, and services they need. Equally important, the CHSP model responds to the needs of the substantial numbers of frail elderly who live in HUD subsidized congregate housing, and a project-based approach addresses the requirements of this separate population who are aging in place and increasingly require a services component to remain there.

- Reinforcing this need for a dual perspective, the HOPE IV and CHSP models correspond to two current and complementary approaches that professionals in the field of aging are using to develop policies, provide financial support, and operate long-term care programs for a frail elderly constituency. The first of these approaches, similar to HOPE IV, seeks to provide case management, home care, and other assistance to frail older persons where they currently live throughout a community, as an alternative to institutionalization or other restrictive settings. An example of this is the Medicaid waiver program, often supplemented with separate state funding, that supports the delivery of home-care in lieu of nursing home placement. The second approach for serving the long-term care needs of a frail elderly population in a community setting is *Assisted Living*. This approach supports a congregate model for housing and services but avoids the restrictive environment often associated with a nursing home or related care facility.

1. INTRODUCTION

With a substantial increase in the number of elderly persons in the United States, especially in advanced age groups associated with frailty, communities across the country have experienced a rise in demand for a range of services to support an aging population. While most elderly individuals continue to live independently in their own homes, the rising number of persons throughout the United States who are reaching advanced age heightens the need for assistance with many personal care and home management activities, such as bathing, dressing, and meals preparation. For the Department of Housing and Urban Development, (HUD) and its local agents — Public Housing Agencies (PHAs) and housing development sponsors and managers — responding to this neighborhood demand required adapting the various housing assistance programs to address the needs of frail elderly tenants and residents by providing a range of services that went well beyond offering affordable housing.

This report presents the evaluation results from two HUD programs that combined housing assistance with case management and a range of supportive services for a frail, low-income elderly population. The purpose of evaluating these programs was to inform and support the consideration of legislation, policies, and programs that address the housing and services needs of frail elderly individuals residing in or eligible for HUD-assisted housing.

1.1 The HOPE for Elderly Independence Demonstration Program and the Congregate Housing Services Program

The HOPE for Elderly Independence Demonstration program (HOPE IV) was designed to explore how HUD could support the needs of a frail, low-income elderly population by combining Section 8 rental Vouchers with case management and supportive services to enhance the quality of life and avoid unnecessary or premature institutionalization. To be eligible for HOPE IV, a person must have been at least 62 years of age, had an income that generally did not exceed 50 percent of the area's median,[2] resided in or have been willing to move to a private market rental dwelling meeting HUD's Section 8 Housing Quality Standards, not have been a current participant in Section 8 or other housing assistance programs, and needed assistance in personal care and home management activities.

The Congregate Housing Services Program (CHSP) provided a combination of housing and supportive services to low-income, frail elderly, ages 62 and over, and non-elderly disabled residents of

[2] The median income is adjusted according to family size.

federally subsidized housing. CHSP was originally authorized under Title IV of the Housing and Community Development Act of 1978 (42 USC 5301). The new CHSP, the subject of this report, was authorized under the National Affordable Housing Act of 1990, amended by the Housing and Community Development Act of 1992. Under this program, HUD and the Rural Housing Service (RHS)[3] of the U.S. Department of Agriculture (USDA) made grants to local housing sponsors to help pay for supportive services for residents who are frail elderly or persons with disabilities. The main purposes of CHSP were to promote and encourage maximum resident independence within their home environment and to improve the ability of management to assess the service needs of eligible residents and provide or ensure the delivery of needed services.

Both HOPE IV and CHSP provided a combination of housing and supportive services. A key difference, however, was that CHSP used a project-based model, providing services to eligible residents of public housing and privately-owned subsidized housing (apartment housing developments) designated for residency by frail elderly and persons with disabilities. This meant that participants lived in the same apartment development (congregate housing) and services were delivered on-site, either in the resident's apartment or in the common areas of the apartment development. By contrast, the HOPE IV model was tenant-based: it combined Section 8 rental assistance with supportive services, with services provided at scattered sites — usually the resident's home — anywhere in the jurisdiction served by the HOPE IV grantee.

For the purposes of eligibility determination, HUD required that HOPE IV and CHSP participants need assistance in three or more activities of daily living (ADLs). HUD defined these ADL limitations as follows:

- Eating (may need assistance with cooking, preparing or serving food, but must be able to feed self);
- Bathing (may need assistance in getting in and out of shower or tub, but must be able to wash self);
- Grooming (may need assistance in washing hair but must be able to take care of personal appearance);
- Dressing (must be able to dress self, but may need occasional assistance); and
- Home management activities (may need assistance in doing housework, grocery shopping, laundry, or getting to and from one location to another, but must be mobile, alone or with the aid of assistive devices such as a wheelchair).

[3] Formerly Farmers Home Administration (FmHA) of U.S. Department of Agriculture.

HUD intended these criteria to identify persons who could live independently in scattered-site and congregate rental housing but needed help to maintain independence.

The HUD ADL definition differs from what is most commonly used in the field of geriatric functional assessment and is actually a combination of two measures used in both research and practice: Activity of Daily Living Limitations and Instrumental Activity of Daily Living limitations. ADL measures were developed by Sidney Katz and his colleagues, and they consist of bathing, dressing, transferring between bed and chair, using the toilet, continence, and eating.[4] These activities often fall under the rubric of personal care. Instrumental Activities of Daily Living (IADLs) are based on definitions developed by M. Powell Lawton and Elaine Brody.[5] IADLs cover more complex activities, including handling personal finances, meal preparation, shopping, traveling about the community, doing housework, using the telephone, and taking medication. Studies of the elderly often refer to these IADLs as home management activities.

A Professional Assessment Committee (PAC), in conjunction with a Service Coordinator, determined eligibility, developed a case plan for services, and regularly monitored each participant's condition and services. HUD paid 40 percent of the program costs; the grantee paid 50 percent; and participant fees comprised at least 10 percent of total program costs. Individually, participants, however, could not be charged more than 20 percent of their income as part of the fee provision.

For HOPE IV, this report is base on the first round of funding during which HUD awarded grants to 16 agencies for projects ranging in size from 25 to 150 persons for a five-year demonstration period. Collectively, these first-round grants totaled about $10 million for the supportive services component and approximately $30 million for rental assistance. For CHSP, HUD awarded 39 grants to fund CHSP in 45 developments, and the number of residents participating ranged from less than 10 to 110.

1.2 Key Features of Hope IV and CHSP

The key elements of CHSP and HOPE IV are summarized in Table 1.1 and are discussed in more detail in the following text.

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[4] Katz, S., and C.A. Apkom, A measure of primary sociobiological functions. International Journal of Health Services 6:493-x508, 1976.

[5] Lawton, M.P., and E.M. Brody, Assessment of older people: Self-maintaining and instrumental activities of daily living. Gerontologist 9:179-186, 1969.

Table 1.1. Key Elements of the HOPE for Elderly and New CHSP Independence Program

HOPE IV Program Elements	New CHSP Program Elements
Combines housing with supportive services: – Tenant-based model – Service coordinator (SC) – Professional Assessment Committee (PAC) – Non-medical supportive services	Combines housing with supportive services: – Project-based model – Service coordinator (SC) – Professional Assessment Committee (PAC) – Non-medical supportive services
Services are targeted: – Low income frail elderly	Services are targeted: – low-income frail elderly and persons with disabilities
Services are tailored to individual needs: – Individualized care plan – Initial assessment and periodic review by SC and PAC	Services are tailored to individual needs: – Individualized care plan – Initial assessment and periodic review by SC and PAC
HUD funds are used to leverage other funding – Grantee match required – Tenant fees	HUD funds are used to leverage other funding – Grantee match required – Resident fees
Program is diverse, flexible – Has common core elements – Implemented differently in different settings	Program is diverse, flexible – Has common core elements – Implemented differently in different settings

Combined housing subsidy with supportive services. A number of residents in federally subsidized housing are frail older persons in need of supportive services. For example, the HOPE IV evaluation found that among existing Section 8 elderly tenants — the comparison group not enrolled in the demonstration program — one in five, or 20 percent, had levels of frailty similar to the participants.

In many cases, older residents have "aged in place," experiencing greater frailty and needs for assistance as they age. HUD recognized that by combining supportive services with housing, current and future residents and tenants may be helped to continue living as independently as possible for as long as possible. Additionally, having a program of supportive services available for these populations of tenants and residents helped HUD carry out its work and cope with the challenges posed by a growing population of persons who need assistance to continue living in their current housing.

Service Coordinator. The Service Coordinator was a key element of both HOPE IV and CHSP. The responsibilities of the Service Coordinator included intake and referral services, formal case management, establishing linkages to service providers in the community, referring and linking individual participating residents to providers, educating tenants and residents on service availability and related topics, monitoring provision of services, helping participants build informal support networks, and educating other staff on aging-in-place and service coordination. The Service Coordinator worked with the Professional Assessment Committee (PAC), which had primary responsibility for determining program eligibility. For HOPE IV, the PAC assessed frailty and service needs for the new applicants for this program. For CHSP, the PAC determined the eligibility of current congregate housing residents for participation. For both programs, each PAC was responsible for conducting regular reassessments and developing case plans for participants. Additionally, the Service Coordinator worked with local service providers in developing and implementing service plans and kept the PAC informed of participant progress.

Types of Services provided. Under HOPE IV and CHSP, a variety of services were provided to participants. These services included meals; housekeeping; personal assistance (grooming, dressing, other activities to maintain personal appearance and hygiene); transportation; nonmedical supervision, wellness programs, preventive health screening; personal emergency response systems; and other supportive services approved by HUD. For HOPE IV, the meal service was primarily home-delivered, given the scattered-site nature of the program. For CHSP, each participating project was required to provide at least one meal per day in a congregate setting for some or all participants. Medical treatment was specifically excluded, although health education, wellness programs, preventive health services, and monitoring of medication consistent with state law, were allowed. Grantees could provide these services directly or contract for them through other agencies or providers.

Services were targeted. Both CHSP and HOPE IV served low-income elderly residents (age 62 or older) who needed assistance with three or more activities of daily living (ADLs) as defined above. To be eligible, the persons must have been able to perform each of the activities at a specified minimal level, either by themselves, or with assistance from a spouse, relative, or other persons.

These eligibility requirements reflect HUD's commitment to targeting services to frail elderly persons who were at risk of needing to move to a higher level of care (such as an assisted living facility or nursing home), but, at the same time, not so frail that they need nursing home levels of care. Also, consistent with the targeting of services to those with an appropriate level of need, the PAC and Service Coordinator had the responsibility to move participants out of HOPE IV or CHSP if they improved enough to be able to function without supportive services or required a higher level of care than could be provided under HOPE IV or CHSP.

CHSP, but not HOPE IV, also provides services to persons with chronic and short-term disabilities, which included adults with physical, mental, emotional, or developmental impairments. However, this report focuses on the frail elderly, the group common to both HOPE IV and CHSP. HOPE IV and CHSP emphasized both tailoring services to individual participants' needs and the active involvement of the participant in developing the plan. The Service Coordinator did intake screening and preliminary assessment of frailty or disability for potential program participants, and referred individuals who appeared eligible to the PAC. The PAC reviewed the case and, with the Service Coordinator, potential participant, and family member(s), developed an individual case plan for the participant. The participant could refuse services or request other services. Other services were covered by HOPE IV or CHSP if the PAC determined them to be needs-based and appropriate under the HOPE IV or CHSP. If not, they could be paid for separately by the participant. Once the case plan was finalized, the Service Coordinator was responsible for working with community agencies, the grantee, and third party service providers to ensure that the services were provided on a regular, ongoing, and satisfactory basis in accordance with the case plan approved by the PAC and the participant. The Service Coordinator and PAC were required to review each participant's care plan when needs changed or at least annually.

HUD funds were used to leverage other funding. The matching funds provisions of HOPE IV and CHSP implemented HUD's expectation that the grantees, HUD, and participants all would have responsibility for contributing to the cost of providing needed services. Under HOPE IV and CHSP, HUD committed its share of costs for the five-year grant period. This commitment provided a sustained period of support and a basis for obtaining commitments of support from other sources.

Allowable matching funds came from a variety of sources. For example, cash matching funds included Community Development Block Grant (CDBG) or Community Services Block Grant funds, funding from Older Americans Act (OAA) programs, and available payments authorized for specific individuals under Medicaid. Individuals could pay fees using cash contributions, including contributions or donations to other eligible programs acceptable as matching funds. Programs had a degree of

flexibility in the way they charged fees for different combinations of HOPE IV and CHSP services, within the ten percent limit specified in the statutes for the two programs.

Program diversity. While each program was operated separately by distinct grantees, HOPE IV and CHSP had a well-defined core of support, operations, and services. Fundamental program elements were common across all sites: the broad requirements for the sharing of financial support for the program; the role of the Service Coordinator and PAC; and the eligibility requirements in terms of low-income, frailty, and need for services. At the same time, HOPE IV and CHSP allowed substantial flexibility, at the level of the individual participant, and for the grantee. Thus, for example, services could have been provided by staff hired for the program or contracted out to other providers in the community. The Service Coordinator could be either hired by the program or contracted (or donated as part of the match), and could work full- or part-time, depending on the program size and participant needs. Funds could be used for a variety of allowable costs, including staff salaries or service contracts, purchase of equipment and supplies needed to provide services approved under the grant, operational costs for transportation services, and a proportional share of administrative expenses.

All these features of the HOPE IV and new CHSP programs contributed to their flexibility and allowed sites with different resources and needs to implement the program in ways that met those needs and contributed to overall program goals of providing primary services that helped sustain the independence of frail elderly receiving HUD-assisted housing.

1.3 HOPE IV and CHSP Grantees

The HOPE IV and CHSP grantee communities presented a rich range of environments for operation of these two programs. They were located in several geographic regions and distributed across urban, suburban, and rural areas. Grantee communities exhibited some racial, ethnic and cultural diversity, and also presented some distinctive housing characteristics and situations.

The 16 first-round HOPE IV grantees represented a broad spectrum of PHAs in terms of size, from small (about 100 units of assisted housing) to very large (about 10,000 units). Each of the 16 HOPE IV grantees administered a Section 8 Certificate and Voucher rental assistance program. The size of the grantees' Section 8 programs ranged from about 100 to about 1,000 Certificates and Vouchers. Most of the grantees also operated a conventional Public Housing program. Altogether, the grantees managed or assisted about 40,000 units of low- and moderate-income housing, which includes over 12,000 public housing units, over 20,000 Section 8 rental assistance Certificates and Vouchers, and the

balance among other housing assistance programs. About one-third of the grantees' assisted housing units served elderly persons. Five grantees operated or assisted nearly 3,000 units of project-based, congregate or other supportive housing for the elderly.

The 16 HOPE IV grantees represented a range of levels of government and types of legal entities. Two grantees were State-level agencies, three represented county jurisdictions, and 11 served municipalities. One PHA had jurisdiction over the Section 8 program in an area that includes both a city and the surrounding county, but a separate city housing authority had responsibility for administering their public housing program.

CHSP projects were implemented in many types of federally subsidized housing, located in communities of different sizes around the country. Of the 32 CHSP projects active in FY 1995, the largest proportion were in Section 202 housing (11, or 34 percent) or Public Housing Authorities (10, or 31 percent).[6] Other CHSP projects were implemented in such settings as Rural Housing Service, Section 236 and Section 8 projects.

In the fall of 1994, there were 34 CHSP projects active, serving 690 residents; by fall 1996, there were 36 projects, serving a total of 941 residents. In Fall 1996, the number of residents served ranged from fewer than 10 at the smallest sites, up to more than 140 at the largest site, and the median was 24.

For HOPE IV, the 16 first-round grantee communities represented a wide variety of geographic regions. Three grantee PHAs were located in Western states (California, Colorado, and Washington), five in the Southwest (two each in Arizona and Oklahoma, and one in Texas), two in the Midwest (Iowa and Ohio), one in the South (Kentucky), and five in the East and Northeast (Maine, Massachusetts, New Hampshire, New Jersey, and Pennsylvania).

There was somewhat less diversity in the degree of urbanization of the areas served by the HOPE IV grantees. More grantees reported serving suburban, rural, or small town communities than urban cities or counties. Five of the 16 grantees served non-metropolitan areas: three of them served a predominantly rural or remote community, and two served small cities but recruited HOPE IV participants from surrounding jurisdictions that included rural or remote areas. There were two suburban

[6] Section 202 is a HUD program that provides mortgage insurance for apartment buildings designed for elderly residents who are income-qualified. The Section 236 and 221(d)(3) programs subsidized the interest rates developers had to pay on HUD-insured loans. These two programs phased out in the 1980s and were replaced by the Section 8 program, which subsidizes the renter's payment to the landlord.

sites and three predominantly urban sites. Four grantees served a mixed urban-rural or suburban-rural area. Likewise, the two State-level grantees served both urban and rural communities.

CHSP developments were located in cities ranging from fewer than 4,000 to more than 600,000 in population. The median size of the host cities is about 60,000, and 35 percent of the developments are in cities or towns with populations less than 25,000. Only four of the projects were in nonmetropolitan areas. Most of the cities or towns were part of larger metropolitan areas; over half of the active projects (18) were in metropolitan areas with populations of 1 million or more.

Geographically, the CHSP developments were concentrated in the Midwest (12 developments) and the Northeast (11 developments). Most of the Midwestern and Western developments were located in large Metropolitan Statistical Areas (MSAs); a relatively large proportion of projects in the Northeast were located in moderate size MSAs; those in the South were primarily located in moderate size MSAs or non-MSA areas.

1.4 Conceptual Design of the HOPE IV and CHSP Evaluations

The U.S. Congress mandated an evaluation of HOPE IV and the new CHSP in Section 802(l) of the National Affordable Housing Act of 1990. The overall objectives of the two evaluations are:

- To provide a comprehensive description of HOPE IV and the new CHSP;
- To assess the effectiveness of the two programs in maintaining the independence of frail elderly by providing a range of supportive services; and
- To compare HOPE IV with the new CHSP.

The conceptual model for the HOPE IV and CHSP evaluations tested the assumption that the ability of frail elderly people to live independently can be enhanced with certain basic supportive services, with the stewardship of a case manager. These services can be and often are, delivered informally by family, friends, and neighbors; but formal delivery of services by community-based agencies may be needed. By helping to fund a variety of community-based support services, HOPE IV and CHSP aimed to reduce inappropriate or premature institutionalization and otherwise increase the quality of life of program participants.

According to this conceptual framework, outcomes of the two programs were likely to be influenced by both the content and the volume of services delivered to participants. These, in turn, depended on the efficiency and effectiveness of program operations. Characteristics of the participants (such as age, physical frailty, mental health, gender, education, and the availability of other formal support services outside the program) could influence outcomes as well. Finally, the degree to which program participants had access to informal support also was a consideration.

In order to determine what these levels of service might have been without the program, the HOPE IV evaluation included a similarly frail elderly comparison group receiving Section 8 rental assistance but not enrolled HOPE IV. The HOPE IV participant and comparison groups were interviewed during a baseline and follow-up survey two years apart to show changes over time between these two groups.

In particular, HOPE IV embraced what was for many grantee PHAs an entirely new Section 8 tenant population. To even begin to meet the special challenges of serving a frail elderly constituency, most HOPE IV PHA grantees had to adapt their normal Section 8 operating procedures and initiate an array of new services and linkages with other agencies in the community. Documenting and assessing the impact of these systemic changes comprised a major component of the evaluation. Without these changes, successful implementation and operation of HOPE IV could not have occurred. For congregate housing developments, CHSP brought a formal case management and supportive services delivery capability within the purview of the local sponsor and building management. It acknowledged the need for a services component as elderly residents in these developments grew older and required more than housing assistance to continue living there. These evaluations based their findings using data collected from a variety of sources: frail elderly program participants, Service Coordinators, representatives of PACs, grantee staff, grant applications, program reports, HUD officials, and secondary data sources.

1.5 Organization of this report

This report consists of an Executive Summary and eight chapters. Following this introduction, Chapter 2 describes the programs' design, implementation, and operation and shows how the programs fit into the existing administrative structure of the grantee agency and the types of problems and changes that occurred as a result. It compares and contrasts the procedures for locating eligible participants for the two programs, including changes to existing practices, problems in recruiting participants, and how the grantees overcame these problems. It also describes how the grantees interpreted the regulations on frailty and other eligibility requirements, the specific instruments and procedures they used to assess

frailty and need for services, the role of the Professional Assessment Committee and the Service Coordinators, and the degree of reliance on other community agencies and organizations to perform assessments, including similarities and differences among the two programs and across the grantees.

Chapter 3 presents the demographic and housing characteristics of the CHSP and HOPE IV participants. It compares and contrasts the demographic profile of the two groups, including age cohort, race/ethnicity, marital status, and living arrangements. It also describes, compares, and contrasts the length of time the program participants lived in their current residences.

Chapter 4 presents the functional status and health of HOPE IV and CHSP participants, comparing and contrasting the disability profile of participants in the two programs. It also presents the physical and mental health status and health care utilization patterns of the participants in the two programs and identifies major similarities and differences.

Chapter 5 covers the informal assistance, social support, and service utilization of HOPE IV and CHSP participants as well as the HOPE IV companion group members, showing the important domain of social functioning. It discusses the nature and frequency of in-person and telephone contact with family and friends, including the types of informal assistance participants receive. It also includes the formal services participants received through the two programs, including similarities, differences, and satisfaction patterns across the two programs.

Chapter 6 presents CHSP and HOPE IV benefits and outcomes, comparing and contrasting the impact of the two programs in several domains of well being. It also compares and contrasts exit patterns for the two programs, including nursing home placement, mortality, and who remained in their respective programs.

Chapter 7 presents the findings, conclusions, and policy implications, suggesting how the results of the two programs might influence public policy and legislation on the provision of housing and supportive services to a growing segment of the U.S. population of interest to HUD, other federal agencies, and the Congress.

2. HOPE IV AND CHSP PROGRAM IMPLEMENTATION

This chapter describes the design, implementation, and operation of the HOPE IV and CHSP Programs. It examines commonalties and between and within the two programs in how participants were identified, recruited, screened and assessed, how long this took, and what difficulties the grantees faced and how they overcame them. The chapter also explores the functions of the Professional Assessment Committees (PACs) and Service Coordinators, as well as the methods for delivering services. We also briefly consider the grantee's sources of funds for operating the HOPE IV and CHSP programs, including HUD and other sources, and how the funds are allocated among different uses, including the various categories of services. In addition, this chapter includes an analysis of participant satisfaction with the implementation of the HOPE IV and CHSP programs, including participant recruitment and assessment procedures.

2.1 Effects of HOPE IV and CHSP on Existing HUD Housing Assistance Programs

Application for and participation in HOPE IV and CHSP had a noticeable impact on the grantees' orientation toward the frail elderly population. For HOPE IV, the internal culture of PHAs and the Section 8 program changed radically from one focusing almost exclusively on housing assistance to acknowledging and accepting responsibility for a broad spectrum of needs among elderly tenants in HUD rental assistance programs. For CHSP, building management was able to broaden its attention beyond the physical structure and accommodate the service needs of the elderly residents in HUD subsidized congregate housing.

For all HOPE IV grantees, at the very least, the program represented a new, unique opportunity to complement Section 8 housing with delivery of supportive services for the frail elderly. A related theme has to do with how participation in HOPE IV affected various aspects of regular Section 8 Program operations at the grantee sites. Virtually all grantees recognized that the Section 8 program in their PHA changed perceptibly as a result of their involvement in HOPE IV. Eight of the 16 grantees went so far as to characterize these changes as "dramatic," "major," or even "revolutionary." Grantees said that prior to HOPE IV the Section 8 programs in the grantee sites had, either consciously or inadvertently, discounted the frail elderly as a service population. In a number of places, this had taken the form of steering elderly away from Section 8 and toward other types of housing such as elderly congregate housing or public housing projects.

Most HOPE IV grantees indicated that the Program was, effectively, the only real opportunity for the frail elderly in their community to both benefit from Section 8 and receive supportive services. The consensus seemed to be that "Most elderly Section 8 Voucher holders are forced to leave the program when they become too frail. Section 8 has just not adapted to their needs."

For CHSP, grantees and service coordinators mentioned several effects on the development and community, including reduced turnover, better maintenance of apartments, and increased capacity to serve resident needs. One of the goals of CHSP was to improve housing management's ability to assess residents and expand the capacity to develop care plans, arrange or provide services, and monitor those services. Comments by Service Coordinators and grantees suggest that CHSP did this.

HOPE IV, from the perspective of community service providers, represented the first chance to link housing and service delivery for the low-income, frail elderly population in a far more systematic and coordinated fashion. Similarly, the CHSP grantees and Service Coordinators said that having CHSP had increased collaboration between housing and service providers to serve the needs of their elderly residents.

2.2 HOPE IV and CHSP Participant Recruitment

On the whole, it took considerably longer to recruit and place participants into the HOPE IV program than it did for CHSP, largely because of who was eligible to participate in each. For HOPE IV, applicants had to come from outside existing HUD housing assistance program. CHSP applicants, by comparison, came from among current residents of HUD-assisted congregate housing. Many HOPE IV grantees had to await development of an entirely new infrastructure within the PHA, and linkages with other service providers, before beginning recruitment. As a result, by the end of 1993, over one year after receiving their awards, only half of the 16 HOPE IV grantees had begun active participant recruitment. A year later in December 1994, only three grantees were at or near full enrollment, and these three agencies had been actively engaged in recruitment for an average of 14-15 months. By this time, the 16 HOPE IV grantees had recruited only about 40 percent of the number of participants specified in the awards. By August 1995, upon completion of the baseline participant and comparison group survey, only about 550 of the 1,260 authorized HOPE IV rental units were filled. By the close of calendar year 1995, Service Coordinators reported a total of 586 participants, or less than half the authorized number. Full implementation of the program did not occur until several years after the awards, given the difficulties of HOPE IV implementation.

For a combination of reasons, including (1) the need to develop new Section 8 recruitment strategies and procedures tailored to HOPE IV, (2) the unexpectedly high percentage of participants having to move to qualify for the program (42 percent), and (3) responding to the very intense physical, emotional and financial needs of the frail elderly while recruiting new participants, HOPE IV implementation was a protracted process.

For CHSP, recruitment was much less onerous than for HOPE IV because all potential applicants were already known to the grantees and living in the grantees' congregate housing developments. In February 1993, HUD and FmHA[7] provided new grant funding to 39 grantees for projects in 45 housing developments. As of December 1994, about one year after receiving their HUD awards, 21 of the 39 grantee organizations were providing new CHSP services in 34 of the 45 developments. Although some of the projects were able to begin implementation quickly, others required time to hire staff, assess residents, and begin providing services to eligible residents. During the first year of funding, the median period grantees had been providing services to eligible residents was 8.5 months; more than one-fourth had provided services for the full year, whereas about 10 percent has only provided services for about one month of the reporting year.

Only six of the 21 CHSP grantees interviewed reported that they had experienced start-up problems or delays. Reasons cited included getting the partner agencies and match firmly in place, finding residents who met the frailty requirements for eligibility, and developing acceptance of the new program among residents.

Recruitment Challenges

Under HOPE IV, the PHAs had to drastically adapt their usual Section 8 recruitment methods to fill the participant slots. Many of the grantees indicated that, because of the popularity of the Section 8 Vouchers and Certificates among the low-income population and the low-turnover rate, the PHA's Section 8 waiting lists had been closed for two or three years prior to the inception of the HOPE IV program. In the past, recruitment for Section 8 had consisted simply of opening the waiting list for very brief periods once every several years. Newspaper notices and other announcements were more than adequate to add new names to the Section 8 waiting lists to fill anticipated vacancies. However, because those responding to the waiting list notices tended to be applicants who were not isolated elderly

[7] Now Rural Highway Service in the Department of Agriculture

or limited in their activity, very few grantees were able to fill many of the HOPE IV units through these usual methods.

With the new HOPE IV program, the PHAs had to adopt an entirely different approach, employing some combination of the following recruitment methods:

- Development and distribution of HOPE IV promotional material;
- Announcements in newspapers, agency newsletters, and radio and television broadcasts;
- Referrals from the Area Agencies on Aging and others serving frail elderly;
- Referrals from physicians, hospitals, churches, nursing homes, apartment landlords, family and friends of the frail elderly; and
- Outreach efforts, including in-person presentations by PHA staff at senior centers and other agencies serving the elderly.

For CHSP, like HOPE IV, the process of recruiting potential participants, screening and assessing them, and developing the case plan was the first stage in the tailoring of CHSP services to participants' needs. Of the 26 Service Coordinators interviewed in Fall 1994, 20 reported they had undertaken publicity and outreach activities. Specific outreach activities they used included: announcements and/or articles in development or community newsletters; fliers or brochures distributed to residents; informational meetings; word of mouth (for instance, through staff or the residents' council), and individual meetings with residents or family members (including going door to door to talk with residents). Outreach included identifying people who might benefit but did not respond to publicity, and meetings with them, and their families if available, to encourage participation.

Most Effective Promotional Activities

For HOPE IV, just under half of the respondents first found out about the program either from their local Area Agency on Aging or the housing authority. Another 17 percent first heard about HOPE IV from relatives, especially their children. Friends and neighbors accounted for another 10 percent of respondents' sources, followed by a range of individuals, including landlords, service workers, doctors, and hospital discharge planners. Interestingly, only about five percent of respondents first heard about the Program from impersonal sources, such as ads, radio announcements, or brochures. This confirms the idea that some form of "word-of-mouth" was the key to the recruitment process.

Among CHSP residents, sixty-nine percent learned about the program from staff of CHSP, the building, or housing authority. Although many sites used written materials, such as newspaper articles or brochures, to publicize the program, only three percent of participants remembered written materials as the source from which they first learned about CHSP. Others learned about CHSP from staff of the local Area Agency on Aging or other community service agency (16 percent) or from informal sources, such as a friend or relative (8 percent).

In an important sense, then, the HOPE IV and CHSP began with personal outreach by program or building staff, who made special efforts to identify and involve persons who might not know about the program or might need extra assistance to enter it. For HOPE IV, the locus of these outreach efforts was the larger community and the existing network of agencies serving potentially eligible frail elderly persons. For CHSP, these outreach efforts were confined, by HUD regulations, to the grantees' existing congregate housing developments.

Participant Satisfaction with Program Entry

HOPE IV and CHSP participants, on the whole, found the process of entering the program fairly easy. Eighty-two percent of HOPE IV participants agreed that it was easy to provide the necessary financial information for entering the Program, 84 percent indicated that the program and its requirements were clearly explained to them, and 78 percent of the respondents reported having actively participated in deciding which services they would receive. ADL assessment was the one area for which there was a slightly lower level of satisfaction among HOPE IV participants: 67 percent disagreed, and 21 percent agreed, with the statement that the process used to determine the need for assistance was complicated. The participants' perception that entering the HOPE IV program was a relatively easy process should be seen in relation to the enormous efforts grantee PHAs and Service Coordinators expended in recruiting and assessing applicants.

CHSP's participants were asked about their experience in the application and service decision process. Their reports indicate the process was generally carried out with active resident involvement: 87 percent said CHSP was explained clearly to them; 82 percent said the process of determining their need for assistance was not complicated or was not required; and 71 percent said they participated actively in deciding on the services they would receive from CHSP.

2.3 Assessing Frailty

2.3.1 The Professional Assessment Committees (PACs)

Professional Assessment Committees (PACs) were charged with assessing the frailty of prospective HOPE IV and CHSP program participants. According to program regulations, PACs could be comprised of health and social services professionals brought together on a voluntary basis by grantees specifically for the HOPE IV or CHSP programs, or the grantees could use existing assessment teams from other service agencies in the community. In either case, HUD regulations required that PACs be made up of three to seven members with at least one medical professional.

HOPE IV grantees reported that the full PACs did not actually conduct the participant assessments. In most cases, either the Service Coordinator alone or a small team consisting of the Service Coordinator and a nurse or geriatric social worker performed the assessments, made an initial eligibility determination, and then presented the results along with a service plan to the full committee for review. Like HOPE IV, the CHSP Service Coordinator served as staff to the PAC and implemented the care plan developed by the PAC and agreed to by the participant.

For HOPE IV, decisions on the size and composition of the PAC were left to the local grantee, as long as the PAC included the Service Coordinator and at least one medical professional. The size of the HOPE IV PACs ranged from three to 13, with an average of 6.6 and a median of six. Concerning the medical professionals, four of the PACs had a physician, 14 included at least one nurse, and 10 included other health care professionals. All of the PACs had at least one social worker, and 14 had at least one other social services professional, such as staff from the Area Agency on Aging.

The survey of PAC members conducted by HOPE IV asked the respondents to rate how large a role the PACs played in each of several key HOPE IV program activities. Ten said the PAC had a large role in assessment of participant eligibility, eight said it had a large role in developing or reviewing the care plans, and seven said it had a large role in frailty assessments and determination of services provided.

2.3.2 ADL Assessment Tools Used by the Grantees

This section summarizes the content and format of the various assessments the HOPE IV and CHSP grantees used to determine ADL limitations, supportive service needs, and program eligibility. The purpose is to show how the grantees interpreted the HUD guidelines and examine the degree of consistency among these grantees in the protocols they used.

Most project grantees used the ADL limitation measures developed by Sidney Katz and the IADL limitations based on definitions developed by M. Powell Lawton and Elaine Brody for the purposes of assessing frailty. These measures are described in detail in Chapter 4. The projects then used their own judgement when applying these personal care and home management disability measures to the program applicants for purposes of eligibility determination.

On the whole, the evaluations found that such eligibility determination was not based on a rigid, consistent process of HUD ADL limitation scoring and thresholds. Instead, the assessment instruments and procedures used by the grantees reflected a desire for a holistic assessment as an informed basis for selecting persons most likely to benefit from the program. The grantees ensured that the participants met the HUD ADL requirements, but there were many other domains of measurement that served as a basis for determining need for HOPE IV and CHSP services. These included other measures of physical and mental well-being. For example, tenants or residents who needed assistance in parts of tasks may have been assessed by the Program as having an impairment, even if they reported themselves as able to perform the function. Some assessments used a scoring system to assess impairment level, (e.g., some versus a lot of difficulty) rather than counts of ADL limitations. In other cases, the sites "mapped" their usual assessment procedures and scoring to the HUD list and computed scores for each of the HUD ADLs; this may have resulted in some differences between the professional assessment of the participant's ADL limitations and the self reports of ADL limitations presented in this report.

2.4 Supportive Services Packages and Service Provision Arrangements

In addition to case management provided by the Service Coordinator, as required under both the HOPE IV and CHSP programs, supportive services listed as allowable under the HUD regulations included personal care and grooming, transportation, meals, housekeeping, laundry, counseling, non-medical supervision, wellness programs, preventive health screening, monitoring of medication (in accordance with the limitations of State law), and other requested supportive services essential for achieving independent living, if approved by HUD.

Both HOPE IV and CHSP provided supportive services to address ADL and IADL limitations (e.g., housework, meal preparation, bathing), as well as other assistance, such as transportation. HUD regulations required all CHSP projects to provide congregate meals; although residents are not required to participate in this element of the program. HOPE IV projects did not provide congregate meals, but often delivered meals to home-bound participants or provided transportation to congregate nutrition programs, such as senior centers.

The HOPE IV and CHSP programs offered participants a similar core package of supportive services designed to enable them to stay in their own homes. As shown in Table 2-1, virtually all HOPE IV and CHSP grantees provided housekeeping and meals---for HOPE IV, home-delivered meals, for CHSP, congregate meals. About two-thirds of both also offered personal assistance services. However, while three-quarters of HOPE IV grantees offered transportation, only slightly under one-half of CHSP sites did so.

Table 2-1.
Percentage of Projects Offering Specific Supportive Services

	Hope IV (%)	**CHSP** (%)
Housekeeping	100	85
Meals	100	93
Personal Assistance	63	65
Transportation	75	44

Beyond this, distinctive clusters of services were offered by one program, but not the other. For example, some HOPE IV grantees offered counseling or other mental health services, medication monitoring, or recreational services. Some CHSP projects offered preventive health and companion services.

The HUD regulations governing the operation of the HOPE IV and CHSP programs permitted grantees to design and operate their supportive services system in a manner appropriate to their particular environments. The grantees were permitted to directly conduct or subcontract the functions of the Professional Assessment Committee (PAC) and the Service Coordinator, as well as the actual delivery of supportive services.

HOPE IV and CHSP projects established partnerships with a wide range of agencies in their communities. Partner agencies that provided services to program participants included: state agencies for the elderly and disabled; Area Agencies on Aging; home health agencies; mental health agencies; Visiting Nurse Associations; the United Way; Meals on Wheels; adult day care providers; and religious organizations. These agencies not only delivered services under contract with HOPE IV and CHSP funds, but also used their own funds to serve program participants. For example, Medicaid waiver funds were used in some states. These partner agencies were an integral part of the web of support and services HOPE IV and CHSP provided. They also helped extend the range and amount of service HOPE IV and CHSP could offer.

Arrangements for provision of services varied within and across the HOPE IV and CHSP programs. For example, 14 of the 16 HOPE IV grantees contracted with other community agencies to provide services; one grantee directly provided some services and contracted for others; and only one, with a history of services for the aging, was directly involved in delivery of services to HOPE IV participants. Similarly, some CHSP sites provided services directly, while others contracted for services from other providers or obtained them as part of the program's match requirement.

2.5 Service Coordinators

Service coordination, or the linkage of the frail elderly participants to supportive services, is a cornerstone of the HOPE IV and CHSP programs. It is also the defining feature of the Service Coordinator Program (SCP), another HUD initiative to enable elderly residents of congregate housing to age in place and live independently. The SCP began in 1992 to coordinate the provision of supportive services to the elderly and persons with disabilities living in HUD-assisted projects constructed with Section 202, Section 8, Section 221(d), and Section 236 support. HUD sponsored an evaluation of the SCP, which focused on 18 sites among the universe of 645 funded projects. Half of the 18 sites were new SCP grantees and the other nine were established projects that had been in operation between 1.5 and 2.5 years. Consistent with CHSP, most of the 18 sites were 202 or Section 8 projects; however, the actual locations were not the same. Unlike CHSP, however, there was no frailty requirement for SCP eligibility, and the use of a Professional Assessment Committee, while permissible, was not required.

This section of the report will discuss the results of the process evaluation of the SCP along with those of the HOPE IV and CHSP evaluations in order to provide as broad as possible a perspective on the critically important Service Coordinator role.

In contrast to HOPE IV, the CHSP and SCP provide on-site Service Coordinators based in the congregate living facilities. Apart from this, the core functions of the Service Coordinators - namely, to link program participants to needed supportive services, and monitor service provision - are essentially the same across all three programs.

2.5.1 Service Coordinator Qualifications and Working Arrangements

Service Coordinators had to meet broadly specified educational and experience requirements. Most Service Coordinators in all three programs were well qualified for the position by both education and experience. All but one or two of the HOPE IV Service Coordinators held at least a Bachelors Degree in a field such as Social Work, Sociology, or Human Services, and several had earned Masters degrees. All had some, and several possessed extensive, prior experience working in programs for the elderly. Most felt that their training and experience had prepared them well for the job, if not always for the intensity of the demands placed upon them. SCP Service Coordinators were similarly well qualified and prepared, with educational backgrounds very similar to those of the HOPE IV Service Coordinators and previous relevant experience working at a variety of community agencies.

HOPE IV grantees were about evenly divided between those who hired a new person for the Service Coordinator position and those who hired someone already part of an existing service delivery network. There was some relationship, in turn, between grantees relying on an existing network and the Service Coordinator spending only a portion rather than all of her time on HOPE IV, at least at the outset. In the Spring of 1995, nine of 16 HOPE IV Service Coordinators reported job responsibilities that extended beyond the HOPE IV program, all but one involving similar case management functions for clients in other community programs for the frail elderly. The 18 Service Coordinator Program sites also had a variety of Service Coordinator working arrangements. Thirteen SCPs had part-time Service Coordinators who worked less than 40 hours per week, and 11 Service Coordinators worked at more than one SCP site.

HUD guidelines also gave the HOPE IV, CHSP, and SCP grantees considerable flexibility in the organizational placement of the Service Coordinators, who could be employees of the housing authorities and developments, or contracted from other agencies. For the HOPE IV Program, in communities with an existing agency capacity to conduct functional assessments and develop service plans, it usually made sense for the PHA to contract with an agency such as the Area Agency on Aging to perform the Service Coordinator functions. HOPE IV grantees were about evenly split between those who directly employed

the Service Coordinator and those who subcontracted with the Area Agency on Aging or others for the performance of this function. In many cases in which the Service Coordinator was an Area Agency on Aging employee, her services were part of a total package contracted by the PHA for the HOPE IV participants. Fewer (only three of 18) SCP sites contracted for their Service Coordinators rather than hire them directly.

The nature of the relationship between the Service Coordinators and housing personnel varied somewhat across the three programs. In both the CHSP and the SCP, Service Coordinators, although functioning autonomously, could work with building personnel on a day-to-day basis. In fact, the SCP was designed, in part, to relieve pressures on the building managers to deal with the burgeoning supportive service needs of residents aging in place. SCP Service Coordinators worked with property managers, to varying degrees, in planning program activities and interacting with residents. Not surprisingly, property managers at new SCPs had more involvement than those at established SCPs, and the level of involvement tended to decrease as Service Coordinators became more familiar with the residents. Overall, SCP Service Coordinators and property managers enjoyed good working relationships that ultimately succeeded, as intended, in freeing the latter to spend more of their time on building management.

Hiring or contracting for a Service Coordinator typically involved HOPE IV grantee PHAs in new and different sorts of working arrangements with other community agencies. Several grantees identified increased frequency of interaction and greater ease of communication between the PHA and the Area Agency on Aging as important unintended side benefits of HOPE IV participation specifically attributable to the presence of the Service Coordinator. In this, as in many other respects, the HOPE IV Service Coordinators assumed a more central role than originally envisioned.

2.5.2 The Dimensions of the Service Coordinator Role

The Service Coordinator responsibilities for all three programs included:

- Intake, including recruitment and enrollment of participants into the program;
- Working with (and, if necessary, constituting) a Professional Assessment Committee (PAC) to assess eligibility and determine service needs (optional for SCP);
- Working with the PAC and service providers to create service packages tailored to the individual needs of the frail elderly participants, and periodically reassessing their needs and adjusting the service plans accordingly (SCP had no frailty requirements for eligibility);

- Providing case management, including establishing linkages to service providers in the community, referring and linking participants to services, and monitoring the provision of services; and,
- Educating participants on services and service availability.

In addition, CHSP and SCP guidelines specified a role for Service Coordinators in helping residents build informal support networks and suggested a possible role in educating other staff on issues related to aging-in-place and service coordination.

The relative mix of activities that developed over time was very different for the HOPE IV Service Coordinators than for the CHSP and SCP Service Coordinators in more established projects. This occurred mainly because recruitment and enrollment into the HOPE IV Program proved far more demanding and time-consuming and continued nearly unabated throughout the life of the Demonstration. The result was that the HOPE IV Service Coordinators stepped into a vacuum to take on a variety of unanticipated functions, including marketing the Program to different audiences, helping applicants fill out Section 8 paperwork, locating appropriate housing, and providing help in obtaining benefits. Over time a conflict often developed between focusing on "front end" activities such as marketing, recruitment and assessment, and paying closer ongoing attention to the shifting needs of the already enrolled HOPE IV participants.

By contrast, CHSP Service Coordinators did not experience the same challenges with recruitment and enrollment in large part because residents were already living in the congregate facilities. Although they employed a variety of outreach methods (e.g., fliers and brochures, newsletters), CHSP Service Coordinators could rely mostly on "word-of-mouth" and the help of the resident services staff in identifying individuals who might benefit from the Program. For the SCP, recruitment was similarly a matter of building on existing channels (placing articles in resident newsletters, holding a social event) and utilizing the knowledge of building managers in locating good candidates for program participation. Consequently, for both the CHSP and SCP, recruitment and enrollment only occupied a significant share of the Service Coordinators' time while the programs were first getting started.

Service Coordinators in all three programs also assumed some responsibility for assessing the applicants' functional status to ensure they met the eligibility criteria for entering the program. However, again, while assessment remained a major part of the HOPE IV Service Coordinators' activities throughout the five-year period, it dwindled in importance after the initial start-up period for CHSP Service Coordinators and was a major activity only for SCP Service Coordinators in new projects.

Again, differences between HOPE IV, on the one hand, and the CHSP and SCP, on the other, reflect the anomaly that enrollment of new participants continued throughout the course of the HOPE IV demonstration. The CHSP and SCP role "normalized" more quickly and completely, permitting these Service Coordinators to dispense more readily with "front end" activities such as recruitment and assessment, and focus their energies on their primary case management duties. For HOPE IV Service Coordinators, the strain was never entirely resolved. However, the situation improved with the availability in 1994 of additional funds for service coordination, which allowed nine of the 16 HOPE IV grantees to extend the Service Coordinator's hours or hire another person part-time.

In addition to performing their officially designated duties, Service Coordinators emphasized the part of their role that involved direct personal engagement with frail elderly program participants. HOPE IV Service Coordinators reported that interaction with participants occupied the single largest share of their time, much of it spent conducting routine checks and friendly visiting. Being located in the same building made it possible for CHSP Service Coordinators to provide the kind of small day-to-day assistance (reading prescriptions, help with the washing machine) that helped participants continue to function and reassured them they could obtain the help they need(ed). Service Coordinators in established SCP projects also reported devoting much of their time to counseling and support, meeting with, and advising residents.

2.5.3 Participant Views of and Interactions with their Service Coordinators

HOPE IV, CHSP and SCP participants were very satisfied with their Service Coordinators. In many cases, participants identified the Program with the person of their Service Coordinator. At baseline, 82 percent, and at follow-up, 91 percent, of HOPE IV participants reported they were very satisfied with their Service Coordinators. Those few who said they would have liked something more from their Service Coordinators wanted more of the same services the Service Coordinators were already providing.

When asked what their Service Coordinators did for them, when first entering the Program, HOPE IV participants emphasized the help they got from their Service Coordinators with obtaining and scheduling services, getting rental assistance/housing, and qualifying for the Program. Two years later, they gave greater emphasis to the monitoring and socializing aspects of the role, as well as the information their Service Coordinators provided to them about services. *At both points in time, however,*

the Service Coordinator activities the HOPE IV participants valued most were help in obtaining and scheduling services, and help in securing housing and rental assistance.

At baseline, CHSP residents also saw the Service Coordinators' central functions as providing information about, and helping to arrange, services. As well, they viewed the Service Coordinator "as their friend and a conduit to whatever help they need(ed)." CHSP Service Coordinators pointed to the benefits of having someone on-site to help with daily problems, check on residents regularly, and monitor service delivery. They reported that knowledge that there was someone there all the time contributed to a greater sense of security for the participants and their families.

Among SCP residents, the largest number also mentioned the Service Coordinator as "someone who would listen to and help solve their problems." Residents also valued the help their Service Coordinators provided in linking them to services and making them aware of available services and how to access them. As with CHSP, residents of SCP projects also said they felt more secure knowing the Service Coordinator was available to them, even if they had never actually solicited her assistance.

At baseline, not surprisingly, CHSP participants saw their Service Coordinators more often than HOPE IV participants did theirs, but this did not translate into more frequent meetings to discuss service needs. Excluding those who reported never having seen their Service Coordinators, two-thirds of CHSP participants but only 14 percent of HOPE IV participants indicated contact of once a week or more. However, CHSP participants were answering the question of how often they saw their Service Coordinator, which in a congregate setting might mean chancing upon her in the hallway or stopping to chat in the dining room. Comparing HOPE IV and CHSP participants' responses to the question of how often they met with their Service Coordinators specifically to discuss their service needs, at baseline, 42 percent of HOPE IV participants, and 34 percent of CHSP participants, indicated they met with their Service Coordinators more than once a month for these purposes.

At follow-up, the percentage of HOPE IV participants who saw their Service Coordinators more than once a month to discuss service needs fell to 13 percent, with the modal category (39 percent) those who reported contact of once a month. Between baseline and follow-up, the average frequency of contact with HOPE IV Service Coordinators fell from nearly 23 times a year to 11 times a year, or from nearly twice a month to just under once a month. A decline in the frequency of the HOPE IV participants' in-person contact with their Service Coordinators reflects a pattern of more intense contact when the participants first entered the Program, followed by more routine, less frequent contact once they were settled in their housing with a service plan in place. Also, as their caseloads rose, some HOPE IV Service Coordinators shifted from in-person to telephone contact as their routine means of staying in

touch with their elderly clients, reserving in-person visits for more pressing or unusual circumstances (e.g., a dramatic deterioration in the participant's health that would necessitate an immediate change in service plans). The data are not available to assess whether the CHSP participants experienced a similar diminution in contact with their Service Coordinators over time. However, one would speculate that the pattern remained more stable because the CHSP Service Coordinators were located in the same buildings as their clients, and were not experiencing the same pressures as their HOPE IV counterparts.

2.5.4 Service Coordinators: A Summary

- Most Service Coordinators in the HOPE IV, CHSP, and SCP programs were well qualified for their positions and had prior relevant experience. Grantees took advantage of the flexibility allowed by HUD to produce a diversity of Service Coordinator working arrangements.

- HOPE IV, CHSP and SCP participants were very satisfied with their Service Coordinators. All emphasized the Service Coordinator's help in linking them to, and providing information about, services. HOPE IV participants also gave primacy to their Service Coordinator's help in obtaining housing and rental assistance, whereas CHSP and SCP residents tended to highlight the more personal, interactive aspects of the relationship.

- At baseline, CHSP participants saw their Service Coordinators much more frequently than did HOPE IV participants on a day-to-day basis, but actually met with to discuss their service plans with their Service Coordinators slightly less often. However, the frequency of the HOPE IV participants' in-person contacts with their Service Coordinators declined considerably between baseline and follow-up.

- Largely because the unexpectedly heavy requirements of recruiting and enrolling participants continued far into the five-year period, the HOPE IV Service Coordinator role developed differently than in the other two programs. HOPE IV Service Coordinators had to continue to devote significant time and energy to "front end" tasks, whereas Service Coordinators in the CHSP and established SCP projects were able to focus more exclusively on case management functions after the initial start-up period.

The implications of these findings, especially as they bear on differences in the Service Coordinator role in scattered site versus congregate settings, are discussed in the conclusion to this report.

3. DEMOGRAPHIC AND HOUSING CHARACTERISTICS OF THE HOPE IV AND CHSP PARTICIPANTS

3.1 Demographic Characteristics

HOPE for Elderly Independence and the new Congregate Housing Services Program brought frail elderly persons and an accompanying system of case management and supportive services well into the purview of HUD housing assistance programs, often for the first time. To be eligible for HOPE IV and CHSP participants had to meet the programs' age, income, and frailty guidelines, but the evaluation identified many other important patterns of demographic characteristics within these criteria. Of particular interest for this chapter are those factors that prior research shows are highly correlated with risk of institutionalization and need for services. These factors include advanced age, living alone, and minority status.

3.1.1 Age, Race/Ethnicity, and Gender

Consistent with the profile of frail elderly, nationwide, the baseline evaluation surveys found that the vast majority of HOPE IV and CHSP participants were white females, many of whom were of advanced age. Table 3-1 shows that over half of the participants were at least 75 years old; however, CHSP participants were markedly older, with a median age of 82 years, versus 74 years for HOPE IV. Of particular interest is the fact that nearly half of the HOPE IV participants were under the age of 75, a group not often at high risk for institutionalization. For example, only 16 percent of elderly nursing home residents are less than 75 years of age.[8] Conversely, only 22 percent of CHSP participants were under

Table 3-1.
Demographic Characteristics:
Age, Race/Ethnicity, and Gender

Characteristics	HOPE IV *(n-543)* (%)	CHSP *(n=591)* (%)
Age		
62-74	*50*	22
75-84	*34*	40
85 and over	*16*	38
Median age in years	*74*	*82*
Race		
White	90	93
Black	3	6
Other	3	1
Hispanic Origin*	10	2
Gender		
Female	80	83
Male	20	17

*Hispanics can be of any race.

[8] National Center for Health Statistics, 1985 National Nursing Home Survey, *Vital and Health Statistics*, Series 13, No. 97, Table 27.

age 75. However, when analyzing HOPE IV participant data on frailty according to age, as discussed in Chapter 4 below, we found that the youngest group reported rates of limitation in activities of daily living similar to those for people age 75 and older.

Nearly all the HOPE IV and CHSP participants were white; only three percent of HOPE IV and six percent of CHSP participants were black. Those of Hispanic origin, who can be of any race, comprised ten percent of HOPE IV and two percent of CHSP participants. Virtually all of the HOPE IV Hispanic participants were from a single grantee PHA in an area with a high concentration of Mexican-American elderly. The percentage figures for Hispanic participants, therefore, are a function of project location and grantee recruitment and placement practices rather than an indication of low-income and frailty levels on the part of Hispanic elderly.

Federal statistical agency data show that most poor, frail elderly in this country are female, and the HOPE IV and CHSP participants reflected this national trend. For example, according to the Census Bureau, of persons age 65 and over who are below the poverty threshold and have a severe disability, 78 percent are women and 22 percent are men.[9] Approximately 80 percent of the HOPE IV and CHSP participants were female, mirroring the profile of America's population of low-income, frail elderly, overall. This pattern generally held across all the grantee sites.

3.1.2 Marital Status and Living Arrangements

Most of the HOPE IV and CHSP participants had been widowed for many years and were living alone. As Table 3-2 shows, only about 10 percent of participants were married at the time of the survey, while over 60 percent were widowed and another 30 to 40 percent were either divorced, separated, or never married. The vast majority of participants in both the HOPE IV and CHSP programs (86 and 88 percent, respectively) lived alone. Consistent with the focus of HOPE IV and CHSP, persons who are frail and live alone are at considerable risk, often relying on outside help for performing basic life activities, such as personal care and home management.

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[9] McNeil, J.M., *Americans with Disabilities: 1991-92*, U.S. Bureau of the Census, Current Population Reports, P70-33, U.S. Government Printing Office, Washington, D.C., 1993, Tables 13 and 14.

Over 40 percent of the HOPE IV participants moved to new rental housing to participate in the program, either to meet Section 8 Housing Quality Standards or the rental (versus owner) housing requirement. This figure is somewhat higher than the approximately one-third of Section 8 Voucher holders (of all ages) who move to quality for rental Vouchers or Certificates. Many HOPE IV applicants lived in rental housing not meeting Section 8 requirements; in some cases, the applicants owned their residences. These individuals either chose to forego enrollment in the HOPE IV program by not moving, or they relocated into qualifying housing as HOPE IV participants. Conversely, nearly 60 percent of participants already lived in rental housing meeting HUD Housing Quality Standards. CHSP, as distinct from HOPE IV, enrolled participants who were already congregate housing residents, avoiding any need to move.

Table 3-2.
Demographic Characteristics:
Marital Status and Living Arrangements

Characteristics	HOPE IV *(n=543)* (%)	CHSP *(n=590)* (%)
Marital status		
Widowed	61	70
Divorced/Separated	25	11
Married	9	10
Never married	5	4
Living arrangements		
living alone	86	88
2 persons	13	12
Moved to qualify for HOPE IV		
Yes	42	NA
No	57	NA
Unknown	1	NA

Figures on moving are important for several reasons. First, studies of the elderly show that changing residence can be a traumatic experience that exacerbates, rather than alleviates, the problems of frailty that HOPE IV was attempting to address. Second, as interviews with Service Coordinators and other HOPE IV staff revealed, locating suitable housing for frail elderly was a substantial barrier to implementation of the program. The rental units not only had to meet Section 8 Housing Quality Standards, but also had to appeal to the frail elderly, in terms of accessibility, safety, and proximity to community services. In this regard, there were problems of housing availability. For example, Service Coordinators reported that after being on a Section 8 waiting list for several years, some HOPE IV participants had to place themselves on waiting lists for private rental housing for the elderly in their community in order to obtain a suitable apartment.

3.1.3 Length of Time in Current Residence

Nearly half of the HOPE IV participants had moved into their current home within one year of enrollment, either in conjunction with the HOPE IV program or for other reasons. In contrast, only 12 percent of the CHSP participants had lived in their current home for less than one year (Table 3-3).

This pattern of housing tenure was a function of design differences in the two programs. All HOPE IV participants were new to HUD housing assistance programs, per the legislative requirements. Current Section 8 and other tenants were ineligible for HOPE IV. In contrast, CHSP participants were drawn from current residents of HUD assisted congregate housing. For this reason, only about one-quarter of HOPE IV participants had lived in their rental housing at least five years versus 53 percent for the CHSP participants.

Table 3-3.
Housing Characteristics:
Length of Time in Current Home/Apartment

Characteristics	HOPE IV *(n=543)* (%)	CHSP *(n=586)* (%)
Less than 6 months	32	5
6-11 months	17	7
1-4 years	27	35
5-10 years	13	26
More than 10 years	11	27

HOPE IV participants who had moved within one year of enrolling in the program identified their reasons for relocating. HOPE IV was a combination of two types of benefits, Section 8 rental assistance and supportive services. Given the long waiting periods for receiving Section 8, in many cases more than two years, grantee locales had a substantial unmet demand for affordable, rental housing. At the same time, given the requirements of HOPE IV, applicants may have had to choose between staying in their current (but unqualified) home and foregoing HOPE IV services, or giving up their residence in order to meet the rental housing and housing quality standards of Section 8. For these reasons, the study sought to distinguish between participants who moved primarily as a function of HOPE IV program requirements and those who reported another primary reason. Of those participants who had lived in their home for less than one year, 42 percent said they had moved as a function of HOPE IV. Fourteen percent cited Section 8 rental assistance, and 43 percent said they had moved for reasons unrelated to program participation, such as proximity to children, safety, and cost. Given the benefits of remaining in place for this frail elderly population, the impact analysis explored the relationship between housing stability and various outcome measures, such as nursing home placement and life satisfaction (see Chapter 6).

4. FUNCTIONAL STATUS AND HEALTH

4.1 Frailty of HOPE IV and CHSP Participants

HOPE IV and CHSP regulations required that participants qualify for HUD-assisted housing by virtue of their low-income and need for assistance in personal care and home management activities. As Chapter 2 described, these activities cut across two primary measures of frailty frequently used in research: limitations in *Activities of Daily Living (ADL)* and *Instrumental Activities of Daily Living (IADL)*. ADLs include very basic activities essential to independent living: eating, dressing, bathing, transferring (between bed and chair), and toileting (getting to and using the toilet as opposed to continence).[10] IADLs go beyond ADLs in level of complexity and include handling personal finances, meal preparation, shopping, traveling about the community, doing housework, using the telephone, and taking medications.[11]

To ensure consistency with the considerable body of prior research on the frail elderly, the HOPE IV and CHSP study designs collected data on these standard ADL/IADL measures, as well as on the additional activities in the HOPE IV and CHSP regulations. By combining these measures, this report can present functional profiles of the HOPE IV and CHSP participants that relate to both the HUD program regulations and to other studies of frailty among the elderly, especially participants in other community-based, long-term care programs. The following tables and accompanying narrative begin with the traditional ADL/IADL measures and end with a presentation and discussion of frailty as defined by the HOPE IV and CHSP program regulations.

4.1.1 Activity of Daily Living Limitations

Table 4-1 identifies the number and percentage of HOPE IV and CHSP participants who reported difficulty in performing each of five ADLs, including those who were unable to do so, as well as those who had some or a lot of difficulty. *Between one-third and one half of the participants in both programs reported difficulty with four of the five activities, indicating substantial levels of frailty among the participants at baseline.*

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[10] Katz, S., and C.A. Apkom, A measure of primary sociobiological functions. *International Journal of Health Sciences* 6:493-508, 1976.

[11] Lawton, M.P., and E.M. Brody, Assessment of older people: Self-maintaining and instrumental activities of daily living. *Gerontologist* 9:179-186, 1969.

Table 4-1. Frailty Characteristics: Activity of Daily Living (ADL) Limitations at Baseline		
Activities	HOPE IV *(n=543)* *(%)*	CHSP *(n=286)* *(%)*
Limitation in		
Bed/chair transfer	55	67
Bathing	46	57
Dressing	45	56
Using toilet	32	46
Feeding self	14	21
Multiple ADL Limitations - One or more	74	79

The ADL scale is hierarchical, and certain activities are more indicative of frailty than others. For example, difficulty feeding one's self, while of relatively low prevalence, represents the most severe limitation.[12] Therefore, when interpreting the figures in the tables, it is important to realize that low rates of difficulty actually represent those activities for which the elderly need the greatest level of assistance.

HOPE IV and CHSP participants were considerably more frail than the elderly population as a whole, in terms of the ADL difficulty criteria in Table 4-1. Measures of ADL difficulty address very basic life activities essential for independent living, affecting a relatively small percentage of the overall elderly population. For example, among all non-institutionalized elderly age 65 and over, only 11 percent reported a limitation in at least one ADL, ranging from about 9 percent for dressing to approximately 1 percent for feeding oneself.[13] In contrast, nearly three-quarters of HOPE IV participants and nearly 80 percent of CHSP participants reported difficulty performing at least one ADL.

When describing physical frailty, other community-based, long-term care surveys or programs often identify the number of persons receiving (or needing) help from another person to perform the activity, as opposed to just having a difficulty or a limitation. These studies use the term ADL dependencies to describe this measure, which identifies a more severe limitation than simply reporting difficulty performing the activity. Using this constructed definition, approximately 30 percent of HOPE IV participants reported receiving help from another person for at least one of the five ADLs. To put these figures in perspective,

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[12] Ficke, R.C. *Digest of Data on Persons with Disabilities.* Washington, DC: National Institute on Disability and Rehabilitation Research, *1992.*

[13] Agency for Health Care Policy and Research, *1987 National Medical Expenditure Survey, Research Findings 4.*

only about 8 percent of the total household population age 65 and older reported receiving such help from another person in performing at least one of these five ADLs.[14]

While HOPE IV and CHSP participants were considerably more frail than the elderly population overall, they were much less frail than persons who receive, or are eligible for, nursing home care. Approximately 92 percent of nursing home residents age 65 and older had at least one ADL dependency, in this case involving the assistance of another person. These dependencies included incontinence (e.g., using a catheter or bedpan), and they range from a high of 91 percent for dressing to a low of 40 percent for eating.[15] Involving a similar clientele needing skilled nursing care, the recent Program for All-Inclusive Care for the Elderly (PACE) programs focused on elderly persons who were eligible for nursing home care but chose to receive services in the community. Between 79 percent and 95 percent of participants in the PACE program had at least one ADL dependency.[16] Also targeting a nursing home eligible elderly population, the Federal government's Long Term Care Channeling Demonstration program participants had an ADL dependency rate of approximately 84 percent.[17]

The purpose of these ADL comparisons, as summarized in Table 4-2, is to show where HOPE IV participants lie along a continuum, from the elderly household population in general through those who receive or qualify for nursing home care. Comparable CHSP data was not available.

4.1.2 Instrumental Activities of Daily Living Limitations

While ADL limitations focus on personal care needs, the Instrumental Activities of Daily Living (IADL) scale covers a higher level of functioning associated with care of the home.

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[14] Wiener, J.M., et al "Measuring the activities of daily living: Comparisons across national surveys," *Journal of Gerontology: SOCIAL SCIENCES, 45,* No. 6 1990.

[15] National Center for Health Statistics, 1985 National Nursing Home Survey, *Vital and Health Statistics*, Series 13, No. 97, Table 27.

[16] Branch, L.G., et al "The PACE evaluation: Initial findings," *The Gerontologist, 35,* No. 3 1995.

[17] Kemper, P., et al *The Evaluation of the National Long Term Care Demonstration: Final Report*, Mathematica Policy Research, Inc., Princeton, NJ, 1986, p. 41.

IADL limitations pertain to many of the frailty criteria in the HOPE IV and CHSP regulations including need for assistance in preparing meals, shopping, doing light housework, and managing money. HOPE IV and CHSP participants reported difficulty performing these activities ranging from a high of 83 and 81 percent, respectively, for light housework to a low of 33 and 45 percent, respectively, for managing money, as Table 4-3 shows. The IADL difficulty rates in Table 4-3 measure the relatively complex domains of functioning that HOPE IV and CHSP participants require for independent living in scattered site and congregate rental housing, with the help of case management and supportive services to perform these activities.

Table 4-2.
Frailty Characteristics:
Comparing HOPE IV with Other Long-Term Care Programs for the Frail Elderly

Program	Persons with at Least One ADL Dependency* (%)
Household population 65+	8
HOPE IV (at baseline)	30
Channeling demonstrations	84
PACE demonstrations	79-95
Nursing home residents 65+	92

*ADL dependency means receiving help from another person to perform an activity of daily living.

To put these figures in perspective, 18 percent of the total household population age 65 and older reported at least one IADL limitation, in this case from a list of six activities include the above four as well as using the telephone and getting around the community.[18] Also by way of comparison, virtually all nursing home residents and participants in the PACE and Channeling programs had at least one IADL difficulty, consistent with the relatively high level of physical and cognitive functioning that IADLs require.

Table 4-3.
Frailty Characteristics:
Instrumental Activity of Daily Living (IADL) Limitations at Baseline

Activities	HOPE IV *(n=543)* (%)	CHSP *(n=590)* (%)
Reports difficulty in:		
Doing light housework	83	81
Shopping	76	72
Preparing meals	56	56
Managing money	33	45

For this study, the main value of data on ADL and IADL limitation rates to control for service need when analyzing impact in terms of nursing home placement, changes in well-being, and the other measures presented in Chapter 6, and in analyzing adherence to HUD eligibility requirements, as covered in the next section.

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[18] Agency for Health Care Policy and Research, *1987 National Medical Expenditure Survey, Research Findings, 4.*

4.1.3 Analysis of HOPE IV and CHSP Eligibility

During interviews with HOPE IV and CHSP grantees, the Service Coordinators and others stated that they had considerable difficulty interpreting the eligibility criteria that participants be "deficient in at least three activities of daily living," as the program regulations defined them. Also, for eligibility determination purposes, all but one of the 16 first-round HOPE IV grantees and many of the CHSP sites used their own existing local assessment instruments and procedures to collect and cross-walk traditional ADL and IADL information to the HUD criteria The grantees used their own judgment in translating their assessment results according to HOPE IV and CHSP eligibility criteria.

For the purposes of standardizing and analyzing grantee adherence to the HOPE IV and CHSP eligibility criteria, the evaluations asked the participants about their ability to perform the 12 activities mentioned in the HOPE IV and CHSP regulations (See Table 4-4). Using these eligibility criteria, 81 percent of HOPE IV participants and 76 percent of CHSP participants reported difficulty performing at least three of these activities.

The ADL difficulty information in Table 4-4 suggests that about 19 percent of the HOPE IV and 24 percent of the CHSP participants had fewer than three ADL difficulties, contrary to the HOPE IV and CHSP program regulations. As one explanation for this disparity, prior research in measuring ADL difficulties shows that frail elderly persons, especially women, self-report fewer difficulties than do professionals when assessing them. For example, in their work with the Women's Health and Aging Study, sponsored by the National Institute on Aging, Westat and Johns Hopkins University researchers found that frail elderly women in the community under-reported their level of ADL difficulties compared to the functional assessments and physical performance tests conducted by study team professional staff.[19] In addition, this study found that such under-reports of functional capacity come, in part, from various adaptive behaviors on the part of the frail elderly (e.g., changing how they approach an activity) to compensate for a limitation in functioning. The study also found that respondents were quite unaware that this decline in functioning had occurred, which may also help to explain some of the under-reporting. These findings are consistent with others in the literature on frailty among the elderly.[20]

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[19] Guralnik J.M., et al., eds. *The Women's Health and Aging Study: Health and Social Characteristics of Older Women with Disability.* Bethesda, MD: National Institute on Aging, *1995, p 28.*

[20] Rubenstein, et al., Systematic biases in functional status assessment of elderly adults: Effects of different data sources. *Journal of Gerontology*, 39:686-69, 1984.

Table 4-4. Frailty Characteristics: HUD ADL Difficulties (12 activity categories)		
Activities	HOPE IV *(n=543)* (%)	CHSP *(n=590)* (%)
Reports difficulty:		
Feeding self	14	9
Preparing meals	56	56
Washing self	46	45
Getting in and out of shower/tub	70	59
Using toilet	32	24
Personal grooming	31	27
Washing hair	52	49
Dressing	45	38
Bed/Chair transferring	55	54
Housework	83	81
Shopping	76	72
Managing money	33	45
Total limitations: *		
0-2	19	24
3-5	27	26
6+	54	50

* *For CHSP the total number of activities was 13, for HOPE IV it was 12 (excluding difficulty using the telephone)*

As another possible explanation for under reporting, the high level of participant satisfaction with the HOPE IV and CHSP programs and fear of losing the benefits may have discouraged participants from reporting ADL limitations. Participants may have been unwilling to admit difficulties that either suggested criticism of the HOPE IV or CHSP programs (for not meeting all their needs) or that implied they might have needed nursing home or other restricted forms of care that they wanted to avoid.

In addition, as the previous interim reports on the HOPE IV and CHSP[21] programs showed, there was considerable variation in how grantees interpreted the program eligibility requirements and measured ADL difficulties using their own assessment instruments and procedures. Most grantee assessments categorized ADL difficulty according to several levels, ranging from inability to perform an activity at all to just having some difficulty with it. Some grantees assigned numeric scores depending on the particular activity and the level of difficulty, and they used these as a basis for determining HOPE IV and CHSP

[21] Ficke, RC and Susan Berkowitz, *Evaluation of the HOPE for Elderly Independence Demonstration Program: Second Interim Report,* U.S. Department of Housing and Urban Development, Washington, D.C. 1996; *Evaluation of the New Congregate Housing Services Program*, Research Triangle Institute, U.S. Department of Housing and Urban Development, Washington, D.C. 1996

eligibility. These procedures varied from site to site, which may explain some of the inconsistency between the evaluation survey findings and local practice in ascertaining HOPE IV and CHSP eligibility. This local indicator also confirms the viability of using the standard frailty measures in the evaluation's survey instruments to ensure consistent data across the program sites for this study.

4.2 Health Status

This section uses a variety of indicators to describe the self-reported health status of the HOPE IV and CHSP participants. Some of these indicators relate to acute medical conditions and care, including hospital stays and doctor visits. Others cover chronic, or long-term, conditions such as heart disease, hypertension, and diabetes. Equally important are the consequences or outcomes of one's health status and conditions, such as the number of days participants are confined to a bed or chair. While the frailty measures listed above were the primary basis for establishing HOPE IV and CHSP eligibility, there is a high correlation between chronic activity limitation and overall health status. For this reason, HOPE IV and CHSP participants would be expected to report numerous medical problems.

4.2.1 Health Conditions

Consistent with their functional limitation status, HOPE IV and CHSP participants at baseline reported having many chronic health conditions. Table 4-5 shows the range of these health conditions (based on what their doctor or other health professional had told them). About one-half of HOPE IV and CHSP participants reported having high blood pressure, and 39 to 45 percent of participants, respectively, indicated having a heart condition. Between 14 and 20 percent of HOPE IV and CHSP participants reported having diabetes, arteriosclerosis, or having had a stroke.

In their health status and ADL limitations, HOPE IV and CHSP participants at baseline were broadly similar to residents of board and care homes and other recipients of community-based supportive services. For example, a probability survey of residents of North Carolina domiciliary care facilities found that 14 percent of residents had diabetes, [22] and a study of elderly recipients of companion services found

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[22] Hawes, C., Lux, L., Wildfire, J., Green, R., Packer, L., Iannachione, V. & Phillips, C. Study of North Carolina Domiciliary Care Home Residents. Submitted to North Carolina Department of Human Resources, Division of Facility Services, 1995a.

ten percent with diabetes. In the North Carolina domiciliary care survey, 12 percent of residents were found to have serious respiratory conditions, and 26 percent had hypertension.[23]

Table 4-5.
Health Characteristics:
Health Conditions at Baseline

Conditions	HOPE IV *(n=543)* (%)	CHSP *(n=590)* (%)
Hypertension	53	49
Heart Disease	45	39
Diabetes	19	20
Stroke	18	15
Arteriosclerosis	14	19

4.2.2 Frequency of Falls

Even with case management and personal assistance, HOPE IV and CHSP participants spent considerable time alone in their homes. For a frail elderly population, the risk of falls was always present and a potential source of injury. As Table 4-6 shows, 22 percent of persons in HOPE IV and 12 percent of CHSP participants said they sought medical care as a result of falling; and 9 percent and 7 percent, respectively, were hospitalized for more than 1 day due to a fall.

Table 4-6.
Health Characteristics:
Frequency of Falls at Baseline*

Characteristics	HOPE IV *(n=543)* (%)	CHSP *(n=590)* (%)
Fallen during past year and:		
Sought medical care	22	12
Hospitalized over 1 day	9	7

* Percent of all persons.

It is interesting to note that these fall rates were almost twice as high for HOPE IV as for CHSP participants. As a possible explanation, the apartments occupied by HOPE IV participants frequently required climbing stairs for entry (41 percent), and some of these participants reported difficulty entering

[23] Differences in the age mix of residents and the ways of measuring the health conditions mean that the figures are not precisely comparable, but the comparisons reinforce the view that HOPE IV and CHSP services were being targeted to a population that was in need of services and potentially at risk of death or institutional placement.

their home (14 percent) and getting around their home (8 percent). Congregate housing typically does not require climbing steps, and architectural designs are usually devoid of barriers to entry and movement around the apartment.

4.2.3 Medical Care Access and Use

Despite their high level of frailty and high prevalence of chronic health conditions, the majority of the HOPE IV and CHSP participants had not been confined to bed or a chair at all during the month prior to the baseline interview and had not stayed in a hospital overnight at all during the prior 12 months. However, more than a third of both groups of participants had stayed overnight as a hospital in-patient over the prior year, which is twice the rate for the elderly household population as a whole (See Table 4-7).[24]

Table 4-7.
Health Characteristics:
Health Care Utilization at Baseline

Characteristics	HOPE IV *(n=543)* (%)	CHSP *(n=590)* (%)
During past year:		
Was overnight hospital patient	42	36
During past month:		
Stayed in bed or chair most of the day due to health problem:		
No days	61	78
1-7 days	9	13
8 or more days	29	9

Disability days, that is, the number of days a person stayed in bed or a chair most of the time due to a health problem, represent a common health status measure. Sixty-one percent of the HOPE IV and 78 percent of CHSP participants reported no disability days at all. However, 36 percent of HOPE IV and 22 percent of the CHSP participants stayed in bed or a chair most of the day at least once during the month prior to the baseline survey due to a health problem.

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[24] U.S. Bureau of the Census, Current Population Reports, Series P-70, No. 8, *Disability, Functional Limitation, and Health Insurance Coverage:* 1984/85, U.S. Government Printing Office, Washington, D.C., 1986.

4.2.4 Mental Health, Quality of Life, and Cognitive Status

While the physical functioning measures presented thus far can effectively assess one's capacity for self-care and independent living, they say little about the quality of a person's life. Indeed, a major purpose of programs that prevent or delay inappropriate institutionalization is to enhance the many domains of mental, emotional, and social well-being. While the physical focus of the HOPE IV and CHSP eligibility criteria was quite appropriate for selecting participants, an important impact measure is the extent to which this program improves (or lessens the decline) in quality of life, relative to a comparison group over time.

The tables which follow show changes between the 1994 baseline survey of HOPE IV participants and a follow-up survey conducted two years later in 1996. There are also corresponding baseline and follow-up survey figures for a comparison group of frail elderly in Section 8 but not in HOPE IV. This allows tracking changes in the well-being of HOPE IV participants over time, relative to what would have occurred without the Program. While the relative changes and differences are interesting, as the following text and tables describe, the primary uses of these data are to support the multivariate analysis in Chapter 6 which shows the relationship between program participants and outcomes.

In spite of their poor health and frailty, most of the HOPE IV participants reported the quality of their lives to be relatively high, although this was not the case for all. Table 4-8 presents five measures of life satisfaction. (The data were collected for HOPE IV but not CHSP) Over one-third of the HOPE IV participants responded at baseline that they were, in general, very satisfied with the way their life is going, and 45 percent indicated they were somewhat satisfied with life. Almost one-fifth, however, said they were not satisfied. Most HOPE IV participants (56 percent) said they had a great deal of choice about what they do and when they do it, and over half reported they were very confident about their ability to deal with daily living. Almost half said they do not worry at all about whom to turn to for help, and over 50 percent reported their appetite as good. However, 17 percent of HOPE IV participants said they worry at lot of the time about not knowing whom to turn to for help, and 45 percent said their appetite was only fair to poor. The comparison group reported similar baseline rates of life satisfaction for all these items.

Table 4-8. Measures of Life Satisfaction				
	Participant		Comparison Group	
Quality of Life Measures	Baseline (n=543) (%)	Follow-Up (n=286) (%)	Baseline (n=523) (%)	Follow-Up (n=324) (%)
Life satisfaction:				
Very satisfied	36	32	32	28
Somewhat satisfied	45	50	47	52
Not satisfied	19	16	18	18
Unknown	1	1	3	2
Amount of choice:				
A great deal	56	48	50	55
Some	34	43	37	35
None	8	7	10	9
Unknown	1	2	2	2
Confidence:				
Very confident	51	48	49	47
Somewhat confident	40	39	43	44
Not confident	7	10	6	6
Unknown	2	2	2	3
Amount of worry:				
A lot	17	11	18	18
Some	35	32	34	28
Not at all	47	55	47	52
Unknown	1	2	1	2
Appetite:				
Good	54	61	53	57
Fair	32	32	35	34
Poor	13	7	12	9
Unknown	1	1	1	0

Between baseline and follow-up, these patterns remained very similar. Both participants and comparison group members, overall, continued to report high levels of well-being. Chapter 6 explores similarities and differences in these patterns for subgroups of participants and comparison group members and controlling for such factors as receipt of services by the comparison group from non-HOPE IV sources.

HOPE IV Participants described themselves as generally happy, peaceful and calm, and many said they were full of life most or all of the time. However, only a few participants reported having lots of energy, and many felt worn out or tired most or all the time. Table 4-9 provides several measures of vitality and mental health using positive and negative indicators about HOPE IV participant feelings. Thirty-seven percent of participants said they felt full of life most or all the time during the past 30 days, and about 60 percent said they were a happy person or felt calm or peaceful most or all of the time during that period.

Few of the HOPE IV participants (14 percent) felt so down in the dumps that nothing could cheer them up, and a similar number (13 percent) felt downhearted or low most of the time. Over one quarter of the HOPE IV participants, however, stated they had been a nervous person during the past month, and only 21 percent said they had a lot of energy. For most of these measures, the baseline comparison group responses were nearly the same.

Table 4-9.
Measures of Vitality and Mental Health

	Percent responding "all or most of the time"			
	Participant		Comparison Group	
During the past 30 day . . .	Baseline *(n=543)* (%)	Follow-Up *(n=286)* (%)	Baseline *(n=523)* (%)	Follow-Up *(n=324)* (%)
Vitality				
Did you feel full of life?	37	27	33	28
Did you have a lot of energy?	21	15	21	18
Did you feel worn out?	32	43	34	44
Did you feel tired?	38	46	40	48
Mental Health				
Have you felt calm and peaceful?	57	55	55	57
Have you been a happy person?	60	61	62	59
Have you been a very nervous person?	26	20	22	26
Have you felt so down in the dumps that nothing could cheer you up?	14	13	12	13
Have you felt downhearted or low?	13	13	13	16

Between baseline and follow-up, both HOPE IV participants and comparison group members reported similar, but often relatively small, changes in well-being. For example, those who reported feeling full of life dropped from 37 percent to 27 percent for participants and from 33 percent to 28 percent for the comparison group. While simple frequencies show little change over time and few differences between the participants and comparison group members, the analysis in Chapter 6 shows that there is a significant positive correlation between HOPE IV participation and receipt of services and between receipt of services and positive responses to these measures of well-being.

Cognitive functioning is an important determinant of risk for institutionalization and ability to function independently in a community-based, long-term care program such as HOPE IV. Generally, the participants and comparison group members had very few incorrect responses to questions that served as indicators of mental status. Table 4-10 presents the rates of incorrect responses to six questions, as a measure of cognitive status: the current year, season, date, day of the week, state of residence, and county of residence. At baseline, 63 percent of the HOPE IV participants and 66 percent of the comparison group members answered all items correctly, while 30 percent of participants and 23 percent of the comparison group made one incorrect response, virtually all of which was reporting the incorrect date. The remaining seven percent of participants and 10 percent of the comparison group had either two or three incorrect responses.

Table 4-10.
Cognitive Status

	Participant		Comparison Group	
Number of incorrect responses	Baseline *(n=439)* (%)	Follow-Up *(n=227)* (%)	Baseline *(n=415)* (%)	Follow-Up *(n=230)* (%)
None	63	75	66	72
One	30	19	23	24
Two	6	4	9	4
Three	1	1	1	0

Excluded from this analysis were all proxy responses for participants and comparison group members. While this might have eliminated persons with the most severe cognitive impairment, virtually all proxy cases were a function of preference by the participant rather than a decision by the interviewer due to inability of the person to respond.

Between baseline and follow-up the number of incorrect responses fell; however, this was not a function of extremely high exit rates among participants and comparison group members with low cognitive status scored at baseline. Cognitive status patterns for those who remained and those who left were similar, for both the participant and comparison group.

Measures of mental health and cognitive status are extremely important additions to recent research practices but often difficult to interpret, and researchers are only beginning to develop methods for scoring and aggregating responses to such questions to ascertain overall well-being.[25] The major application of these measures occurs in Chapter 6 when scoring and analyzing data from the baseline and follow-up interviews to determine changes over time, between the participants and comparison group members, and the relationship between positive scores and participation in HOPE IV.

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[25] Ware, J.E., *SF-36 Physical and Mental Health Summary Scales: A User's Manual,* The Health Institute, New England Medical Center, Boston, 1994.

5.0 INFORMAL ASSISTANCE, SOCIAL SUPPORT AND SERVICE UTILIZATION

5.1 The Importance of Informal Assistance and Social Support

Informal assistance, social support and sociability are important aspects of an older person's quality of life that also tend to correlate with measures of mental health and life satisfaction. In addition, the quality and level of social support received, independent of other factors, can affect a frail elderly person's risk of institutionalization. Consequently, the HOPE IV participants', comparison group members', and CHSP participants' informal social interactions are important to a comparison of both programs for several related reasons: (1) the amount and quality of informal assistance and support received may independently affect the risk of institutionalization for all three groups; (2) informal social support may enhance life satisfaction, itself an outcome variable in the conceptual model guiding the HOPE IV evaluation's quasi-experimental design; and (3) prior research has examined whether and how receipt of formal services influences the amount and type of informal assistance that elderly persons receive and how this, in turn, affects outcomes such as institutionalization.

5.1.1 Frequency and Nature of In-Person Social Contacts

To ascertain the level and kinds of social support they were receiving, HOPE IV participants and comparison group members as well as CHSP participants were asked about the frequency and patterns of their informal social contacts with relatives, friends and neighbors. Although the data for CHSP participants are not as comprehensive as those for the HOPE IV participants and comparison group members, on certain points they are similar enough to enable making three-way comparisons. Follow-up data, however, are available only for the HOPE IV participants and comparison group members.

On the whole, both the frequency and pattern of social contacts reported at baseline and at follow-up are remarkably similar for the HOPE IV participants and comparison group members. Eighty-two percent of both groups reported seeing another person—whether a family member, friend, or neighbor—on a regular basis at least once a month. Eighteen percent said they saw no one monthly except for service personnel or others living in their households. The percentages for both groups were identical at follow-up.

The average frequency of social contacts was slightly higher for comparison group members than for HOPE IV participants at baseline. The comparison group reported somewhat more frequent contact

with children (an average of 9.5 versus 7.8 times per month) and other relatives (an average of 5.1 versus 3.3 times per month). However, both groups saw someone, on average, almost every day in a month—22 days for HOPE IV participants and 25 days for the comparison group. At follow-up, while comparison group members still reported somewhat more frequent contact with children and other relatives (an average of 10.0 as compared to 8.9 times per month for children and 4.4 versus 3.0 contacts per month for other relatives), HOPE IV participants reported more contact with friends and neighbors than did comparison group members (11.5 as against 9.1 times per month). Moreover, at follow-up, overall average frequency of social contact was the same for both groups—about 24 times per month.

In sum, the overall frequency of in-person contact stayed more or less the same for the comparison group between baseline and follow-up, but increased somewhat for HOPE IV participants. Greater frequency of contact with friends and neighbors appears to account for much of this increase. This finding is especially interesting given that so many HOPE IV participants had to relocate to qualify for the Program, which one might speculate would have been disruptive of social ties. By contrast, most comparison group members were long-term residents of Section 8 housing, who would presumably have had ample time to develop a network of social support. *Thus, somewhat surprisingly, in some cases participating in HOPE IV appears to have spurred greater sociability with friends and neighbors.,*

As presented in Table 5-1, at baseline, most HOPE IV respondents and comparison group members showed a bimodal pattern of seeing a child either less than once a month or several times a week or more. Forty-seven percent of HOPE IV and 51 percent of comparison group respondents saw a child less than once a month. At the other end of the spectrum, 26 percent of HOPE IV participants saw a child more than three times a week and 12 percent saw a child every day. The same figures for the comparison group were 17 percent, and 18 percent, respectively. Thus, a slightly higher percentage of comparison group members than HOPE IV participants saw a child every day, which might reflect that HOPE IV was targeted to frail elderly with more limited support available from family members or others living in close proximity.

Table 5-1.
Monthly Frequency of Different Types of In-Person Social Contacts for HOPE IV and Comparison Group Respondents at Baseline and Follow-Up

Baseline	Participant *(n=541)*				Comparison Group (n=523)				CHSP Participants (n=564, 542)	
Times per month regularly sees . . .	Child (%)	Other relative (%)	Friend or neighbor (%)	Anyone (%)	Child (%)	Other relative (%)	Friend or neighbor (%)	Anyone (%)	Family* (%)	Friends (%)
Less than once (0-<1)	47	74	57	21	51	70	55	20	25	23
A few times (1-3)	4	5	3	3	4	4	3	3	17	12
Once or twice a week (4-7)	12	7	4	9	10	7	6	8	30	12
Several times a week (8-27)	26	10	14	31	17	10	15	24	22	19
Every day (28+)	12	4	22	37	18	9	22	45	6	35
Follow-Up	Participant *(n=286)*				Comparison Group (n=523)					
Less than once (0-<1)	43	76	56	19	45	70	61	19		
A few times (1-3)	6	6	3	3	4	4	2	3		
Once or twice a week (4-7)	15	6	5	10	13	7	4	9		
Several times a week (8-27)	19	7	13	29	19	9	14	26		
Every day (28+)	17	6	24	39	20	10	19	43		

*Includes all family members, not just children.

However, as shown in Table 5-1, the pattern of contact with family for CHSP participants at baseline was not similarly bimodal; the distribution of in-person contact with family members is much more even across the different categories. Only about half as many (25 percent) CHSP participants as HOPE IV participants and comparison group members reported seeing a family member (a child or any other family member) once a month or less. At the same time, considerably fewer CHSP participants (6 percent) reported daily contact with family members.

Looking at these results at just at one point in time and comparing only the HOPE IV and CHSP participants, one might be tempted to argue that the HOPE IV participants' greater frequency of in-person contact with family members at baseline reflected their newness in the Program, and would level off after a period of transition. However, the same basic bimodal pattern of contact with children also prevailed for both the HOPE IV participants and comparison group members at follow-up. Furthermore, the frequency of daily contact with children increased for both groups between baseline and follow-up, with a greater increase for the HOPE IV participants (from 12 percent to 17 percent) than for comparison group members (from 18 percent to 20 percent). *Consequently, these data do not support the idea that contact with children was abnormally high during the period of* entry *into the HOPE IV Program. If anything, the opposite is true*: at follow-up, 95 percent of participants' contacts with children had either stayed the same or increased since entering HOPE IV.

For HOPE IV participants and comparison group members, both at baseline and follow-up, the distribution of in-person contact with friends and neighbors was even more bimodal than contact with children. At baseline, 57 percent of HOPE IV and 55 percent of comparison group respondents did not see a friend or neighbor at least once a month, while 22 percent of both groups did so every day. At follow-up, 56 percent of participants and 61 percent of comparison group members indicated seeing a friend or neighbor less than once a month, while 24 percent of HOPE IV participants and 19 percent of comparison group members reported daily contact with a friend or neighbor.

The pattern of in-person contact with friends and neighbors was again quite different for CHSP participants at baseline: CHSP participants had more frequent contact with neighbors than either HOPE IV participants or comparison group members. About half as many CHSP participants as HOPE IV participants and comparison group members reported seeing a friend or neighbor less than once a month, and a considerably higher percentage (35 percent, as compared with 22 percent of both HOPE IV groups) indicated daily contact. Although follow-up data are

lacking, there is no reason to think that contact with friends and neighbors would have declined during this period. *The CHSP participants' greater social involvement with friends and neighbors can probably be attributed to their living in a congregate setting that provides a large pool of other older persons with whom to socialize, and is set up to encourage interaction among residents.*

Frequency of contact is only one ingredient of social support; it is also important to know how the time together is spent. Some researchers have suggested that one beneficial outcome of an elderly parent's receipt of formal in-home help with household and personal care activities is that it frees children to spend more "quality time" with their parents. Time that might previously have been occupied running errands for their parents or taking care of household chores can now be spent sitting and talking. This provides benefits to the elderly parent by enriching the quality of their visits with their children, and also lessens the children's caregiver burden.

HOPE IV participants were therefore also queried both at baseline and follow-up about what they usually do when their children, other relatives, and neighbors come to visit. Their answers covered a broad span of activities, from helping with housework to running errands, eating out or attending social functions together. *While there does seem to be a division of activities according to the type of visitor, at both baseline and follow-up, the most frequently named activity by far across all categories of visitors was spending time informally talking and visiting with the participant.*

5.1.2 Telephone Contact

In an increasingly mobile society, when elderly persons may live far from family and friends, keeping in touch by telephone is another important form and source of social contact.

As with in-person social contacts, the frequency of telephone contact with relatives and friends was very similar for HOPE IV participants and comparison group respondents, both at baseline and follow-up. At both points in time, about three quarters of both groups reported speaking to someone on the phone on a regular basis, while roughly one-quarter said they did not. At baseline, 37 percent of participants and 39 percent of comparison group members, and at follow-up, 30 percent and 36 percent, respectively, indicated they spoke with someone on the phone every day.

Overall, at baseline, HOPE IV participants had an average of 20.1 monthly phone contacts and comparison group members an average of 23.2 such contacts. At follow-up, the average number of such contacts declined slightly for both groups, to 18.8 for participants and 21 for comparison group members.

As with in-person contacts, the HOPE IV participants and comparison group members were characterized by a bimodal pattern of either very infrequent or quite frequent telephone contacts with children at both baseline and follow-up. As shown in Table 5-2 , at baseline, at one end of the spectrum, a little over half of both groups reported less than monthly phone contact with their children. At the other end of the spectrum, a total of 38 percent of HOPE IV participants and 36 percent of comparison group members reported phone contact with children several times a week or more. Between baseline and follow-up, the pattern shifted slightly. At follow-up, an even higher percentage (41 percent) of both groups reported contact of several times a week or more, but somewhat fewer HOPE IV participants (15 percent as compared to 22 percent at baseline) reported having daily phone contact with a child.

Again, at baseline, the pattern was very different for CHSP participants, who had much more frequent telephone contact with family members. Two-thirds of CHSP participants--nearly twice as many as HOPE IV participants and comparison group members -- indicated having phone contact with family members of several times a week or more. Thirty-nine percent (as compared to 22 percent, and 20 percent, respectively) indicated they spoke with a family member on a daily basis, another 27 percent (as compared to 16 percent of both HOPE IV groups) said they talked on the phone with a family member several times a week. At the other end of the spectrum, more than half of both HOPE IV groups, but only about nine percent of CHSP respondents, reported less than monthly phone contact with a family member. For CHSP participants, more frequent telephone contact may have served to substitute or compensate for less frequent in-person social contact with family.

As seen in Table 5-2, phone contact with other relatives as well as with friends and neighbors was less frequent than with children for both HOPE IV groups and declined slightly between baseline and follow-up. *CHSP participants had much more frequent telephone contact with friends and neighbors than the HOPE IV participants and comparison group members.*

Table 5-2.
Frequency of Telephone Contacts

Baseline	Participant *(n=497)*				Comparison Group (n=466)				CHSP Participants (n=560, 541)	
Times per month regularly speaks to . . .	Child (%)	Other relative (%)	Friend or neighbor (%)	Anyone (%)	Child (%)	Other relative (%)	Friend or neighbor (%)	Anyone (%)	Family* (%)	Friends (%)
Less than once (0-<1)	54	74	71	30	56	70	67	29	9	16
A few times (1-3)	2	4	2	3	3	3	2	2	9	8
Once or twice a week (4-7)	7	7	4	8	6	6	4	8	16	14
Several times a week (8-27)	16	9	8	23	16	10	12	22	27	28
Every day (28+)	22	7	14	37	20	10	15	39	39	34
Follow-Up	Participant *(n=260)*				Comparison Group (n=282)					
Less than once (0-<1)	49	76	70	29	50	74	74	28		
A few times (1-3)	2	3	1	2	3	2	1	2		
Once or twice a week (4-7)	8	7	6	6	6	6	3	4		
Several times a week (8-27)	26	9	10	34	21	10	11	32		
Every day (28+)	15	5	13	30	20	8	11	36		

* Includes all family members, not just children

At baseline, over 60 percent of CHSP participants spoke on the phone with a friend or neighbor several times a week or more, with about one-third indicating daily phone contact. By contrast, only 22 percent of HOPE IV participants and 27 percent of comparison group members reported contact of several times a week or more. Nearly three-quarters of HOPE IV participants and comparison group members indicated not speaking with a friend or neighbor on the phone at least once a month, while the same was true for less than one-quarter of CHSP participants. In this case, phone contacts were not substituting for in -person contacts, because CHSP participants also had more frequent in-person social contact with friends and neighbors than either of the HOPE IV groups. *The CHSP participants' greater frequency of all types of contact with friends and neighbors may reflect a general pattern of more intense socialization that results from living in a congregate setting.*

5.1.3 Informal Contacts: A Summary

What is most striking about these findings is, first, the strong similarity between the HOPE IV participants and comparison group members, and the contrast between them and the CHSP participants, in patterns of in-person and telephone contact. These differences are probably at least partly related to differences between the scattered site and congregate living arrangements.

Second, these data suggest relatively few of any of the three groups of frail elderly individuals might have been socially isolated.

Third, from a programmatic and policy perspective, it is clear that participation in the HOPE IV Program did not have a negative effect on the frequency of the HOPE IV participants' social contacts.

The implications of these findings are discussed further in Chapter 6.

5.1.4 Social Satisfaction and Loneliness

Because of varying perceptions of what constitutes a satisfactory level of social contact, different individuals may express rather different degrees of satisfaction with the same frequency of visits and telephone calls. Some elderly respondents may feel quite satisfied with seeing a child once or twice a month, while others may be unhappy with anything less than daily visits. To gauge this more subjective aspect of social support and sociability, HOPE IV participants and comparison group respondents were asked about the quality of their social ties and how they assessed their then current level of social

activity. Respondents in all three groups were also asked about how often they experienced feelings of loneliness and whether they had at least one other person in whom they could confide.

Overall, both at baseline and at follow-up, HOPE IV participants and comparison group respondents enjoyed fairly full social lives, with which most were reasonably satisfied. At baseline, about half of both HOPE IV participants and comparison group members said they saw their relatives and friends about as often as they wanted, and another third of both groups was only somewhat unhappy about how little they saw their relatives and friends. Only about ten percent of both groups said they were very unhappy with the frequency of their social contacts. At follow-up, a slightly lower percentage of both groups indicated seeing their friends and relatives as often as they wanted, while a slightly higher percentage said they were somewhat unhappy about how little they saw their relatives and friends. It is interesting that satisfaction with their level of social contact declined slightly at the same time that their actual level of social activity increased a bit.

Along a slightly different dimension, HOPE IV and comparison group respondents as well as CHSP participants reported low levels of loneliness, and almost all in all three groups had at least one confidante. In fact, there are striking similarities across the three groups in these respects.

At baseline, 20 percent of HOPE IV respondents, 17 percent of comparison group members, and 21 percent of CHSP participants said they felt lonely quite often; 41 percent, 42 percent, and 43 percent, respectively, said they felt this way sometimes; and, 38 percent, 40 percent, and 36 percent, respectively, indicated they almost never felt lonely. About 87 percent of HOPE IV respondents, 91 percent of comparison group members, and 89 percent of CHSP participants said they had someone whom they trusted and in whom they could confide.

At follow-up, both HOPE IV groups reported feeling somewhat less lonely overall. The percentage of those reporting frequent feelings of loneliness declined slightly, while the percentage saying they felt lonely sometimes increased slightly, and the percentage of those saying they almost never felt lonely stayed about the same. The percentage of HOPE IV participants who had a confidante rose slightly (to 92 %) while remaining more or less the same (90 %) for comparison group respondents.

5.2 Service Utilization

5.2.1 Receipt of Services

A higher percentage of CHSP participants than HOPE IV participants had received comparable formal services prior to entering their respective Programs. At baseline, about 29 percent of CHSP participants receiving housekeeping from CHSP or other formal sources, 28 percent of those getting congregate meals, 28 percent of those getting emergency response services, 24 percent of those receiving transportation, 22 percent of those getting formal in-home health services, and 20 percent of those receiving health screening and health education services reported having gotten these services from formal sources prior to entering the CHSP. By contrast, only for formal housekeeping services was the percentage of HOPE IV participants (30 percent) who reported having received the service prior to program entry comparable to that for CHSP participants. These findings are not surprising given that CHSP participants were already living in congregate housing prior to entering the CHSP, which gave them some access to services. By contrast, many HOPE IV participants had to relocate to enter HOPE IV, and were selected into the Program partly on the basis of their demonstrated need for supportive services and distance from family members who might have been able to assist them.

Table 5-3. Supportive Services Received

	Hope IV Participants		**Hope IV Comparison Group**		**CHSP**
Services	Baseline *(n=543)* (%)	Follow-up *(n=286)* (%)	Baseline *(n=523)* (%)	Follow-up *(n=324)* (%)	Participants *(n=570**)* (%)
Housekeeping	80	84	49	51	83*
Transportation	46	50	32	24	46
Home-delivered meals	38	40	24	27	30
Congregate meals	13	10	10	7	73*
Personal care	25	33	26	31	--
In-home health	29	34	29	36	29
Recreational	14	14	10	8	--
Counseling	6	5	4	7	--

* Indicates percent receiving formal or informal help in this area from any source.

** Estimate

Table 5-4 presents the percentage of HOPE IV participants, HOPE IV comparison group members, and CHSP participants who reported receiving different types of services.

The figures for CHSP are for baseline only and are not strictly comparable with those for HOPE IV for all categories of service. At baseline, similar percentages of HOPE IV and CHSP participants reported receiving housekeeping, transportation, and in-home health services. The only major difference in the percentages saying they got congregate meals is easily explainable by the CHSP program requirement to provide such meals.

Thus, the core services received are much the same across these two programs, with about four-fifths of both participant groups reporting they got housekeeping, slightly under one-half indicating receipt of transportation services, and just under one third saying they got in-home health services. While comparison group members clearly received fewer services overall, the differences between them and the HOPE IV and CHSP program participants are fairly considerable for some categories of services (housekeeping, transportation, home-delivered meals), but negligible for others (personal care, in-home health).

Table 5-4 also shows that service provision was stable over time for both HOPE IV participants and those comparison group members who were receiving services. The percentages of those receiving specific services did not change greatly between baseline and follow-up for either the HOPE IV participants or the comparison group.

5.2.2 Satisfaction with Services

The vast majority of HOPE IV participants, comparison group members, and CHSP participants were happy with the amounts and types of services they were receiving. As shown in Tables 5-5 and 5-6, both HOPE IV groups reported similar, extremely high levels of satisfaction with individual services both at baseline and at follow-up. Although slightly different, the figures for CHSP participants, as shown in Table 5-5, also indicate high levels of satisfaction with individual services.

HOPE IV participants and comparison group members were also asked if they needed more of any of their current services or felt they could use services they were not getting at the time of either survey. At baseline, 82 percent of HOPE IV participants and 77 percent of comparison group members responded that they did not need any more of their current services. Of those indicating they would have liked more of their current services, the greatest number of participants (44) and comparison group

members (36) expressed a desire for more housekeeping. At follow-up, the percentage of those who felt well served by their current level of service rose to 89 percent among HOPE IV participants and to 81 percent among comparison group respondents. Of those few expressing a desire for more of their current services, most in both groups wanted more housekeeping

Table 5-4.
Baseline: Average Monthly Frequency of Receipt and Satisfaction with Specific Services

Hope IV Participants *(n=543)* Service	% Receiving	Average Frequency (days per month)	% Very Satisfied
Transportation	46	5.9	66
Home-delivered meals	38	21.1	69
Meals at senior center	13	14.3	71
Personal care services	25	12.7	88
In-home health	29	7.2	85
Housekeeping	80	8.0	79
Counseling	6	3.9	63
Recreational services	14	10.0	81
HOPE IV Comparison Group *(n=523)*			
Transportation	32	6.1	73
Home-delivered meals	24	21.0	76
Meals at senior center	10	11.5	80
Personal care services	26	15.7	85
In-home health	29	8.1	90
Housekeeping	49	11.0	78
Counseling	4	2.0	52
Recreational services	10	10.0	79
CHSP Participants *(n=547)*****			% satisfied
Transportation	46	*	94
Home-delivered meals	30	*	81
Congregate Meals	73	*	81
Personal care services	--	*	*
In-home health	29	*	96
Housekeeping	83	*	87
Counseling	--	*	*
Recreational	--	*	*

* = Missing data
** = Percent indicating they were satisfied or very satisfied with service, whether received from a formal or informal source.

Table 5-5. HOPE IV Follow-Up: Average Monthly Frequency of Receipt, and Satisfaction with Specific Services			
Participants *(n=286)* Service	% Receiving	Average Frequency (days per month)	% Very Satisfied
Transportation	50	4.5	72
Home-delivered meals	40	22.7	67
Meals at senior center	10	14.9	75
Personal care services	33	14.1	88
In-home health	37	8.2	90
Housekeeping	84	8.8	86
Counseling	5	--	--
Recreational services	14	7.7	87
Comparison Group *(n=324)*			
Transportation	24	5.4	71
Home-delivered meals	27	21.8	78
Meals at senior center	7	12.0	70
Personal care services	31	17.0	89
In-home health	35	9.6	86
Housekeeping	51	12.7	84
Counseling	7	3.0	68
Recreational services	8	9.1	88

Similarly, 75 percent of HOPE IV participants and 71 percent of comparison group respondents at baseline, and 78 percent of both groups at follow-up, reported they did not need any services other than those they were then getting. At follow-up, of the roughly 20 percent of both groups who did want additional services, transportation was the service most frequently named by the participants (12 mentions), while comparison group members indicated the strongest desire for housekeeping (27 mentions), followed by transportation (15 mentions) and home companion services (14 mentions).

Data for CHSP participants show a broadly similar pattern of overall satisfaction with services received. When asked about the specific services they received from both formal and informal sources, at baseline, the vast majority of CHSP participants (75 percent or more) indicated that these services adequately met their needs. Considering the major CHSP service areas, 92 percent of those who got congregate meals, 91 percent of those who got transportation, and 81 percent of those receiving housekeeping said they got enough of these services to meet their needs.

Table 5-7 presents the one service HOPE IV participants and comparison group members considered most important in allowing them to continue to live in their own homes. At baseline, housekeeping headed the participants' list, noted as most important by 40 percent of those who responded to the question, followed by rental assistance (24 percent), home health aide services (14 percent), and Meals on Wheels (10 percent) — all core in-home services designed to maximize the participants' ability to remain independent. At follow-up, housekeeping and rental assistance still headed the list, but in reverse order. By contrast, those in the comparison group who answered this question responded that housekeeping and home health aide services were most important to maintaining their independence. Rental assistance ranked third both times.

Table 5-6.
Service Seen as Most Helpful for Maintaining Independence for Hope IV Participants and Comparison Group

	Participant		Comparison Group	
Service	Baseline (percent) *(n=521)* (%)	Follow-Up (percent) *(n=266)* (%)	Baseline (percent) *(n=445)* (%)	Follow-Up (percent) *(n=282)* (%)
Housekeeping	40	22	28	24
Rental assistance	24	36	18	22
Home health aide	14	10	25	29
Meals on wheels/meals program	10	4	7	6
All help equally	5	14	6	8
Miscellaneous others (e.g., transportation, food stamps)	7	4	16	11

5.2.3 Services: A Summary

The full range of services offered to HOPE IV and CHSP participants varied across projects, as did service delivery arrangements. However, the highest percentages of HOPE IV and CHSP participants received a similar core package of supportive services that included (roughly in this order) housekeeping, transportation, and meals. Many fewer comparison group members got these services. However, the percentages receiving personal care and in-home health services (a little more than one-quarter) were about the same for HOPE IV, CHSP and the comparison group.

Most participants in both programs were very satisfied with the types and amounts of services they received. Interestingly, however, comparison group members, many fewer of whom got supportive services as well as rental assistance, were also highly satisfied.

Both at baseline and follow-up, HOPE IV participants considered rental assistance and housekeeping the two services most important in allowing them to continue to live in their own homes.

The implications of these findings are further discussed in Chapter 6.

6. HOPE IV AND CHSP BENEFITS AND OUTCOMES

6.1 Outcome Measures

This chapter presents the benefits and outcomes of the HOPE IV and CHSP programs, using a combination of the measures presented thus far. The simple frequencies and percentages in the previous chapters, while quite informative from a descriptive perspective, may not control for all the relevant factors influencing outcomes. Indeed, we found that the similarities between the participants and the comparison group baseline and follow-up survey results actually masked some of the real impacts the multivariate analysis revealed.

The following section first presents the results of the HOPE IV and CHSP analyses separately, followed by a summary comparing and contrasting the findings from the two studies.

6.2 HOPE IV Outcomes

The primary purpose of HOPE IV was to allow a frail elderly tenant population to participate in Section 8 scattered-site rental housing through the provision of case management and supportive services. PHA staff reported that prior to HOPE IV, the frail elderly often did not come into Section 8 but went, instead, to congregate housing or other programs specifically for the elderly. In addition, when exiting from Section 8 because of aging in place and frailty, they often left for nursing homes or other restrictive settings due to the absence of care to address their limitation in basic life activities.

6.2.1 Reasons for Leaving HOPE IV

A major research question HUD wanted this evaluation to answer was the extent to which participation in HOPE IV allowed frail elderly tenants to participate in Section 8 housing and avoid unnecessary or inappropriate nursing home placement. To answer this question, the evaluation collected detailed information on the HOPE IV participants and a frail elderly Section 8 comparison group who were not in HOPE IV but were otherwise similar in terms of functional status, age, and gender. From both groups, we identified who remained in, or exited from, their respective programs over a two-year period, and why, including mortality, nursing home placement, and moving to other locations. Table 6-1 shows the retention and exit patterns for the HOPE IV participants and comparison group members, according to these categories.

Table 6-1. Program Status After Two Years		
Status	Participants (n=543) (%)	Comparison Group (n=523) (%)
Remained in HOPE IV	53	N/A
Left HOPE IV, remained in Section 8	7	N/A
Total remaining in Section 8	60	62
Left HOPE IV/Section 8	40	38
Died	15	13
Nursing home	9	8
Moved to other locations	9	9
Other/Unknown	7	8

There was no statistically significant difference between participants and comparison group members in terms of the five final status categories of: remaining in the program; dying, transferring to a nursing home or another care facility; moving elsewhere; or other ($p = 0.79$, Chi-square = 1.72, df=4). This finding is consistent with the assumptions in the research design and the results of prior studies that show that the impact of similar programs influences the quality of life and care, rather than changing such overt outcomes as mortality, institutionalization, or otherwise having to leave one's home due to frailty.

Over the two-year period, 40 percent of the participants left the HOPE IV program, including Section 8. This consisted of 15 percent who died, nine percent who went into a nursing or related care home, nine percent who moved to another location, and seven percent who left HOPE IV and Section 8 for other or unspecified reasons. Sixty percent of the participants remained in assisted housing, including seven percent who left HOPE IV but retained their Section 8 rental assistance.

Over the same two-year period, 38 percent of the frail elderly comparison group left Section 8, including 13 percent who died, eight percent who went into a nursing or related care home, nine percent who moved to another location, and eight percent who left for other or unspecified reasons. These exit patterns were nearly identical between the HOPE IV participants and comparison group members.

In an attempt to better understand what differentiates persons (participants and comparison group members) who remained in their respective programs versus those who left, we estimated the effects of

several factors on the probability of retention versus exit. Using stepwise logistic regression, we examined how the probability of remaining in HOPE IV and Section 8 was affected by participating in HOPE, the number of services persons received, age cohort (62-74, 75-84, 85+), length of time in current residence (less than one year, one to four years, five or more years), indexes of frailty (ADL and IADL limitations), and an index for feeling safe (feeling safe and secure in one's neighborhood most of the time, some of the time, rarely, or never).

Only being between ages 75 and 84 and the number of IADL limitations were included by the stepwise inclusion procedure indicating that none of the other variables had a statistically significant effect on remaining in HOPE IV or Section 8. Being between ages 75 and 84 and each additional IADL reduced the probability of remaining in HOPE IV and Section 8, respectively, by about 37 percent (odds ratio = 0.63 Wald Chi-Square=9.01, $P < 0.001$) and 14 percent (odds ratio = 0.84, Wald Chi-Square=10.02, $P < 0.001$). The above analysis included HOPE IV participants who left the Program but remained in Section 8. The rationale for including this latter group is that these persons did not actually exit, given the primary purpose of HOPE IV to sustain the frail elderly in Section 8 private market, scattered-site housing.

We also used stepwise logistic regression analysis to examine the probability (among those still alive) of moving to a nursing or care facility before the time of the follow-up interview as a function of participating in HOPE IV, the number of services received, age cohort, length of time in current residence, indexes of frailty, and an index for feeling safe. The final model included the variables for the number of services, the indicator variable for being over age 84, under one year residence, and the index for feeling safe. We also found that the number of services received, being over age 84, under one year of residence at the same location, and not feeling safe all increased the probability of moving to a nursing or related care facility.

These results may appear paradoxical, but actually are consistent with prior research, especially concerning the high correlation between receipt of services and exiting to a nursing home. The most likely explanation for this pattern is that frail, older clients receive more services than others do, and these clients tend to exit to nursing homes regardless of the services they receive.

We used a similar approach to examine the probability of death before the time of the follow-up interview among those who had not moved to a nursing home or care facility. Not surprisingly, this analysis showed that only being 85 or older increased the odds of death. Again, this confirmed the results of prior research that the value of a community-based, long-term care program for the frail elderly

lies in enhancing the quality of life and care, rather than reducing the rates of nursing home placement or mortality.

6.2.2 Changes in Quality of Life

Beyond these issues of remaining in Section 8 and avoiding nursing home placement, the evaluation studied the impact of HOPE IV on many other domains of well-being.

We found that the quality of life and care was significantly higher for HOPE IV participants than comparison group members for many domains of well-being. Specifically, participants in the HOPE IV program received a significantly higher level of supportive services than the comparison group, and this disparity in access to care remained over time. For example, at baseline, over one-quarter (26 percent) of the comparison group reported receiving no services at all, despite levels of frailty that were similar to those of participants, and this figure remained at a relatively high level (32 percent) between baseline and follow-up (the two percentages are not statistically different). The corresponding figures for Hope IV participants receiving no services were three percent, and seven percent, respectively, at baseline and follow-up. These differences remained significant when controlling for differences in ADL limitation and other factors influencing need for services.

Most important, receipt of services had a significant association with a range of positive outcomes, across multiple domains of functioning. For example, service recipients scored significantly higher in four major mental health dimensions (anxiety, depression, loss of behavioral/emotional control, and psychological well-being), social functioning (quantity and quality of social activities), vitality (energy level and fatigue), and other measure of social well-being.[26] The key predictor for the quality of life measures is the *Number of services*. A key finding is that, other things being equal, participants received significantly more services than the comparison group members. This clearly documents the positive impact of the HOPE IV program.

In addition to showing this overall beneficial impact of HOPE IV on the receipt of services, we found that the distribution of these services varied considerably within the participant and comparison groups. For example, while virtually all of the participants (93 percent) reported receiving at least one service, almost one-third of the comparison group (32 percent) reported receiving no services at all at the

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[26] Ware, J.E., SF-36 Health Survey, Manual and Interpretation Guide. The Health Institute, New England Medical Center, Boston, MA, 1993.

time of the follow-up survey, despite similar levels of frailty between the two groups. The analysis also confirms our assumptions that that the number of ADL and IADL limitations are predictive of need for care, for these are significantly and positively correlated with the number of services the participants and comparison group members receive. Feeling safe and receiving more services, at baseline, were associated with increased satisfaction with neighborhood.

Taken together, these models suggest that, to the extent that HOPE IV participants experienced increased satisfaction with their neighborhood, they did so because, at a given level of service need—as this is determined by the number of ADL limitations—participants received a greater number of services than comparison group members. For those still in their programs at follow-up, the *Number of Services* was always associated with improved outcomes, and the parameter measuring this effect was statistically significant for *Mental Health*, and *Health*—that is in three out of seven models (including *Satisfaction with Neighborhood*). This means that we cannot measure the impact of HOPE IV by direct association with the outcome variables. We must, instead, measure impact indirectly through association with increases in levels of service.

One variable that was also highly correlated with these positive outcomes was having a case manager who helped identify and arrange for the delivery of services the person needed. All HOPE IV participants had a case manager (Service Coordinator) as part of the program. However, there also was an extremely high correlation between having a case manager and the number of services the comparison group received. This relationship between having a case manager and the number of services the comparison group members receive is, itself, an extremely important finding. One assumption underlying the design of HOPE IV is that the combination of case management and services, rather than one or the other, constitutes the most effective approach to addressing the needs of frail, elderly tenant population. It appears reasonable to interpret the significant beneficial relationship between receipt of services and positive outcome measures for both HOPE IV participants and comparison group members, as a benefit due to receipt of case management.

6.3 CHSP Outcomes

Analyses of CHSP continuation or discontinuation were conducted using data for all elderly CHSP participants interviewed in Fall 1994. Twenty four months later, in Fall 1996, Service Coordinators at all sites completed a roster that provided the following for each participant as of 24 months after the baseline:

- Whether or not they were still participating in CHSP at the 24-month point; and

- If they were no longer participating in CHSP and the next location they had gone to after being in the program. The categories of post-CHSP locations were as follows:
  - Still in the development, but no longer participating in CHSP (dropped out);
  - Moved—either living in another development or living with family;
  - Moved to a more restrictive living environment—such as a group home, nursing home, or assisted living facility; or
  - Died.

These data were used to address the questions about CHSP's effect on residents' continued ability to live independently and the factors that affect decisions to stay in the program among those who have a choice. The analyses were done using cross-tabulations, estimation of models of program discontinuation, and comparisons with other data to help understand how the experience and outcomes for CHSP participants compare with those of other older Americans.

6.3.1 CHSP Continuation and Discontinuation

Analyses of data on CHSP continuation and discontinuation address several issues: Who left CHSP, and why? Did CHSP help frail elderly residents continue to stay in their homes? What factors led participants to choose to drop out of the program, while continuing to live in the congregate housing development?

Overall, 51 percent of the original CHSP participants were still participating in the program 24 months after the baseline interview. Another 10 percent dropped out of CHSP's services component but remained living in the HUD-subsidized building, and 11 percents had died. This pattern is almost identical to HOPE IV. However, 22 percent had moved to a group home, nursing home, or other higher level of care, a figure considerably higher than for HOPE IV. A few (three percent) had moved to another development or to live with family. As would be expected, more of the very old (85 or older) had died (15 percent) or moved to a more restrictive living environment (35 percent), compared with younger participants.

Those with the highest level of ADL impairments (six or more ADL limitations) were most likely to die (13 percent) or move to a higher level of care (30 percent). However, it is important to note that, even among the least-impaired participants (two or fewer ADL limitations), a number had died (eight percent) or moved to a higher level of care (16 percent). This finding supports the view that CHSP served residents with significant levels of ADL impairment.

Focusing on the numbers that dropped out of CHSP (those who stayed in the development, but did not continue to receive services), there were more drop-outs among the younger participants (21 percent of participants age 62-74 had dropped out, compared with eight percent of those 75-84, and six percent of those 85 or older). Additionally, residents who were less satisfied with CHSP services were more likely than others to drop out, as would be expected. Among those who were very satisfied with CHSP, nine percent dropped out, compared with 14 percent among those who were somewhat satisfied, and 21 percent among those who were neutral or dissatisfied.

Differences in Exit Patterns by Levels of ADL Limitations

Additional descriptive analyses compared the percentage who died or moved to a higher level of care by whether or not they had impairments in specific ADLs at the baseline. These data give an indication of what ADLs areas are indicative of high risk—as measured either by the absolute level (the percentage who die or move to higher level care) or by the differential rate (the difference in the percentage of those with impairments who die or go into higher care, compared with the those who do not have impairments). Data presented in Table 6-2 show that several ADL impairments are indicative of high risk by both of these measures. The table lists the top four ADL impairments, as measured by the percentage of those impaired who died or moved to more restrictive care (more than 45 percent for each). In addition to percentages who had these adverse outcomes, the table shows how much higher the percentage for the impaired is than the corresponding percentage for those who did not report impairment.

Table 6.2.
CHSP ADL Impairment Areas
Associated with Dying or Moving to Higher Level of Care

ADL impairment areas	Percent who died or moved to a higher level of care (%)	Difference between impaired and not impaired (%)
Feeding self	51.0	17.2
Personal grooming	47.7	16.7
Using telephone	46.8	16.1
Managing money	46.0	19.1

Residents who could not feed themselves had a high likelihood of dying or moving to a nursing home or other higher level of care (51 percent), compared with those who did not have difficulty with

self-feeding (the differential is 17 percentage points). Having been impaired in ability to do personal grooming, use the telephone, or manage money are also indicative of risks for adverse outcomes.

Residents had to have been able to perform in the different functional areas, at least at a minimal level, to have participated in CHSP. The regulations specified that residents must have been able to feed themselves or have had help from a spouse, relative, or attendant provided by the individual or family that allowed them to do so; similarly, the regulations required that people be able to take care of personal appearance (although they may need help washing their hair). The fact that program participants who had limitations in these areas of personal care were at high risk for moving to a higher level of care is consistent both with program regulations and with research showing that high levels of basic personal care needs are related to nursing home placement. Although the other two risk factors—difficulty managing money and using the telephone—are classified as impairments in instrumental activities of daily living, they are indicators of cognitive impairment which, in turn, is a major risk factor for institutional placement. Overall, then, these data show the importance of these ADLs as risk indicators.

The descriptive data show that several factors — such as age and number of ADL limitations -- are related to CHSP participants' dying or going to a higher level of care, and satisfaction is related to dropping out. However, these factors tend to be interrelated — for instance, older residents also had higher levels of ADL impairments. This leads to the question: When all the factors are taken into account, which ones are still important in determining outcomes for CHSP participants?

This question was addressed by modeling the program outcomes. Logistic regression models were estimated to predict: 1) Which residents died or moved to a higher level of care? and 2) of those who had the choice of remaining or leaving the program (those who do not die or have to move to a higher level of care), what factors affected the choice to stay in the program, rather than dropping out of it?[27]

A series of models were run. These models included: age; number of ADL limitations; gender; services;[28] level of fees paid by resident; resident's satisfaction with CHSP; and degree of social integration or the availability of family as an alternative source of assistance (how often resident saw family).

[27] Logistic regression models are appropriate for analyzing categorical outcomes. In the analyses reported here, the outcomes were dichotomous. The program continuation variable has 5 outcomes: staying in CHSP, dropping out, moving to another location, moving to a higher level of care (group home, hospital, assisted living, nursing home), or dying. Although it would be possible to include multiple outcomes in the model by using multinomial logistic regression, the results of such models are difficult to interpret and have less clear policy relevance than the simpler models. For the models, dying or moving to a higher level of care were combined because they tend to be predicted by the same individual, non-programmatic factors. The decision to remain in CHSP is modeled separately for residents who do not die or move to a higher level of care. These models directly address the question of what program and individual factors are related to the decision to remain in the program. The variables in the models were collected at the baseline survey, both because these directly relate to the outcomes and because these measures are available for all residents, including ones who died or left the program before later data collection rounds. For discussion of the models, a .05 probability of significance was used.

[28] Including all services in the model would make it unstable and difficult to interpret. Because of this, a decision was made to include services that were important in themselves and represent the range of services residents need and receive from CHSP. The services included in the model were congregate meals, housekeeping, transportation, and personal grooming.

Mortality

Several demographic variables predict mortality or moves to a higher level of care: older age; higher number of ADL impairments; and gender (higher mortality among men than women). Once age and level of ADL impairments were controlled in the model, services received, fees, service satisfaction, and level of contact with family are not related to mortality or moving to a higher level of care.

Program continuation

For those who could choose, several factors have a significant effect on whether or not residents remained in CHSP. Older participants were more likely to stay in the program, but the number of ADL limitations does not have an independent effect after controlling for age. In addition, residents who had less frequent interaction with family were more likely to remain in CHSP. There also is a clear program effect: residents who were satisfied with CHSP and said they got services often enough from the program were more likely to stay in the program.[29]

Several findings are not surprising: for instance, that older and frailer residents were more likely than younger, less frail ones to die or move to a nursing home or other more restrictive living environment. It is interesting to note, however, that the model results show that both age and ADL levels have significant independent effects. Higher mortality among men than women is consistent with known mortality patterns. Once these powerful factors are included in the model, services and service satisfaction have no independent effect on mortality or higher level care placements.

The findings on program continuation show other important effects. First, the fact that residents with lower levels of family contact were more likely to stay in the program shows the special role CHSP potentially played for those who did not have family assistance and supports the conclusion that CHSP does not displace family assistance. Second, specific services received from CHSP did not affect continuation, but satisfaction with the program as indicated by — both residents being satisfied with CHSP and their saying they got services often enough — had a significant positive effect.

This latter finding shows the importance of satisfaction with the program for people's decisions to stay in CHSP. Recalling that the large majority of residents expressed satisfaction, these findings support the conclusion that CHSP did a good job of satisfying residents and maintaining their participation through providing valued services.

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[29] There is not a separate effect of receiving specific individual services from CHSP on continued participation. The model results show a significant positive effect of receiving housekeeping or congregate meals from non-CHSP sources, but not other services. Only relatively few residents receive congregate meals or housekeeping from sources other than CHSP, however; this result may reflect some random variation in the model, or, because non-CHSP sources for these services are unusual, the receipt of services from these sources may indicate especially high levels of need.

Finally, the fact that, once other factors are controlled, older age has an effect on continuation, but ADL level does not, underlines the importance of CHSP for meeting the needs of increasingly old residents, who have fewer alternatives and probably have needs and frailties that are not fully captured by a measure such as ADL level.

Overall, the model results both confirm the findings and explain some apparent anomalies. The most important conclusions are that CHSP (1) did an effective job of satisfying elderly residents, and this contributed to relatively high levels of program continuation; (2) CHSP was particularly important for helping to maintain the oldest participants and those with fewer family resources.

6.3.2 Program Drop-Outs: Reasons for Leaving CHSP

Under CHSP regulations and practice, it was expected that residents whose condition improved would leave the program, permanently or until such time as they again needed assistance. In addition, the tabulations and model results show that residents who were satisfied with CHSP were more likely than dissatisfied ones to remain in CHSP, as would be expected. Another source of data that helps explain reasons for leaving CHSP comes from interviews with residents who left the program.

In the second round of data collection, in Fall 1995, residents who had been in CHSP at the baseline but had subsequently left the program and continued to live in the same development were asked their reasons for leaving the program. Overall, 29 percent of those who had left the program said they no longer needed CHSP services, and another six percent said they were no longer eligible. Another 23 percent said they were not satisfied, and 12 percent cited problems with the food or meals, such as: there was too much food or they gained too much weight from the meals, that going down for meals was too much for them, or that they did not like the food.[30] Only a small number (seven percent) said the reason they left the program was they could not afford CHSP services, although another six percent said they got a service more inexpensively from another source. In addition, 12 percent reported that they dropped out of CHSP because they got services from another source—this was particularly true among the oldest participants (29 percent of those 85 or older said they got services from another source), which suggests that needing a higher level of care was an important reason for changing to another service source than CHSP. The evaluations of both HOPE IV and CHSP programs found that participants often received services concurrently from other community home care programs, and after exiting continued to do so while remaining in their HUD-subsidized housing.

These findings help to explain the dynamics of CHSP participation, and the role of the Service Coordinator and PAC. They are consistent with the expectation that Service Coordinators and PACs should have moved residents out of CHSP when their functional level improved ("no longer needed

[30] Although meals are not mandatory and residents could choose to omit meals from their set of services, it may be that some residents identified CHSP as primarily a meals program, or that saying there were problems with the food is an "easy" reason to give for dropping out.

services") or shifted them to another source of care when their needs changed ("got service from other sources"), especially for the oldest participants. Data show that some residents' functional status improved over time, consistent with the finding that some left because care was no longer needed.

6.4 Comparing HOPE IV and CHSP Outcomes

Both HOPE IV and CHSP provided services to frail, low income elderly community residents at risk of needing to move to a higher level of care. As the data presented in the preceding sections show, the participants in the two programs were generally similar both in their levels and patterns of needs and in the services they received. HOPE IV included a larger proportion of younger, more ADL-impaired elderly, and CHSP had somewhat more participants who were very old. And, although participants in both programs met periodically with the Service Coordinator to discuss service needs, CHSP participants had more informal on-going interaction with the Service Coordinator, who worked on site in the development.

The basic issue to be addressed is: Are HOPE IV and CHSP similar in their patterns of program exits and other outcomes? If not, what are the reasons for the differences, and what can be learned from them? For both programs, data on resident location were collected 24 months after the baseline for all residents surveyed at the baseline. For HOPE IV participants who remained in the program were surveyed again, and data on those who had left the program were obtained from the service coordinator or other proxy source. These data allow a comparison of program continuation and, for those who left, reasons for leaving, for the whole population who entered these programs at the baseline.

6.4.1 Exiting from HOPE IV and CHSP

Table 6.3 summarizes the data on program continuation and exits for the two programs. These data show, first, that about half the residents who entered HOPE IV or CHSP were still in the program 24 months later.

Second, comparably a small percentage (7 percent of HOPE IV, 10 percent of CHSP) had dropped their participation in the supportive services program but remained in their respective HUD-assisted housing.

Third, mortality was similar for the two groups, between 11-15 percent of the program entrants. For both programs, the level of mortality among those who reported 2 or fewer ADL limitations was very similar to that of participants classified as more highly ADL-impaired. This provides support for the view that HOPE IV and CHSP accurately targeted their services to relatively frail populations, but some participants under-reported their ADL impairments.

Table 6.3. HOPE IV and CHSP Program Continuation

Outcome	Program	
	HOPE IV *(n=540)* (%)	**CHSP** *(n=540)* (%)
Remained in program	53	51
Dropped out of supportive services Program (remained in congregate housing)	7	10
Died	15	11
Moved to nursing home or other more Restrictive environment	9	25
Moved to other or unknown location	16	3

The major difference between the two programs is that more CHSP than HOPE IV participants moved to a higher level of care, such as a nursing home or assisted living facility.[31] When the proportion who moved to a higher level of care is analyzed within each of the age and ADL categories, the finding remains the same: at each age and frailty level, CHSP participants were more likely than HOPE IV participants to have gone to a nursing home, assisted living facility, or other similar environment.

Compared with HOPE IV participants and comparison group members as well as the general population of frail elderly in the National Long-term Care Survey (NLTCS), CHSP participation was associated with a higher likelihood of moving to a nursing home or other higher-level care facility. The reasons for these differences are unclear. One possible reason for the higher rate of nursing home placement among CHSP participants is that they had less family support available, as suggested by the findings on frequency of seeing family in Chapter 5. Another possibility is that CHSP residents were considerably older than HOPE IV tenants within each age and ADL category. While the ADL limitation profiles were similar for the two groups of participants, age may have contributed to the decline in functioning and nursing home placement among those in CHSP. The two possibilities are not mutually exclusive either because most of the higher percentage of HOPE IV participants who moved to another (non-nursing home) location moved in with family members. Moreover, as seen above, those CHSP participants with several family resources were more likely to stay in the programs.

[31] Even if the "unknown location" cases are excluded for the HOPE IV group and the proportion who moved to a higher level of care recalculated without them, the percentage of HOPE IV participants who made such a transition is increased only to 9 percent, so the finding remains unchanged.

6.4.2 Sociability and Social Contacts

Looking at who exited and who remained in their respective programs is but one outcome of interest. Social isolation is always a concern for the frail elderly population, particularly those who live alone, as did many of the participants in both the HOPE IV and CHSP. *Taken together, the data suggest that very few HOPE IV or CHSP participants were isolated or lonely.*

The data on frequency of social contact give little cause for alarm for either HOPE IV or CHSP participants, the vast majority of whom saw or spoke to someone at least on a monthly basis. Isolation might potentially be a problem for a small segment (roughly one-fifth to one-quarter) of the HOPE IV group, depending on whether it was the same individuals who had neither in-person nor telephone contact with anyone at least monthly. Nevertheless, Program participation, which stimulated social contact with service providers and the Service Coordinator, would have been a benefit in itself for this group. In addition, both HOPE IV and CHSP participants reported infrequent feelings of loneliness, and almost all indicated they had a confidante.

What is noteworthy is how similar the HOPE IV and comparison group members were in their patterns of social contact and how dramatically these contrasted with the patterns of the CHSP residents. These differences are at least partly attributable to differences in the congregate versus scattered site living environments

Both HOPE IV groups exhibited strongly bimodal patterns of either very infrequent (less than once a month) or quite frequent (several days a week or more) in-person and telephone contact both with children and friends and neighbors. By contrast, the pattern of in-person contact with family was much more even for the CHSP participants, who tended to see family members less often than the HOPE IV groups but to speak to them more often on the telephone. However, CHSP residents had a much higher frequency of both in-person and phone contact with friends and neighbors.

Not surprisingly, congregate settings appear to encourage greater sociability with friends and neighbors. By contrast, the HOPE IV groups' more frequent in-person contact with their children may reflect that the latter assumed a greater share of the responsibility for maintaining in-person contact in the absence of such a peer support network of friends and neighbors. Following this line of reasoning, the CHSP participants' children could "afford" to rely more heavily on telephone contact to keep in touch, knowing their parents lived in the more sociable congregate setting.

Another issue of policy relevance concerns the impact of program participation on the frail elderly individuals' social networks. *On the whole, participating in HOPE IV enhanced the participants' social lives and feelings of social well being. This is particularly noteworthy given that over 40 percent of participants had moved before entering the Program.* The HOPE IV participants' in-person contacts with children, as well as with friends and neighbors, increased between baseline and follow-up, as did their level of out-of-home social activity. From a subjective perspective, as well, most were happy with their level of social activity, and reasonably content with the frequency of visits from family and friends.

At the very least, the increase in frequency of social contact and social activity between baseline and follow-up represents a "normalization" of social relationships for participants with the benefit of two years in which to have adjusted to any temporary social dislocations caused by Program entry. That it may represent something more is suggested by the finding that, at follow-up, HOPE IV participants had more social contact with friends and neighbors than did comparison group members, who had lived in their Section 8 housing for much longer. *This raises the intriguing possibility that, for some, entering the HOPE IV Program may have energized their social lives.*

The policy implications of these findings are two-fold:

--T*here was no "substitution effect"—the HOPE IV participants' children did not visit their frail elderly parents less often now that the latter were receiving formal supportive services. Moreover, most visiting time was spent in informal socializing and chatting.* These findings, consistent with the results of other studies, should serve to allay policymakers' concerns that receipt of formal services will undermine informal patterns of assistance and socialization with children.

--*Contrary to what might have been expected for a scattered site program in which nearly half of the participants had to move, over the long run, Program participation did not have a negative impact on the HOPE IV participants' social lives.* If anything, the opposite was true. In their tendency to focus on the potentially disruptive consequences of moving, researchers may be underestimating the resilience of the frail elderly and their ability to form and sustain social ties later in life. At the very least, these findings should help to allay concerns that entering a scattered site program such as HOPE IV will necessarily undermine or permanently damage frail elderly participants' social networks, which is not to say that moving did not, or will not, have other negative consequences.

6.4.3 Services

Another outcome was access to needed services. The entire range of services available varied considerably both within and across the two Programs. *However, the vast majority of HOPE IV and CHSP projects offered a similar "core" set of services: virtually all offered housekeeping and meals, two-thirds offered personal assistance services, and about three-quarters of HOPE IV and one-half of CHSP projects offered transportation.*

There were strong similarities on the recipients' end, as well: about four-fifths of both HOPE IV and CHSP participants got housekeeping, one-half received transportation services, and a little less than one-third got in-home health services. Although a much smaller percentage of the comparison group received housekeeping and transportation, a similar percentage got in-home health and personal assistance. The similarity in the percentages receiving in-home health and personal assistance may reflect similar levels of frailty in the three groups. These findings may also suggest that HOPE IV had the greatest "value added" in provision of housekeeping and transportation services.

HOPE IV and CHSP participants were very satisfied with the types and amounts of supportive services they received; HOPE IV participants were even more satisfied at follow-up than they had been at baseline. Housekeeping ranked first on the list for the few who did want more of their current services. However, comparison group members, many fewer of whom received supportive services in addition to rental assistance, were only slightly more likely than HOPE IV participants to say they needed more or other services. *While not denying the very real value of the services provided by the HOPE IV and CHSP, these findings may suggest that frail elderly tend to be extremely grateful for and satisfied with whatever services they are getting.*

HOPE IV participants considered housekeeping and rental assistance the two services most important in enabling them to continue living independently in their own homes.

6.4.4 Service Coordinators

The availability and impact of service coordination as an advocacy and stewardship function was a key outcome as well. HOPE IV and CHSP *Service Coordinators played a pivotal role that went well beyond their formal job descriptions. In many ways, it was the Service Coordinators who came to define the character of these programs.* This an important finding, especially given evidence from the SCP

evaluation that Service Coordinators can be successfully "grafted onto" existing housing programs. *In the absence of monies to create entire new programs such as HOPE IV and CHSP, providing additional funding for Service Coordinators may be the best way to diffuse some of their benefits to the broader population of frail elderly living in HUD-assisted housing.*

Differences in how the Service Coordinator role developed in HOPE IV as opposed to the CHSP and SCP are linked to the qualitatively different requirements of establishing a program of service coordination and supportive services in a Section 8 versus a congregate housing environment Largely because the grantee PHAs were unprepared for the scope and level of demands for enrolling frail elderly participants, HOPE IV Service Coordinators took on an unexpectedly heavy load of often unanticipated "front end" activities associated with recruiting, assessing, and enrolling participants. Since recruitment and assessment were continuous, many HOPE IV Service Coordinators experienced a conflict between attending to these "front end" activities and taking care of the ongoing needs of the already enrolled participants. By contrast, partly because prospective participants already resided in the buildings, recruitment and assessment only occupied a major share of the CHSP and SCP Service Coordinators' time during program start-up, after which they could turn their attention to ongoing case management responsibilities. *In effect, it was the Service Coordinators who paid the largest part of the price for the HOPE IV grantee PHAs' inexperience in dealing with frail elderly in the context of the Section 8 program.* This should serve as an object lesson in any future efforts to bring service coordination to frail elderly populations in Section 8 or other scattered site housing.

Despite very high levels of satisfaction with their Service Coordinators across all three groups, the nature of the Service Coordinators' relationship to the frail elderly program participants was somewhat different in HOPE IV as contrasted with the CHSP and SCP. Participants in all three programs emphasized the help they got from their Service Coordinators in linking them with, and informing them about, services in their communities. However, although HOPE IV participants placed equally great emphasis on the Service Coordinator's assistance with obtaining housing and rental assistance, CHSP and SCP participants were more likely to see their Service Coordinators as persons with whom to talk and work out solutions to their problems. Observers of the CHSP and SCP also commented on the reassuring nature of the Service Coordinator's day-to-day presence in the apartment buildings.

Again, these differences appear to reflect differences between the HOPE IV Program, on the one hand, and the CHSP and SCP, on the other. Conceptually, HOPE IV and CHSP both provided a combination of housing assistance, service coordination and supportive services. But, experientially, the

supportive service and service coordination components of the CHSP were "overlays" insofar as the CHSP participants, as well as their SCP counterparts, were already living in the housing facilities. It was only in HOPE IV that the housing came as part of the new package that the evaluation explored. Thus, not surprisingly, HOPE IV participants saw provision of rental assistance as a critical part of the Service Coordinators' role. In the congregate setting, program participants and Service Coordinators saw one another more frequently on a day-to-day basis, which allowed for the growth of a relationship in which Service Coordinators could provide help with small, routine daily tasks. Hence, the CHSP and SCP participants' characterizations of their Service Coordinators as "friends" who offered solutions to their problems. By contrast, HOPE IV participants in scattered site settings saw their Service Coordinators less often, and mainly to discuss their service plans. Similarly, because they were located on-site, the CHSP and SCP Service Coordinators could maintain a continuous "presence" of a sort that was not possible for their HOPE IV counterparts who served a dispersed population.

These findings should not be taken to mean that service coordinator programs can only work in congregate settings, but, rather, that Service Coordinators perform somewhat different, but equally important, functions in congregate versus scattered site settings. It is important to stress that it was the combination of service coordination, with supportive services from whatever source, that contributed to the success of the programs.

7. POLICY IMPLICATIONS OF THE HOPE IV AND CHSP PROGRAMS

This chapter presents the lessons learned from the evaluations of HOPE IV and CHSP and the implications for public policy affecting housing and services for the aging. These two programs comprise a rich body of experience that can inform and support the development of effective legislation and programs for low-income, frail elderly persons.

Each of several suggested policy initiatives appears below in italics followed by a brief explanation and recommendations for action, based on the evaluations' findings.

1. *The role of the HOPE IV and CHSP Service Coordinators was essential for not only linking participants with services, but also creating an internal grantee climate conducive to the successful design and implementation of the two programs. In the absence of new funding for HOPE IV and CHSP, HUD might consider expanding and allowing the Service Coordinators who now support congregate housing, to operate within HUD tenant-based programs as well. This expansion of the Service Coordinator's role would create a locus within the PHA for recruitment, placement, and arranging supportive services for frail elderly tenants and new applicants for Section 8 rental assistance. Enhancing the capacity of PHAs in this regard is particularly important given the recent federal legislation allowing the use of Section 8 Vouchers for a portion of costs for assisted living facilities.*

Systemic change often requires the presence of a key individual to increase awareness among staff and promote policy and program initiatives, in this case to respond to the complex needs of a frail elderly population. The evaluations showed that prior to HOPE IV and CHSP, existing policies and procedures often discouraged application and participation in HUD housing assistance programs by eligible frail elderly persons. In-person application requirements, the need for assistance in locating accessible rental housing for elderly persons with functional limitations, the absence of linkages with service providers, and the steering of older applicants with service needs to other, restrictive options, often excluded frail elderly persons from HUD housing assistance programs altogether, especially tenant-based Section 8. These barriers adversely affected not only new frail elderly applicants, but also existing tenants and residents who had aged in place.

The HOPE IV and CHSP Service Coordinators played an important role in changing this restrictive orientation by educating existing PHA Section 8 staff and building managers, by developing linkages with other community agencies, and by providing case management services to individual HOPE IV and CHSP participants. At the national level, Congress and HUD could expand the Service

Coordinator funding and allow it to be used to address the concerns of frail elderly Section 8 Voucher holders. In addition to providing individual case management for these Section 8 tenants, Service Coordinators could provide an important PHA staff training and orientation function to help encourage frail elderly recruitment, placement, and the linkage with other community service providers. At the same time, expansion of the Service Coordinator Program to other congregate developments would enhance what has proven to be a successful addition to HUD housing assistance programs.

As a result of HOPE IV, there are already models for such broad-based PHA leadership positions and functions to address the needs of frail elderly tenants. For example, with supplemental HUD funding during the HOPE IV programs, grantees often hired staff and divided the responsibilities of the Service Coordinator between: 1) stewardship of the program as a staff function within the PHA and 2) case management services for individual clients, frequently through subcontracts with other community agencies.

The expansion of the Service Coordinator Program is especially important given the new legislative provisions for the use of Section 8 rental Vouchers for assisted living facilities. The law now allows Public Housing Agencies to designate assisted living facilities as eligible rental housing for the use of Section 8 Vouchers. The Voucher may pay for the cost of the housing component of assisted living but not the services, which must be financed separately with other funds. There is no provision for funding additional Section 8 rental Vouchers under this legislation, however.

In the absence of new tenant-based Section 8 funding, it is unlikely that this new legislation can succeed without the support of a Service Coordinator to ensure an internal PHA capacity and resolve to recruit and place frail elderly Voucher holders in assisted living facilities. All the barriers to frail elderly participation in tenant-based Section 8 — sizable impediments that the HOPE IV programs had to overcome to implement the demonstration — will continue to exist for this new assisted living initiative. In the absence of new funding, and without the stewardship of a Service Coordinator, few PHAs are likely to use their existing Section 8 Vouchers for this purpose. Competition for the current pool of Vouchers is keen, and waiting lists typically take several years to clear. Frail elderly persons who cannot apply for tenant-based Section 8 in-person or who may not be aware of waiting list openings due to their disabilities, could be summarily excluded from participation in this potentially important use of Section 8 Vouchers for assisted living.

2. *To complement its housing assistance programs and facilitate an expanded role for the Service Coordinators, HUD could encourage the provision of supportive services for frail elderly Section 8 Voucher holders and congregate housing residents through formal linkages*

with other federal, state, and community-based programs on aging. This is especially important given the new legislation authorizing and funding the conversion of HUD-subsidized congregate housing to assisted living facilities, if third parties cover the costs of supportive services.

The HOPE IV and CHSP evaluations found that a key factor for the success of virtually all the programs was effective linkages and purchase of service agreements between the grantees and other community agencies operating programs on aging. Prior to HOPE IV and CHSP, such relationships were infrequent, and program grantees often tapped the resources of these other agencies to supplement the supportive services funding from HUD. This suggests that opportunities for collaboration and potentially beneficial relationships exist beyond the purview of HOPE IV and CHSP. Most of the community agencies that worked with the HOPE IV and CHSP grantees, such as Area Agencies on Aging, receive funding from the national, state, and local level, and Congress and HUD may be able to facilitate local partnerships thorough collaboration with the federal, state, and local agencies and organizations sponsoring such programs. For example, a HUD partnership with the HHS Administration on Aging could promote corresponding interaction at the state and local levels with State and Area Agencies on Aging. Across the country, there are 57 State Agencies on Aging, over 660 Area Agencies on Aging, and literally thousands of service providers funded by them that may be able to serve frail elderly participating in HUD housing assistance programs.

Apart from the issue of alternative funding, the results of the HOPE IV and CHSP programs raise a core policy issue for Congress and HUD to consider: deciding how to best serve the needs of its low-income, frail-elderly constituency outside the bounds of housing assistance. In the past, Congress and HUD have funded many programs that combine housing assistance with various types of services for special populations. These include support for homeless persons and those with substance abuse problems, child care and other assistance to encourage tenant and resident employment, and a range of other services that recognize needs beyond housing assistance. Some of these programs have moved from an initial phase of development to on-going funding for PHAs, congregate housing developments, and other community agencies. Others, such as HOPE IV, have not.[32]

[32] For CHSP, there have been additional funds as the current grants expire. Each Federal Fiscal Year's expiring grants have been extended for one year since FY 1998. Also, when grant agreements expire, HUD provides amendments to those grantees that still have available funds to allow them to continue. Under HOPE IV, HUD has allowed grantees that have remaining funds to extend their project periods and continue using their awards. For both programs, the housing assistance component of the programs remains available to the participants.

An overriding policy concern for Congress and HUD, therefore, is determining whether the Department and its local agencies should address these special needs, such as supportive services for frail elderly, directly through funding and programs, or indirectly through collaborative relationships with other agencies that serve these special population groups. Combined approaches may be viable as well, with Congress and HUD providing demonstration or seed money to help identify long-term options for serving the diverse needs of low-income tenants and residents.

In particular, the HOPE IV and CHSP programs can offer many valuable lessons for guiding the new Congressional legislation authorizing and funding the conversion of Section 202 congregate housing projects to assisted living facilities. This legislation covers the housing but not the services costs of assisted living, which must be paid for through collaborative arrangements with other agencies, organizations, and programs that serve the needs of frail elderly persons. Bringing together the many key individuals who represent these diverse programs and funding streams is an extremely difficult but essential task in order to develop a viable conversion of a Section 202 building to an assisted living facility.

In addition to HOPE IV and CHSP, there are many other examples of states and communities consolidating and coordinating supportive services programs, in conjunction with HUD housing assistance, to create assisted living facilities and other housing and supportive services endeavors. For example, individual localities have developed community partnerships involving public housing, Section 202 projects, and Section 8 rental Vouchers, in conjunction with an array of supportive services. The services component of these ventures is often supported by multiple funding streams, including Medicaid Home and Community-Based Waivers financed by state appropriations and the U.S. Health Care Financing Administration (HCFA), Older Americans Act funding through State and Area Agencies on Aging, among many other sources.. Documenting and disseminating the results of these successful efforts may help inform and support implementation of this new legislation, as suggested, below.

3. *The HOPE IV and CHSP programs and evaluations constitute a valuable information resource, and Congress and HUD can encourage dissemination and utilization of the results through existing clearinghouse and communication mechanisms.*

In addition to the evaluation reports, each HOPE IV and CHSP grantee developed a considerable body of printed material documenting and supporting the design and implementation of the programs. *HUD User* might acquire and abstract this specific documentation from the grantees and, proactively, make it available to other interested agencies and organizations. The program descriptions, operations

manuals, recruitment materials, assessment instruments, partnership agreements, and other documents may be quite helpful to those wishing to adopt HOPE IV and CHSP models on their own and expand services to the frail elderly. Also, Internet access to these documents, or abstracts of them, could assist local agencies and others to identify and request material of interest to them.

HUD's Office of Policy Development and Research has a Division that deals exclusively with research utilization. This Division prepares a research dissemination strategy for the initial distribution of every PD&R report. This dissemination strategy targets the range of individuals, organizations, and entities that would benefit from the research findings. In addition, the *Recent Research Results* (RRR) publication is widely distributed as a vehicle for encouraging the application of HUD research findings and recommendations. Each report from PD&R research projects is available through *HUD User* and on the Internet through the World-Wide Web. This current HUD capacity provides an excellent opportunity to document and disseminate not only the research reports, but also the additional and potentially helpful documentation and best-practice information on which individual state and community leaders rely to foster creative partnerships and innovative programs.

Another approach to dissemination includes presentations at national conferences and publication of journal articles. For example, through the National Association of Housing and Redevelopment Officials (NAHRO), such efforts might encourage PHAs and congregate housing sponsors and managers to develop such programs by linking them with information and assistance from their peers in the program sites.

There are now specific models for the design, implementation, and operation of a Section 8 Voucher program or congregate housing developments that effectively combine case management and home care with housing assistance for frail elderly tenants and residents. In addition, there is an experienced and committed cadre of HOPE IV and CHSP staff and personnel from other partner agencies in the community who could potentially assist in the sharing of information and transfer of best-practice approaches. Congress and HUD could consider tapping this experience and making it available to others by sponsoring forums, training, and technical assistance to promote replication of the results of HOPE IV and CHSP. The study teams for these two evaluations have conducted many workshops on HOPE IV and CHSP at professional meetings, covering both housing and supportive services professionals, and we suggest that this practice continue. As the programs end, these grantee agency staff and written resources may become increasingly difficult for audiences to tap.

An important finding from the study was that even with the benefit of federal funding and local commitments to develop HOPE IV and CHSP, grantees often took considerable time to actually

implement these programs. In the absence of new financial support and in the face of such implementation difficulties, it is reasonable to assume that concerted Congressional and HUD policy and program initiatives, such as those highlighted in this section, are essential for adoption of these best practices.

For example, during the evaluations, the Service Coordinators said they would have benefited greatly from training, technical assistance, and the sharing of information among grantees on the initial development of the programs. This included having access to the underlying conceptual designs other grantees used, such as what structural and functional changes to make within the PHA or congregate housing developments, and what linkages to make with other community agencies already serving the case management and home care needs of frail elderly. This would have allowed building on and not duplicating the development of existing models. According to these Service Coordinators, such training and technical assistance also could have included guidance on the development of specific client assessment instruments and procedures for selecting eligible and appropriate participants for this program, given the common eligibility requirements.

4. *Long waiting lists for congregate housing and limited availability of Section 8 rental Vouchers severely restrict opportunities to expand HUD housing assistance programs for a frail elderly constituency. Congress and HUD could provide incentives to PHAs and congregate housing developments that would help ensure that frail elderly are not summarily excluded from these very popular programs.*

Concerning HOPE IV, the evaluation found that many PHA grantees applied for the demonstration funds in large part to overcome a severe shortage of Section 8 Vouchers, given the high demand for this program in general. Congress and HUD recognized this reality by including new funding for both Section 8 Vouchers and supportive services as part of HOPE IV demonstration awards. Waiting lists for Section 8 Vouchers often require more than two years to clear, which works to the considerable disadvantage of frail elderly applicants.

To address the waiting list problem under Section 8, Congress and HUD could permit PHAs to set aside a certain number of Vouchers for the frail elderly. Or they might offer additional Vouchers as an incentive to PHAs that commit to arranging supportive services through collaborative ventures with other agencies serving the elderly. In a similar vein, Congress and HUD could provide additional money for Service Coordinators as incentives to congregate housing sponsors who include a supportive services component through effective linkages with other community agencies. This is especially germane to the

new legislation allowing the conversion of Section 202 projects and the use of Section 8 Vouchers for assistive living facilities.

5. *HUD should continue to monitor the activities of HOPE IV and CHSP grantees after the programs end to determine how successful they were in continuing the program using alternative resources.*

The loss of HOPE IV and CHSP funding creates an opportunity to determine if the programs can continue using other resources in the community. For example, based on meetings and discussions with HOPE IV Service Coordinators in April 1998, the grantees were confronting the end of the program in several ways. At least one of the demonstration sites was no longer recruiting and placing new HOPE IV participants when vacancies occurred, but most were filling vacancies when someone left the program. This meant that even as the programs neared their end, many of the participants were quite new to the program, and it was likely that their need for a Service Coordinator and supportive services would continue beyond the effective end of the program and available funds. In response to this situation, most Service Coordinators reported they were exploring alternative sources of funds, but they had made no specific provisions for continuation.

The evaluations have ended and will not be able to track how well the current programs have been able to continue as a result of contingency planning and alternative programming. For this reason, HUD should monitor the progress of these efforts by local grantees. This will identify how and to what extent the grantees and their other community partner agencies successfully incorporated the concepts and specific examples from the HOPE IV and CHSP projects into their on-going housing assistance and supportive services programs.

It is reasonable to assume that the greatest prospects for permanent adoption of the HOPE IV and CHSP models are at the original grantee sites. Tracking the efforts to sustain the program within these agencies will show both the viability of the programs for continuation on their own, and the specific steps and resources grantees might use to do so. This monitoring also will identify any risks to the health and safety of HOPE IV and CHSP participants who may no longer have access to the services they need as grantees exhaust their project funds.

6. *An .examination of the HOPE IV comparison group and current congregate housing residents revealed relatively high levels of frailty and unmet need for services among current recipients of HUD housing assistance. It is likely that these patterns of frailty exist in many other communities and HUD housing assistance programs that did not participate in HOPE*

IV or CHSP. Congress and HUD could promote adoption of the HOPE IV and CHSP models for both existing tenants and residents, as well as for new Section 8 Voucher and congregate housing applicants.

The evaluations clearly showed that serving a frail elderly population involves not only reaching out to a new constituency, but also acknowledging and responding to the needs of existing HUD housing assistance recipients. Current residents of Section 8 scattered-site housing and congregate housing developments are aging in place, and a substantial number have levels of frailty similar to those of HOPE IV and CHSP participants.

For example, during the HOPE IV evaluation's comparison group selection process, random screening of elderly Section 8 Voucher holders who were not participating in HOPE IV revealed that one in five, or 20 percent, had levels of frailty similar to HOPE IV participants. At the same time, the study showed that over one-third of these persons were not receiving any services, despite similar indicators of need for services. All frail elderly CHSP participants came from within the current resident population, and it is likely that many other congregate housing developments have similar patterns of need.

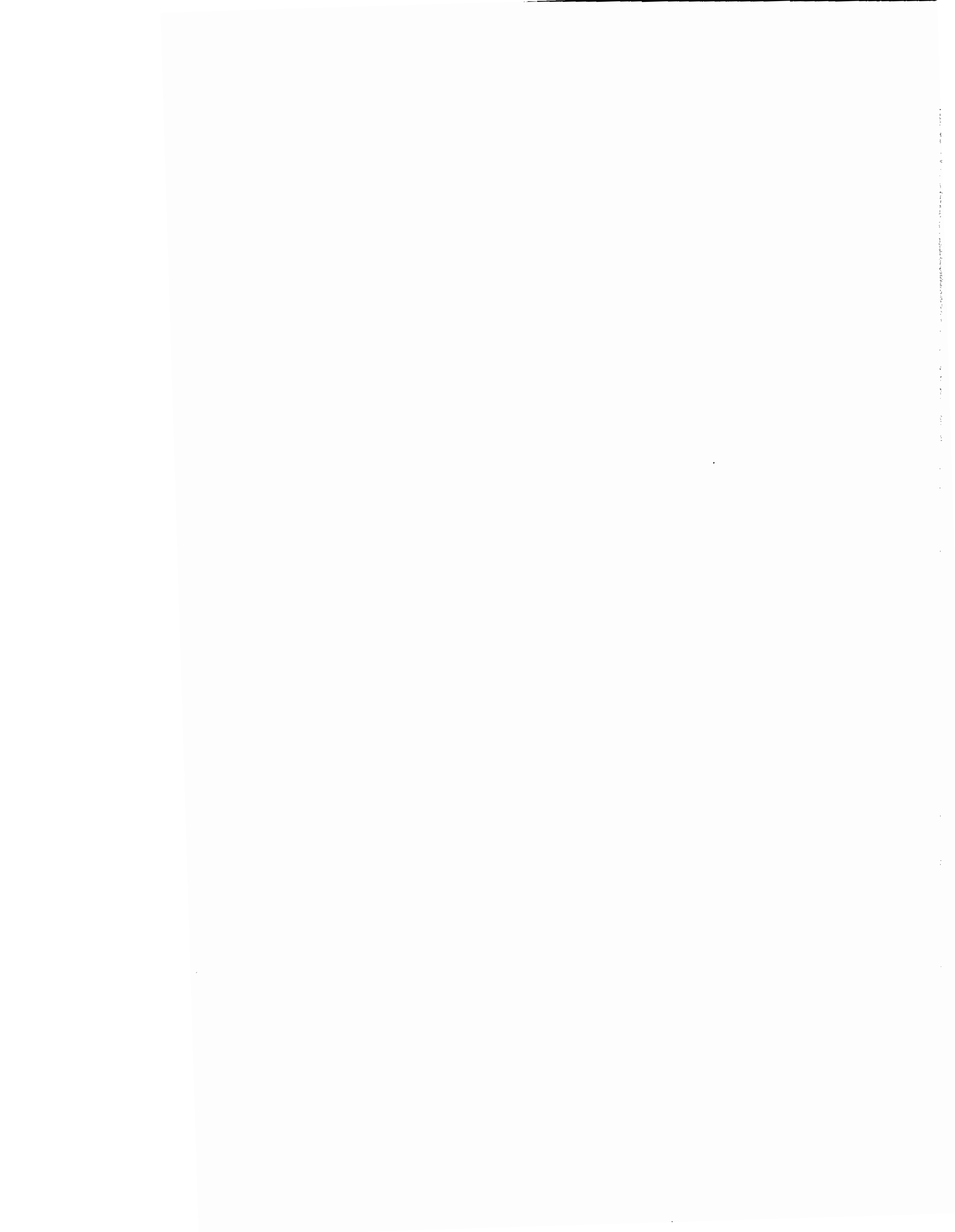
7. *HUD policies should ensure that frail elderly have a range of housing assistance options and the opportunity to choose from among them, rather than favoring either congregate or scattered-site programs. Comparing HOPE IV and CHSP operations and outcomes showed that one approach is not necessarily better than another. Tenant-based and project-based models for housing and supportive services are both essential for addressing the realities of an aging HUD constituency who current receive or are eligible for housing assistance.*

The evaluations showed that both HOPE IV and CHSP were successful in terms of producing positive outcomes and generating a high level of satisfaction among program participants. However, Chapter 6 shows that turnover of participants was substantial, and during the two-year period between the baseline and follow-up periods, approximately 40 percent the HOPE IV and CHSP participants left their respective housing and services programs altogether, many as a function of increasing levels of frailty. This high exit rate suggests that the presence of ADL limitations beyond certain levels, even with a viable services component, may preclude participation in tenant-based Section 8 or congregate housing for both current tenants or residents, and new applicants.

One critical policy issue, therefore, is deciding how to provide a range of choices and several levels of care in the community for frail elderly persons, rather than focusing on a narrow range of options. For example, Congress and HUD are beginning to explore how to provide the many benefits of

assistive living to low-income, frail elderly eligible for HUD housing assistance. At this point in time, assistive living facilities that provide considerable flexibility and choice are an option for only high-income elderly in most cases.

Finally, emerging long-term care policy trends in the United States, in the public and private sectors, favor both home care models in scattered-site settings, similar to HOPE IV, and congregate programs with a services component, similar to CHSP. For instance, states are increasingly using Medicaid Waivers and other state-funded home care programs to provide case management and supportive services to frail elderly where they currently live, avoiding the need to move to more restrictive settings to qualify for care. At the same time, for those frail elderly who need additional supervision, congregate models that combine housing and services are becoming increasingly popular among providers, funding agencies, and the elderly as viable alternatives to nursing home placement. While the two new HUD legislative initiatives favor the assisted living model, it is important for HUD to encourage other congregate models, as well as the use of Section 8 Vouchers in conjunction with scattered-site rental housing and in-home services programs for low-income frail elderly persons.



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