ASPE Grant #02 ASPE403A:

Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place

(Service Access for Elders in Public Housing – SAEPH)

Final Report

February 2004

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Maryland Department of Aging

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**Final Report for ASPE Grant #02 ASPE403A:
Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place**

Abstract

The (ASPE Track 2) planning project, referred to as Service Access for Elders in Public Housing or SAEPH, addressed issues that affect the quality of life of elderly residents of an urban public housing complex. A SAEPH Steering Committee conducted a survey of elderly residents, collected data from area providers, and designed a preliminary model to better coordinate information and services provided by public and private agencies that serve the residents to assist them to better age in place in their apartments. Surveyed elderly residents are primarily single, low-income, African-American women with chronic health problems, possible depression, some difficulty accessing and paying for adequate medical and dental care, and concern about the safety of their housing environment. Public and private providers in the community identified several significant barriers to implementation of a model. Final design and implementation of a feasible model with the potential for expansion to other housing sites is dependent on addressing barriers and resolving issues by involving individuals in positions of authority in key organizations, carefully crafting new approaches to coordination and delivery of information and services, and developing funding resources.

Final Report for ASPE Grant #02 ASPE403A:
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Executive Summary

For convenience, this Track 2 planning project, funded from October 2002 through February 2004, is referred to as Service Access for Elders in Public Housing or SAEPH. The project was conceived in response to issues and perceptions concerning the outcomes and quality of life of frail or at-risk elderly residents of public housing by the Maryland Department of Aging (MDoA) in cooperation with other concerned agencies.

A project Steering Committee addressed questions about the status of elderly public housing residents and their needs; information and services available to them as well as gaps in service coordination and delivery; and barriers to better coordination and delivery of services. Three strategies were developed to address the questions: a) survey residents, b) collect data from providers, and c) design a preliminary model for systems change. The project was conducted as a pilot in the McCulloh Homes public housing project in Baltimore City where approximately 400 elderly residents live in two high-rise apartment buildings and in surrounding low-rise apartment units.

Resident Survey: A survey of 101 elderly residents of McCulloh Homes was conducted by the University of Maryland, Baltimore County Center for Health Program Development and Management. The survey provides a profile of elderly public housing residents who are single, low-income, African Americans, primarily female, with social connections but lacking adequate support if they become less independent. Although most respondents are functional, most have chronic conditions and there appear to be significant mental health issues, including depression, that are not being treated. Most of the respondents have mouth pain and most (81%) had not seen a dentist in the past year.

Provider Survey and Focus Group: A survey of public and private organizations in the area that provide health, long-term support, and other services to elderly McCulloh residents was conducted to solicit information about the services they provide. In addition, a focus group of area providers was conducted. Local providers offer services to assist with access and direct medical and support services. Providers indicated that there is a lack of information and coordination of services within the Housing Authority and with other agencies serving McCulloh residents as well as limited use of the local aging network services. The providers recommended a central phone number to share concerns about customers served; increased coordination and collaboration between agencies serving the same customers; development of a "home team" to implement hospital discharge plans; increased involvement of the local Area Agency on Aging; and a centralized record-keeping system with adequate safeguards to assure the confidentiality and privacy of residents.

Model Development: As the project proceeded, it became clear that several systems issues must be addressed before finalizing the design and implementation of a feasible pilot. Systems change involves work with key individuals and organizations to identify and address the issues that

emerged and to recommend changes. In addition, further funding will be required to support the continued planning process and implementation of the model. Steps have been taken to inform key agency personnel of the findings of the SAEPH project and to involve them in further discussion.

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Final Report

Purpose of the Project

In October 2002, the Maryland Department of Aging (MDoA) received funding from the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE) for a Track 2 planning project to convene an interagency steering committee to complete project tasks. For convenience, the project, titled Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place, has been referred to as Service Access for Elders in Public Housing or SAEPH. Henceforth in this document, the project will be referred to as the SAEPH (pronounced "safe") Project. The planning project was funded through February 2004.

The SAEPH Planning Project was developed by MDoA in cooperation with the Housing Authority of Baltimore City; the University of Maryland, Baltimore County Center for Health Program Development and Management; the Maryland Department of Health and Mental Hygiene; and additional Baltimore City, State, and private organizations. The project was conceived in response to issues and perceptions concerning the outcomes and quality of life of frail or at-risk elderly residents of public housing:

- There appeared to be evidence of preventable hospital admissions and re-admissions, and placement in nursing homes; inappropriate evictions; and lack of adequate supports to allow elderly residents to age in place.
- There also appeared to be a lack of coordination of information and service delivery among the multiple public and private agencies serving elderly public housing residents.

Questions Considered by the Project

The project proposed to address the following questions:

- **What are the social, health, and functional status of elderly public housing residents and their met and unmet service needs?** Little data existed concerning the status and needs of the residents. Data from the Housing Authority and other agencies that serve the residents was sparse and limited by privacy/confidentiality and other considerations.
- **What information and services are available to elderly public housing residents?** No centralized directory of information and service resources was available.
- **Are there barriers to adequate coordination of information and service delivery to elderly public housing residents?** Although there was considerable anecdotal information

suggesting that such barriers existed and affected the well-being of residents, they had not been systematically addressed.

- **How can barriers be eliminated and information and service delivery be better coordinated?** No formal effort had been made to design and implement a joint intervention to improve residents' access to information and services that are administered among several State and local public and private health and service agencies. Interventions that would reduce institutionalizations and hospital admissions and re-admissions among older public housing residents had not been addressed in depth.

Methodology

The SAEPH Executive Planning Group met in October 2002 to establish Steering Committee membership and meeting dates and continued to meet as needed to assess project status and to plan for future action. The first Steering Committee meeting was held in November 2002 and the Committee met every two months after that date. Steering Committee membership included representatives from:

- The Maryland Department of Aging
- The Maryland Department of Health and Mental Hygiene
- The Maryland Department of Housing and Community Development
- The Baltimore City Commission on Aging and Retirement Education [local Area Agency on Aging (AAA)]
- The Baltimore City Health Department
- The Housing Authority of Baltimore City
- Baltimore Mental Health Systems
- McCulloh Homes Tenant Council
- McCulloh Health Center
- Johns Hopkins Bayview Medical Center
- Family and Children's Services of Central Maryland
- University of Maryland, Baltimore County Center for Health Program Development and Management

Three strategies were developed by the SAEPH Steering Committee to address the questions: a) survey residents, b) collect data from providers, and c) design a preliminary model for systems change. The project was conducted as a pilot in one public housing project in Baltimore City known as McCulloh Homes. McCulloh Homes has approximately 400 elderly residents including those who live in two high-rise apartment buildings and those in surrounding low-rise apartment units in the complex.

A. Survey of Residents

MDoA contracted with the University of Maryland, Baltimore County Center for Health Program Development and Management (the Center) to conduct a survey of elderly residents of McCulloh Homes. A random sample of residents 62 years old and older was selected from a

Housing Authority listing of tenants with housing eligibility designation of aged (62 years old or older) or disabled. The survey not only included those residents living in the high-rise buildings designed specifically for older adults, it also identified elderly residents who have aged in place in low-rise family public housing, who have no staff support, and whose apartments are not physically adapted for frail seniors with disabilities. The interview instrument was adapted from Older Americans Resources and Services Multifunctional Assessment Questionnaire, developed at Duke University in 1979 and modified to render the instrument more appropriate for urban, low-income seniors, and the SAEPH project. Trained interviewers met with participants in their own homes except in a few cases where the participant requested a change of venue. Interviews lasted 60-90 minutes. The final sample included 101 residents living in both high-rise (n=68) and low-rise (n=33) buildings in the McCulloh Homes complex. Attachment A provides the full final report of the resident survey.

B. Survey of Providers

Provider Survey: The Provider Survey sub-committee of the SAEPH Steering Committee met to develop a list of public and private organizations in the area that provide health, long-term support, and other services to elderly McCulloh residents. A four-page survey instrument was mailed to all of the organizations on the list to elicit information about the services they provide and other comments. Of 49 surveys mailed, 25 were completed and returned. A report of the provider survey is in Attachment B.

Focus Group: A focus group of area providers was conducted in October 2003 to assist in the further identification of barriers to the implementation of a model for change in the way services are coordinated and delivered for elderly residents of public housing. In addition, the group suggested strategies for change. The discussion followed a review of the mission of the Steering Committee, barriers and issues raised in Committee meetings and surveys, and a brief description of a proposed program model. Questions to guide the discussion were organized around the three innovative strategies for change that were the focus of the SAEPH planning process. The questions were supplemented by select responses from the provider and resident surveys. A summary of the group's discussion can be found in Attachment C.

C. Design of the Model

A goal of the SAEPH Steering Committee was to design a preliminary model of information and service coordination and delivery that would address existing barriers and provide the supports needed to allow elderly public housing residents to age in place. The model would incorporate systems changes to coordinate and reshape the way in which State and local public agencies work with senior residents of public housing to identify and access services in order to limit inappropriate institutional placements, including nursing home and hospital admissions and re-admissions.

Findings of the Project

The Residents

(See also Attachment A.) The majority of elderly residents of McCulloh Homes are female, nearly all are African American, and most are not married. More than one-third of survey respondents are age 75 or older and have lived in McCulloh Homes an average of twelve years. Most of the residents surveyed have a high-school education or less. They are mostly Protestant and feel their access to religious services is adequate. Most participants have social connections, often via the telephone; however, they do not have much support. Although only a few of the residents surveyed have no one to help them if they become sick or disabled, the majority have someone to help only "now and then."

As public housing residents, it is not surprising that most of the survey respondents are at or near the poverty level. Income is derived for the most part from Social Security and Supplemental Security Income (SSI). Nearly all of the survey participants have health insurance, primarily through Medicare, Medicaid, and Pharmacy Assistance.

Nearly one-third of respondents feel that their mental health is fair or poor, and on the Short Portable Mental Health Status Questionnaire, more than one-third had scores that indicate probable depression or other psychiatric symptoms. Conversely, only 7 percent are currently receiving mental health services. Most survey participants had seen a doctor within the past year, and 30 percent of them had been in the hospital. Nine respondents said they did not have the help they needed after leaving the hospital. The majority of residents surveyed reported having high blood pressure and arthritis or rheumatism. In addition, many reported having circulation problems, heart trouble, diabetes, and problems with their feet. Approximately one-fifth of the survey participants need medical care beyond what they are currently receiving; the same amount of them have a problem paying for medications. Most of the respondents have mouth pain and most (81%) had not seen a dentist in the past year. Cumulative impairment scores calculated for the survey participants indicate that although most of them have good functional ability, the greatest amount of impairment is in physical health.

Nearly one-third of survey participants said they had considered moving in the past month. The most frequently given reasons were neighborhood safety and lack of security in their building or apartment. One-third of respondents have used the McCulloh Health Center, located in the complex, but many of them did not know about it or did not know they were eligible to use it. One-quarter of residents surveyed feel they need more transportation than is available to them, and the most common type of transportation used is public transportation (the bus). Respondents travel most frequently to health-related destinations or shopping. Less than 20 percent of respondents used personal care (12 percent), nursing care (12 percent), physical therapy (10 percent), continuous supervision (9 percent), help with household chores (16 percent) and with meals (11 percent), and/or help with legal issues or personal business (17 percent) in the past six months. Fifteen residents had received a multi-dimensional assessment within the past year and half of them had received some assistance with coordination, information, and referral, primarily from family members.

The Providers

In the Provider Survey, agencies were asked what types of services they provide from a list of services. The organizations surveyed indicated that they provide a total of 41 services to assist with access such as information and referral, advocacy, assessment, service coordination, and case management. Eighteen offer direct services, such as meals, transportation, and counseling. In addition, 35 medical services including pharmacy, home health, medication management, mental health counseling, personal care, adult day care, and hospital and medical services are available to McCulloh residents, but are underutilized. The providers are located primarily within Baltimore City and have been serving residents of McCulloh Homes for an average of 10 years. When asked how services can be improved, the most frequent responses were:

- Central phone number to share concerns/problems about customers served
- Develop a home team to implement hospital discharge plans
- Increase coordination and collaboration between agencies serving the same customers
- Determine additional steps that should be taken by the Aging Network to be an effective advocate and resource for older persons in public housing
- Fill service gaps not covered by existing reimbursement systems

In both the Provider Survey and in the provider focus group, confidentiality was identified as a major barrier to the sharing of information. However, the focus group felt that protected sharing of computerized data by agencies through a centralized point would help to effectively coordinate information and services for residents. Lack of adequately trained staff is a barrier as is lack of effective marketing and transportation. The focus group also identified a lack of clarity on the part of the Housing Authority in its role as landlord to elderly residents aging in place as a significant barrier.

Barriers and Issues in Model Development

As the SAEPH project proceeded, it became clear that in order to fully design and implement a model pilot project several systems issues must be addressed. Final design and implementation of a feasible pilot with the potential for expansion to other housing sites is dependent on resolving issues and carefully crafting new approaches to coordination and delivery of information and services. This would involve work with key individuals and organizations to identify and address the issues that emerged and to recommend changes. In addition, further funding will be required to support the continued planning process and implementation of the model.

The following agencies or organizations were identified as key stakeholders in the process:

- The Housing Authority of Baltimore City, the landlord
- Hospitals that serve McCulloh residents
- Community and public providers that serve McCulloh residents
- The McCulloh Homes elderly resident community

- Housing Authority of Baltimore City

Several issues have emerged within the Housing Authority that present potential barriers to implementation of a SAEPH project model of inter-agency and intra-agency coordination. The Housing Authority has two divisions: one division operates facilities and collects rent whereas the other division is responsible for service coordination. There appears to be little communication or coordination between the two divisions. There is also a lack of clarity concerning the commitment of the Housing Authority to assisting elderly residents to age in place. The current economic climate has resulted in cuts in resources, particularly in staffing. Concerns have also emerged concerning the adequacy of selection and training of staff.

- Area Hospitals and Dental Providers

Residents who were surveyed were asked to identify hospitals they had been in within the past year. Residents had been in several hospitals in Baltimore City. The largest number had been in Maryland General Hospital, which is the hospital closest to the McCulloh complex. The resident survey also identified dental care as a needed service. The preliminary model design includes involvement of hospital discharge planners and dental providers as key to implementation of the project. To date, hospital and dental personnel have not been included in the SAEPH planning process.

- Community and Public Providers

Baltimore City has many providers that serve older adults offering a wide range of services. SAEPH provider survey respondents indicate that they offer medical, mental health, legal, transportation, and meal services among many others. A number of agencies provide services to coordinate or otherwise assist elderly residents to access necessary services. However, there is no mechanism available to elderly residents of McCulloh Homes on site to help them identify services they may need and assist them to access those services. Public agency services, primarily those available through the local AAA, do not seem to have penetrated the resident population. Only 20 residents are enrolled in the Congregate Housing Services Program and another 20 residents use the Nutrition Program. Not one resident is participating in Senior Care, a state funded program for frail seniors. At this time, no resident has been identified who is participating in the Medicaid Home-and Community-Based Services waiver program for older adults. There is no formal mechanism for the AAA or other aging service providers to work directly with Housing Authority staff to assist elderly residents to access services.

- Resident Community

Residents of public housing have low incomes and many of them have little formal education. The elderly residents have health and mental health problems. Many of them do not have family or other social supports to assist them to navigate systems in order to have their needs met. However, survey interviewers note that residents have a strong desire to remain independent and use their limited resources to do so. They also evidence courage and a sense of hopefulness in the face of their own limitations and those of the systems with which they must cope.

Transition and Implementation

In August 2003, MDoA submitted a proposal to ASPE to fund transitional planning and implementation of a SAEPH model. The proposal was not funded. The proposal presented six goals to be met in the transition from planning to implementation.

Goal 1: Address systems barriers that affect change in the configuration of service access and delivery for elderly residents in Baltimore City public housing.

Goal 2: Increase communication, cross education, and collaboration among public housing property management and service staff, and external service agencies and providers.

Goal 3: Reduce housing turnover by reducing inappropriate evictions and transitions to institutional care.

Goal 4: Reduce unnecessary hospital admissions and re-admissions among older public housing residents.

Goal 5: Work with public and private health and service providers to better coordinate with senior residents of McCulloh Homes.

Goal 6: Assist additional Housing Authority of Baltimore City public housing facilities to reconfigure their service design.

Communication from ASPE staff indicated that whereas the goals were admirable, they were over-reaching and did not always address the findings of the planning phase of the project. Given the commitment of time and resources to this project to date as well as the continued need, MDoA will continue to pursue funding and strategies to affect change in the coordination and delivery of information and services to elderly residents of public housing.

Based on the goals listed above and the findings of the SAEPH planning project, the following steps would be taken to develop a model for a pilot:

- Inform executives of public agencies of the findings of the SAEPH surveys and engage them and their staffs in a collaborative planning process

- Increase communication, cross education, and collaboration among public housing property management and service staff, and external service agencies and providers.

- Develop an on-site placement for a services coordinator from the local AAA to work in conjunction with existing housing managers and service coordinators and to work directly with residents to obtain services or develop new services such as dental care.

- Work directly with providers to develop better collaboration for services, especially hospital discharge planning.

- Create a position within the Maryland Department of Aging to work directly with McCulloh and AAA staff to increase communications and education among staff and residents regarding available services and to assist the AAA in developing new services.

- Assist additional public housing in Baltimore City to reconfigure their service design.

The findings of the planning project are being presented to key personnel in the Housing Authority, the Baltimore City AAA, and other agencies that are identified as essential to a successful effort to better coordinate the delivery of information and services to those elderly residents who are most in need. Following preliminary meetings, further review of existing data, and collection of additional data, a service-coordination model will be carefully crafted that has the potential for bringing about systems change on a feasible scale.

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Attachment A

Report on the Survey of Residents

Service Access for Elders in Public Housing (SAEPH)

Report on the Survey of Residents

February 2004

Prepared for:
Maryland Department of Aging

Prepared by:
Center for Health Program
Development and Management at
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Service Access for Elders in Public Housing (SAEPH)
Report on the Survey of Residents

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Service Access for Elders in Public Housing (SAEPH)
Report on the Survey of Residents

Executive Summary

A survey of 101 elderly residents of McCulloh Homes in Baltimore City was conducted in 2003 as a principal component of the federally funded Service Access for Elders in Public Housing (SAEPH) project. The purpose of the SAEPH project is to improve service access, coordination, and delivery for frail or at-risk older residents of public housing. The survey was conducted to provide a profile of frail, low-income older adults who live in public housing, to determine what services the older residents of public housing are receiving, and to help identify obstacles to service provision and gaps in the coordination and delivery of services.

Survey respondents (n=101) live in both high-rise (n=68) and low-rise (n=33) buildings in the housing complex. The majority of elderly residents of McCulloh Homes are female, nearly all are African American, and most are not married. More than one-third of survey respondents are age 75 or older and have lived in McCulloh Homes an average of twelve years. Most of the residents surveyed have a high school education or less. They are mostly Protestant and feel their access to religious services is adequate. Most participants have social connections, often via the telephone; however, they do not have much support. Although only a few of the residents surveyed have no one to help them if they become sick or disabled, the majority have someone to help only "now and then."

As public housing residents, it is not surprising that most of the survey respondents are at or near the poverty level. All but two of the respondents have incomes of less than $15,000 per year. Income is derived for the most part from Social Security and Supplemental Security Income (SSI). Nearly all of the survey participants have health insurance, primarily through Medicare, Medicaid, and Pharmacy Assistance.

More than one-quarter of respondents feel that their mental health is fair or poor, and on the Short Portable Mental Health Status Questionnaire, more than one-third had scores that indicate probable depression or other psychiatric symptoms. Conversely, only 6 percent are currently receiving mental health services. Most survey participants had seen a doctor within the past year, and 30 percent of them had been in the hospital. Nine respondents said they did not have the help they needed after leaving the hospital. The majority of residents surveyed reported having high blood pressure and arthritis or rheumatism. In addition, many reported having circulation problems, heart trouble, diabetes, and problems with their feet. Approximately one-fifth of the survey participants need medical care beyond what they are currently receiving; about the same number of them have a problem paying for medications. Most of the respondents have mouth pain and most (81 percent) had not seen a dentist in the past year. Cumulative impairment scores calculated for the survey participants indicate that although most of them have good functional ability, the greatest amount of impairment is in physical health.

More than one-quarter of survey participants said they had considered moving in the past month. The most frequently given reasons were neighborhood safety and lack of security in their building or apartment. One-third of respondents have used the McCulloh Health Center, but many of them did not know about it or did not know they were eligible to use it. One-quarter of residents surveyed feel they need more transportation than is available to them, and the most common type used is public transportation (the bus). Respondents travel most frequently to health-related destinations or shopping. Less than 20 percent of respondents received personal care (12 percent), nursing care (12 percent), physical therapy (10 percent), continuous supervision (9 percent), help with household chores (16 percent) and with meals (11 percent), and/or help with legal issues or personal business (17 percent) in the past six months. Fifteen residents had received a multi-dimensional assessment within the past year, and half of them had received some assistance with coordination, information, and referral, primarily from family members.

Service Access for Elders in Public Housing (SAEPH)
Report on the Survey of Residents[1]

Background and Introduction

Overview of the SAEPH Project

In October 2002, the Maryland Department of Aging (MDoA) received funding from the Department of Health and Human Services, Office of the Secretary, Assistant Secretary for Planning and Evaluation (ASPE) for a planning project to convene an interagency steering committee to complete project tasks. For convenience, the project has been referred to as Service Access for Elders in Public Housing, or SAEPH (pronounced "safe"). The current planning project is funded through February 2004.

The purpose of the SAEPH project is to promote systemic change in order to improve service access, coordination, and delivery for frail or at-risk older residents of public housing. Systemic change will coordinate and reshape the way in which state and local public agencies and private providers work with senior residents and staff of public housing to identify and access services. Primary services are long-term care support and financial assistance for health-related needs, including pharmacy, dentistry, transportation, disability equipment and apartment adaptations, and hospital discharge transitional care. Long-term care support will be coordinated through the Area Agency on Aging (AAA) and MDoA programs. These changes are intended to limit inappropriate institutional placements, including nursing home and hospital admissions and re-admissions. The SAEPH project is being conducted as a pilot in one public housing complex in Baltimore City known as McCulloh Homes. The McCulloh Homes complex has approximately 400 elderly residents, including those who live in two high-rise apartment buildings and those in surrounding low-rise apartment units, encompassing a two-by-six block area.

Purpose of the Survey of Residents

The survey was conducted to provide a profile of frail, low-income older adults who live in public housing, including their health and functional status, social support systems, and met and unmet care needs. The survey was also conducted to help determine what services the older residents of public housing are receiving and, in concert with other project activities, to help identify obstacles to service provision and gaps in the coordination and delivery of services.

Summary of the Survey Methodology

The survey was conducted with a sample of elderly residents (age 62+) of McCulloh Homes by trained interviewers between February and July 2003. The final sample included 101 residents living in both high-rise (n=68) and low-rise (n=33) buildings in the McCulloh Homes complex. The survey instrument is a modification of the Older Americans Resources and Services/ Multidimensional Functional Assessment Questionnaire (OARS/MFAQ). A description of the methodology is available at the end of this report.

[1] Final Sample Size = 101. Except where indicated, "n" is the size of the total sample, 101. In some cases, percentages may not add to 100 due to rounding. Percentages will not add up to 100% where discrete questions were analyzed and responses are not mutually exclusive.

Profile of Older Residents of McCulloh Homes

> The average survey participant is a man or woman who is 72 years old, African American (99 percent), Protestant, lives alone, and has less than a high school education. Three respondents reported being age 90 or older. The average length of time living at McCulloh Homes is 12 years.

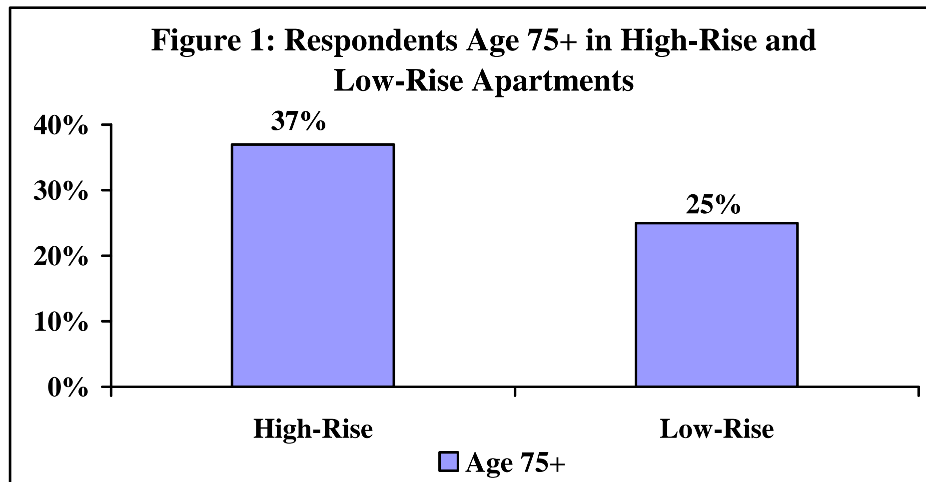
Who Are They?

Table 1 provides demographic data and comparisons with other populations.

Table 1: Demographic Characteristics of Survey Respondents

	High-Rise (%)	Low-Rise (%)	Total (%)	Other Populations
Sex • Female • Male	 51 49	 78 22	 60 40	• In 2000, 59% of the U.S. population age 65+ was female (U.S. Administration on Aging)
Age • 62 – 74 • 75 – 84 • 85+ (Missing = 6)	 35 23 29	 65 77 71	 66 27 7	
Race • African American • Other (Missing = 3)			 99 1	• In 2000, 8% of the population over age 65 in the U.S. was African American (U.S. Administration on Aging) • In Maryland, in 2000, 18% of the population over age 65 was African American (U.S. Administration on Aging)
Education • <High school • High school • Post high school/ vocational/ technical • 1 – 3 years college • Post college			 72 18 2 6 1	• Nationally in 1998, 67% of Americans age 65 and over had completed high school (Federal Interagency Forum on Aging Related Statistics) • In 2001, 51% of all African Americans 65+ in the U.S. had completed high school (U.S. Administration on Aging)
Religion • Protestant • Catholic • Muslim • Other (Missing = 3)			 85 11 1 3	

- Thirty-seven percent of high-rise residents in the survey are age 75 or older, whereas 25 percent of the low-rise survey participants are in that age category.



Social Connectivity

- Only 5 percent of survey respondents are married. Of the remainder, 49 percent are widowed, 19 percent were never married, and 28 percent are divorced or separated. In the general population age 65 and over, 73 percent of men and 41 percent of women are married (U.S. Administration on Aging).

- The 5 percent of respondents who are married live with their spouse; the majority of participants (77 percent) live alone. The remaining survey participants live with children (7 percent), grandchildren (3 percent), parents (1 percent), other relatives (3 percent), or friends (2 percent). Among African American elderly in the United States, 54 percent of men and 24 percent of women live with a spouse; 25 percent of men live alone, as do 41 percent of women (U.S. Administration on Aging).

- Four percent of respondents have a pet and have someone who would care for the pet if needed. Of those responding (n=93), 33 percent do not have and do not want a pet, 1 percent say they cannot afford to care for one or are not well enough to do so (3 percent), and 62 percent say that they do not have a pet because it is not allowed.

> Pets can be important social supports. Those who report not having one because they are not allowed could benefit from services that support pet ownership, though building maintenance/hygiene could be an issue.

- Thirteen percent say that they know no one well enough to visit them.

- Nearly the same proportion of high-rise (31 percent) and low-rise (28 percent) residents surveyed participated in social programs or group activities in the past six months.

- In the week prior to being surveyed, 30 percent had visited no one and 13 percent had visited or been visited only once.

- Ninety percent had talked with someone on the phone 2 to 6 times in the past week, or more than once a day.

- A majority (56 percent) of respondents reported almost never feeling lonely, whereas 3 percent feel lonely quite often, and 42 percent feel lonely sometimes.

Most participants have social connections (mostly phone contacts). However, they do not have much support: 11 percent have someone to help them only "sometimes," and 84 percent only "now and then."

Table 2: Characteristics of Those with No One to Help

		No One Willing and Able to Help
Sex	Male	4
	Female	4
Age	62-74 Years	4
	75-84 Years	3
	85+ Years	1
Total Household Income Per Year	$5,000-$9,999	7
	$10,000-$14,999	1
High-/Low-Rise	Low-Rise	3 (38%)
	High-Rise	5 (63%)

- Forty-two percent do not see friends and relatives as often as desired.

- Nineteen percent provide care to others, including two to a mother-in-law, five to a child or grandchild, two to a sibling, and nine to a non-relative or friend.

Nineteen percent provide care to others, which seems to be a source of great pride.

- Most respondents (94 percent) said they have someone to confide in.

Economic Resources

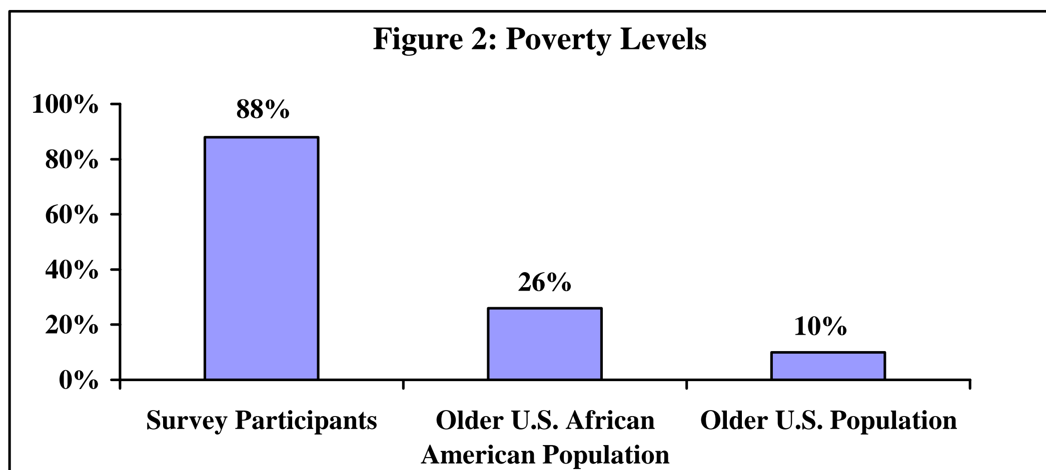
- None of the survey participants reported that they work full-time; 4 percent work part-time. Thirteen percent of all adults over age 65 in the United States participate in the labor force (U.S. Administration on Aging).

- Sixty-eight percent of respondents worked as semiskilled or unskilled laborers or as service workers.

Among survey participants, 88 percent are below or near poverty. In the United States, 26 percent of older African Americans are below the poverty level (U.S. Administration on Aging).

Table 3: Total Household Income Per Year

Income	Percent
$0 - $3,999	1
$4,000 - $4,999	5
$5,000 - $5,999	36
$7,000 - $9,999	46
$10,000 - $14,999	10
$20,000 - $29,999	1
$30,000 - $40,000	1



- In 2001, 6.5 percent of older adults in the United States reported income under $5,000; 25.3 percent had incomes from $5,000 to $9,999; 21.6 percent received $10,000 to $14,999; and 46.7 percent had incomes over $15,000 (U.S. Administration on Aging).

Table 4: Sources of Income (respondents may have more than one source of income)

Source	Percent	Source	Percent
Social Security	82	Family Members	3
SSI Payments	39	Rental, Interest, Investments, Etc.	1
Retirement Pension from Job	11	Child Support	0
V.A. Benefits	9	Private Organizations and Churches	0
Disability Payments	7	Public Assistance	0
Employment	4		

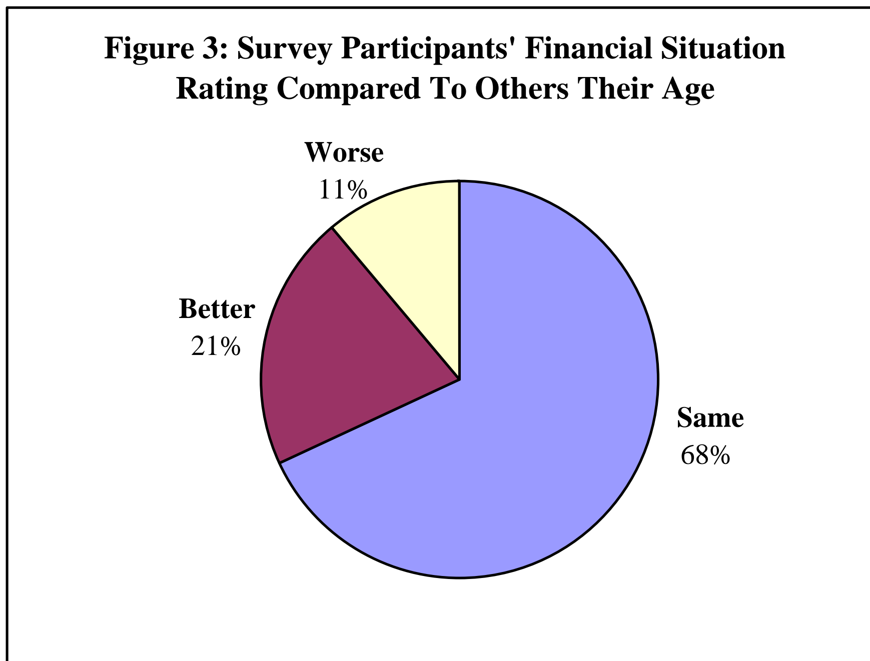
- For older adults in the United States during 2002, 90 percent received Social Security income, 59 percent had income from assets, 41 percent from pensions, and 22 percent from earnings (U.S. Administration on Aging).

Nationally, 38 percent of older adult income comes from Social Security, 21 percent from earnings, and 19 percent from pensions (Federal Interagency Forum on Aging Related Statistics). Among survey respondents, 82 percent receive Social Security income, 4 percent earnings, and 11 percent pensions.

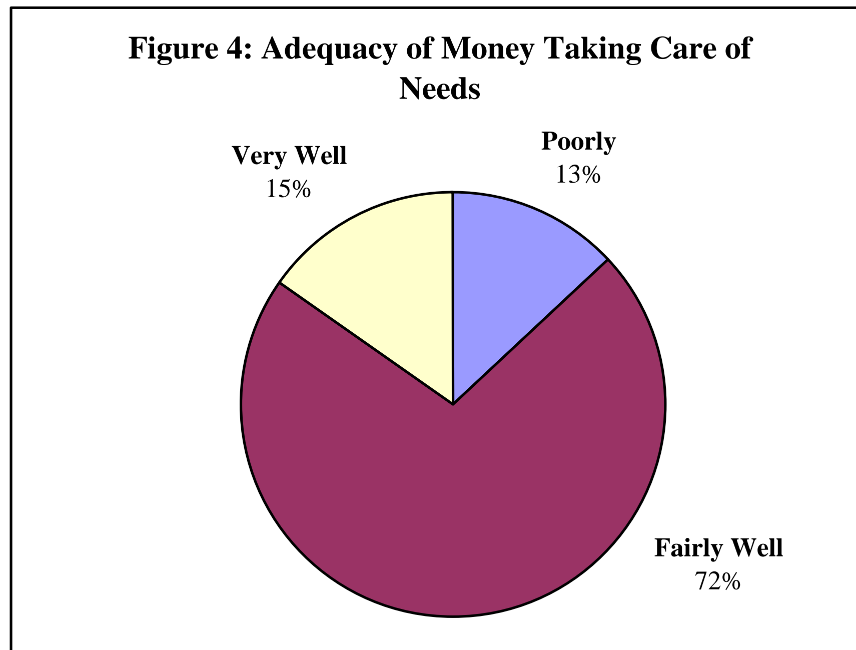
Survey participants were asked to rate their financial situation:

- Sixty-eight percent feel their finances are the same as compared to others their age, 21 percent feel they are better off, and 11 percent believe their financial situation is worse.

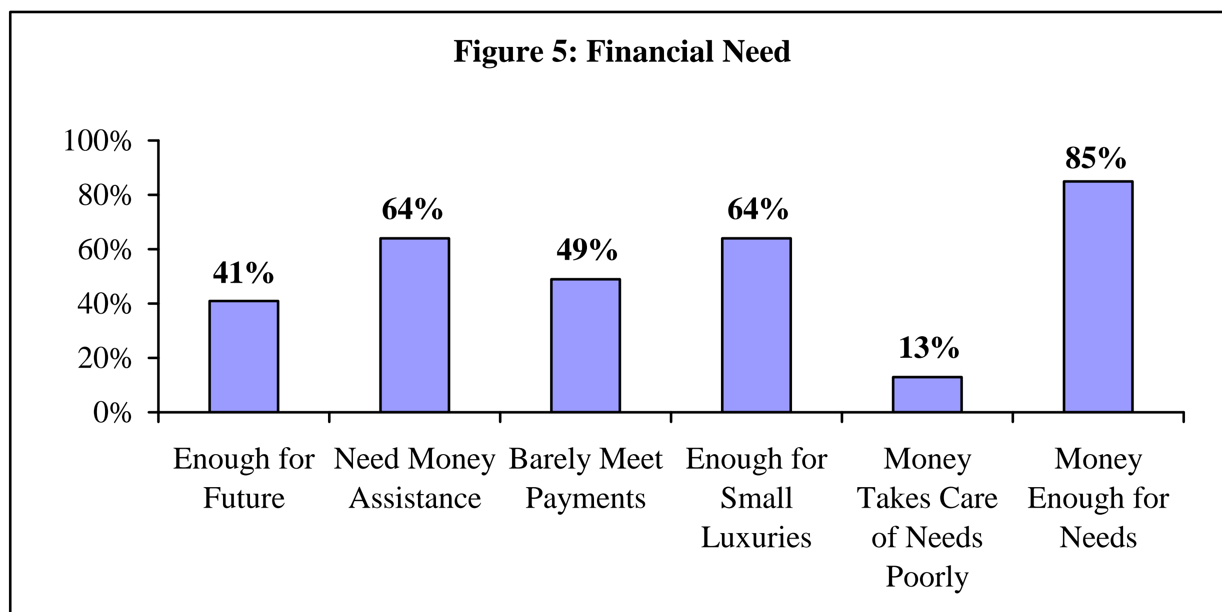
Figure 3: Survey Participants' Financial Situation Rating Compared To Others Their Age



- Money takes care of needs poorly for 13 percent of respondents, fairly well for 72 percent, and very well for 15 percent.



- Sixty-four percent feel they have enough to buy small luxuries and 41 percent (of 93 who responded) have enough money for future needs. However, over 45 percent say they can barely meet payments, and nearly two-thirds say they need additional assistance.



- Of all survey participants, 95 percent have health insurance.

- Forty-five percent of 96 respondents are Medicaid recipients and 29 percent of 93 receive Pharmacy Assistance. In Maryland, 42 percent of Medicaid recipients over age 50 are African American (U.S. Administration on Aging).

Table 5: Characteristics of Those Who Do Not Have Medical/Health Insurance

		Have Medical Insurance	
		Yes	**No**
Sex	Male	40	1
	Female	58	4
Age	62-74	57	5
	75-84	26	0
	85+	7	0
High-/Low-Rise	Low-Rise	34 (100%)	0 (0%)
	High-Rise	65 (93%)	5 (7%)
Total Household Income	Up to $4,000	6	0
	$5,000 - $9,999	80	3
	$10,000 - $14,999	9	1
	$20,000+	2	0

The Health Status of Survey Respondents

Mental Health

- When asked about how often they worry, 20 percent of survey respondents said they worry very often, 32 percent fairly often, and 47 percent said hardly ever.
- When asked if they find life dull, 7 percent said yes, 52 percent find it pretty routine, and 41 percent say life is exciting.
- When asked how satisfied they are with their lives, only 3 percent find it poor, 34 percent find it fair, and 63 percent said it is good.

Of the 45 percent who feel lonely quite often or sometimes:

- 26 percent report not seeing relatives/friends as often as desired
- 74 percent score as having probable psychiatric problems
- 48 percent report not being active in social activities and "prefer not to"

- Six percent received mental health (MH) treatment in the last six months.

Table 6: Characteristics of Those Who Have Received MH Treatment in Past 6 Months

		Received MH Treatment	
		Yes	**No**
Mental or Emotional Health Self-Rating	Poor	1	11
	Fair	4	62
	Good	2	23
Mental or Emotional Health Compared to Five Years Ago	Worse	0	5
	About the Same	3	22
	Better	3	45

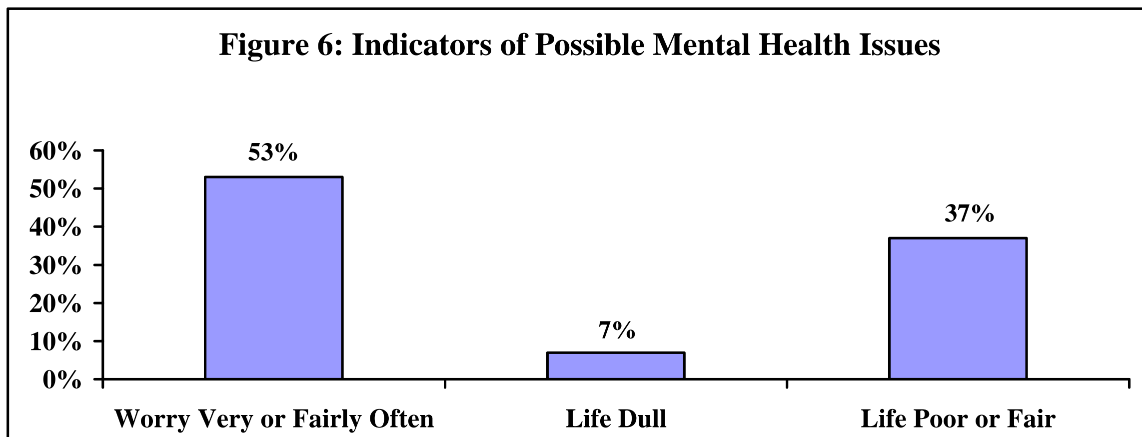
- Thirty-eight percent of respondents had a score of 5 or more on a mental health scale, suggesting depression or other psychiatric symptoms; 9 percent scored 10 or more, indicating more severe symptoms. Nationally, 15 to 23 percent of older adults (differing by age groups) in 1998 had severe depressive symptoms (Federal Interagency Forum on Aging Related Statistics).

- A mental health self-rating question indicates that 28 percent of respondents feel their mental health is poor or fair; 72 percent rate their mental health as good or excellent.

- Nearly one-quarter of respondents (23 percent) feel their mental health is better than it was five years ago, 65 percent feel it is about the same, and 12 percent said it is worse.

On a mental health scale, while 38 percent scored 5 or more, indicating probable psychiatric symptoms, only 8 percent currently receive mental health services.

Figure 6: Indicators of Possible Mental Health Issues



- Among the seven respondents who received mental health services, three respondents had 4, 3, and 2 activity of daily living (ADL) impairments.

Physical Health

Doctor Visits:

- Of 95 participants who responded, 88 percent had been seen by a doctor in the past year.

Total number of visits for 88 persons: 595

- Nationally, the rate of physician visits and consultations among Medicare beneficiaries aged 65+ was 13,100 per 1,000.

Average number of visits per person in the past year: 6.76

Table 7: Number of Doctor Visits per Person in the Past Year

Frequency of Visits	Number of Respondents
1	5
2	6
3	6
4	36
5	4
6	8
8	1
10	1
12	14
18	1
24	6

Twelve percent of participants have not seen a doctor in the past year.

Table 8: Participants With Illnesses Who Have Not Seen a Doctor

Illness	Seen Doctor in Past Year	
	Yes	No
High Blood Pressure	75	6
Arthritis or Rheumatism	56	4
Circulation Trouble in Arms/Legs	29	2
Glaucoma	29	1
Asthma	15	1
Emphysema or Chronic Bronchitis	16	1
Tuberculosis	1	1
Heart Trouble	32	1
Ulcers of the Digestive System	7	1
Other Stomach or Intestinal Disorders or Gall Bladder Problems	11	1
Effects of Stroke	11	1
Problem with Feet	86	1
Speech Impediment	5	1
Currently Need to Cut Down on Your Drinking	5	1
People Currently Annoy You by Criticizing Your Drinking	4	1
Currently Feeling Bad or Guilty About Your Drinking	3	1
Problem Paying For the Drugs You Need	17	1
Diabetes	28	0
Cancer	0	0

Hospitalization:

- Thirty percent of survey participants had been hospitalized in the past year for an average of eight days; the number of days hospitalized ranged from 1 to 31, and there was a range of one to four admissions. In the United States, 365 out of 1000 people (approximately 36.5 percent) age 65+ were hospitalized in 1998; the average length of stay was six days.

- Nine respondents (30 percent of those who had been hospitalized) said they did not have the help they needed after leaving the hospital.

Twenty percent were unable to carry on usual activities for more than a week.

- Most (64 percent) said they were never too sick to carry on usual activities in the past year.

- Sixteen percent were too sick to carry on normal activities for a week or less; 12 percent for more than a week but less than a month, 7 percent for 1 to 3 months, and 1 percent for 10 to 12 months.

Table 9: Impact of Illness Reported by Survey Participants

Illness	Number who have the illness	Impact of Illness (%)		
		Not at all	A little	A great deal
High Blood Pressure	82	9	65	27
Arthritis/Rheumatism	62	2	50	48
Heart Trouble	34	3	71	26
Circulation Trouble In Arms/Legs	33	6	58	36
Glaucoma	32	9	63	28
Problem With Feet	30	70	14	17
Diabetes	28	18	57	25
Asthma	18	0	61	39
Emphysema/Chronic Bronchitis	16	0	63	38
Stroke	12	0	33	67
Urinary Tract Disorders	12	17	50	33
Stomach/Intestinal Disorders or Gall Bladder Problems	12	0	75	25
Thyroid/Other Glandular Disorders	9	33	56	11
Ulcers Of Digestive System	9	11	56	33
Anemia	8	25	63	13
Kidney Disease	6	0	4	3
Speech Impediment	6	17	67	17
Cancer/Leukemia	5	20	80	0
Skin Disorders	2	0	0	100
Tuberculosis	2	50	0	50
Liver Disease	2	0	50	50
Epilepsy	1	0	100	0
Parkinson's Disease	0	0	0	0

- The most frequently occurring conditions in the elderly in the United States are arthritis, hypertension, hearing impairment, heart disease, cataracts, orthopedic impairments, sinusitis, and diabetes (U.S. Administration on Aging). In our sample, the most prevalent illnesses were high blood pressure, arthritis/rheumatism, heart trouble, circulation trouble in arms/legs, glaucoma, problems with feet, diabetes, and asthma.

- Forty-five percent of respondents reported that their health is good or excellent, 49 percent feel it is fair, and 6 percent said their health is poor. Among African Americans age 65 and older in 1994-1996, 58 percent rated their health as good or excellent; in the general population of 65 and older, 72 percent rated their health as good or excellent (Federal Interagency Forum on Aging Related Statistics).

- Most respondents (96 percent) have enough to eat each day but most (80 percent) usually eat alone.

End-of-Life Issues:

- Twenty-eight percent of participants have a living will.
- Forty percent want to be put on life support and 20 percent want to be artificially fed if permanently unconscious or terminally ill.

Vision:

Among respondents, 48 percent have fair-poor eyesight and 27 percent have fair-poor hearing.

Table 10: Reported State of Eyesight and Hearing Conditions

	% Excellent	% Good Sense	% Fair Sense	% Poor Sense
Eyesight	7	44	36	12
Hearing	18	55	17	10

Dental Health:

- Sixteen percent report having mouth pain.
- There was a change in appearance of gums, lips, or teeth for 20 percent.

Of all participants who do not have dentures (n=46), 62 percent think they need dentures.

- Nineteen percent report trouble eating and 9 percent have trouble swallowing.
- Fifty-four percent have dentures.
- Nineteen percent of the respondents have seen a dentist in the past year; 81 percent have not; in 1999, 65 percent of Maryland residents age 65+ had seen a dentist within the past year (U.S. CDC, National Center for Health Statistics).
- Reasons given by those who have not seen a dentist in the past year (81 percent) include lack of money (32 percent), do not think they need to (46 percent), and putting it off (15 percent).

Of the 81 participants who have not seen a dentist in the past year, 32 percent report financial reasons for not going and 46 percent did not think they needed to see a dentist.

Tobacco and Alcohol Use:

- Fifty-four percent of the respondents have used tobacco (50 respondents say from cigarettes); 17 respondents no longer use tobacco.

- Among current cigarette smokers, 40 percent smoke more than one-half pack a day.

- Alcohol has been used at some time by 76 percent of respondents.

Table 11: Reported Problems with Alcohol

	Present (n)	Past (n)
Feel you should cut down	6	35
Annoyed by criticism	5	25
Feel guilty	4	26
Use alcohol as an eye opener in the morning	1	26

Though alcohol use was a problem for a fair number of persons (~42 percent) in the past, a lot fewer report it as a current problem (~8 percent).

Physical Fitness:

- Two-thirds (68 percent) of respondents said they exercise. The most frequently reported form of exercise is walking, reported by 58 of 67 survey participants who exercise. In 1995, 35 percent of adults age 65+ in the United States reported having a sedentary lifestyle (U.S. Administration on Aging).

- Three of the respondents (4 percent) are "extremely overweight"; among the 65 or older population in the United States in 2000, 18 percent were obese (U.S. CDC, National Center for Health Statistics).

Ability to Function

- Although most survey respondents are able to function independently, 9 percent said they need help taking medications, 12 percent need help managing money, 4 percent need assistance getting in and out of bed, and 12 percent say they need help with bathing. In 1997, 21.6 percent of older adults reported difficulties with instrumental activities of daily living (IADLs) like preparing meals, shopping, etc., and 14.2 percent had difficulty in carrying out activities of daily living (ADLs) like bathing, dressing, etc. (U.S. Administration on Aging).

- In 1995, 33 percent of African Americans age 70 and over were unable to perform one of nine physical functions (U.S. Administration on Aging).

- Six respondents have partial paralysis or missing/non-functional limbs.

- Forty-four survey participants use a cane, 26 use a walker, and 14 use a wheelchair.

- Six percent of the respondents report having physical problems that seriously affect their ability to function, including: hip problems (need surgery), bipolar disorder, HIV, small stroke, nerve damage to a hand, pace maker, sciatica, breaking teeth.

- Getting to places out of walking distance (n=21), shopping (n=26), meal preparation (n=8), and housework (n=16) were also activities with which some respondents feel they need help.

Cumulative Impairment Scores:

- A cumulative impairment scale (CIS) with a range of 5 to 30 shows an average score of 10 for survey participants; 52 percent had a score of 10 or less, indicating little impairment.

- Five percent of respondents had a CIS score of 17.5 or more, indicating mild to total impairment.

Table 12: Percent with Cumulative Impairment Scores

Resource Domain	Excellent (%)	Good (%)	Mildly Impaired (%)	Moderately Impaired (%)	Severely Impaired (%)	Totally Impaired (%)	Percent With Some Impairment
Social Resources	32	59	7	1	0	1	9
Economic Resources	13	69	15	3	0	0	18
Mental Health Status	34	51	11	2	2	0	15
Physical Health Status	9	40	28	14	9	0	51
ADLs	40	38	15	1	4	2	22

The CIS of 10 can be compared to the middle of the range (5-30) of 17.5, showing this to be a population with "good" functional ability. The greatest amount of impairment is in physical health.

Table 13: Number of Persons Showing Impairment in Multiple Domains

Number of People	Number of Impaired Domains
2	5
3	4
9	3
19	2
31	1
40	0

Note: Scales measure individual status in the following five domains: 1) social resources, 2) economic resources, 3) mental health, 4) physical health, and 5) ADLs.

Needs of McCulloh Homes Survey Respondents

➢ Finances
- Eighty-eight percent of respondents are at or near the poverty level.
- Nearly 17 percent of 100 respondents have a problem paying for the medications they need.

➢ Mental Health
- Thirty-eight percent had scores on a mental health scale that indicate depression or other psychiatric symptoms.
- Three percent said they feel lonely quite often and 41 percent feel lonely sometimes.
- Only 6 percent of participants are currently receiving mental health services.

➢ Cumulative Impairment Scores
- A cumulative impairment scale (CIS) indicates that survey participants are most impaired in physical health status.
- Six percent of respondents had a CIS score of 17.5 or more, indicating mild to total impairment.

➢ Health
- 88 percent of the six people who have high blood pressure have not seen a doctor in the past year.
- Thirty-six participants currently smoke cigarettes; 40 percent smoke more than one-half pack a day.

➢ Nutrition
- Four respondents said they do not have enough food to eat each day; 1994-1996 data indicate that the dietary quality of 67 percent of adults age 65+ in the United States was rated as “needing improvement” and for 13 percent it was poor (Federal Interagency Forum on Aging Related Statistics). Among those in poverty, dietary quality was poor for 21 percent of older adults.
- Ten percent said they do not eat one or more days a month.

- Mobility
  - Forty-four participants use a cane, 26 use a walker, and 14 use a wheelchair.
  - Twenty-two percent of participants need supportive aids they currently do not have.

- Illness
  - Twelve percent were unable to carry on usual activities for more than a week; 7 percent for 1 to 3 months, and 1 percent for 10 to 12 months in the past year.

- Dental
  - Sixteen percent of respondents report having mouth pain.
  - Eighty-one percent have not seen a dentist in the past year.
  - Of participants who do not have dentures, 62 percent think they need dentures.

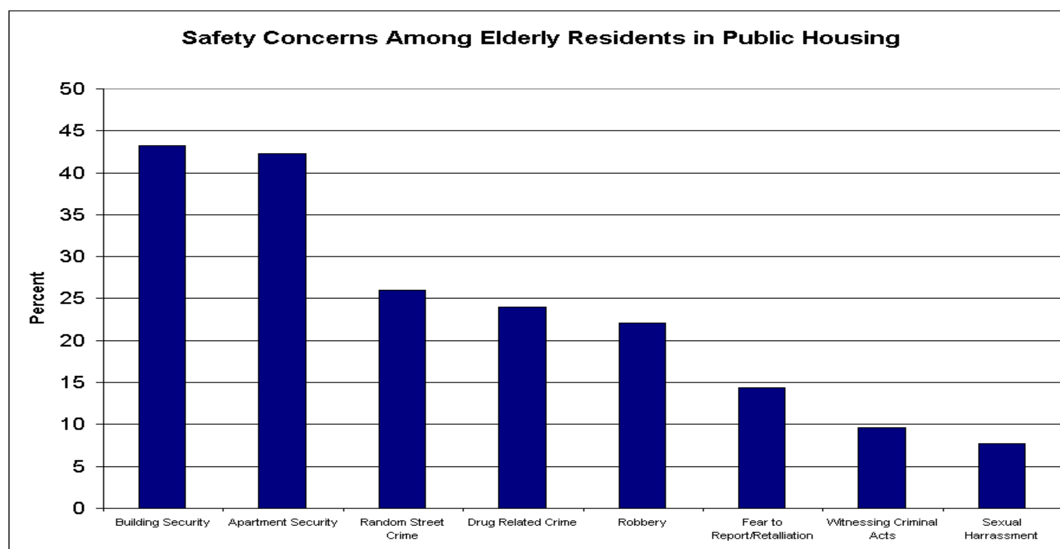
- Housing
  - Twenty-eight percent of respondents considered moving in the past six months.

Table 14: Reasons Given by Respondents Considering a Move

Reason	Number
Cost	3
Displacement	1
Steps	6
Neighborhood Safety	13
Facility Safety	8
Need More Support	7
Facility Maintenance	4
Health/Mobility	2

Of those who say they need a new place to live, 70 percent cite neighborhood or facility safety as a reason; 23 percent say they need more support.

Figure 7: Safety Concerns



- Transportation
  - Twenty-four percent feel they need transportation more often than it is available to them.
  - Although 95 percent of respondents said they have no problem making arrangements for transportation to places they need to go, they gave many reasons they do not travel to activities related to: the activity itself, travel conditions, transportation access, and health/safety.

Table 15: Reasons Preventing Travel

Reason	%	Reason	%
Activity-Related		Transportation Access	
• Cost	25	• Availability of transportation	22
• Day of week activity held	8	• Cost of travel to the activity	18
• Time of day activity held	38	• Vehicle handicap accessibility	8
• Lack of elderly support services at destination	7	• Vehicle overcrowding	8
		• Having to wait for vehicle	15
		• Return trip problems	15
Travel Conditions		Health/Safety	
• Weather conditions	72	• Illness other than mobility	13
• Travel conditions	13	• Cumbersome health equipment	4
• Road problems	20	• Personal security risks	8
		• Unsafe walking conditions	30

- End-of-Life Issues
  - Most survey respondents (72 percent) do not have a living will.

➢ Someone to Help

- Although most participants have social connections, 11 percent would only have someone to help them "sometimes" if they were sick or disabled, and 84 percent would have such help only "now and then"; 8 percent have no one to help if they were sick or disabled.

> Survey responses indicate that although participants function fairly well, there are many social, mental health, physical health, health care, personal care, and other service needs that are currently not being met.

- Nine respondents did not have the help they needed following a hospital stay.
- Seventeen percent of 94 respondents said they need medical care beyond what they are now receiving.
- Many respondents said they need services they are not receiving.

Table 16: Services Needed But Not Received

Service	#
Prescription Medicine for Nerves	1
Religious/Spiritual Services	16
Personal Care or Help Needed	3
Nursing Care	5
Physical Therapy	11
Someone to Consistently Look After You	3
Help with Routine Household Chores	10
Help Preparing Meals	4
Help Managing Personal Business or Legal Matters	5
Evaluation of Overall Condition	11
Service Coordination, Information, or Referral	8

Use of Services by Survey Participants

- Thirty-four percent of respondents have used the McCulloh Health Center.

> Many respondents said they do not use the McCulloh Health Center because they have their own private physician. Of 66 participants, 22 either did not know that they were eligible for services at the Health Center or did not know it was there.

- Seventy-six percent of survey participants do not feel they need more transportation than is available to them.

Table 17: Types of Transportation Used

Type of Transportation	Yes (%)
Automobile (as driver)	9
Automobile (as passenger)	58
Public transportation	67
Para-transit	18
Specialized transportation for elderly	17
Low-speed motorized vehicle	8
Walk	63
Bicycle	1

Only 9 percent of participants drive. The predominant modes of transportation are public transportation (68 percent) and automobile as a passenger (58 percent). Seventy-seven percent list the bus as their form of public transportation.

Table 18: Travel Destinations

Destination	Not at all (%)	Daily (%)	Weekly (%)	Monthly (%)	Yearly (%)	Yes, unspecified frequency (%)
Health-related	8	0	4	68	15	4
Visit homes of family/friends	19	18	23	28	6	5
Social/recreational activities	51	17	11	16	4	1
Religious activities	30	7	36	19	5	2
Shopping	7	2	34	54	2	1
Other	67	8	8	8	0	8

Respondents travel most frequently to:

- Health-related destinations: 92 percent (68 percent monthly)
- Shopping: 93 percent (54 percent monthly and 34 percent weekly)

Respondents travel less frequently to:

- Social/recreational activities (51 percent not at all)
- Religious activities (30 percent not at all)

Table 19: Use of Services by Survey Participants in the Past Six Months

Service	% Using	Comments
Social Programs/ Group Activities	30	• 17 respondents use them 1 time a week or less, 11 use them 2 or 3 times a week, 2 people use them 4 or more times a week • 46 do not participate because they prefer not to; 15 are not aware of such activities or say they are not available; 10 have other reasons
Treatment for Mental Health	6	• Number of visits ranges from 3 to 48 • Only 1 was hospitalized for emotional disturbance • Only 1 reports receiving services currently • 4 % say they need counseling for personal/emotional problems
Medicines for Nerves	12	• 11 still taking medication for nerves/emotional problems • 12% say they need this type of medication
Religious Services	46	• 24 different churches identified from 38 responses • 84% feel that their access is adequate • 35% would like more access; more high-rise residents (19%) than low-rise residents (9%) feel they do not have adequate access
Personal Care	12	➢ Who provides personal care? • 5 (42%) from unpaid family member • 2 (15%) unpaid friend • 8 (67%) hired help ➢ How much personal care received? • Less than ½ hour/day 2 (17%) • ½-1 ½-2 hours/day (17%) • More than 1-1½ hours/day 8 (67%) • The number of ADL impairments ranged from 3 to 11 among those who received personal care.
Nursing Care	12	➢ Who provides nursing care? • Unpaid friend n=1 • Hired help n=10 ➢ How much nursing care received? • Occasionally/not every day n=5 • ½ to 1 hour/day n=1 • More than 1 hour/day n=6 ➢ How long was nursing care received? • Less than 1 month n=2 • 1-3 months n=5 • More than 3 months n=5 ➢ 8 are still receiving nursing care ➢ 14 of 99 respondents said they need nursing care

Physical Therapy	10	➢ 9 said physical therapy was provided by hired help ➢ How much physical therapy was received? • Less than 1 time a week n=1 • 1 time a week n=5 • 2 or more times a week n=4 ➢ 5 are still receiving physical therapy ➢ 16 of 96 respondents said they need physical therapy
Continuous Supervision	9	➢ Who provides continuous supervision? • Unpaid family n=7 • Unpaid friend n=1 • Hired help n=2 ➢ 7 are still using continuous supervision ➢ 9 of 100 respondents said they need continuous supervision
Help with Household Chores	16	➢ Who helped with household chores? • Unpaid family n=9 • Unpaid friend n=3 • Hired help n=6 ➢ How much help was provided? • Less than 4 hours/week n=5 • 4-8 hours/week n=3 • 9 or more hours/week n=8 ➢ 15 are still receiving help with household chores 24 of 100 respondents said they need help with routine housework
Regular Help with Meals	11	➢ Who helped with meals? • Unpaid family n=6 • Unpaid friend n=1 • Hired help n=2 ➢ 8 are still getting regular help with meals ➢ Need Help n=12 of 97
Help with Personal Business/Legal	17	➢ Who helped with personal business or legal issues? • Unpaid family n=13 • Unpaid friend n=3 • Hired help n=4 ➢ 17 still use help with personal business or legal issues
Multi-dimensional Assessment in past year	15	➢ 18 of 99 said they need a multi-dimensional assessment
Coordination/ Information/ Referral	53	➢ Who provided coordination, information, or referral? • Family member n=37 • Friend n=6 • Hired help n=16 ➢ 21 of 95 said they need someone to provide coordination, information, or referral

Survey Methodology

Sampling: A random sample of residents 62 years old and older was selected from a Housing Authority listing of tenants with housing eligibility designation of aged (62 years old or older) or disabled. A sample of 188 people was selected using a random number start, and selecting every other person who fit the age criteria. A second draw was done to replace those persons in the first draw who were found, upon contact, to be ineligible for the study due to being too young or unavailable (having moved away or died). The final sample included 101 persons, with a response rate of 47 percent.

Instrument: The instrument used for the interview was a modification of the Older Americans Resources and Services Multidimensional Functional Assessment Questionnaire, developed at Duke University in 1979. Modifications were made to render the instrument more appropriate for urban, low-income seniors, as well as other content not included in the original questionnaire. Added content includes end-of-life decision-making, neighborhood safety, and enhanced transportation and housing sections. The questionnaire collects basic demographic data as well as information on five domains of functional status—physical health, mental health, social resources, economic resources and ADLs, as well as use and perceived need for sixteen services, including housekeeping, transportation, meal preparation, nursing, and physical therapy.

Interviewing: Interviewers who were trained in the administration of the survey instrument interviewed participants in their own homes except in a few cases where the participant requested a change of venue. Only a few of the interviews took place with a proxy or helper present. Interviews lasted 60-90 minutes.

Analysis: Data was entered into an ACCESS database and imported in SAS for analysis using basic descriptive processes.

Principal Sources of Non-Survey Data

- U.S. Administration on Aging: http://www.aoa.gov/
- U.S. CDC, National Center for Health Statistics: http://www.cdc.gov/nchs/fastats/elderly.htm
- Federal Interagency Forum on Aging Related Statistics, Older Americans 2000: Key Indicators of Well-Being

ASPE Grant #02 ASPE403A:
Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place
Final Report

Attachment B

Survey of Providers that Serve Elderly Residents of the McCulloh Homes Complex: Summary of the Data

Survey of Providers that Serve Elderly Residents of the McCulloh Homes Complex
Summary of the Data

Methodology

The Provider Survey sub-committee of the SAEPH Steering Committee met to develop a list of public and private organizations in the area that provide health, long-term support, and other services to elderly McCulloh residents. A four-page survey instrument was mailed to all of the organizations on the list to elicit information about the services they provide and other comments. Of 49 surveys mailed, 25 were completed and returned. Twenty surveys were completed by supervisors in the responding agencies and direct care staff completed five surveys.

Findings

Agencies were asked what types of services they provide from a list of services, checking all they provided. The services can be categorized as:

- *Assistance with access*, 41 services encompassing: information and referral, advocacy, assessment, service coordination, case management
- *Direct services*, 18 services: meals, transportation, counseling
- *Medical services*, 35 services: pharmacy, home health, medication management, mental health counseling, personal care, adult day care, hospital and medical services

The providers are located primarily within Baltimore City and have been serving residents of McCulloh Homes for an average of 10 years.

When asked how services can be improved, the most frequent responses were:

- Central phone number to share concerns/problems about customers served
- Develop a home team to implement hospital discharge plans
- Increase coordination and collaboration between agencies serving the same customers
- Determine additional steps that should be taken by the Aging Network to be an effective advocate and resource for older persons in public housing
- Fill service gaps not covered by existing reimbursement systems

In addition, one respondent said that all new residents should be made aware of available services and another respondent said that steps should be taken to make McCulloh Homes a safe place for elderly residents.

Whereas a majority of providers surveyed keep information about age, sex, health conditions, problems encountered in providing services, and referrals to other agencies, fewer than half of them document financial information, race, and length of service. If providers have problems serving customers, seven of them turn to the Service Coordinator in the McCulloh complex, eight confer with the Congregate Housing Services Coordinator in the building, eight consult friends of the customer, and 22 contact family members who may be local or out-of-state, three may turn to a church, and two contacted no one[1].

[1] Respondents could select more than one response to this question.

Eighteen of the providers said they were aware when customers were having financial difficulty or were experiencing other problems. Of those who were not aware of these issues, five said they do consider them a concern.

Almost all of the providers surveyed said they would be interested in receiving more information about services to which they could refer their customers and they would be interested in being included in a printed directory of services for McCulloh residents. Seventeen providers said they would be willing to share confidential information on a "need to know" basis through a memorandum of understanding with other agencies.

In open-ended responses, providers completing the survey made the following comments:

- Establish better coordination between the management of the McCulloh complex and outside agencies
- Increase attention to elderly residents of the low-rise apartments
- Reduce crime, establish a safe, attractive, caring, user friendly environment and improve coordination of services through better communication among agencies and programs
- Increase access to information to assist discharge planning from hospitals
- Address the need for written consent in order to share confidential client information

ASPE Grant #02 ASPE403A:
Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place
Final Report

Attachment C

Summary of Focus Group Discussion in SAEPH Steering Committee Meeting
October 20, 2003

Summary of Focus Group Discussion in SAEPH Steering Committee Meeting
October 20, 2003

Purpose: The purpose of the focus group discussion was to assist in the further identification of barriers to the implementation of a model for change in the way services are coordinated and delivered for elderly residents of public housing. In addition, the group suggested strategies for change.

Format: The discussion followed a review of the mission of the Steering Committee, barriers and issues raised in Committee meetings and surveys, and a brief description of a proposed program model. Questions to guide the discussion were organized around the three innovative strategies for change that have been the focus of the planning process. The questions were supplemented by select responses from the agency and resident surveys that have been conducted by the Steering Committee. Summary of the group's discussion follows each strategy and the associated questions.

I. Design a formal system among agencies that work with residents of public housing to **coordinate information, access, and services**.

- What are the barriers to coordination of information among agencies?
- What can be done to better coordinate information and services/service delivery among agencies?
- What are access issues for McCulloh residents in getting the services they need?
- What can be done to provide better access to services?
- Is there duplication of services?
- Are there services that McCulloh residents need and are not able to access?

Barriers to coordination of information, access, and services and strategies for change:

- Confidentiality is a major issue (particularly considering HIPAA requirements); use one form to collect data and provide consent that can be shared by all agencies.
- Data are not centralized; provide a one-stop shop.
- Lack of information about services available; provide a resource directory; computerize information; provide an admissions packet to current and new residents.
- Lack of qualified staff to provide the level of care required by some residents; some residents require a higher level of care than is available to them.
- Service coordinators don't have adequate access to service providers; develop memoranda of understanding (MOU) with agencies that is clarified at the operational level including policy, procedures, and job descriptions.
- Lack of sufficient qualified, trained staff in public housing.
- Lack of commitment and clarity of mission on the part of HABC in providing for needs of elderly who are aging in place; provide staff assistance through the project to help residents get services they need to remain independent.
- Coordinators need to advocate (act as ombudsman) for the residents and intervene to prevent evictions and unnecessary institutional placements.
- Lack of visibility/information about aging network services and lack of focus by aging network on public housing residents.

- Lack of effective marketing of public service programs; elicit information from residents about effective marketing strategies.
- Lack of adequate transportation; some hospitals provide non-emergency transportation.
- Too many case managers from different agencies are involved with one client; centralize data.

II. Assess the need and **responsiveness of residents and agencies to a change strategy**.

- Would your agency be very responsive, somewhat responsive, somewhat non-responsive, or not at all responsive to specific change strategies that would help McCulloh residents have better access to necessary services? What specific strategies would your agency respond to in these ways?
- What do you think would be the responsiveness of other agencies to change strategies? Please be prepared to discuss specific agencies and barriers.

Barriers to agency and resident responsiveness and strategies for change:

- There are legal barriers to coordination and sharing of data.
- Agencies would be responsive if they see a benefit to the agency.
- Effective marketing of the program will encourage residents to expect agencies to respond; there is a need to develop trust among residents; advertise successes.

III. **Develop interventions** that would reduce institutionalizations and hospital re-admissions of older public housing residents (e.g., outplace AAA caseworkers to assist housing service coordinators working with older residents).

- Can you identify barriers and issues in developing and implementing interventions to better assist McCulloh residents to avoid unnecessary nursing home or hospital admissions?

Barriers to development of interventions and strategies for change:

- Lack of effective monitoring of resident "events" (e.g., ambulance to hospital) after hours.
- Lack of effective sharing of information by building monitors with service coordinators; develop a partnership between monitors, service coordinators, and aging network.
- Elderly residents in low-rise buildings are more difficult to connect to monitoring system; provide individual monitoring devices.

ASPE Grant #02 ASPE403A:
Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place
Final Report

Attachment D

Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place: Transition from Planning to Implementation

Proposal to the Office of the Assistant Secretary for Planning and Evaluation for an Innovation Grant, Federal Register/Vol. 68, No. 117

Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place: Transition from Planning to Implementation

I. Goals, Objectives, and Usefulness of the Project

A. Purpose of the Project

In October 2002, the Maryland Department of Aging (MDoA) received funding from the Department of Health and Human Services, Office of the Assistant Secretary, Assistant Secretary for Planning and Evaluation (ASPE) for a Track 2 planning project to convene an interagency steering committee to complete project tasks. For convenience, the project, titled Changing Interagency Service Delivery Systems to Help Older Public Housing Residents Access Services to Assist Them to Age in Place, has been referred to as Service Access for Elders in Public Housing or SAEPH. Henceforth in this document, the project will be referred to as the SAEPH (pronounced "safe") Project. The current planning project is funded through February 2003.

The purpose of the SAEPH project is to change service access, coordination, and delivery for frail or at-risk older residents of public housing. The systems changes will coordinate and reshape the way in which State and local public agencies and private providers work with senior residents and staff of public housing to identify and access services. Primary services are long-term care support and financial assistance for health related needs including pharmacy, dentistry, transportation, disability equipment and apartment adaptations, and hospital discharge transitional care. Long-term care support will be coordinated through the Area Agency on Aging (AAA) and MDoA programs. These changes are intended to limit inappropriate institutional placements, including nursing home and hospital admissions and re-admissions. The SAEPH project is being conducted as a pilot in one public housing project in Baltimore City known as McCulloh Homes. McCulloh Homes has approximately 400 elderly residents including those who live in two high-rise apartment buildings and those in surrounding low-rise apartment units in the complex.

B. Innovation

The SAEPH project involves a number of innovations to Maryland's service delivery system that could be applied in other states. This is the first inter-agency effort to survey the needs of older adults living in Baltimore City public housing. It is also the first formal effort to design and implement a joint intervention to improve residents' access to information and services that are administered among several State and local public and private health and service agencies.

Interventions that would reduce institutionalizations and hospital admissions and re-admissions among older public housing residents have not been addressed in depth. The possibility of creating and implementing a model to place public service workers in a public housing project to assist housing service coordinators and residents will be a significant innovation in inter-agency collaboration. This project will not only address those residents living in public housing designed specifically for older adults, it also will identify elderly residents who have aged in place in low-rise family public housing, who have no staff support, and whose apartments are not physically adapted for frail seniors with disabilities.

C. Accomplishments of the Planning Project to Date

The SAEPH Executive Planning Group met in October 2002 to establish Steering Committee membership and meeting dates. The Executive Planning Group continues to meet as needed to assess project status and plan for future action. The first Steering Committee meeting was held in November 2002 and the Committee has met every two months since that date. Steering Committee membership includes representatives from:

- The Maryland Department of Aging
- The Maryland Department of Health and Mental Hygiene
- The Maryland Department of Housing and Community Development
- The Baltimore City Commission on Aging and Retirement Education [local Area Agency on Aging (AAA)]
- The Baltimore City Health Department
- The Housing Authority of Baltimore City
- Baltimore Mental Health Systems
- McCulloh Homes Tenant Council
- McCulloh Health Center
- Johns Hopkins Bayview Medical Center
- Family and Children's Services of Central Maryland
- University of Maryland, Baltimore County Center for Health Program Development and Management

The SAEPH Steering Committee has three goals under the planning grant:

- Conduct an extensive survey of public housing residents to determine their social, health, and functional status and met and unmet service needs
- Conduct a survey of local public and community providers who serve these residents
- Design the model under which the project will be implemented.

These goals are largely met. The resident and provider surveys have been completed and analysis has begun. The major elements of a program model have been identified along with barriers to implementation. Additional analysis and follow-up information is needed and the model design needs to be refined with input from key stakeholders, agencies, providers, and residents. Following are summaries of preliminary results from the resident and provider surveys.

<u>Survey of Residents</u>

MDoA contracted with the University of Maryland, Baltimore County Center for Health Program Development and Management (the Center) to conduct a survey of elderly residents of McCulloh Homes. A random sample of residents 62 years old and older was selected from a Housing Authority listing of tenants with housing eligibility designation of aged (62 years old or older) or disabled.

Attachment A provides more detailed information from the resident survey. Administration of the survey has just been completed. The only analysis done to date is a count of individual

responses to specific questions. The results will be further analyzed after review by the Steering Committee and cross correlations will be conducted.

The interview instrument was adapted from Older Americans Resources and Services Multifunctional Assessment Questionnaire, developed at Duke University in 1979 and modified to render the instrument more appropriate for urban, low-income seniors, and the SAEPH project. Trained interviewers met with participants in their own homes except in a few cases where the participant requested a change of venue. Interviews lasted 60-90 minutes.

The sample was 40 percent male and 60 percent female, and nearly 100 percent African American. Thirty-three percent of the sample participants live in the low-rise buildings in the complex and 67 percent reside in a high rise. Seventy-two percent of the participants in this survey have less than a high school education. The largest portion live alone (78%). The majority have incomes under $7,000 annually. Mental and/or physical health problems were indicated among more than 80% of the respondents. Prevalent illnesses were hypertension, cardiac and circulation, and arthritis. Only a small portion reported not seeing a doctor in the last year, but this group had an alarmingly high incidence of hypertension and stroke. One of the most troubling findings was how few had seen a dentist in the last year (81%) and how many reported mouth pain (84%). Sixty-seven per cent reported needing dentures.

Survey of Providers

The Provider Survey sub-committee of the SAEPH Steering Committee met to develop a list of public and private organizations in the area that provide health, long-term support, and other services to elderly McCulloh residents. A two-page survey instrument was mailed to all of the organizations on the list to elicit information about the services they provide and other comments. Of 49 surveys mailed, 25 were completed and returned.

Agencies were asked what types of services they provide from a list of services. The organizations surveyed indicated that they provide a total of 41 services to assist with access such as information and referral, advocacy, assessment, service coordination, and case management. Eighteen offer direct services, such as meals, transportation, and counseling. In addition, 35 medical services including pharmacy, home health, medication management, mental health counseling, personal care, adult day care, and hospital and medical services are available to McCulloh residents, but are underutilized. The providers are located primarily within Baltimore City and have been serving residents of McCulloh Homes for an average of 10 years. When asked how services can be improved, the most frequent responses were:

- Central phone number to share concerns/problems about customers served
- Develop a home team to implement hospital discharge plans
- Increase coordination and collaboration between agencies serving the same customers
- Determine additional steps that should be taken by the Aging Network to be an effective advocate and resource for older persons in public housing
- Fill service gaps not covered by existing reimbursement systems

Additional data from the provider survey will be used to further develop the SAEPH program model. In addition, information will continue to be collected about services available to McCulloh residents to develop as extensive an inventory as possible.

Design of the Model

The SAEPH Executive Planning Group and the Steering Committee are using the information collected to date to design the model that will be implemented to assist public housing residents to avoid unnecessary admissions to nursing homes and hospitals and to enhance service coordination and delivery. The resident survey provides information about service needs and unmet needs. The provider survey provides a snapshot of service availability and gaps in services that exist. Additional information that has come anecdotally from interviewers, Steering Committee meetings, and Housing Authority and AAA staff reveals systems' barriers to service delivery and coordination that must be addressed in order to implement a successful service delivery and coordination model. Much of the focus of the transitional planning will be to eliminate systems' barriers to successful implementation.

D. Challenges to Date: Gaps, and Barriers

As the SAEPH project has proceeded, it has become clear that in order to implement a model to better coordinate services to public housing residents and avoid unnecessary admissions to nursing homes and hospitals, several systems issues must be addressed. A major focus of the project as it transitions from planning to implementation is to work with key individuals and organizations to address the systems issues that have emerged and to recommend changes that will enhance the model. Issues have been identified in several systems:

- The Housing Authority of Baltimore City, the landlord
- Hospitals that serve McCulloh residents
- Community and public providers that serve McCulloh residents
- The McCulloh Homes elderly resident community

Housing Authority of Baltimore City

Several issues have emerged within the Housing Authority that present potential barriers to implementation of a SAEPH project model of inter-agency and intra-agency coordination. The Housing Authority has two divisions, one division operates facilities and collects rent; the other is responsible for service coordination. There appears to be little communication or coordination between the two divisions, resulting in avoidable evictions of elderly residents and other problems. For example, anecdotal information indicates that elderly residents may be evicted from McCulloh Homes for non-payment of rent when they are in institutions such as rehabilitation facilities and unable to handle finances temporarily. Although the service side may be aware that the resident is temporarily in another facility, mechanisms for communicating this information to the division that processes evictions seem inadequate.

Area Hospitals and Dental Providers

Residents who were surveyed were asked to identify hospitals they had been in within the past year. Residents had been in several hospitals in Baltimore City. The largest number had been in Maryland General Hospital, which is the hospital closest to the McCulloh complex. The resident survey also identified dental care as a needed service.

The preliminary model design includes involvement of hospital discharge planners and dental providers as key to implementation of the project. To date, hospital and dental personnel have not been included in the planning process. Involvement of key hospitals, particularly Maryland General, will be an important part of the transitional planning stage of the SAEPH project. In addition, the University of Maryland Hospital and Dental, Pharmacy, Law, and Nursing Schools, and the Dental Association of Maryland will be included in model refinement and implementation.

Community and Public Providers

Baltimore City has many providers that serve older adults offering a wide range of services. SAEPH provider survey respondents indicate that they offer medical, mental health, legal, transportation, and meal services among many others. A number of agencies provide services to coordinate or otherwise assist elderly residents to access necessary services. However, there is no mechanism available to elderly residents of McCulloh Homes on site to help them identify services they may need and assist them to access those services. Public agency services do not seem to have penetrated the resident population. Only 20 residents are enrolled in the Congregate Housing Services Program and another 20 residents use the Nutrition Program. Not one resident is participating in Senior Care, a state funded program for frail seniors. At this time, no resident has been identified who is participating in the Medicaid Older Adult Home-and Community-based Waiver. There is no formal mechanism for the AAA or other aging service providers to work directly with Housing Authority staff to assist elderly residents to access services.

Resident Community

Residents of public housing have low incomes and many of them have little formal education. The elderly residents have health and mental health problems. Many of them do not have family or other social supports to assist them to navigate systems in order to have their needs met. However, survey interviewers note that residents have a strong desire to remain independent and use their limited resources to do so. They also evidence courage and a sense of hopefulness in the face of their own limitations and those of the systems with which they must cope.

E. Needs of the Target Population

The resident survey identifies a number of health and support needs: information and assistance in enrolling in available state service programs; access to dental care; personal and chore services; coordination of health care and related therapies; assistance with prescriptions and medically related transportation; engagement in health activities and monitoring and advance directives. In addition, a number of environmental conditions that affect mental and physical health need to be addressed including fire safety, maintenance, sanitation, building temperature, and elevator operation in the high-rise buildings. See Attachment A for more information about the residents who participated in the SAEPH survey.

F. Results and Benefits

The transition grant will be used to finalize planning and implement a pilot program in the McCulloh Homes. The overriding goal of the program is to improve the efficiency and effectiveness of service delivery for older public housing residents. The transition funding will help accomplish six discrete and measurable goals, each of which is listed below with specific objectives.

Goal 1: Address systems barriers that affect change in the configuration of service access and delivery for elderly residents in Baltimore City public housing.

Objectives:

- Prepare a report on SAEPH project findings for dissemination to stakeholders
- Convene two or more briefing meetings with stakeholders
- Present to one meeting of the McCulloh Tenant Council
- Facilitate six to eight Steering Committee meetings

Goal 2: Increase communication, cross education, and collaboration among public housing property management and service staff, and external service agencies and providers.

Objectives:

- Hire two full-time staff
- Furnish office and meeting space in the McCulloh Homes complex
- Convene four quarterly meetings with project staff, agencies, providers, and residents
- Design and implement a training program for agency and provider staff
- Design and implement a HIPAA-compliant electronic communication system to coordinate and track services to residents

Goal 3: Reduce housing turnover by reducing inappropriate evictions and transitions to institutional care.

Objectives:

- Establish policies and procedures to: track resident admissions to hospitals and other institutions, notify appropriate staff of the admissions, and take actions to avoid unnecessary transfers or evictions
- Avoid or delay institutionalization or eviction of at least five elderly residents
- Establish and support a "buddy system" among elderly residents

Goal 4: Reduce hospital admissions and re-admissions among older public housing residents.

Objectives:

- Convene a focus group with hospital discharge planners from area hospitals
- Establish policies and procedures to: track resident admissions to hospitals and other institutions, notify appropriate staff of the admissions, and take actions to avoid unnecessary admissions and re-admissions
- Coordinate assessments of 50 elderly residents and make appropriate referrals for services
- Avoid unnecessary hospital admissions or re-admissions of at least five elderly residents
- Establish and support a "buddy system" among elderly residents

Goal 5: Work with public and private health and service providers to better coordinate with senior residents of McCulloh Homes.

Objectives:

- Convene a focus group of community providers
- Develop a directory of community providers that serve McCulloh Homes residents

- Work with local dental providers to establish a low-cost or no cost program for McCulloh residents and serve at least 20 residents
- Enroll at least 20 residents in state programs administered by the local AAA

Goal 6: Assist additional Housing Authority of Baltimore City public housing facilities to reconfigure their service design.

Objectives:

- Convene two meetings with Housing Authority managers and City AAA staff to describe the project
- Develop a training program for housing managers and AAA staff

II. Methodology and Design

A. Strategy for Transition from Planning to Implementation

The planning period has allowed MDoA, the University Center for Health Program Development, HABC, and the Baltimore City AAA to become a strong, efficient team. This teamwork will continue through the transition and implementation stages.

The SAEPH Executive Planning Group and the Steering Committee have accomplished much of the work of the planning project since it began in October 2002. A model has emerged that can be implemented when transitional planning objectives have been met. The model is built on: principles of increased cross-staff location, training, and engagement; significant outreach to residents, housing staff, and providers; and added staffing and resources to promote and sustain change.

Several barriers have been identified that will be addressed in the continued planning phase of the project. Designated Steering Committee members will meet with executives and key staff in the collaborating agencies, focus groups will be held with specified stakeholders, additional community providers will be included in the planning process, and data will continue to be gathered and analyzed. As the project moves toward implementation, additional meetings will be held and staff will be hired, trained, and placed on site in McCulloh Homes.

There are few instances where the systemic effect of poverty is more poignantly visible than in public housing. The situation is intensified when you add the factors of age and frailty. People, many of whom have lived in poverty most of their lives, become increasingly more vulnerable with health and disability problems. Residents may be afraid to disclose to housing managers information about their disabilities for fear of defacto eviction. Public housing is generally under-funded and understaffed. Staff are frequently under-qualified and do not have adequate training for the services side of working with seniors.

Increasing the residents' access to adequate services requires changing both the attitudes and practices of the residents, housing staff, and providers working with residents. This change requires a vision among residents of better care and its benefits, a vision among staff of their ability and responsibility to work collaboratively with service agencies and providers, and a vision among government officials, and public service agency workers of public housing that

provides quality in services and facilities. Activities designed to bring about changes in attitude, knowledge, and practice are a significant part of the SAEPH program. Not only will public agency staff be placed on site, but SAEPH program staff will work closely with existing staff and residents to create situations where staff and service workers communicate regularly and receive information and training. An effort will be made to develop a sense of "team" among SAEPH staff and existing housing management and service staff. Research conducted by the Lewin Group in support of this project affirms the importance of cross communication and team building in multi-unit senior housing. State and local government agencies administering the public housing program will be kept apprised of program activities, barriers, and results and will be asked to assist when necessary.

B. Action Steps to Meet Project Goals

Goal 1: Address systems barriers that affect change in the configuration of service access and delivery for elderly residents in Baltimore City public housing

1. Distribute a report on the planning phase of the SAEPH project to the Baltimore City Housing Commissioner, the Directors of the Housing Authority of Baltimore City, and the Commission on Aging and Retirement Education (AAA) and upper level management within these organizations, and liaisons from the Mayor's and Governor's offices for housing and persons with disabilities.

2. Convene briefing meetings with the agencies' leaders described to obtain commitment to the program and its future expansion and maintenance and to provide on-going liaison.

3. Work with individual residents and groups of residents of McCulloh Homes and McCulloh staff to develop knowledge, trust, and participation in the program design, implementation, and utilization. This will be accomplished through individual meetings, a door to door campaign, presentations at resident meetings, working with elected and identified resident leaders, convening special meetings, and distributing written information to staff and residents.

4. Meet with public and private health and service providers to review the program design, and discuss on-going participation in program activities. Primary targets are the AAA, the on-site health clinic, Maryland General Hospital and University of Maryland Medical Systems, the University of Maryland Dental School, and ElderHealth.

5. Continue work with an expanded Steering Committee that is representative of stakeholders and able to assist with information, education, service development, and decision making among multiple agencies.

Goal 2: Increase communication, cross education, and collaboration among public housing property management and service staff and external service agencies and providers.

1. Hire one full-time staff person (Program Coordinator). The nature of this person's work is community organizing and organizational change. The position will report to the SAEPH

Program Director at the Maryland Department of Aging and will be located in McCulloh Homes. Responsibilities are to:

- Coordinate overall program activities.
- Identify key property management staff and service staff of the Housing Authority and in McColloh Homes and work with identified staff, contractors, and service agencies to design and implement cross-educational training and meetings on issues relevant to senior residents of McCulloh Homes.
- Provide liaison between property management and service staff on issues relevant to residents' ability to remain in their apartments.
- Assist in the design of a HIPPA compliant electronic communication system to allow better coordination of information between property management and service staff regarding health and eviction issues arising with residents.
- Participate in efforts to coordinate resident and housing staff input into program design and to coordinate with external public and private service agencies.
- Assist in developing a dental services program.
- Assist in the design of curriculum and meeting content and for housing staff and providers and residents.
- Provide support to the AAA Coordinator.
- Engage the housing management and service coordination staff in regular meetings to review program activities and assure support for their efforts and responsibilities.
- Assist in the furnishing office space for the Program staff in McCulloh Homes.
- Prepare for and organize briefings to the Housing Authority, Mayor's Office, and AAA.
- Develop a resident outreach initiative through personal contact, contact with formal and identified resident leaders, attendance at resident meetings, distribution of written materials and on-site accessibility.

2. Hire one full time AAA Coordinator through the Baltimore AAA who will be out-placed at McCulloh Homes. This person's responsibilities are to:
    - Identify key staff with public and private health and service providers to participate in program planning and activities.
    - Assist in coordinating, designing, and implementing information sessions with providers and meetings among providers, residents, and housing staff.
    - Act as liaison between housing staff, residents, and health and service providers to assure that individual residents receive all the benefits for which they are eligible and to fill gaps with direct Program services.
    - Assist in the design of curriculum and meeting for housing staff, providers, residents and AAA representatives.
    - Establish and manage direct Program services and subsidies, e.g. dental and pharmacy assistance, transportation vouchers and arrangements , prescription assistance, apartment cleaning, etc.
    - Coordinate services for residents and locate resources for residents.
    - Meet regularly with housing management and services staff and the Program Coordinator to review Program activities and resident services.

- Develop regular reports on services requested and used and identify areas of need.

3. Furnish space at McCulloh Homes to provide office and meeting space for the Program staff. The space also will allow for meetings between housing management and services staff as well as confidential meetings with residents. The space will have telephone and computer capacity for two staff.

4. Convene initial meetings of housing staff, AAA staff, providers, and residents to review program design and establish regular quarterly meetings.

5. Design a curriculum and implement regular cross-training sessions for housing property and services and AAA staff and providers.

6. Design and implement a HIPAA compliant electronic communication system to assist service coordinators and housing management staff and program staff to work together to intervene on behalf of residents experiencing housing or health issues that may jeopardize their ability to remain in their apartment. The Center at the University of Maryland has been involved in developing a number of state information systems for Medicaid programs, all of which involve HIPAA compliant security. The Center will assist in development of this system.

Goal 3: Reduce housing turnover by reducing inappropriate evictions and transitions to institutional care.

1. Develop an "alert system" among residents, housing, program, AAA staff, and providers to identify residents who are in danger of eviction for non-payment of rent or health and disability related issues and provide assistance to residents through the Program Coordinator.

2. Establish a procedure for property managers to notify housing service coordinators, AAA staff, and program staff of potential eviction issues.

3. Provide assessment services for residents facing eviction and provide assistance if evictions are related to health and disability issues.

4. Provide cleaning service or other relevant services to residents if desired and if warranted by resident health and disability or housing staff concerns and the possibility of eviction.

5. Maintain a record of the number of eviction notices, interventions, and outcomes.

Goal 4: Reduce hospital admissions and re-admissions among older public housing residents.

1. Develop an "alert system" among residents, housing staff, program, AAA staff, and providers to identify residents who are anticipating a hospital stay or actually in a hospital or rehabilitation facility. This will be accomplished through educational and informational

meetings with staff, and residents and their families, and providers. This initiative will require voluntary participation due to stringent privacy restraints concerning individual medical information including hospitalizations.

2. Educate and encourage residents, families, all housing staff, and providers to contact the program staff if a hospital stay is anticipated or occurring through direct contact, written information, and group presentations.

3. The AAA Coordinator will act as a central contract for the "alert" system and will work with the resident or her family and provider to evaluate needed pre-admission or discharge assistance. The Service Coordinator will work with hospital discharge staff and service agencies where possible and will provide direct program assistance if the resident is not eligible for existing programs.

4. Assess residents' eligibility for pharmacy assistance, Medicaid or state funded programs, and arrange for non-program funded services as needed, e.g., assistance for prescriptions and dental care.

5. Contact hospital discharge staff in hospitals used by residents and provide an accessible method for them to contact the Service Coordinator who will provide assistance in implementing the hospital discharge plans.

6. Provide or arrange for voluntary social, physical, and financial assessments for residents and provide assistance and advocacy in obtaining needed services. This will be done by the Service Coordinator.

7. Provide financial vouchers for transportation to medical appointments and assist in arranging accessible transportation.

8. Identify and establish contract service agencies for non-public-funded program services.

9. Maintain a record of hospital admissions, re-admissions, and interventions.

Goal 5: Work with public and private health and service providers to better develop and coordinate needed services among senior residents of McCulloh Homes.

1. Meet with providers individually or in groups to review and refine the program design and identify ways in which the providers can work with the program. It is expected that providers will participate in designing training and information sessions and will work with housing and program staff to provide health fairs.

2. Provide informational/educational sessions with providers interacting with residents to understand special needs of the resident population of McCulloh Homes.

3. Develop a list of known providers interested and participating in the Program and monitor resident and program staff satisfaction with provider services.

4. Work with the Maryland Schools of Dentistry and Pharmacy to design and implement services for residents and work with the Maryland School of Law to provide end-of-life education and counseling (advanced directives) and services.

Goal 6: Assist additional Housing Authority of Baltimore City public housing facilities to reconfigure their service design.

1. Convene two meetings of upper-level agency management, housing managers and service coordinators from the Housing Authority of Baltimore City and AAA. The first meeting will describe the program and grant effort. The second meeting will provide data and anecdotal information on the program after is has been in operation for eight months.

2. Provide technical assistance for public housing complexes interested in designing a program to better address the coordination of housing and services and access to public and private services.

C. Location of the Project/Pilot Site and Target Population

The Housing Authority of Baltimore City owns and operates 17 complexes serving 3,000 low-income elderly and disabled residents. The target population for the SAEPH planning effort and the implementation consists of frail older adults living in one of Baltimore's largest public housing developments. Located in West Baltimore just outside of the central business district, McCulloh Homes has the capacity to house 970 families and disabled, and/or elderly residents. McCulloh Homes provides housing to older adults and younger persons with disabilities in two high-rise buildings that contain apartment units on 14 and 15 floors. Families, including some elderly and disabled residents, are housed in low-rise units that surround the high-rise structures. There are currently approximately 400 residents aged 60 and over living in McCulloh Homes. One high-rise structure in the McCulloh Homes complex has 187 units and currently houses approximately 130 elderly residents. Another high-rise has 207 units and currently houses about 100 older adults. A total of 586 low-rise units house approximately 170 elderly residents. A privately operated health clinic is operated in the complex, but is greatly underutilized.

McCulloh Homes is located within blocks of several key health care provider systems, the Maryland General Hospital and the University of Maryland Hospital and professional School Campus which includes schools of dentistry, nursing, pharmacy, law, medicine, social work, and allied health.

The typical elderly resident of McCulloh Homes is a 75-year-old African-American female who has not graduated from high school, and has only one support person in her life and has multiple health problems. The elderly population of McCulloh Homes is characterized by low incomes. In 2002, a total of 226 older residents had annual incomes of less than $6,500. Sixty-eight residents had annual incomes between $6,500 and $8,000 and 60 residents had annual incomes that range from $8,000 to $10,000. Nearly 88 percent of the elderly residents of McCulloh Homes had annual incomes of less than $10,000 in 2002.

D. Assurances
The Maryland Department of Aging and its contractors are willing to field test strategies and will comply with the requirement to participate in a process evaluation. Mechanisms will be in place throughout the project to assure the privacy and confidentiality of project participants.

E. Sustainability
Much of the effort of the SAEPH program is to bring about organizational change and integration among existing programs and services. Once this change is accomplished, regular maintenance and monitoring of the program and its spin-off for other public housing can be monitored through MDoA in collaboration with the AAA and the Housing Authority. In addition, reduction in current duplication and confusion should result in staffing efficiencies going forward.

Once training curriculums are developed and tested, ongoing training can be conducted by MDoA, the AAA, HABC, and their contractors. Following implementation, MDoA will seek to commit financial resources for one staff to maintain and expand the program in other public housing and to obtain contractual services as needed for training, communications systems, and provider and services development.

It is expected that as the SAEPH program develops, residents of McCulloh Homes will more regularly access existing State service programs. Additional efforts will be made to continue funding for one FTE AAA coordinator to work on site at McCulloh and other public housing sites with seniors. Existing State programs will be refined as possible to provide gap services as needed, e.g. dentistry. Efforts will continue to build pro bono services among providers.

A Seniors in Public Housing Advisory Committee will be established under the umbrella of MDoA. The Committee will consist of at least three resident representatives and representatives from MDoA, the Baltimore City AAA, the Housing Authority of Baltimore, University of Maryland long-term care staff and faculty, providers, and the Mayor's and Governor's liaisons for aging and housing.

III. Background of Personnel and Organizational Capacities
Additional information about the participating organizations and biographical information for key staff are included in Attachment B. Letters of support from current and future participating agencies are included in Attachment C. MDoA will provide staffing for the project and will contract with the Center to conduct specified functions for the project. The SAEPH Steering Committee will continue to advise the project.

Maryland Department of Aging
MDoA is the grantee for the SAEPH project to transition from planning to implementation. MDoA and AAAs administer a range of programs and services for older adults. Many of these programs and services are available to older residents of public housing, including Senior Care, Senior Information and Assistance, Senior Legal Assistance Program, Senior Nutrition Program/Congregate Meals, Congregate Housing Services Program, and the Home and Community-Based Medicaid Waiver Program for Older Adults.

The Department of Aging will oversee the grant and will chair the Steering Committee. MDoA will staff the program as follows:

- Project Director - Ilene Rosenthal, M.S.W., Chief of Housing Services, will monitor the activities of the project to assure that they are carried out in a timely fashion. She will provide oversight and supervision of staff hired under the project and will monitor activities conducted under contract with the Center and HABC. She will chair the Steering Committee and work with other committee members to gather information necessary for the committee to carry out its mission. Ms. Rosenthal has been with MDoA since 1977 and has extensive experience within the Maryland public services sector and in supervising programs involving housing and services for seniors.
- Janice MacGregor, M.S., Manager, Congregate Housing Services Program, will assist the Project Director to carry out her responsibilities. She will function as liaison between the MDoA, the Steering Committee, and the Center. Ms. MacGregor has been with MDoA since 1985. She has a background in administration and Theraputic Recreation with a specialty in gerontology.
- Program Coordinator, to be named will hold a masters degree in social work, public health, or related area and will have three or more years experience in developing service programs and a demonstrated ability in "organizing for change".

Baltimore City Commission on Aging and Retirement Education (Area Agency on Aging/AAA)

The Area Agency on Aging in Baltimore City, known as the Commission on Aging and Retirement Education, supports and administers a range of programs and services for older adults. Many of these programs and services are available to older residents of public housing, including Senior Care, Senior Information and Assistance, Senior Legal Assistance Program, Senior Nutrition Program/Congregate Meals, Congregate Housing Services Program, and the Home and Community-Based Waiver Program for Older Adults. The AAA Coordinator, to be named will be an employ of the AAA. Commission staff will take a more active role in on-site activities in implementation of the project and will supervise the AAA Coordinator position which is funded by the program. The AAA will staff the program as follows:

- John Stewart, MSW, LCSW, Executive Director of the Commission on Aging and Retirement Education (AAA) will provide oversight for the participation of the AAA in the program and will participate in inter-agency meetings and efforts.

- Marcy Gouge, J.D., Director of Community Programs for the Commission on Aging and Retirement is a Steering Committee Member and will supervise the AAA Coordinator.

- AAA Coordinator to be named will hold a masters degree in social work or nursing and have at least three years experience in working with clients to develop and obtain services.

Housing Authority of Baltimore City

A five-member Board of Commissioners oversees the operating policies of the Housing Authority of Baltimore City (HABC), which owns and operates housing projects for low-income residents of the City. An Executive Director, in cooperation with residents, develops strategies

for service development. Divisions in the Housing Authority include: Housing Management, Human Resources, Fair Housing, Engineering Services, Auditing, Communications, Resident Initiatives, Office of the Comptroller, Applications, Family Support Services, and the Police Force. The Housing Authority owns and operates seventeen complexes, serving 3,000 elderly and disabled residents.

The dedicated staff of the Office of Resident Services of HABC is committed to providing the best continuum of innovative/diverse services and support programs that maximize individuals' and families' capacities to become empowered, stable, self-sufficient, and economically independent. HABC will administer funds for direct resident service under the program. Eligibility for funds will be determined by the AAA Coordinator in conjunction with the McCulloh Homes Resident Services Coordinator. HABC will continue to work with the SAEPH project to assist in planning and implementation. The HABC will staff the project as follows:

- Cotrell Wesson, M.S.W., Social Work Supervisor, Superintendent for Resident Support Services, will continue to work with Center staff to coordinate activities of HABC staff and is a member of the Steering Committee.
- Ms.Augustine Jennings, McCulloh Homes Service Coordinator will work with program staff to provide outreach to residents and coordinate resident meetings, distribute information, and develop information systems, alert systems, act as liaison with the Resident's Council, and coordination of eviction and service issues.
- Ms. Emma Scott, McCulloh Homes Property manager will work with program staff to coordinate staff meetings and facility space and improvement needs.

Center for Health Program Development and Management

MDoA will contract with the Center to conduct specified activities including, but not limited to, focus groups, staffing committees, conducting research, strategic planning, providing implementation support, recruitment of providers, staff training, and educational activities. Under the planning grant, the Center participated in the Executive and Steering Committees and provided staffing support to the Steering Committee and its subcommittees. The Center worked with the Steering Committee to design the resident survey and coordinated its application and analysis.

The Center is a multi-faceted health services research organization that develops, manages, and evaluates healthcare programs and policies. Center staff are experienced in coordinating inter-agency program review and development, and conducting a wide range of surveys. The Center has worked with the MDoA and the Maryland Department of Health and Mental Hygiene on other long-term care projects. The Center will staff the program as follows:

- Project Coordinator – Stephanie Hull, M.S.W., J.D., Director of Long-Term Care Unit, will monitor and facilitate the activities of the Center. She will represent the Center on the Steering Committee and facilitate Steering Committee meetings. Ms Hull has 17 years experience in developing housing and service programs for seniors. She is educated as an attorney and a social worker with a specialization in community organizing.

- Stephanie Lyon, Ph.D., Long-Term Care Specialist, will assist with specified project activities. Dr. Lyon has 25 years experience in research and program development and evaluation for frail seniors.

- Annette Snyder, R.N., M.S.N., Director of Community and Public Health Activities, will assist with specified project activities. Ms. Snyder has extensive experience in public health nursing and the administration of surveys and research.

- Linda O'Hara, R.N., M.S., Research Analyst, Long-Term Care, will assist the Project Coordinator in her activities.

Steering Committee

In addition to the MDoA, the AAA, the Center, and the HABC, four other public agencies participate as members of the Steering Committee. Private provider organizations are also represented on the Committee including Baltimore Mental Health Systems, McCulloh Homes Tenant Council, McCulloh Health Center, Johns Hopkins Bayview Medical Center, and Family and Children's Services of Central Maryland. The Committee will be expanded to include additional providers such as the University of Maryland Professional Schools, Maryland General Hospital, and ElderHealth.

- Baltimore City Health Department

The mission of the Baltimore City Health Department (BCHD) is to provide all Baltimoreans access to comprehensive, preventive quality health services and care, as well as to ensure a healthy environment. The Adult Evaluation and Review Services (AERS) unit in the BCHD conducts comprehensive health and social evaluations of elderly citizens. AERS evaluations will be an important function in the model for coordinating services for SAEPH project participants. A representative of the AERS unit is a member of the Steering Committee.

- Maryland Department of Health and Mental Hygiene

The Department of Health and Mental Hygiene is the State Medicaid agency and provides reimbursement for a range of services to older adults who are eligible for Medicaid. In addition to co-payments and deductibles for Medicare-covered services, Medicaid covers pharmacy assistance, primary and acute care services, and long-term care services for individuals who qualify because they have low-incomes and/or meet certain health and functional criteria.

A representative from the Department is a member of the Steering Committee and will assist in identifying services and creative funding that may be available to support a systems change model of service delivery and coordination. As the State Medicaid agency, the Department has responsibility for funding a range of long-term care programs and services, including a recently expanded Home-and Community-Based Services Waiver for Older Adults.

- Maryland Department of Housing and Community Development

The Maryland Department of Housing and Community Development (DHCD) is a cabinet-level State agency created in 1987. Two of DHCD's missions are to strengthen communities, and provide affordable housing for people of limited income.

The DHCD is dedicated to providing the citizens and communities of Maryland with responsive, compassionate, fair, and efficient service. DHCD has access to a variety of funding sources, including Low-Income Housing Tax Credits, Mortgage Revenue Bonds and various State-funded programs for elderly housing. In reviewing funding applications for these programs, extra consideration is given to projects that prove a variety of well-coordinated services to assist and support senior housing. A representative from the DHCD is a member of the Steering.

- Baltimore Mental Health Systems

Baltimore Mental Health Systems, Inc. (BMHS) was established in 1986 as the local mental health authority for Baltimore City. BMHS is a public nonprofit entity, which maintains accountability to government. BMHS is the manager, funder, coordinator, and local authority for mental health services in Baltimore City. BMHS is not a direct service provider. Mental health services are provided by a network of nonprofit agencies (including general hospitals) and private practitioners.

- McCulloh Homes Tenant Council

The McCulloh Homes Tenant Council meets monthly to discuss issues concerning residents and arranges educational and entertainment programs for residents in the meetings.

- McCulloh Health Center

The McCulloh Health Center provides general medical care, eye examinations (Ophthalmology), foot care (Podiatry), laboratory tests, heart monitoring services (EKGs), and home health services to residents of McCulloh Homes.

- Johns Hopkins Bayview Medical Center, Pyschogeriatric Assessment and Treatment in City Housing (PATCH) Program

The PATCH Program provides mental health services to elderly residents of Baltimore City through nurse visits.

- Family and Children's Services of Central Maryland

For nearly 150 years, Family and Children's Services has assisted families who are facing hardships that damage and disrupt their lives. They work with fragile seniors and people with disabilities.

IV. Work Plan

Work Plan

Attachment D is a detailed two-year work plan. Final analysis of the resident and provider surveys and additional collection of information from providers and HABC and McCulloh property management staff is expected to be complete by December 2003. Efforts are underway to convene a meeting with agency executives and governmental liaisons by January. If funded for transition and implementation, work would begin immediately even if coinciding with completion of the planning phase funding.

Initial work will involve hiring of MDoA and AAA staff and furnishing office space in McCulloh Homes. Focus and workgroups will be convened with residents, staff, and providers to

review and refine the model design. Meetings will be convened with University of Maryland professional schools of Dentistry and Law to discuss and plan for a service program for McCulloh residents. A plan for evaluation and quality improvement will be developed to monitor the SAEPH program progress. Staff are expected to be placed and functioning in McCulloh Homes and a program quality monitoring system in place and working groups formed with the University professional schools and providers within three months of funding.

Second steps will be developing content and schedules for resident, provider, and staff meetings to provide information about the program and training, both as an opportunity for cross communication and additional education in services for seniors. Individual meetings with housing staff, providers, and residents will be conducted and program staff will participate in resident and staff activities. Service gaps will be confirmed and a system for determining eligibility and providing financial assistance for specific services will be established. The alert system will be designed and implemented. A user friendly and HIPPA compliant electronic information system will be designed for program and housing staff. Gap services, including dental assistance, and the informational and educational meetings are expected to be initiated six months into the program.

Full implementation will begin within nine months of funding although full participation of residents, staff, and providers will build over the next 15 months. Measurable results are expected within a short time after placing program staff on site and initiating the informational and educational initiatives. Actual targets have been established for reductions in evictions and transitions, assistance with hospital admissions and discharges, and increased participation in existing programs. These targets are expected to be met within two years of funding.