EVALUATION OF THE NEW CONGREGATE HOUSING SERVICES PROGRAM

Contract No: DU100C000005908

SECOND INTERIM REPORT

Submitted to:

U.S. Department of Housing and Urban Development
Office of Policy Development and Research
Washington, DC 20410

Submitted by:

Research Triangle Institute
Research Triangle Park, NC

May 1996

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Prepared by:

Janet Griffith
Angela Greene
Leslie Stewart
Merry Wood

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EXECUTIVE SUMMARY

INTRODUCTION

The new Congregate Housing Services Program (CHSP) provides housing combined with community-based supportive services to frail elderly and non-elderly persons with disabilities who are residents of federally assisted housing. CHSP provides professional service coordination, in addition to non-medical supportive services, such as housekeeping, personal care, congregate meals, and transportation.

The main purposes of the new CHSP are to promote and encourage maximum resident independence within a home environment, to improve the ability of management to assess eligible residents' service needs, and to ensure the delivery of needed services to them.

CHSP was originally authorized in 1978, and the new CHSP was authorized in 1990. Under the new CHSP, HUD funding is limited to 40 percent of the total; grantees provide 50 percent of the funding in the form of matching funds (cash, imputed value of services or staff, or in-kind items), and 10 percent from resident fees. Fees, which are required for meals, are optional for other services; total fees cannot exceed 20 percent of the resident's adjusted income.

The new CHSP is being evaluated for the period 1993 through 1998. The objectives of the evaluation are to provide a comprehensive description of the new CHSP and to assess the effectiveness of the program in maintaining resident independence. This report presents data from the baseline evaluation data collection conducted in late 1994.

EVALUATION HIGHLIGHTS

Grantees

In September 1993, HUD and the Farmers Home Administration awarded the new CHSP first-round grants to 27 grantees in 44 federally assisted developments throughout the United States and in locations ranging from non-metropolitan areas to some of the largest cities and large MSAs in the country. However, more than half of the CHSP developments in operation are in metropolitan areas in the Northeast and Midwest.

- Almost two-thirds of the CHSP programs were implemented by Section 202 or PHA grantees.

- Most grantees began operations within the first year of grant agreements. Some grantees have dropped the program—21 grantees in 34 developments remain active in the program after the first year.

- About half of the active grantees experienced start-up or implementation problems. Obtaining matching funds was one of the most challenging problems for grantees. Most grantees, however, believe that the sources and amounts of matching funds will be stable for the life of the program.

- Most grantees serve frail elderly residents; about half of them also serve persons with disabilities. About half of the sites had reached or exceeded their first year enrollment targets, and, of those, about half already had some people on a waiting list for services.

Participants

The CHSP is targeted to the frail elderly persons (62 years and over) and non-elderly persons with disabilities who need supportive services to continue to live independently.

- Overall, in developments with CHSP, about one-fourth of the residents participate in the program. Depending on the type of housing, the proportion ranges from under 10 percent to 66 percent. The number of participating residents ranges from less than 10 to more than 120.

- Most CHSP participants are elderly (89 percent). Most of them have "aged in place," are over 75 years of age, white, females who live alone, but maintain frequent contact with family and friends. Most elderly participants have three or more ADL limitations, and many report serious medical conditions. Comparison with other populations shows they are substantially more impaired than the general population of U.S. elderly. Overall, CHSP is serving persons with significant ADL limitations, although a minority of elderly participants appear less impaired.

- There is substantial attrition among elderly CHSP participants. Overall, 18 percent left CHSP within a period of about a year; the majority of those moved to a more restrictive environment or died. Of the elderly participants, 7 percent entered a nursing home, and 4 percent died (the others left the program or development for other reasons). These rates of attrition are similar to those for prior research on the frail elderly.

Service Coordinator

The service coordinator is typically a social service staff person who is responsible for assuring, through case management, that program participants are linked to services. The service coordinator is responsible for intake and, together with the professional assessment committee (PAC), determines resident eligibility for the program.

- The participants see the service coordinators as more than case managers. Service coordinators act as counselors and problem solvers. At times, they need to deal with social and psychological problems, such as isolation or loneliness.

Services

In addition to case management, the new CHSP provides non-medical supportive services, such as meals, housekeeping, personal care, transportation, and other kinds of help.

- The CHSP services used by the largest proportion of elderly participants are housekeeping, congregate meals, and transportation.

- The majority of participants are satisfied with the services they receive; with the amount, frequency, and availability of CHSP services; and with CHSP provider attitudes. At the same time, some residents say they want more services, lower fees, or greater flexibility in the services they receive (e.g., getting housekeeping on demand rather than on a set schedule).

- Both grantees and residents report that services help residents continue living as independently as possible in their own homes. In addition to direct benefits, the services provide a sense of security and increased social integration.

1. INTRODUCTION

The Congregate Housing Services Program (CHSP) provides a combination of housing and supportive services to frail elderly and non-elderly disabled residents of federally assisted housing. CHSP was originally authorized as a demonstration program under Title IV of the Housing and Community Development Act of 1978 (42 USC 5301). The new CHSP[1] was authorized under the National Affordable Housing Act of 1990, amended by the Housing and Community Development Act of 1992. Under this program, the U.S. Department of Housing and Urban Development (HUD) and the Farmers Home Administration (FmHA) make grants to local housing sponsors to help pay for supportive services for eligible residents. The main purposes of the new CHSP are:

- To promote and encourage maximum resident independence within a home environment, and
- To improve the ability of management to assess the service needs of eligible residents and provide or ensure the delivery of needed services.

1.1 The New Congregate Housing Services Program (CHSP)

The new CHSP is similar to the original CHSP in its commitment to helping residents maintain their independence and in several major program features. At the same time, there are important differences between the programs. Major program features and differences between the old and new CHSP are summarized in Table 1.1.

As Table 1.1 shows, there have been important changes in the funding and fees for services under the new CHSP. Grantees, or third parties, are required to provide 50 percent of

[1]This report examines the new CHSP. Unless otherwise specified, the term CHSP is used to refer to the new CHSP.

Table 1.1 Comparison Between New and Old CHSP

Program feature	Old CHSP	Ways new CHSP differs from old CHSP
Population served	Frail elderly and persons with disabilities.[a]	3+ ADLs[b] or non-elderly persons with disabilities
Services provided	Nonmedical supportive services: meals, housekeeping, personal care, transportation, other.	Does not require resident to take meal service; encourages shift from program focused primarily on meals to personal assistance, housekeeping, other services.
Service coordination	Assessed resident service needs, linked resident to services and providers, monitored services.	Service coordinator does not have other program responsibilities; required to have professional training/experience.
Program funding	Major funding provided by HUD.	HUD funding limited to 40%; 50% from match; 10% from resident fees.[c]
Resident fees	Resident paid some fees; most grantees used sliding scale.	No sliding scale; maximum fee 20% of adjusted income; fee can be waived if no income.

[a]Over time, the eligibility requirements for the old CHSP were made increasingly stringent; effective in 1987, residents needed to have at least three ADL limitations (at least one of which needed to be in eating or preparing food).
[b]ADL = Activities of daily living.
[c]If the waiver of fees for participants who have no income results in collected fees of less than 10 percent, the grantee and HUD each pay half of the difference, up to a maximum of 45 percent of funding from HUD.

the new CHSP funding (the match requirement) from cash, imputed value of services or staff provided by a third party, some in-kind contributions, and value of services provided by volunteers. Resident fees are required for meals, but are optional for other services; there is not a sliding scale (based on income) for resident fees, although fees cannot exceed 20 percent of the resident's adjusted income, and fees may be waived for residents who have no income.

Other important changes from the old to the new CHSP are greater emphasis on service coordination and tailoring of services to resident needs. Under the new CHSP, service coordinators must have professional training or experience and are required not to have other program responsibilities (unless they work part-time as service coordinator). Residents are no

longer required to accept meal services as part of their program participation. The objective is to provide meals to residents who need them, but also to make the bulk of service funds available for personal assistance, housekeeping, and other kinds of support. The new program rules require that residents be actively involved in choosing the package of services they receive. Residents must be provided with at least the minimum supportive services needed to help maintain independence and may elect additional services (if available) at cost.

A description and brief history of the program, including more detailed information on the differences between the new and old CHSP, are included in Appendix A.

1.2 Definitions of Terms

Terms used to specify new CHSP requirements are important for describing and evaluating the program.[2] These terms and their definitions are discussed in this section.

Activities of Daily Living. Activities of daily living are divided into two major categories: instrumental activities of daily living (IADLs), which include activities regularly necessary for home management, and physical activities of daily living (PADLs, or ADLs), which include activities regularly necessary for personal care. Elderly residents' eligibility for CHSP services is determined on the basis of their need for assistance in three or more ADLs (including IADLs). For purposes of determining eligibility for the new CHSP, HUD defined a set of ADLs. These can be grouped as: household management (shopping for personal items, managing money, using the telephone, and performing housework), transferring (getting in or out of a bed or a chair), personal grooming and care (washing hair, getting dressed, getting in or out of the shower or tub, bathing, personal grooming, and using the toilet), and food and eating (preparing meals, feeding self).

[2]Definitions and program requirements are presented in detail in several sources, including Interim Common Rule and Notice of Funding Availability (236 *Fed. Reg.* 58042-58065 [1992]), Congregate Housing Services Program Request for Grant Application and Amendment Number 1 (DU100G000016992).

Disability. In addition to elderly residents with ADL impairments, adults with disabilities (physical, mental, or emotional impairments) and persons with temporary disabilities are eligible for CHSP services, regardless of age.

Service Coordination and Case Management. For purposes of the new CHSP, **case management** is defined as:

> implementing the processes of: establishing linkages with appropriate agencies and service providers in the general community in order to tailor the needed services to the program participant; linking program participants to providers of services that the participant needs; making decisions about the ways resources are allocated to an individual on the basis of needs; developing and monitoring of case plans in coordination with a formal assessment of services needed; and educating participants on issues including, but not limited to, supportive service availability; application procedures and client rights (236 *Fed. Reg.* 58046 [1992]).

The **service coordinator** is a social services staff person who is "...responsible for assuring, through case management, that program participants are linked to the supportive services they need to continue independent living" (236 *Fed. Reg.* 58047 [1992]). The specific responsibilities of the service coordinator include intake and referral services, formal case management, establishing linkages to service providers in the community and referring and linking individual participating residents to providers, educating residents on service availability and related topics, monitoring provision of services, helping residents build informal support networks, and educating other staff on aging-in-place and service coordination. The service coordinator works with the professional assessment committee (PAC), which has primary responsibility for determining resident eligibility for CHSP, conducting regular reassessments of residents, and developing case plans for participating residents.

Additionally, the service coordinator works with local service providers in developing and implementing service plans and keeps the PAC informed of participant progress.

Cost Distribution: Matching Funds and Fees. Under the new CHSP, the grant provides 40 percent of costs; 50 percent or more of costs must come from matching funds (cash, imputed value of other agency or third-party-provided direct services or staff, in-kind items [no more than 10 percent of the match], and value of services provided by volunteers), and at least 10 percent of program costs must come from fees paid by participating residents. Fees must be

paid by participating residents for services received, but are not to exceed 20 percent of the participant's adjusted income; fees may be waived for residents with no income. The waiver of fees for participants with no income may result in collected fees of less than 10 percent. In this case, the grantee and HUD each pay half of the difference, up to a maximum of 45 percent of funding from HUD.

1.3 Profile of New CHSP Grantees

1.3.1 Housing Types

New CHSP projects are in many types of federally assisted housing. Table 1.2 shows the distribution of the 34 active new CHSP projects by housing type and the project size, measured by number of participants in Year 1 (median number and range).

More than half of the new CHSP projects are in Public Housing Authority (PHA) or Section 202 housing. Over 70 percent of the residents served live in these two types of housing. Of 932 total participants served in the first year of CHSP, 232 (25 percent) are in PHA housing and 447 (48 percent) are in Section 202 or Section 8 housing.[3]

The average (median) number of participating residents is 24. The percentage of residents participating in the new CHSP ranges from less than 20 percent in public housing authority sites to nearly two-thirds in the two Section 8 sites. Overall, about one-fourth of the residents in CHSP developments are in the program.[4]

[3]Two of the Section 202 developments also classified themselves as Section 8.

[4]The percentage participating in the new CHSP was calculated by summing the total number of residents participating in the new CHSP in each housing type and dividing this by the total number of units in the developments in that housing type, as reported by the grantees. This may somewhat overestimate participation in developments that have a number of apartments with more than one resident but gives a useful approximation to the participation rates.

Table 1.2 Active CHSP Projects by Housing Type

Housing type	Active new CHSP projects		Number of participating residents served in Year 1		
	Number	Percent of total	Median	Range	Participants as percent of total units
Section 202	11	32.4	30	10-129	28.6
Public housing authority	10	29.4	21	0[a]-43	16.0
Section 236	6	17.6	31	4-87	25.8
FmHA	4	11.8	5	3-12	17.4
Section 8	2	5.9	31	5-56	65.6
221(d)(2)	1	2.9	14	15	6.7
Total	34		24	0-129	22.9

Source: Grantee first annual reports.

[a]One project that was active at the time of RTI data collection in November 1994 had no participants enrolled by September 1994.

1.3.2 Geographic Location

The new CHSP developments are located in cities ranging from fewer than 4,000 to more than 600,000 in population. The median size of the host cities is about 60,000, and 35 percent of the developments are in cities or towns with populations less than 25,000. Only four of the active projects are in nonmetropolitan areas. Most of the cities or towns are part of larger metropolitan areas; over half of the active projects (18) are in metropolitan areas with populations of 1 million or more. Table 1.3 shows the distribution of developments in the new CHSP by Census population categories for both the city and the larger metropolitan area in which it is located.

Geographically, the CHSP developments in operation are concentrated in the Midwest (12 developments, 35 percent of the total) and the Northeast (11 developments, 32 percent of the total). Most of the Midwestern and Western developments are located in large

Table 1.3 Distribution of CHSP Developments by City and SMA Size

Size category	City size		Metropolitan area	
	Frequency	Percent of total	Number of developments	Percent of total
1 Million +	0	0.0	18	52.9
250,000-999,999	11	32.4	8	23.5
100,000-249,999	3	8.8	2	5.9
25,000-99,999	8	23.5	2	5.9
Under 25,000	12	35.3	4	11.8
Number of developments	34		34	

Metropolitan Statistical Areas (MSAs); a relatively large proportion of projects are located in the Northeast in moderate size MSAs; those in the South are primarily located in moderate size MSAs or non-MSA areas.

Overall, the new CHSP is diverse. The number of residents participating ranges from less than 10 to more than 120. CHSP is being implemented in all regions of the country and in locations ranging from nonmetropolitan areas to some of the largest cities and MSAs in the country.

1.3.3 New CHSP Service Provision

Under the new CHSP, a variety of services are provided to participating residents. Services include meal service adequate to meet nutritional needs (at least one hot meal a day, 7 days a week); housekeeping services; personal assistance (grooming, dressing, other activities to maintain personal appearance and hygiene); transportation; nonmedical supervision, wellness programs, preventive health screening, and related services; personal emergency response systems; and other supportive services approved by HUD. Grantees may provide these services directly or contract them through other agencies or providers.

Interviews with 21 grantees also provided information on other services they provide and on their participation in the old CHSP. Overall, 5 (24 percent) of the new CHSP grantees had participated in the old CHSP and 12 (57 percent) also sponsor other programs of services for residents. As Section 5 describes, residents receive services from the new CHSP, other programs, and family or other informal sources.

1.4 Evaluation of New CHSP

The U.S. Congress mandated an evaluation of the new CHSP in Section 802(l) of the National Affordable Housing Act of 1990. This evaluation is being conducted by Research Triangle Institute (RTI) under a contract from HUD's Office of Policy Development and Research (PD&R). The overall objectives of this evaluation are:

- To provide a comprehensive description of the new CHSP;
- To assess the effectiveness of the program in maintaining the independence of frail elderly residents and younger residents with disabilities by providing a range of supportive services; and
- To compare the new CHSP with the HOPE for Elderly Independence Demonstration Program (HOPE IV), another HUD program with a similar mission.[5]

The evaluation focuses on two sets of issues: (1) implementation and administration of the new CHSP and (2) performance and impact of the program (see Table 1.4). It is designed to address a set of specific questions under each of the major issue areas. Appendix B provides the full matrix of evaluation questions and data sources.

[5]HOPE IV also provides a combination of housing and supportive services to frail elderly residents to help them continue living in the community as long as possible. It differs from CHSP in several ways: all HOPE IV grantees are Public Housing Authorities; HOPE IV participants live in Section 8 (scattered-site) housing in the community; and supportive services are tenant-based (rather than project-based as in CHSP).

To conduct the 5-year evaluation (1993-1998), RTI is collecting data from a variety of sources: residents who participate in the program, service coordinators, representatives of PACs, grantee staff, grant applications, program reports and records, HUD officials, and secondary data sources. Initial data collection took place in November to December 1994, near the beginning of new CHSP implementation (baseline). Subsequent data collection is scheduled at 12 and 24 months after the baseline.

Table 1.4 Evaluation Issues

Implementation and administration	Performance and impact
1. Grantee and project characteristics; ability of grantees to maintain match 2. Role and performance of Professional Assessment Committees (PACs) 3. Targeting of CHSP services 4. Provision, quality, and cost of services	1. Impact of co-payment agreements 2. Role and impact of service coordinators 3. Effectiveness of CHSP in fostering independent living; comparison with HOPE for Elderly Independence

These data will be used to describe CHSP projects, the types of housing in which the projects are located, and CHSP operations, services, and residents over time; to analyze the implementation of the program as grantees move from planning and start-up to full implementation and then maturity; and to assess the impact of the program on residents, grantees, and their communities. Comparisons with the HOPE for Elderly Independence Demonstration Program will be used to increase understanding of CHSP and to assess its effects.

This second interim report presents data from four major sources:

- Baseline interviews with grantees and service coordinators;
- Baseline questionnaires administered to residents participating in CHSP;

- Data on participating residents and on residents who had entered and left CHSP prior to the baseline data collection, provided by the service coordinators at participating sites; and

- Annual reports requested by HUD's Office of Elderly and Assisted Housing and submitted by grantees to local HUD field offices.

Table 1.5 summarizes the data from these sources. Evaluation methods are discussed in more detail in Appendix C.

1.5 Report Content and Organization

This report provides information on the early period of program implementation, describes the services and residents participating in the new CHSP, and gives preliminary evaluations of program effects on residents and grantees. The content and organization by sections is summarized below:

Section 2: The New CHSP Grants: Funding and Early Implementation. This section provides findings from grantees' descriptions of their experience in implementing the new program, including problems they experienced in developing funding and beginning program operations, and the funding achieved in the first year of program operations.[6]

Section 3: Resident Recruitment and Selection. Sections 3 through 5 focus on the residents who participate in the new CHSP, their needs, and the supportive services they receive from CHSP and other sources.

As programs started up, major activities focused on getting information to residents about the new CHSP and the services it offers, identifying and assessing potentially eligible residents, and enrolling eligible residents in the new CHSP. Section 3 describes this process, from the perspective of both service coordinators and participating residents.

[6]These data supplement analyses of the grant applications and program plans, which were presented in the *First Interim Report*.

Although the process of resident recruitment and selection is particularly important in program start-up, the fact that substantial resident turnover is expected because of residents' age and frailty means it will be a continuing function for programs. Thus, information learned from the early period of new CHSP operations has continuing importance for the programs.

Section 4: Characteristics of Residents Participating in New CHSP. The new CHSP is targeted to frail elderly persons and non-elderly persons with disabilities, and the resident selection process is designed to select participants who need supportive services.

Table 1.5 Baseline Data Collection and Summary

Data source	Number of respondents	Data collection		Topic areas
		Period	Method	
Grantees	21 grantees (for 34 active programs)	November to December 1994	Telephone interviews	● Grantee agency ● Program staffing ● Services in development ● Matching funds ● Program design and implementation ● Impacts of CHSP
Service coordinators	26 service coordinators (for 34 active programs)	November to December 1994	Telephone interviews	● Participant selection and enrollment ● Service provision ● Impacts of CHSP
Residents	667	November to December 1994	Group, individual, and proxy interviews	● CHSP neighborhood ● Health and use of medical services ● Physical functioning ● Services received through CHSP and other sources ● Social activities and help from families
Grantee annual reports	42 (34 active in Year 1)	November 1994 to January 1995	Requested from grantees	● Project type ● Participant mix ● Service levels and costs ● CHSP entries/exits ● Narrative report

This section describes the residents who were selected for CHSP and were participating in the program at the time of the baseline survey and the mix of elderly and non-elderly residents in programs in different sites.

The resident description is provided separately for elderly and non-elderly residents. This is done because of important differences between the groups and because of the importance of comparing new CHSP elderly residents with the elderly participants in HOPE IV.[7]

Residents are described in terms of age and other demographic characteristics, length of residence in their current location, social resources and interaction, ADL impairments, and health status, health care utilization, and health coverage. These data present a picture both of resident vulnerability (ADL limitations, health status) and of the social resources that help them function and that can work with CHSP services and staff to help them maintain their current living arrangements. These data also serve as background to the description of supportive service utilization.

Section 5: CHSP Services. This section presents data on new CHSP services and their use by CHSP participants. The analysis of services is organized around areas of ADL functioning. In addition to current use of supportive services from CHSP and other sources (other programs or informal sources), use of services prior to CHSP is examined.

Section 6: Program Administration. The new CHSP has several important administrative features, including new funding requirements (matching funds and resident fees) and new requirements for service coordinator position. This section focuses on these two issues. First, it examines the costs of providing different CHSP services, participating residents' experience and attitudes about the fees, and service coordinators' views of the impact of fees on resident participation and choices. Second, it examines the service coordinator role and the ways service coordinators work with participating residents to help them access and use available services.

[7]Only the elderly are eligible for participation in HOPE IV.

Section 7: Dynamics of Participation in CHSP. The new CHSP is designed to serve residents with great need of support who are at high risk of being moved to a more restrictive living environment. Many participating residents are frail and elderly, so mortality is also expected to be relatively high. CHSP projects face challenges in serving these residents and also in handling a continuing influx of new participants who enter the program as others leave.

This section examines data on participation dynamics for the first year of the new CHSP: waiting lists for CHSP services, the sources and numbers of residents entering CHSP in this period, and the numbers who leave CHSP. The analyses of exits from CHSP consider major patterns of leaving (death, institutionalization, moves, program dropouts) and the differences by age.

The data on program dynamics are important for understanding why residents leave, rates of participant turnover, and the administrative challenges CHSP projects face because of participant turnover.

Section 8: Program Impacts, Evaluation, Improvement. This section brings together evaluation data from participating residents, grantees, and program staff. The analyses examine: effects of services on participating residents (how well services meet their needs, how satisfied they are with services); satisfaction with CHSP overall and with aspects of CHSP, such as provider attitudes and timeliness of services; major benefits of CHSP for residents and grantees; services needed by residents, including services residents do not currently receive; impacts of CHSP on the grantee organization and on other providers in the community; grantees' views of the program; and residents' and grantees' recommendations for changes in the program.

These analyses provide preliminary information on CHSP performance and impact. They give insights on the accomplishments of the new CHSP in its first year of operation and provide a background for the continuing evaluation of the program over time.

Section 9: Summary and Conclusions. This section summarizes the results of the analyses and discusses their implications for the new CHSP and for services to the frail elderly and persons with disabilities who are residents of federally supported housing.

2. NEW CHSP GRANTS: FUNDING AND EARLY IMPLEMENTATION

The *First Interim Report*[1] analyzed data from grant applications on grantees' proposed sources of funding and planned use of funds. In the baseline data collection, reported in this *Second Interim Report*, grantee interviews and grantee annual reports collected data on grantees' experience in obtaining the needed funds and in implementing the program in its early months.

These data on new CHSP implementation are important for several reasons. First, the grantees' experience is useful to grantees that will be funded in subsequent years, as they begin implementing their programs. Second, the experience in first-year implementation provides background for the analysis of resident experience with the program. Third, information on grantees' experience in developing funding in the first year of operations and their confidence in the reliability of future funding begins to address evaluation questions relating to new CHSP implementation and administration.

This section briefly summarizes the results of analyses of grantee interview and annual report data on program implementation, especially the funding distribution attained in the first year.

2.1 Initial Implementation of New CHSP

HUD and FmHA provided new CHSP grant funding to 27 grantees for projects in 44 housing developments. As of December 1994, 21 grantee organizations were providing new CHSP services in 34 developments.[2]

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[1] *Evaluation of the New Congregate Housing Services Program: First Interim Report.* Submitted to Department of Housing and Urban Development by Research Triangle Institute, March 1995.

[2] Three grantees had dropped out and three others had not yet begun to provide services. Baseline interviews were conducted with 21 grantees.

As described in Section 1, new CHSP grantees are diverse. The program is being implemented in all regions of the country and in settings ranging from nonmetropolitan areas to major MSAs. The grants are being implemented in a variety of housing types, although the majority of grants and participating residents are in PHA or Section 202 housing.

Although some of the projects were able to begin implementation quickly, others required time to hire staff, assess residents, and begin providing services to eligible residents. During the first year of funding, the median period grantees had been providing services to residents was 8.5 months; more than one-fourth had provided services for the full year, whereas about 10 percent had only provided services for about 1 month of the reporting year.[3]

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

2.2 Sources of Funding

Under the new CHSP, grantees provide at least 50 percent of CHSP costs in the form of matching funds. HUD provides up to 40 percent of costs, and 10 percent or more is required to be obtained from fees paid by residents for services they receive from the program.[4]

[3]These data are approximate, based on grantees' answer to the question "When (month) did you begin providing services," which was asked when RTI contacted grantees for planning and scheduling the baseline data collection.

[4]Because fees can be waived for participants with no income, collected fees may be less than 10 percent. HUD and the grantee each pay half of the fee differential, up to a maximum of 45 percent of costs being provided by HUD.

Data from baseline interviews with grantees and the first annual reports indicate that developing the matching funds was a challenge in the new CHSP application process and, for some, in the early period of program implementation.

Eleven of the 21 grantees interviewed reported that raising the 50 percent match was one of the most significant challenges they faced in applying for new CHSP funding. At the time of the interview, however, most grantees were confident that the matching funds they obtained would be reliably available for the program period. In response to the question, "How reliable do you expect the sources and amounts [of matching funds] to be over the five-year period," 15 (71 percent) said "very reliable," another 4 said "somewhat reliable," and only 2 said they were "uncertain."

Table 2.1 provides data on the actual sources and amounts of funding for the first year of new CHSP operations, from grantees' first annual reports to HUD.[5] On average, the projects met the match requirements and were close to the required levels for fees and the HUD share. At the same time, as Table 2.1 shows, grantee experience varied, with some substantially under the required amounts from the match or fees. These variations occurred

Table 2.1 Sources of First-Year Funding

Percent of total from source			Number of grantees
Funding source	**Median percent[a]**	**Range (%)**	
Match	51.2	31.1-78.1	32
Resident fees	8.5	0.4-24.0	28
HUD	37.5	5.1-65.8	28

Source: Grantee first annual reports.

[5]The annual reports include some discrepancies and inaccuracies that are being corrected. These may affect the calculation of the percentages of funding from different sources for at least some sites. For this reason, the discussion focuses primarily on the averages (medians), rather than on the ranges, which may include some inaccurate data. Analyses in subsequent reports will use the most current corrected data available.

[a]Each reporting grantee provided data on funding from the different sources. For the analyses, this was converted to a percentage of the total funding. The table gives the median of the percentages, computed across all reporting grantees. Because of variability in the distribution of these percentages, the sum of the medians does not equal 100 percent, even though the sum of percentages for each individual site does equal 100 percent.

for a variety of reasons. In some cases, delays in resident enrollment resulted in low revenues from fees or slow expenditure of the match. At the same time, these sites may have experienced relatively heavy early expenditure of the HUD funds for program start-up and administrative costs. In at least one case, a grantee that had not been able to obtain sufficient funding from fees and match subsequently withdrew from the program. In other cases, the grantees may be able to come into compliance with the funding requirements as projects achieve full implementation.

2.3 Discussion

Some grantees required time to hire staff, identify eligible residents, and recruit residents in the first year. By the end of the first year, most grantees had succeeded in these aspects of implementation; others included sites that would subsequently withdraw from the program and ones that still expected to implement it.[6]

The data on funding show that some sites did not achieve the required cost distribution.[7] In terms of the new CHSP evaluation, these first-year data show that, at least in the start-up period, some sites did not fully succeed in developing the match or collecting the required level of resident fees. Most, however, expect that they will be able to maintain the match over time.[8]

Subsequent sections of this report provide additional data on program performance and services during the first year of operations. These include resident recruitment and enrollment services provided to residents and residents' and grantees' assessment of the program and services.

[6]The subsequent data collection and analysis will include those grantees able to begin implementation at a later time.

[7]Data from the second annual reports submitted by grantees will be analyzed in subsequent evaluation reports. The results are expected to show improving compliance with the cost distribution requirements as programs become fully operational or deal with funding deficiencies and as noncompliant grants are terminated.

[8]Grantee interviews will be conducted after two years of CHSP operation. Data will be collected and analyzed on grantees' perceived ability to maintain the match, as well as actual funding at that time.

3. RESIDENT RECRUITMENT AND SELECTION

As projects began implementation, they provided information to residents of the housing developments, recruited potential participants, and assessed eligibility and selected residents to participate in the program.

This section examines the efforts of grantees and projects to publicize CHSP availability and encourage resident applications, resident and program factors affecting participation, and residents' experience of the application and selection process. This discussion is based on data from grantees, service coordinators, and residents.

3.1 Publicity and Outreach

Major program activities in the early period involved familiarizing residents with CHSP services and encouraging those who could benefit from services to apply for CHSP.

Twenty (77 percent) of the 26 service coordinators interviewed reported that they had undertaken publicity and outreach activities. The particular forms of publicity activity and mix of activities undertaken varied among the sites. Specific ways the sites publicized CHSP include:

- Announcements and/or articles in development or community newspapers;
- Flyers, brochures, or other printed materials and/or letters sent to residents with information on CHSP;
- Informational meetings or presentations (in some sites, lunches or open houses);
- Word of mouth through staff, residents' council, or other means; and
- Individual meetings with residents or family members, including door-to-door contact with residents.

Outreach was undertaken to residents who might not be aware of services, might not understand the program, or might be reluctant to ask for services. Typically, outreach included

both identifying people who might benefit but did not respond to publicity and meeting with them and their families to encourage participation.

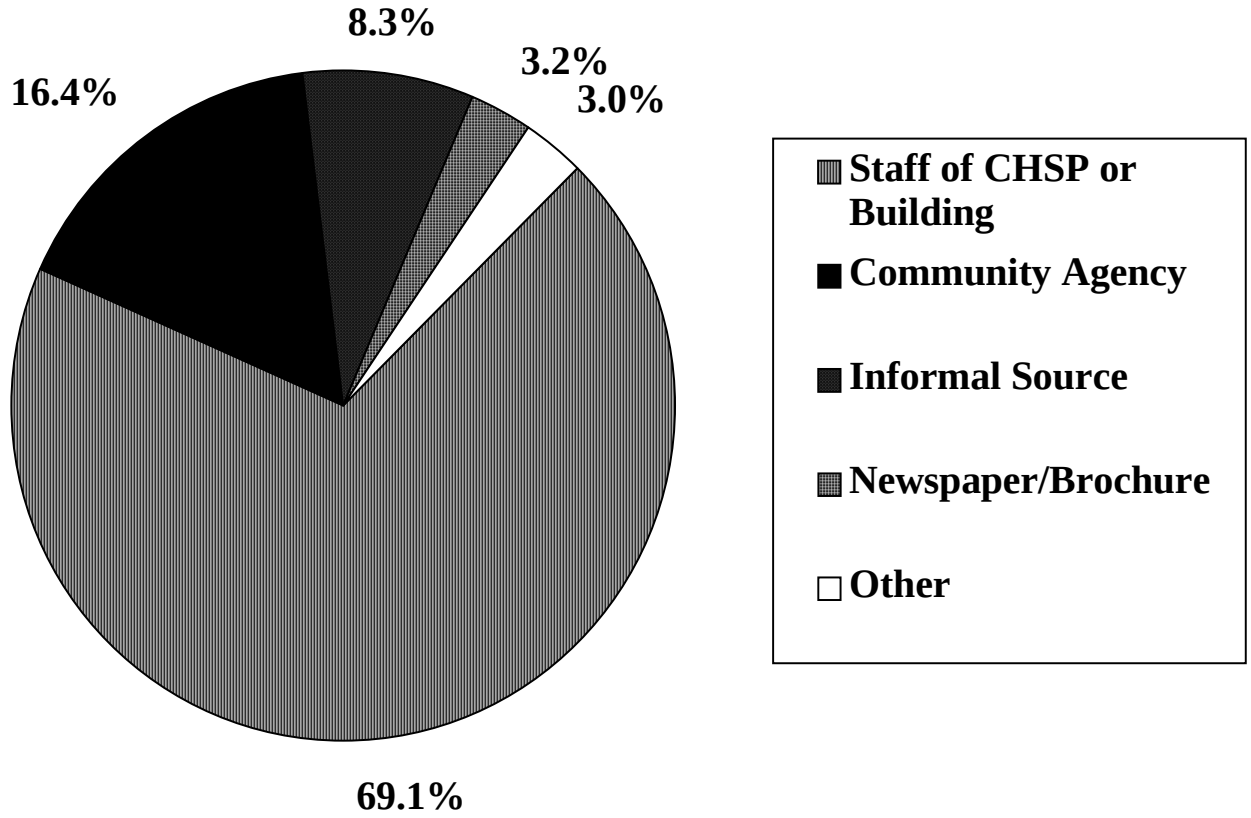
Examples of outreach activities give a picture of the special efforts CHSP staff have made to reach residents who could benefit from the program:

> We have a strong resident program here, so word of mouth helps a lot. But our resident services staff know everyone in the development and can help identify people who may need CHSP assistance. Then we spend a lot of intensive time one-on-one with those residents and usually their families to tell them about the program. A lot of them can't remember or understand, so it's important to get the families involved too.
>
> [We] asked management if particular people needed help, then someone would go to them and encourage them to join. Neighbors would tell us if they thought a particular person or friend in the apartment complex would do well in the program.

The residents participating in CHSP were asked how they learned about the program. Figure 3.1 lists the sources from which residents learned about the program. These data demonstrate the importance of publicity and outreach by staff of the CHSP, the building, or housing authority. More than two-thirds of participating residents say they first learned about CHSP from this source. In addition, some residents (16 percent) learned about CHSP from staff of the local Area Agency on Aging or another local community service agency. Informal sources—a friend, relative, or the resident's place of worship—were the main source from which 8 percent of residents first learned about CHSP.

Finally, although many sites distributed information in written form (newspaper articles, brochures), only 3 percent of residents recall this as the source from which they first learned about CHSP. Most sites that used printed materials also used staff outreach to individual residents. This use of personal approaches, in addition to written materials, undoubtedly reflects awareness that personal contact is more effective than written materials in reaching residents.

Figure 3.1
Main Sources of Resident's Information on CHSP



Source: Baseline survey of CHSP participants.

3.2 Resident and Program Factors in Participation

Depending on the housing type, between about 15 percent and 65 percent of residents participate in CHSP. Service coordinators were asked why some eligible residents are not being served by CHSP. The 26 service coordinators interviewed cited both resident and program factors: residents chose not to participate (mentioned by 17 of the 26 service coordinators); some residents cannot afford services (mentioned by 10 service coordinators); program does not have enough funds (mentioned by 10); and program does not have appropriate services (mentioned by 3).

Comments made by service coordinators underscore the effect of resident factors and the importance of active outreach efforts:

> They already have in-home services and don't want to switch — or are too isolated to fit in with congregate style — or control issues — they want more say, don't want to be dependent on someone else's schedule, have to do something regularly, or are inexperienced with systems — or feel they can or should manage on their own — or fear [that if] they indicate needs they might get kicked out.

> Residents chose not to participate. Some are suspicious, think they're going to be ripped off. Some are humiliated about their own or their home's condition. A lot of it is pride. Or fear — that they might get kicked out to a nursing home, which is exactly what the program helps prevent! Some are intensely independent and private, even if they're dying. The same independence that got them this far in life can be self-defeating when their bodies start to get frail. We have an empowerment model here, we do not force people into the program — or allow their families to without their express consent.

Additional information on the program side of the selection process comes from service coordinators' responses to questions about the criteria they use for selecting among potentially eligible residents in general or in cases where there are more eligible applicants than the program can serve. These responses indicate that the main criteria used for selecting among eligible residents—used alone or in combination—are level of need or frailty and "first come, first served." In addition to need and date of application, selection criteria mentioned by service coordinators include income level, ability to benefit from the program (e.g., resident's unmet needs can be met, in whole or in part, by the program), and availability of family or other support. Taken together, these factors — frailty, income, family support, date of application, and

ability to benefit — are used by sites to target services to residents most in need of supportive services.

3.3 Resident Experience in New CHSP Application Process

The new CHSP emphasizes the importance of providing services responsive to resident needs and the active participation of the resident in decisions about services. The baseline survey of residents asked residents about their experience in the application and service decision process. Their responses are given in Table 3.1.

Table 3.1 Participant Experience with CHSP Application Process[a]

Experience	Percent of participants
Financial information was easy to provide or not required	98.3
CHSP was explained clearly	87.2
Process of determining need for assistance was not complicated or not required	80.9
Resident participated actively in deciding on CHSP services to receive	70.7
Number of cases	515-519[b]

Source: Baseline survey of CHSP participants.

[a]Residents were asked about each component of the application and selection process. For each component, a response category of "did not participate" or "was not required" was included. This has been grouped with other responses in this table. These questions were asked only of respondents who could reply for themselves; they were not asked in proxy interviews. The table thus reflects the residents' own perception of the process.

[b] This table and some subsequent tables give percentages for a set of related questions. Where the number of respondents is very similar for each of the questions, the "number of cases" shown at the bottom of the table is the range of the number of cases for the questions included in the table. This was done to make the table easier to read and because the small difference in the number of cases does not affect the interpretation of the results.

As this table shows, most residents say the program was clearly explained to them and that they did not find it difficult to provide the required financial information or to undergo the assessment process.

Nearly three-quarters of the residents say they participated actively in deciding on the services they would receive. In view of the fact that the program requires active resident participation in deciding on services, however, this figure suggests there may be a need to involve residents more actively in this stage of the process and, possibly, to communicate to them, or to the service coordinator, the importance of resident participation in choosing the services they will receive.

Overall, however, the responses of residents who have gone through the selection process and are currently receiving services indicate that, for this group, the experience has not been particularly difficult or demanding.

3.4 Discussion

Recruiting and selecting residents is a key CHSP function. This is true in the early period of implementation described in this report but also will continue to be important over time, as participants leave the programs and opportunities arise to serve other residents.[1]

The data make clear that active outreach efforts are crucial. Residents may be fearful or reluctant to accept services for which they are eligible, or may not understand what services are available. Both the resident and grantee surveys show that distributing printed information (e.g., flyers, brochures, or articles) is not enough, and that personal efforts by the service coordinator or other staff to encourage resident participation are needed. It is also apparent that information alone is not enough for at least some residents. Service coordinators or other staff need to target residents who need assistance, talk with them—and with their families, if available—about the program, help them to understand what the program does and how it can help them, and overcome fears and concerns ranging from a sense of humiliation at the idea that they need help to specific concerns about program operations (e.g., who will provide services, when) and costs.

[1] Section 7 of this report presents data on resident turnover and waiting lists.

In terms of the major evaluation issues, these data on resident recruitment and selection indicate that:

- Reaching out to residents is an important function for the service coordinator and other staff;
- Program fees appear to be a barrier to participation for at least some residents;
- The CHSP application process is generally not perceived as difficult or unpleasant by participants; and
- More efforts may be needed to involve residents in decisions about what services to receive or to make them aware of the resident's role in service decisions.

4. CHARACTERISTICS OF RESIDENTS PARTICIPATING IN NEW CHSP

CHSP provides nonmedical supportive services to frail elderly and non-elderly persons with disabilities. To be eligible to participate in CHSP, residents must have temporary or permanent disabilities or, for the elderly (age 62 or older), must need assistance in at least three ADLs. The areas of activity limitations included under the HUD regulations are eating or preparing food, bathing, dressing, grooming, getting in and out of bed and chairs, walking, toileting, and household management.

This section describes participating CHSP residents, including both elderly and non-elderly participants. The description focuses on demographic characteristics, housing, and social resources, and functional and health status. Data used in the analyses in this section come from the resident baseline questionnaires.

4.1 Participant Mix in New CHSP Projects

CHSP serves both the elderly and non-elderly persons with disabilities. Overall, 89 percent of the CHSP participants surveyed are elderly (age 62 or older) and 11 percent are non-elderly.

As shown in Table 4.1, CHSP projects vary in the mix of residents they serve.

Table 4.1 Mix of Elderly and Non-Elderly Residents in CHSP Projects

	Predominantly non-elderly		**Mixed**	**Predominantly elderly**		**Total**
	All	90-99%		90-99%	All	
Number	1	1	8	7	16	33
Percent	3.0	3.0	24.2	21.2	48.5	100.0

The majority (70 percent) of new CHSP projects serve a population that is entirely or

almost entirely elderly (90 percent or more elderly). Only two projects serve an exclusively or nearly exclusively non-elderly population.[1]

Nearly half (16 projects) serve at least some residents in both groups. Although there are challenges involved in serving a mixed population in one development, one grantee commented that, by supporting this type of living arrangement, CHSP has provided opportunities to these developments and their residents:

> It [CHSP] gives clients—especially the younger disabled—a much better place to live than an institution. It gives them [the elderly] more choice—they can "age in place" in their own community. Both the disabled and the elderly feel better. It [CHSP] helps deal with the mixed population issue better. As everyone eats their meals together every night, they get to know each other as people, not as disabled, etc.

4.2 Length of Residence and Age of Participating Residents

Table 4.2 shows the length of time CHSP participants have lived in their current homes. As this makes clear, a number of the elderly have "aged in place." Over a quarter have lived there more than 10 years, and more than half (53 percent) have lived there 5 or more years. Even among the non-elderly residents with disabilities, a third have lived in their current homes for 5 years or longer.

Table 4.2 Length of Time Lived in Development by CHSP Residents

Time in development	Elderly (%)	Non-elderly (%)
More than 10 years	27.3	19.7
5-10 years	26.1	14.5
1-4 years	34.8	46.1
6-12 months	6.7	6.6
Less than 6 months	5.1	13.1
Number of cases	586	76

Source: Baseline survey of CHSP participants.

[1] One of these is Section 236, the other classified itself as Section 202 and Section 8.

In addition to the effects of aging in place, these data show that, especially for the elderly CHSP participants, very few have experienced a recent move—either to obtain services or for other reasons. This contrasts with the HOPE IV program. Preliminary data from that evaluation show about one-third of the early HOPE IV program entrants had moved in order to participate in the program, many of them because they lived in housing that could not meet HUD's Housing Quality Standards (Westat, 1995, p. 5-7).

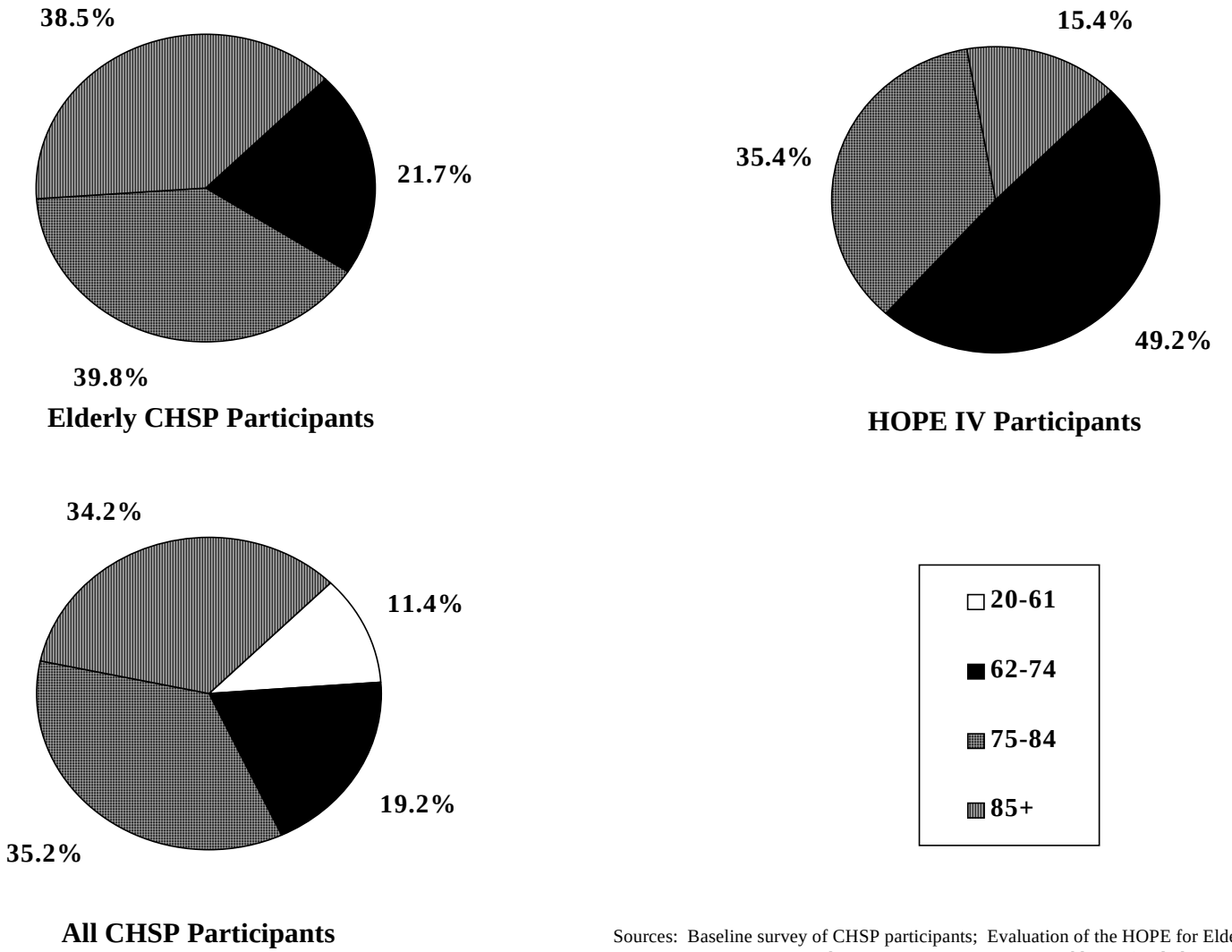
Data from a 1992 survey by the American Association for Retired Persons (AARP) show that the great majority (85 percent) of older persons (age 55 and older) want to "age in place" in their current homes rather than having to move (Dobkin, 1993). Kane and Kane (1987) report that the elderly and persons with disabilities prefer to receive supportive services in their own home or, if that is not possible, in their communities.

The data on the proportion of program entrants who have not had to move to obtain services suggest that CHSP is successful in allowing residents to meet their preferences to receive supportive services in the current home.

The fact that many CHSP participants were able to enter the program while still staying in their long-term homes has several implications for the program. CHSP typically allowed services to be added to existing housing arrangements, without requiring a move. In a number of sites, residents had at least some services available before CHSP, and these services generally were still available as a supplement or alternative to CHSP. Also, in CHSP sites that had staff with relevant experience, the outreach to residents and resident assessment could be done by someone who was already familiar to residents of the development. The analyses of CHSP over time and the comparisons between CHSP and HOPE IV will explore the implications of these aspects of the programs.

Figure 4.1 shows the age distribution of the population of CHSP participants and compares it with preliminary data on participants in HOPE for Elderly Independence (HOPE IV).

Figure 4.1
Age Distribution of CHSP and HOPE for Elderly Independence Participating Residents



Sources: Baseline survey of CHSP participants; Evaluation of the HOPE for Elderly Independence Demonstration Program Evaluation, First Interim Report, Table 5-1 (excluding "not ascertained").

To be eligible for either program, residents must have three or more limitations in ADLs; furthermore, HOPE IV eligibility is limited to the elderly.

As Figure 4.1 shows, elderly HOPE IV participants are substantially younger than CHSP elderly participants; in particular, HOPE IV has considerably fewer old-old (85 or older) residents than CHSP.

Overall, 69 percent of CHSP participants are 75 or older (78 percent of elderly CHSP participants are in this age range), compared with 51 percent of HOPE IV participants. Data from other studies help place the age of CHSP participants in broader context. Hawes and colleagues have recently studied residents of nursing homes and board and care facilities.[2] In recent multistate surveys, Hawes and colleagues found that 81 percent of nursing home residents and 64 percent of board and care residents were age 75 or older (Hawes et al., 1995b). CHSP participants, with 69 percent in this age group, fall in between the residents of these two kinds of facility. This indicates that CHSP services are targeted to the age group that is at high risk of needing higher levels of care in nursing homes, board and care homes, or other higher level care environments.[3]

4.3 Other Demographic Characteristics

Table 4.3 summarizes other demographic characteristics of CHSP residents. Among both the elderly and non-elderly CHSP participants, the population is predominantly female and white. Only a small percentage of participants are Hispanic.

[2]Board and care facilities generally fall between nursing homes and congregate housing on the continuum of care. Board and care homes generally are nonmedical, community-based residential settings that provide assistance with ADLs, transportation, meals, or other services similar to those offered by CHSP.

[3]Comparisons of ADL limitations by age are provided in Section 4.5.

Table 4.3 Demographic Characteristics of CHSP Participants

	Elderly (%)	Non-elderly (%)
Marital status		
Widowed	69.6	4.0
Married	9.8	6.6
Separated/divorced	11.4	14.4
Never married	9.2	75.0
Living arrangements		
Live alone	87.8	43.4
Gender		
Female	82.7	67.1
Male	17.3	32.9
Race		
White	93.2	97.4
Black	5.9	1.3
American Indian	0.5	1.3
Asian/Pacific Islander	0.3	0.0
Ethnicity		
Hispanic[a]	1.7	2.6
Number of cases	588-590[b]	76

Source: Baseline survey of CHSP participants.

[a] Hispanic can be of any race.

[b] See footnote b to Table 3.1 The number of cases shown is the range of the number of cases for questions that have little variation in the number of respondents.

The majority of elderly CHSP residents are widowed or divorced and live alone. Of those who do not live alone, most live with a spouse or partner; only a very small number live with a child or other relative.

In terms of gender, race/ethnicity, and marital status and living arrangements, elderly CHSP participants are similar to elderly home health recipients and residents of board and care homes (which offer some services and supervision) and nursing homes. Most of the elderly residents of these other kinds of facilities also are white women who are not married and who live alone (Griffith, Greene, Stewart, Hawes, Mor, and Wildfire, 1995; National Center for Health Statistics, 1996).

The non-elderly CHSP residents are more likely than the elderly to have never married. More than half of these non-elderly residents have someone else living in the apartment with them. The other person is typically a friend or "other person," rather than a spouse.

4.4 Social Resources and Interaction

Table 4.4 shows participating residents' availability and frequency of interaction with family and friends. These data make clear that, although most elderly residents live alone, they are not socially isolated. The great majority of elderly residents have at least one relative living within an hour's drive of them. Almost two-thirds of these residents talk by phone with a family member at least several days a week, and more than half of them see a family member at least once a week—more than a quarter of them see a family member several days a week or daily.

Non-elderly CHSP participants are somewhat less likely than the elderly to have family living nearby or to speak to or see family frequently. This may be because more of the non-elderly residents are in specialized housing that is not available in as many locations as is housing that can accommodate elderly residents. Even among the non-elderly CHSP residents, however, almost three-quarters have family nearby, two-fifths speak with family by telephone at least several times a week, and a third see family at least once a week.

Table 4.4 Social Resources and Interaction of CHSP Participants

	Elderly (%)	Non-elderly (%)
Number of family living nearby (within 1 hour)		
3 or more	33.7	29.7
1-2	50.6	44.6
None	15.7	25.7
Number of cases	579	74
How often resident speaks with family by telephone		
Daily	38.2	18.4
Several days a week	25.4	21.1
One day a week	15.9	14.5
Less than one day a week, no family, or no telephone	20.5	46.0
Number of cases	579	76
How often resident sees family		
Daily	6.2	2.6
Several days a week	22.0	7.9
One day a week	29.6	21.1
2-3 days a month	16.0	18.4
One day a month or less, or no family	26.2	50.0
Number of cases	582	76
How often resident speaks with friends by telephone		
Daily	33.5	26.7
Several days a week	26.9	18.7
One day a week	13.3	10.7
Less than one day a week, no friends or no telephone	26.3	43.9
Number of cases	565	75
How often resident sees friends		
Daily	33.6	29.3
Several days a week	18.2	24.0
One day a week	11.0	12.0
2-3 days a month	11.4	9.3
One day a month or less, or no friends	25.7	25.3
Number of cases	571	75

Source: Baseline survey of CHSP participants.

Both elderly and non-elderly CHSP residents have frequent interactions with friends.[4] Half or more of them see friends at least several days a week. And many residents, especially among the elderly, talk with friends by telephone daily or several days a week.

Table 4.5 shows that, consistent with the evidence of their degree of interaction with others, the large majority of residents who responded to the questionnaire say they have someone they can trust and confide in—an important indicator of social-psychological support. And, although a number of respondents say they feel lonely at least sometimes, relatively few report that they quite often feel lonely.[5]

Table 4.5 Social-Psychological Well-Being

	Elderly (%)	**Non-elderly (%)**
Resident has someone to trust and confide in	89.2	77.1
Resident feels lonely		
Quite often	20.6	28.6
Sometimes	43.4	45.7
Almost never	36.0	25.7
Number of cases	491	35

Source: Baseline survey of CHSP participants.

[4]The questions about both family and friends asked frequency of contact with those who do not live in the same apartment with the respondent.

[5]Some residents were unable to answer for themselves, generally because of cognitive impairment. The service coordinator provided factual data for them, but was not asked the attitudinal questions. For this reason, the number of cases is smaller for the attitudinal questions, and the results cannot necessarily be generalized to those who were not able to answer for themselves.

4.5 Functional Status and Health of CHSP Participants

Impairments in activities of daily living make people less able to function on a day-to-day basis and place them at risk of institutional placement or death. This is true for impairments in IADLs as well as physical ADLs (Fillenbaum, 1985; Manton, 1988). Health conditions also require care and raise risks of death or needs for higher levels of care.

This section analyzes data on the ADL and health impairments of CHSP participants and relates these to other data on comparable populations, to HUD rules for CHSP eligibility, and to assistance needs.

4.5.1 Impairments in Activities of Daily Living

HUD's rules specify that elderly residents must have impairments in three or more ADLs to be eligible for CHSP. The activities in the HUD ADL list include: eating or preparing food, bathing, dressing, grooming, getting in and out of bed and chairs, walking, toileting, and household management.[6]

Table 4.6 shows the number of ADL impairments the elderly CHSP participants report having, by age.

Overall, three-quarters of elderly CHSP residents report having limitations in three or more ADLs, and half report six or more limitations. As would be expected, the degree of impairment is related to age: 18 percent of the oldest-old (age 85+) report fewer than three impairments and 58 percent report six or more, compared with 32 percent and 38 percent, respectively, for the youngest old residents (age 62-74).

[6]Residents were asked about limitations in a list of 13 specific functions in these ADL areas. They were coded as having impairment in an ADL if they reported having "some difficulty" or "a lot of difficulty" in performing a function or that they are "unable to [perform the function] by myself."

Table 4.6 ADL Limitations of Elderly Participants

Number of ADL limitations	Resident Age (%)			
	All Elderly	62-74	75-84	85+
0-2	24.7	32.0	26.8	18.4
3-5	25.5	29.7	24.7	24.1
6+	49.8	38.3	48.5	57.5
Number of cases	591	128	235	228

Source: Baseline survey of CHSP participants.

It appears from the data in Table 4.6 that about one fourth of elderly CHSP participants do not meet the ADL eligibility criteria for the program. At least part of this is attributable to the fact that the data on number of ADL impairments come from resident self-report, rather than a professional assessment of resident need. (Rubenstein, Schairer, Weiland, and Kane, 1984). Residents may tend to underreport ADL impairments for several reasons. They may believe they function better than they actually do. This may be especially true for those who have experienced a relatively slow decline in functional status and have lived in the same place, so familiarity with the setting can help mask the effects of declining capability. In other cases, residents may fear that reporting significant impairments could place them at risk of nursing home placement or other loss of independence. Although the data collection staff assured respondents that their data would be kept confidential, it is likely that some still had this fear.

In addition to self-report effects, sites differ in their assessment procedures in ways that may result in differences between the site's assessment and the measure based on resident self-report. Examination of assessment instruments and procedures of CHSP projects shows ways these differences may occur. For example, a resident who needs assistance in parts of tasks may be assessed by the program as having an impairment, even if the resident may report himself/herself as able to perform the function. Some assessments use a scoring system to assess impairment level, rather than the ADL counts used in the analysis of resident self-report data. In

other cases, the sites "mapped" their usual assessment procedures and scoring to the HUD list and computed scores for each of the HUD ADLs; this may result in some differences between the assessment of the resident and the resident self-report.

The longitudinal evaluation will examine stability or change over time in resident ADLs and will relate these to program participation and services. Thus, the longitudinal evaluation component will be able to give a better picture of how CHSP supports residents in their continued functioning over time. Also, it will be possible to explore whether there is a closer match over time between HUD regulations about ADL-based eligibility and the patterns for residents, as residents become frailer or as sites develop more experience in using the HUD definitions and rules.

Preliminary data from the HOPE IV evaluation suggest that their population has a similar level of overall impairment (77 percent have three or more ADL limitations), but that the level of impairment does not vary by age (the percentages with three or more limitations for the different HOPE IV age groups are: 62 to 74, 78 percent; 75 to 84, 75 percent; and 85+, 78 percent) (Westat, 1995). The difference in participant ages is consistent with differences in program design and execution—with HOPE IV actively seeking elderly residents in the community who are eligible both for housing and supportive services assistance, and CHSP directing its services to current housing residents who show the more typical patterns of greater frailty with increasing age.

Data from the 1987 National Medical Expenditure Survey (NMES) allow a rough comparison between the level of impairment of CHSP residents and that of the general community resident population of the elderly (LaPlante and Miller, 1992). The NMES data use a somewhat different categorization of ADLs, have a different age cutoff for the younger old (65 vs. 62 for HUD), and provide tabulations of the number with one or more ADL

impairments. With these caveats, the comparable percentages with one or more ADL limitations are:

	Age		
	62(65)-74	75-84	85+
NMES	12%	27%	58%
CHSP	84	95	98

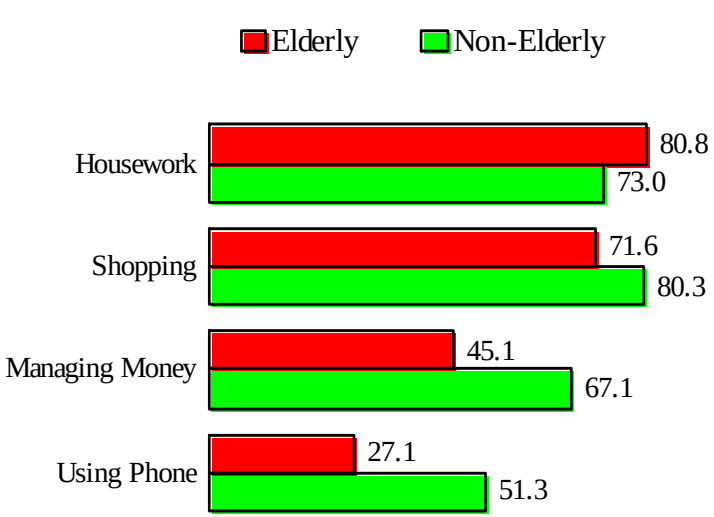
Although not exact, this comparison indicates that the CHSP is reaching a population that is substantially more impaired than the population of community resident elderly in general. This is one indication that CHSP services are being targeted to frail elderly.

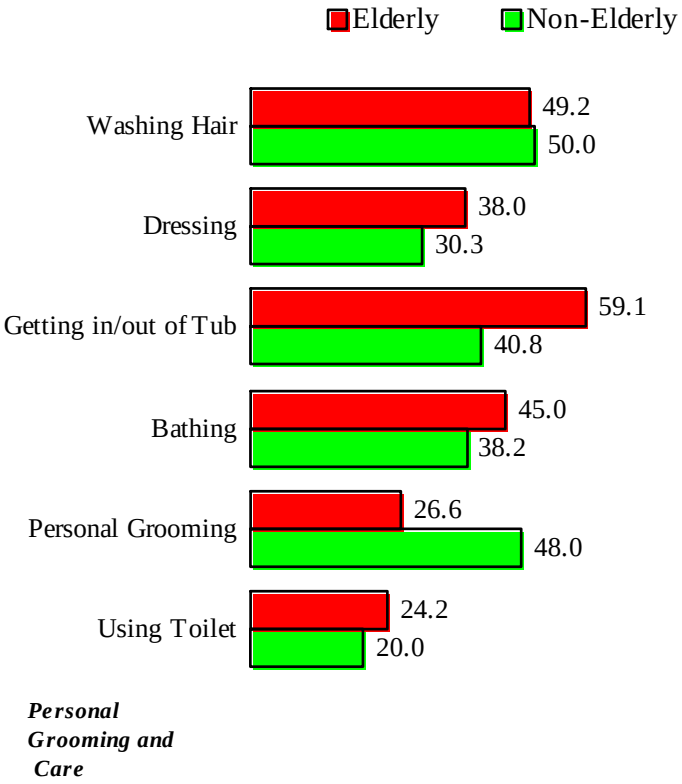
CHSP participating residents' ADL limitations can be grouped into categories: household management (light housework, shopping, managing money, using telephone); transferring (getting in or out of bed or chairs), personal grooming and care (washing hair, dressing, getting in and out of the tub, washing self, personal grooming, using toilet), and eating (preparing food or feeding self).

As Figure 4.2 shows, the most commonly reported ADL limitations of the elderly involve household management activities. Over three-fourths of the elderly residents have at least some difficulty doing light housework and more than two-thirds have trouble shopping. This is higher than the noninstitutionalized elderly population studied in the 1987 National Medical Expenditure Survey. In that survey, 11 percent had problems shopping and 10 percent had problems doing light housework (Leon and Lair, 1990).

Elderly CHSP participants also report problems with transferring (getting in or out of bed or chairs), higher-level, self-care activities such as getting in and out of the tub, washing their hair or washing themselves, and preparing meals.

Figure 4.2
ADL Limitations of CHSP Participants

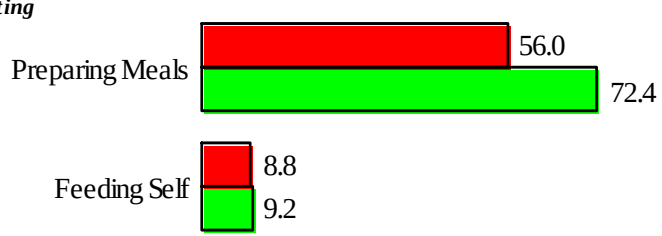




Personal Grooming and Care

Household Management

Food and Eating



Transferring

Source: Baseline survey of CHSP participants.

Non-elderly CHSP participants are less likely than the elderly to have mobility or transferring problems but are relatively more likely to have problems with such areas of household and personal management as shopping, preparing meals, managing money, and using the telephone.

A relatively small number of CHSP participants report limitations in the most basic activities: feeding and using the toilet. About 10 percent of both groups report difficulties feeding themselves, and 20 to 25 percent report having problems in using the toilet (getting on or off the toilet or wiping themselves).

Data from Hawes et al. (1995b) on residents of board and care facilities and nursing homes provide a context for these figures. They measured ADLs by receipt of assistance from another person, which yields lower estimates than need for assistance. Based on this measure, they report that 46 percent of board and care residents and 97 percent of nursing home residents receive help bathing—compared with the 45 percent of elderly CHSP participants who need help washing themselves and the 59 percent who need help getting in and out of the tub. They also found that 5 percent of board and care residents and 72 percent of nursing home residents receive help feeding themselves; this compares with a figure of 9 percent of CHSP participants needing such assistance.

Overall, the comparisons show that CHSP participants are considerably more impaired than the general population of the elderly. They appear less impaired than nursing home residents and possibly somewhat less impaired than board and care facility residents.

4.6 Health Status and Experience

4.6.1 Health Status and Limitations

In addition to limitations in functional capabilities, CHSP participants—especially the elderly—have medical conditions and health limitations. Table 4.7 summarizes information on the medical conditions and activity limitations of CHSP participants.

Overall, elderly CHSP participants' medical conditions are consistent with their limitations in ADL functioning and, in a number of cases (e.g., residents with diabetes or those who have had serious falls), put them at further risk of needing higher levels of care. A number report hypertension, heart trouble, or diabetes. About one-tenth report having had a fall during the past year that caused them to seek medical care, and a smaller number had a fall that resulted in spending one or more nights in the hospital. About one-fourth report being bed- or chairfast for one or more days during the past month.

Compared to the elderly participants, the non-elderly have fewer serious medical conditions (hypertension, heart trouble, or diabetes), but they have physical and mental disabilities that limit their ability to live independently. Also, somewhat more of the non-elderly than elderly experienced a fall in the past 12 months that caused them to seek medical care, and about one-fourth spent one or more days confined to bed or a chair in the past month.

In their health status, as well as ADL limitations, CHSP participants are broadly similar to board and care residents and other recipients of community-based supportive services. For example, a probability survey of residents of North Carolina domiciliary care facilities found that 14 percent of residents had diabetes (Hawes et al., 1995a), and a study of elderly recipients of companion services found 10 percent with diabetes (Research Triangle

Institute, 1994). In the North Carolina domiciliary care survey, 12 percent of residents were found to have serious respiratory conditions, and 26 percent had hypertension.[7]

Table 4.7 Medical Conditions and Activity Limitations of CHSP Participants

Health measure	Elderly (%)	Non-elderly (%)
Have health condition:		
Hypertension	48.9	18.7
Heart trouble	39.4	17.1
Diabetes	19.7	11.8
Arteriosclerosis	19.5	9.2
Respiratory	19.0	14.5
Effects of a stroke	14.6	2.7
Number of days in bed or chair in past 30 days		
None	77.9	72.2
1-7	12.7	18.1
8 or more	9.4	9.7
Experienced fall during past 12 months and		
Sought medical care	11.5	18.4
Spent 1 or more nights in hospital	5.4	6.6
Number of cases	551-591	72

Source: Baseline survey of CHSP participants.

4.6.2 Health Care Utilization

Table 4.8 shows participating residents' use of medical and hospital care. These data give an indication of the degree of medical risk as well as medical services received.

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

A substantial majority of the participating residents has received medical services from a doctor at least once in the past 3 months.[8] This is consistent with the evidence that they have health conditions that require regular medical care and also indicates that a number are getting regular medical care. A third or more also have been a patient in a hospital emergency room in the past 12 months—either for emergency medical services (e.g., treatment for a fall) or for routine care.

A little more than one-third of the elderly residents and one-fourth of the non-elderly have spent one or more nights in the hospital during the past year. These data, like those on functional limitations and health conditions, point to the frailty of CHSP residents, especially the oldest among this group.

Table 4.8 Health Care Utilization by CHSP Participants

Health care utilization	Elderly (%)	Non-elderly (%)
Number of doctor visits in past 3 months		
None	19.5	10.1
1-2	45.4	32.0
3-5	25.0	30.4
6 or more	10.0	27.5
Number of times patient in hospital ER in past 12 months		
None	57.1	64.9
1-2	34.7	17.6
3 or more	8.2	17.5
Number of nights in hospital in past 12 months		
None	64.0	75.7
1-2	4.1	8.1
3 or more	31.9	16.2
Number of cases	548-573	69-74

[8]This measure excludes hospital or nursing home stays or emergency room visits, which are not counted as doctor visits.

Source: Baseline survey of CHSP participants.

Data on board and care residents (Hawes et al., 1995b) show similar patterns of health service use: 89 percent have had one or more doctor's visits in the past year; 28 percent have been a patient in an emergency room in the past 12 months; and 32 percent have spent one or more nights in the hospital in this period.

4.6.3 Health Care Coverage

Coverage by Medicare, Medicaid, and/or private insurance plans is important for residents' current and potential use of health services to treat medical conditions and help maintain health. Also, these plans may cover services that complement CHSP's nonmedical supportive services or that provide an alternative to CHSP for some services.

Table 4.9 summarizes residents' reports of their insurance coverage. As this indicates, almost all have some insurance coverage. Most elderly residents are covered by Medicare. Additionally, more than half the elderly have private insurance, and a substantial

Table 4.9 Health Care Coverage for CHSP Participants

Health care coverage	Elderly (%)	Non-elderly (%)
Have coverage from:		
Medicare	90.4	59.7
Medicaid	37.5	92.1
Private Insurance	58.0	9.6
No insurance coverage	1.2	1.3
Number of cases	559-591	72-76

Source: Baseline survey of CHSP participants.

number have Medicaid coverage. Almost all the non-elderly participants are covered by Medicaid, and a substantial number also have Medicare coverage.

4.7 Discussion

This section has focused on the characteristics of CHSP participants: age, other demographic characteristics, ADL limitations, health status, and health service use. Data on community-resident U.S. elderly, residents of board and care facilities and nursing homes, and HOPE IV participants have been used to provide a context for the CHSP participant data.

Major findings and their implications include:

- CHSP participants have typically "aged in place" and have not had to move to receive supportive services.

  This conforms to most older Americans' preference to stay in their homes or local community and receive services there. HOPE IV participants have continued living in the community, but a number have had to move to get HOPE IV services. The effects of staying in place versus moving on participants long-term functioning and satisfaction with the program will be more fully analyzed at the end of the two-year period.

- Participants include a number of very old residents and residents with multiple ADL limitations.

  Their age and frailty are substantially greater than the general population of U.S. elderly. In a number of ways, CHSP participants are similar to residents of more restrictive living environments—board and care facilities and, in some cases, nursing homes. Using an estimate from the present study that, in housing developments that have CHSP, about one fourth of residents participate in the program, this suggests that a substantial minority of residents of federally assisted housing need supportive services—consistent with the fact that many are aging in place. It also indicates that CHSP services are being delivered to a population at risk of needing higher levels of care.

- A minority of participants report having fewer than three ADL limitations.

  This may have several explanations: older persons tend to rate themselves as less impaired than others would; sites use ADL measures that do not directly map to HUD ADLs; or, in some cases, residents who do not strictly meet program requirements are being admitted into CHSP. This will be explored further in longitudinal analyses of resident functional status and services.

- Residents have medical coverage and use health services.

  The emphasis of CHSP is on nonmedical supportive services. The data on health service use indicate that CHSP participants are broadly similar to residents of board and care facilities in this area. Supportive services, particularly combined with case management, can be valuable in identifying participant needs for health services and getting residents to care (e.g., through transportation services). The evaluation will monitor resident use of health care over time, as the program matures and residents continue to become older and frailer.

5. CHSP SERVICES

CHSP provides a broad range of nonmedical support designed to meet functional needs of residents and help them continue living for as long as possible in a home environment. Major categories of service include one or more meals (including a hot meal) daily, housekeeping, transportation, assistance with shopping, other home management (money management, assistance with using telephone), personal care assistance (e.g., grooming, dressing), health-related support (e.g., health screening, health education), and personal emergency response systems.

This section analyzes data on the services offered by CHSP projects and on current use of supportive services and pre-CHSP service use by CHSP participants. Data for these analyses come from two sources: the annual reports provide data on services provided by CHSP, and the resident surveys provide data on service utilization.

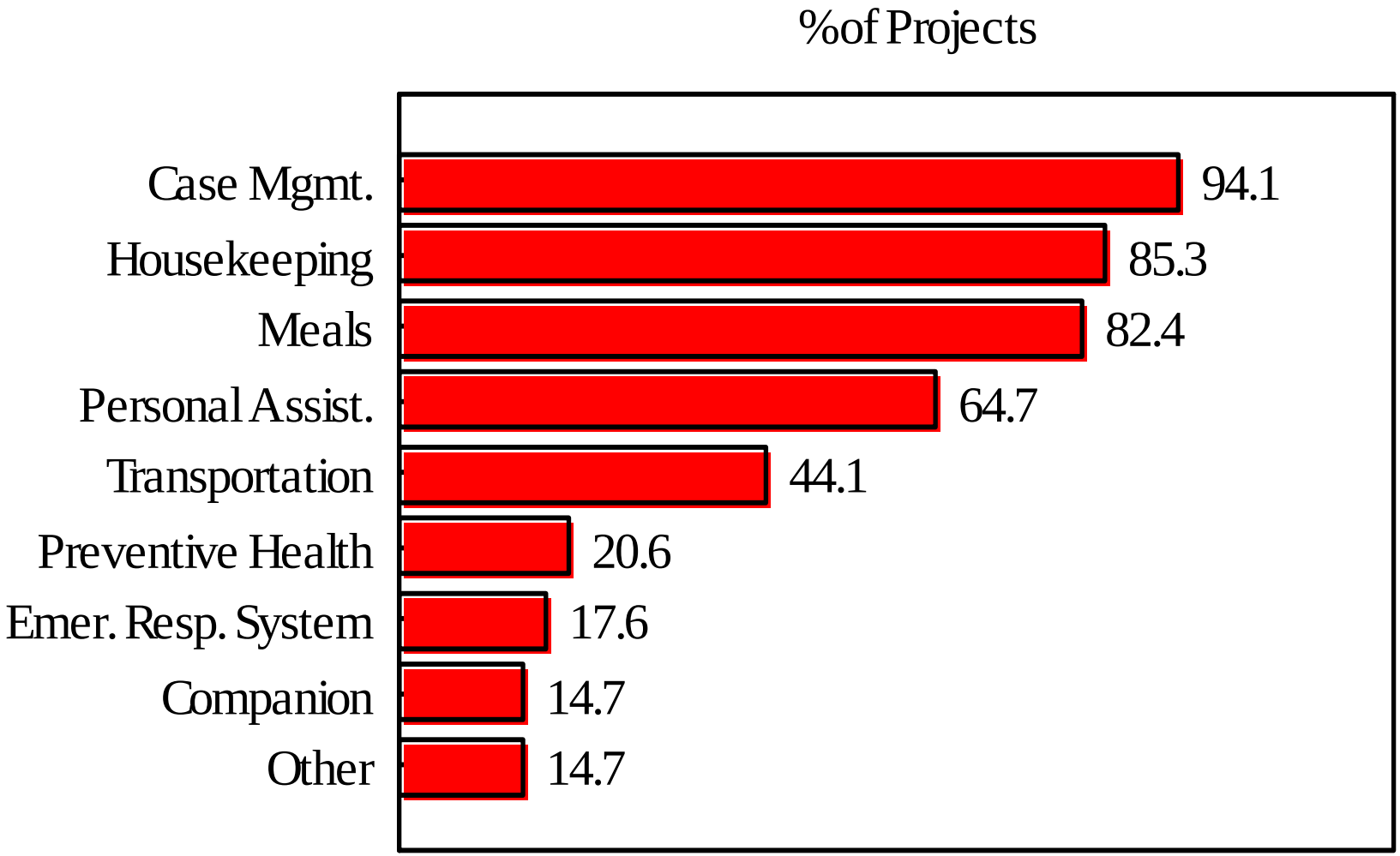
5.1 Services Provided by CHSP Projects

Figure 5.1 shows the services provided by the CHSP projects. The large majority provide case management, housekeeping, and meals.[1] A number of sites also provide personal assistance and transportation under CHSP. Other services—including preventive health (e.g., wellness programs, preventive screening, health education), personal emergency response systems, and companion services—are offered by some sites.

Approximately equal numbers of sites offer all five of the categories of service (case management, meals, housekeeping, personal assistance, and transportation) listed in the annual reports to HUD (34 percent), four services (34 percent), or fewer than four services (31 percent).

[1]All projects are required to provide meal services for participating residents. The seven projects that did not report any costs for meals include two projects that indicated in their budgets they would provide meals without CHSP or matching funds and five that had not yet started planning meal services at the time they submitted their first annual report.

Figure 5.1
Services Provided by CHSP Projects



5.2 Data on Use of Supportive Services by Participating Residents: Types of Services Used

The resident questionnaire asked participating residents about a number of specific activities of daily living and, for each activity, asked about assistance they receive for carrying out that activity. In addition, the questionnaire asked participants about other services that provide important support but do not have a one-to-one mapping to a specific ADL limitation (e.g., transportation, preventive health services).

For each specific area of ADL functioning and support, the questionnaire asked about:

- Current receipt of assistance: whether the resident receives assistance with the function and, if so, the source of assistance (CHSP, another program, informal help) and how frequently the resident receives the assistance.[2]
- Assistance received prior to CHSP: whether the resident received assistance with the activity before CHSP and, if so, the source from which the assistance was received (from a program or informal help).

5.3 Use of Services by Elderly CHSP Participants

5.3.1 Current Use of Services

Table 5.1 summarizes the services used by elderly participants, the sources from which they receive those services, and the most typical (modal) frequency for each service. The services are grouped by major ADL areas and, within each area, by clusters of related activities. The bottom section of the table presents data on services that do not directly map to ADLs (e.g., transportation, health screening/education).

[2]In developing the questionnaire, consideration was given to asking questions separately for CHSP and other services. This was not done, however, for several reasons: it would be more burdensome for respondents to be asked separately about different services, and, for those residents who receive assistance from more than one source, the extent to which their needs are met reflects the overall service "package" rather than each individual source of service.

Table 5.1 Services Currently Used by Elderly CHSP Participants, from CHSP and Other Sources

Service	Service users		Source of service for service users (%)			Modal frequency of use
	Percent of total	Number	CHSP	Other[a] program	Informal	
ADL Support Services						
Household management						
Housework	82.4	487	70.0	27.5	12.7	1 day a week or more
Shopping	64.8	383	18.0	22.2	75.2	1 day a week or more
Managing money	39.6	234	8.1	6.8	89.3	1 day a month
Using telephone	9.5	56	21.4	8.9	82.1	Every day
Transferring						
Getting in/out of chair/bed	7.8	46	30.4	32.6	67.4	Every day
Personal grooming and care						
Washing hair	41.1	243	20.2	32.5	51.9	1 day a week or more
Getting dressed	12.7	75	20.0	48.0	45.3	Every day
Getting in/out of shower/tub	32.7	193	33.7	52.3	20.7	Several days a week
Washing self (bathing)	30.3	179	30.7	53.1	17.3	Several days a week
Personal grooming	14.0	83	38.6	44.6	37.3	Every day
Using toilet	4.7	28	17.9	39.3	53.6	Every day
Food and eating						
Congregate meals	72.5	428	65.2		6.5	Both weekdays & weekend
Home-delivered meals	29.3	173	47.4		15.0	Both weekdays & weekend
Preparing meals	27.9	165	39.4		44.2	Every day
Feeding person	3.2	19	26.3		73.7	Every day
				45.7		
				34.5		
				21.1		
Other Services						
Transportation	66.7	393	46.6	35.4	42.0	Less than 1 day a week
Health screening/Education	42.3	246	27.6	56.9	20.7[b]	Less than 1 day a week
Personal emergency response system	61.0	360	31.9	57.2	12.5	NA[c]
Mental health services	9.6	56	21.4	67.9	19.6	Less than 1 day a week
In-home health care	34.6	203	18.7	78.3	10.8	Several days a week

Source: Baseline survey of residents.

[a]"Other programs" include home health agency, home chore agency, visiting nurses association, meals on wheels, and other formal sources of assistance other than CHSP.

[b]Informal help includes "someone else" as a response for who provides health screening.

[c]NA = Not applicable

Overall, four services receive the most use by elderly CHSP participants: housework, congregate meals, transportation, and shopping (65 to 82 percent). These correspond to major areas of ADL limitations.

Assistance with personal grooming and care (washing hair, getting in and out of the shower or tub, bathing, personal grooming, and dressing) is reported by smaller numbers of residents (13 to 41 percent). In part, the lower use of assistance for these than for instrumental services reflects smaller proportions of participants who need the service. In addition, however, comparing the data on services received with the data on ADL limitations (Figure 4.2) indicates that a number of participants who have some difficulty performing physical ADLs still handle these functions themselves, without regular assistance from others.

The proportion of elderly CHSP participants who receive help with transferring (getting in and out of bed or chair), toileting, or feeding is small (3 to 8 percent). These numbers may increase over time as residents currently receiving limited services become frailer and need more help.

CHSP provides preventive health services (e.g., health education, health screening) but not medical care. Overall, 42 percent of elderly participants report getting preventive health services, and they get these services from CHSP and from other programs. In-home health care and mental health services, received by some participants, are typically provided by other programs. Some kinds of day-to-day assistance—bathing, getting in and out of the shower or tub—are also provided from programs other than CHSP. In many cases, these may be services provided by home health aides as part of a home health program.

The frequency of use of services varies from daily to weekly or less frequently. Help with such activities as transferring, feeding, personal grooming, or dressing is typically received on a daily basis. Meal services (congregate meals, in-home meal delivery, or meal preparation) are generally received daily, on both weekdays and weekends. Housework,

shopping, and help with washing hair are generally received one or more times a week, and help in bathing (getting in or out of the shower or tub and washing) is typically received several days a week.

Other assistance is received less frequently. Although transportation is available, it is typically used less than once a week by elderly CHSP participants. And other services—such as mental health services, health education or screening, and money management—also are generally used less than once a week.

For the most part, these patterns of use are consistent with the frequency and time patterns of need. Basic physical assistance (e.g., transferring, feeding, toileting, dressing) is needed on a daily basis, whereas other kinds of help (e.g., housecleaning or shopping) are normally used less often or can be postponed if needed.

At this point, early in the implementation of the new CHSP, relatively small proportions of elderly participants need assistance with the kinds of activities that require daily assistance. Over time, needs for these services are likely to increase as the participants become frailer and less able to carry out daily physical care activities.

5.3.2 Sources of Assistance

The sources of assistance vary in ways that are consistent with CHSP regulations and with patterns of resident and family preference. In total, 58 percent of CHSP participants received housework assistance from CHSP (this is 70 percent of CHSP participants who get housework assistance from any source) and 47 percent of CHSP participants get congregate meals from CHSP (65 percent of those who get congregate meals from any source). Similarly, CHSP is an important provider of transportation services (in total, 31 percent of CHSP participants get transportation from CHSP; this is 46 percent of CHSP participants who get any transportation assistance).

Some forms of assistance are more commonly provided by informal sources (usually the family), although CHSP and other programs provide assistance to some residents. Help in

shopping and in money management are both provided by family members. Family members also help with other needs: using the telephone; getting in and out of bed or a chair; and, for a small number of participants, feeding the person. These findings are consistent with those of other research, which show that money management and help with shopping or errands are functions typically performed by family.

One implication of the data on family assistance and on frequency of interaction with family (Table 4.4) is that the family continues to be actively and directly involved with the participant and provides supportive services, even though those services are available from CHSP or other formal sources. That is, these findings support the view that formal services do not displace family support. This finding also is consistent with results of earlier research on CHSP (Sherwood et al., 1984) and other programs.

5.3.3 Use of Services by Elderly Participants Prior to CHSP

Residents who currently participate in CHSP and receive help in each of the ADL areas were asked whether they had received assistance with the same functional area before entering CHSP and, if they had, the source of assistance. Table 5.2 shows the responses to these questions.

Slightly more than half the residents who receive congregate meals (55 percent) said they had not received congregate meals before entering CHSP. For most other kinds of assistance, the majority of residents who currently receive help also had received help previously, generally from informal sources (mostly family members), from another program (e.g., home health agency, home choice agency, visiting nurses association), or both.

Table 5.2 Service Use by Elderly Participants Prior to CHSP Enrollment

Service	Number who currently use service	Received service prior to CHSP (%)	Received prior service from:	
			Other program (%)	Informal help (%)
ADL Support Services				
Household management				
Housework	487	58.9	57.8	45.1
Shopping	383	80.2	21.8	86.1
Managing money	234	81.1	5.9	95.7
Using of telephone	56	82.7	11.6	93.0
Transferring				
Getting in/out of chair/bed	46	71.1	28.1	81.3
Personal grooming and care				
Washing hair	243	71.4	32.4	69.4
Getting dressed	75	76.7	50.0	57.1
Getting in/out of shower/tub	193	64.7	65.5	37.0
Washing self (bathing)	179	67.4	63.8	37.9
Personal grooming	83	78.5	51.6	58.1
Using toilet	28	81.5	40.9	72.7
Food and eating				
Congregate meals	428	44.5	83.5	17.6
Home-delivered meals	173	64.9	79.8	26.6
Preparing meals	165	73.3	49.2	61.0
Feeding person	19	93.8	20.0	86.7
Other Services				
Transportation	393	79.4	43.7	65.7
Health screening/Education	246	77.8	59.9	40.7[a]
Personal emergency response system	360	55.5	78.6	21.9
Mental health services	56	75.9	78.0	24.4
In-home health care	203	72.8	87.8	12.9

Source: Baseline survey of residents.

[a]Informal help includes someone else as a response for provision of health screening.

The fact that residents had already been receiving some services before CHSP is not surprising for several reasons. The residents who entered CHSP were already frail at the time they entered the program. In many cases, the resident would not have been able to continue living independently without some assistance. Also, data on current assistance (Table 5.1) show that family members or other informal sources and other programs continue to be important sources of assistance to CHSP residents. This is consistent with policy and program philosophy. CHSP serves as one important source of assistance but is not designed or intended to be the sole help to frail elderly residents.

In another analysis, residents were asked if the amount of help they receive from family has changed since they entered CHSP and, if so, whether the change was the result of their participation. Overall, 87 percent of elderly respondents said the amount of help they receive from family had remained the same since they entered CHSP (6 percent said it had increased, and 7 percent said it had decreased). When asked about the effects of CHSP participation on family help, 14 percent said there had been an increase resulting from CHSP, and 22 percent said there had been a decrease resulting from CHSP. (The others said there had been no change (34 percent), or that the change experienced had not resulted from CHSP.)

These figures suggest that, for most older participants, assistance from CHSP has been added to on-going family help, rather than replacing it. The finding that 22 percent said the effect of CHSP had been to decrease family assistance (compared with 14 percent who said it had resulted in an increase) could be interpreted as a negative impact of CHSP—substituting formal services for previous family assistance. However, several factors need to be considered in interpreting the results. First, for the large majority of elderly participants, there has been no reduction in the amount of family help since entering CHSP. Second, in some cases, CHSP may have taken burdens off the family that allowed the family to focus its assistance in the key family areas, such as shopping, money management, and, for those who need it, help with such intensive, frequent needs as feeding and toileting. Third, research suggests that receiving at least some assistance from formal providers, rather than being dependent solely on family or other informal sources, is associated with better psychological well-being, possibly because people are less likely to feel they are a burden or that they have no alternatives to dependence on family

(Coward, 1982, and Shenk, 1987, cited in Stoller and Cutler, 1993). Particularly in a case like CHSP, in which many residents pay fees for the services they receive, formal care sources may increase residents' independence as well as their ability to function. This explanation is consistent with the fact that, among elderly CHSP participants, 25 percent said their confidence in their ability to deal with daily activities had increased since they entered CHSP (74 percent said their confidence was unchanged, and only 2 percent said it had decreased).

5.4 Use of Services by Non-Elderly CHSP Participants

5.4.1 Current Use of Services

Table 5.3 shows the services used by non-elderly residents, the sources from which they receive those services, and the typical frequency for each service.

Like the elderly residents, the non-elderly CHSP residents with disabilities use housework, congregate meals, transportation, and shopping services most (72 to 85 percent). In addition, a large proportion of non-elderly patients receive health education and screening and help with managing money and meal preparation. Assistance with physical activities of daily living is reported by smaller numbers of non-elderly than elderly (5 to 35 percent). Very few non-elderly residents receive help with transferring, toileting, or feeding. These patterns are consistent with the lower level of frailty of the non-elderly and the fact that they tend to need training and assistance with instrumental activities of daily living in order to be able to live independently.

Table 5.3 Services Currently Used by Non-Elderly CHSP Participants from CHSP and Other Sources

Service	Use of service		Source of service for service users (%)			Modal frequency of use
	Percent of participants	Number of users	CHSP	Other program	Informal	
ADL Support Services						
Household management						
Housework	75.0	57	89.5	38.6	10.5	1 day a week or more
Shopping	72.4	55	72.7	47.3	29.1	2-3 days a month
Managing money	61.8	47	68.1	59.9	14.9	1 day a week or more
Using telephone	38.2	29	96.6	37.9	24.1	Several days a week
Transferring						
Getting in/out of chair/bed	6.6	5	–[a]	–[a]	–[a]	–[a]
Personal grooming and care						
Washing hair	28.9	22	72.7	31.8	9.1	1 day a week or more
Getting dressed	14.5	11	45.5	45.5	45.5	Several days a week or more
Getting in/out of shower/tub	18.4	14	57.1	42.9	7.1	Several days a week
Washing self (bathing)	21.1	16	68.8	37.5	12.5	Several days a week
Personal grooming	35.5	27	81.5	37.0	11.1	Every day
Using toilet	5.3	4	–[a]	–[a]	–[a]	–[a]
Food and eating						
Congregate meals	80.3	61	95.1	39.3	4.9	Both weekdays and weekend
Home-delivered meals	52.6	40	87.5	45.0	5.0	Both weekdays and weekend
Preparing meals	60.5	46	76.1	54.3	19.6	Every day
Feeding person	0.0	0	–[a]	–[a]	–[a]	NA
Other Services						
Transportation	85.3	64	73.4	62.5	25.0	Every day
Health screening/education	71.1	54	42.6	64.8	24.1[b]	Less than 1 day a week
Personal emergency response	34.2	26	53.8	42.3	0.0	NA
Mental health services	36.8	28	7.1	67.9	28.6	1 day a week or less
In-home health care	21.1	16	50.1	67.9	0.0	Every day

Source: Baseline survey of residents.

[a]10 or fewer residents use service.
[b]Informal help includes "someone else" as a response for who provides health screening.

Data on non-elderly participants' receipt of help from CHSP are:

- 68 percent of non-elderly CHSP participants receive housework assistance from CHSP (this is 90 percent of CHSP participants who get housework assistance from any source),
- 77 percent get congregate meals (95 percent of those who get congregate meals from some source),
- 85 percent get transportation from CHSP (74 percent of CHSP participants who get any transportation assistance), and
- 72 percent get assistance shopping from CHSP (73 percent of non-elderly CHSP participants who get shopping assistance from any source).

Services such as mental health, home health care, and health screening are mainly provided by other programs.[3] Family members provide some help with other needs (e.g., transportation, shopping, and dressing on some days); however, the majority of assistance for the non-elderly is provided by the CHSP program.

Like the elderly, non-elderly CHSP residents tend to get congregate meals on both weekdays and weekends. Housekeeping is typically received once a week. However, in contrast to the elderly, the non-elderly tend to use transportation every day; and other instrumental assistance, such as help managing money, is provided as often as once a week.

Personal assistance (help washing hair, bathing, grooming or dressing) is used as often as daily and as little as one or a few days a week.

[3]Under the regulations, CHSP can provide "non-medical supervision, wellness programs, preventive health screening, [and] monitoring of medication consistent with state law", but not direct health care or mental health services (236 Fed. Reg. 58048 [1992]).

5.4.2 Use of Services Prior to CHSP

Table 5.4 summarizes data on prior service use for non-elderly residents who currently receive assistance from CHSP.

More than two-thirds of the non-elderly CHSP participants who receive congregate meals said they had received congregate meals before entering CHSP. For most other kinds of assistance, the majority of residents who currently receive help also had received help before. The usual source of previous help was from other programs, although some help was received from informal sources.

Non-elderly CHSP participants include persons with mental retardation or developmental disabilities, persons with severe and persistent mental illness, and persons with physical disabilities, as well as persons with temporary disabilities. In view of the kinds of disabilities these non-elderly participants have, it is not surprising that they, too, had received some services prior to CHSP. Had they not received services before, it seems likely that they would not have been able to function as independently as they did.

Among non-elderly participants, 87 percent said there had been no change in the amount of help received from family since entering CHSP; 4 percent said there had been an increase; and 9 percent said there had been a decrease.

5.5 Discussion

The data on service availability, use, and sources address several of the major evaluation questions.

- Nearly all sites provide several categories of service under CHSP—case management, housekeeping, and meals—and two-thirds provide personal assistance.

Table 5.4 Service Use by Non-Elderly Participants Prior to CHSP Enrollment

Service	Number who currently use service	Received service prior to CHSP (%)	Received prior service from:	
			Other program (%)	Informal help[b] (%)
ADL Support Service				
Household management				
Housework	57	78.4	67.5	40.0
Shopping	55	84.3	67.4	41.9
Managing money	47	97.7	78.6	28.6
Using telephone	29	96.0	83.3	29.2
Transferring				
Getting in/out of chair/bed	5	–[a]	–[a]	–[a]
Personal grooming and care				
Washing hair	22	7	68.8	31.3
Getting dressed	11	6	–[a]	–[a]
Getting in/out of shower/tub	14	.	–[a]	–[a]
Washing self (bathing)	16	2	58.3	41.7
Personal grooming	27	–[a]	69.6	30.4
Using toilet	4	58.3	–[a]	–[a]
		75.0		
		92.0		
		–[a]		
Food and eating				
Congregate meals	61	70.2	95.0	7.5
Home-delivered meals	40	80.6	82.8	24.1
Preparing meals	46	90.5	71.1	34.2
Feeding person	0	NA	NA	NA
Other Services				
Transportation	64	85.0	80.4	39.2
Health screening/Education	54	90.6	85.4	20.8[b]
Personal emergency response system	26	52.0	92.3	7.7
Mental health care	28	85.2	73.9	30.4
In-home health care	16	56.2	–[a]	–[a]

Source: Baseline survey of residents

NA = not applicable

[a]10 or fewer residents received service.

[b]Informal help includes "someone else" as a response for who provides health screening.

- Residents make use of these and other services, from CHSP and other sources. In particular, large proportions of both elderly and non-elderly CHSP participants receive assistance with housework, shopping, and transportation and participate in congregate meals.

- The elderly and non-elderly differ in receipt of some other forms of assistance, in ways that would be expected given their functional and other limitations. The elderly are more likely to get help with getting in or out of a chair or bed and with washing their hair. The non-elderly are more likely to receive assistance with money management.

- The two groups differ in the relative importance of CHSP and informal sources. For both the elderly and non-elderly, CHSP is the main source of help with housework and congregate meals. For the elderly, family members play the major role in other household management tasks (shopping, managing money, using the telephone) and in such personal assistance as transferring, washing hair, dressing, and feeding. This is consistent with the time demands of many of these needs, as well as the fact that more of the elderly than non-elderly live with another family member or have family nearby. The non-elderly depend more on CHSP than on informal sources or other programs for household management, consistent with their support needs and the fact that somewhat fewer of the non-elderly than the elderly have family living nearby and visiting frequently.

- One important question is: Has CHSP resulted in an increase in the total amount or frequency of assistance to participants, or has it displaced other sources of assistance? The results indicate both effects happen to some extent. On the one hand, the majority of residents who currently receive CHSP services had previously received the same categories of service, many of them from another program. On the other hand, (1) the data show that family or other informal sources as well as other programs continue to provide services to many residents, and (2) most participants said the level of family assistance has remained the same after entering CHSP as it had been before. And a number of residents receiving help from CHSP had not received the same kind of help from another source before entering the program. Thus, on the whole, it appears that CHSP participation has resulted in an increase in needed assistance.

- Data on sources of different services indicate that the average participant receives help from more than one source (that is, the sum of the percentages for the different sources is greater than 100 percent). Although this does not necessarily mean that the total amount of services received by a participant increased (since there could be an offsetting reduction in the amount received from another source), these data lend additional support to the conclusion that, for at least a number of residents, the total amount of assistance has increased.

- A few report that family help has decreased as a result of CHSP participation. This suggests some degree of displacement of prior services by CHSP. However, the effect is small and, even for these cases, greater reliance on CHSP may result in better services and quality of life for the resident, since it makes residents less dependent on family and may free family to provide the kinds of informal support that residents prefer to get from families and families prefer to give.

6. PROGRAM ADMINISTRATION

Several administrative features of the new CHSP differ from the predecessor CHSP. In particular:

- The requirements for funding the new CHSP include obtaining 50 percent or more of the program costs from matching funds provided by the grantee or a third party and 10 percent or more from resident fees.

- There is greater specialization and professionalization of the service coordinator role, with the requirements that the service coordinator have professional training and not have other administrative responsibilities as part of the service coordinator position.

This section examines these aspects of the new CHSP.

6.1 Funding for New CHSP

Under the new CHSP rules, grantees must provide at least 50 percent of their funding in the form of the match (cash, value of services or staff provided by a third party, some in-kind contributions, and the value of volunteer services), at least 10 percent from resident fees, and no more than 40 percent from HUD. Data from the first annual reports show that, on average, new CHSP grantees were close to attaining the required funding mix (Section 2.2).

6.1.1 New CHSP Service Costs

An important aspect of grantees' ability to achieve the required levels of funding from sources other than the HUD grant is the cost of services. Grantees need to meet several challenges simultaneously. First, they need to provide an array of services that meet the HUD requirements and the needs of their residents. Second, the services need to be provided at a cost that residents can afford—and are willing to pay—and that HUD and third parties can support.

Data from the first annual reports submitted by grantees are used to analyze the costs of services provided by the new CHSP. For each CHSP project, total costs for each service were used to calculate the average cost of services per participating resident, the unit costs for each service, and the costs of the service as a percentage of total CHSP costs.

The costs per participant—shown in Table 6.1—are determined by several factors: number of residents who use the service, amount of the service they use, and cost per unit for providing the services. In addition, the measure is based on figures for the whole year, although services may not have been available or used for the whole period. Thus, the first-year costs per resident may be higher than costs will be when the program is fully operational.

Table 6.1 Annual Per-Participant Costs for First Year of Services Provided by CHSP Projects

Development Type	Elderly and Mixed Residents		Non-Elderly Disabled Residents		Total	
Service	Median ($)	No. of Projects	Median ($)	No. of Projects	Median ($)	No. of Projects
Meals	$729	24	$3,464	1	$820	25
Personal assistance	637	18	2,847	3	646	18
Case management	605	26	305	2	557	28
Transportation	227	16	1,928	2	253	18
Housekeeping	237	23	991	2	237	25
Preventive health	223	6	NA		223	6
Emergency response system	81	5	NA		81	5
Companion	62	4	NA		61	4
Total cost	2,070	29	$3,922	3	$2,101	34
HUD cost	913	27	1,529	3	$925	32

Source: Grantee first annual reports. Calculated as total project costs for service for developments offering each service, divided by total number of residents participating in each service.

The median total cost per participant in Year 1 has been about $2,100; HUD's cost per participant was $925. Per capita costs for projects serving non-elderly persons with disabilities are on average higher ($3,922) than for projects serving elderly participants ($2,070). HUD's cost per participant in developments serving non-elderly persons with disabilities was about $1,500.

Three services have median costs per resident in excess of $500 per year: meals, personal assistance, and case management. Several factors help account for these costs. Participants typically receive meals and personal assistance daily or several times a week. Case management also is a regular and continuing process, perhaps especially so in the early period as residents are being enrolled and services started.

Other major services—housekeeping and transportation—are important but are typically used less frequently. Additional services offered by some projects have lower per-resident costs, both because some are low-cost services, and because they may be used infrequently or by relatively few residents. These include preventive health services, emergency response system, and companion services.

The per capita costs for the developments that serve non-elderly persons with disabilities tend to be substantially higher, especially for personal assistance and transportation services. For example, per capital costs for personal assistance were $2,847 for developments serving non-elderly residents and $637 for those serving elderly residents. The corresponding figures for transportation were $1,928 and $227.

Table 6.2 shows the median cost per unit of services, calculated for an hour of service or other unit (e.g., meal, one-way trip). Three services have average hourly costs in the range of about $10 to $20 per hour: case management, personal assistance, and housekeeping. These are generally consistent with costs for these services from other sources, such as home health or home chore services. Preventive health services are somewhat more expensive, consistent with costs of such professional services. Personal emergency response system costs, calculated on a monthly basis, are also about $25.

Table 6.2 Unit Costs of Services Provided by CHSP Projects[a]

Development Type	Elderly and Mixed Residents		Non-Elderly Disabled Residents		Total	
Service	**Median ($)**	**No. of Projects**	**Median ($)**	**No. of Projects**	**Median ($)**	**No. of Projects**
Emergency response system[b]	$25.59	6	--	--	$25.58	6
Preventive health[c]	25.38	3	--	--	25.38	3
Case management	18.28	28	13.97	2	18.28	30
Personal assistance	17.82	18	8.45	2	16.97	20
Transportation[d]	17.79	14	9.67	1	16.44	15
Housekeeping	12.61	24	21.92	1	12.63	25
Meals[e]	5.82	26	3.17	1	5.83	27
Companion	5.20	4	--	--	5.20	4
Number of projects		31		3		34

Source: Grantee first annual reports. Calculated as total costs of service divided by total units of service provided.

[a]Except where indicated, costs are given on a per-hour basis.
[b]Cost per month.
[c]Cost per examination.
[d]Cost per one-way trip.
[e]Cost per meal.

Companion services—friendly visiting, informal peer counseling, and other in-home informal supportive services—are often provided by older persons on a volunteer basis (which may include a small stipend). This volunteer participation helps explain the low hourly costs (about $5) for companion services.

Costs for meals and transportation are both somewhat higher than projected in the grantees' applications. Comments from grantees in several annual reports point to several factors that may have kept early costs relatively high. First, slow early enrollment of participants resulted in lower than expected utilization and higher unit costs. Second, unanticipated costs

(e.g., costs of providing low salt, low sugar, low fat diets) resulted in higher meal costs than planned. Unit costs of CHSP services may drop over time, as more residents enter the program.

Table 6.2 indicates that the unit costs for most services are somewhat lower for developments serving non-elderly than elderly residents. The higher costs per participant (Table 6.1) reflect the greater numbers of service hours and trips that staff provide to the non-elderly participants.

Table 6.3 presents data on the costs of individual services as a percentage of total CHSP costs for the projects. These reflect the combination of resident use, unit costs of services, and fixed costs for each area of service.

Overall, CHSP funding is concentrated in five areas: case management, meals, administration (not including case management), personal assistance, and housekeeping. The pattern of total costs is generally consistent with the unit costs and patterns of use of the different services (see Sections 5.3 and 5.4 for data on service utilization.)

Data on the range among the sites in the percentage of total costs for the different services show that the different CHSP projects have undertaken different strategies and service mixes to meet the needs of their residents. For example, the proportion of CHSP funds devoted to case management ranges from 3 percent in one site to 82 percent in another. Personal assistance costs range from virtually no cost at one site serving elderly only to 70 percent at another site serving non-elderly persons with disabilities. The CHSP projects serving elderly residents have their budgets concentrated in case management and meal costs, while those serving persons with disabilities spend most of their CHSP funds on personal assistance, meals, and transportation services.

Table 6.3 Costs of Services as a Percent of Total CHSP Costs[a]

Development Type	Elderly and Mixed Residents		Non-Elderly Disabled Residents		Total	
	Median	No. of	Median	No. of	Median	No. of

Service	(%)	Projects	(%)	Projects	(%)	Projects
Case management	39.1	29	17.1	2	36.2	31
Meals	24.8	26	23.8	1	24.6	27
Administration	15.0	31	12.9	3	15.0	31
Personal assistance	12.7	19	55.7	3	14.4	22
Housekeeping	13.6	24	8.4	2	13.5	26
Preventive health	8.9	7	--	--	8.9	7
Transportation	5.3	17	19.3	2	5.5	19
Emergency response system	0.6	6	--	--	0.6	6
Companion	0.4	5	--	--	0.4	5
Other	0.4	5	--	--	0.4	5
Number of projects		31		3		31

Source: Grantee first annual reports.

[a]For each project that offers a service, the percentage of total costs for a service was calculated as the total cost for that service divided by total Year 1 costs for the project. The table entries are the median percentages for the projects that offer each service. Because of this, the total median percentages do not sum to 100 percent.

It is important to note that these figures refer only to utilization of CHSP funds (from HUD, matching funds, and resident fees), not to the site's total service budget. For example, some sites may provide case management or other services through funding other than CHSP and thus provide the service even though it does not appear in the CHSP budget.

6.1.2 Fees for CHSP Services

Under the new CHSP, residents are charged 10 percent or more of their adjusted income for meals and additional fees for other services, up to 20 percent of their adjusted income. There is no sliding scale for fees, although fees can be waived for residents who have no income.

There has been a concern on the part of grantees and others that requiring the payment of fees may discourage participation by residents, because residents may fear they cannot afford to pay the fees or because they can get similar services from other sources for a lower fee or

without charge. Participant survey data describe the fees residents pay for services, as well as their attitudes about paying for services they receive.

6.1.2.1 Fees Paid by Participating Residents for CHSP Services

Table 6.4 shows the amount residents participating in CHSP say they pay for the services they get from the program. About one-fourth of participants say they do not pay for CHSP services. About 40 percent of elderly participants and nearly 60 percent of the non-elderly pay more than $25 per month for CHSP.

The fees paid by participating residents appear somewhat low. Data presented earlier (Table 2.1) show that, on average, the grantees obtained 8.5 percent of their first year funding from resident fees, somewhat below the 10 percent they were expected to obtain from this source. Taken together, the data on fees paid by residents and fees as a source of funding for services indicate that fees are below the level specified in the grant agreements. Subsequent rounds of the survey of service coordinators and grantees will ask questions to help resolve the apparent difference between fees paid by residents and the grant agreement.

Table 6.4 Fees Paid Per Month for CHSP Services

Amount paid for services	Percent of participants who pay	
	Elderly	Non-elderly
Do not pay	26.7	25.7
$1-25	33.6	15.5
$26-50	15.7	31.0
More than $50	23.9	27.6
Number of cases	535	58

Source: Baseline survey of CHSP participants.

In many cases, residents did not pay for services prior to CHSP. Table 6.5 shows, for each current fee level, the percent of participants who had not previously paid any fees for services.

Overall, 63 percent of elderly residents and 73 percent of non-elderly residents participating in CHSP had not previously paid for services.[1] This percentage is high (90 percent) among those who currently pay no fees, which may be accounted for by very low income among these participants. They would be likely to have fees waived for many programs. In addition, however, a large proportion of residents now paying fees had not previously paid fees. Thus, it appears that, for a number of participants, even the relatively low fees paid for CHSP services are an increase from paying no fees for services before CHSP. It may be that participants receive a larger number of services, get services more often, or get a coordinated set of services instead of the more fragmented service received before CHSP. It will be important to

Table 6.5 Percent of Participants Who Had Not Paid Fees Prior to CHSP by Current CHSP Fees

Current fee level	Percent previously did not pay fees			
	Elderly		Non-elderly	
	Percent	No. of cases	Percent	No. of cases
Do not pay	89.5	124	92.9	14
$1-25	47.7	153	–[a]	6

[1] Additional tabulations determined that all the residents in this analysis had received at least some services prior to enrollment in CHSP. Thus, the data show prior fee experience of those who previously received services, and the finding that a number had not previously paid fees cannot be explained by their not having previously received supportive services.

$26-50	64.5	62	–[a]	6
More than $50	52.8	106	–[a]	7
Overall	62.9	445	72.7	33

Source: Baseline survey of CHSP participants.

[a]Because there are fewer than 10 cases as a demonimator for calculating the percentages, the percentages are not presented in the table.

examine resident fees in relation to program participation over time and determine the effects of fees on continuing participation.

6.1.2.2 Participants' Attitudes about CHSP Fees

In addition to questions about the fees they pay, participants were asked whether those who can afford to pay for services should pay, whether they would be able to pay more for services and, if able, whether they would be willing to pay more.

The large majority of participants (92 percent of elderly and 84 percent of non-elderly participants) say they think it is a good thing that people who can afford it have to pay something for CHSP services.

Residents were asked whether they would be able to pay higher monthly fees than they currently do and, if they could afford to pay more, whether they would be willing to pay more for the same services they receive now (assuming their financial situation was about the same as it is now and if program rules changed to require payments).

Table 6.6 shows, for each current fee level, the percentage of participating residents who say they could pay more and, of those who say they could pay more, the percentage who say they would be willing to pay more for the services they currently receive.

These figures need to be interpreted with caution, both because the questions were hypothetical and somewhat complicated and because, especially for the willingness to pay question, the number of cases is small.[2] The data suggest that, among those elderly residents who entered the program—which excludes ones who thought they could not afford it—about one-fifth of them could pay at least something more than they currently pay and, among those, two-thirds would be willing to pay more.

Taken together, these figures suggest that about 15 percent of current elderly participants might be both able and willing to remain in CHSP if fees increased. Conversely, they suggest that raising fees could make it difficult or impossible for as many as 86 percent of current elderly participants to stay in the program. The percentages of non-elderly participants who could afford to pay more are even lower (16 percent), suggesting that increases in fees would have an even greater impact on those CHSP participants.

Thus, although many CHSP participants pay for services and value those services, their ability to pay more is limited—as would be expected for frail, low-income residents of federally assisted housing.

[2]Fewer than 10 of the non-elderly responded to the willingness to pay question, so their data are not reported here.

Table 6.6 Participant Report of Ability and Willingness to Pay More for CHSP Services, by Current Fee Level[a]

	Could pay more (%)				Willing to pay more (of those who could pay more) (%)	
Current fee level	**Elderly**	**No. of cases**	**Non-elderly**	**No. of cases**	**Elderly**	**No. of cases**
Do not pay	11.2	116	14.3	14	50.0	14
$1-25	26.9	149	–[b]	5	67.5	40
$46-50	15.0	60	–[b]	6	–[b]	9
More than $50	29.3	106	–[b]	7	61.3	31
Overall	21.6	431	15.6	32	66.0	94

Source: Baseline survey of CHSP participants.

[a]The questions about ability and willingness to pay more for CHSP services were asked only of residents who could answer for themselves; they were not asked in proxy interviews.

[b]Percentages are not presented for these responses because there are fewer than 10 cases as a denominator for calculating the percentages.

6.1.2.3 Service Coordinator Perspective on Impact of Resident Fees

The preceding results show that more residents than expected have paid low fees or no fees, and that relatively few say they would be able to pay higher fees. To provide further perspective, service coordinators were asked several questions about resident fees and the impact of fees on participation. Table 6.7 shows their responses to these questions.

As this table shows, the majority of source coordinators say residents use services from other sources at lower cost than CHSP services, and a number express concern that CHSP fees discourage participation or are a burden on participants. The issue of resident fees and the costs of services to residents has been an important concern for CHSP. The statutory fees for meals under CHSP and the requirement that CHSP obtain 10 percent of its funding from fees make the costs to participating residents for meals higher than meals from other sources (especially meals through the Administration on Aging funding). The problem of meal and other service costs has

been a reason for shutting down some programs, in both the old and new CHSP, and continues to be an area of concern.

Table 6.7 Service Coordinator Views on Resident Fees for New CHSP

	Percent
Service providers in the area provide free or very low cost services that residents use instead of CHSP	61.5
Fees have discouraged participation by at least some residents who need the services	50.0
Fees have been a burden on at least some participants	34.6
Number of cases	26

Source: Baseline source coordinator instruments.

The detailed responses by service coordinators give more in-depth perspective on how fees affect resident participation—including cases in which the services or fees are such that they are seen as not discouraging CHSP service use:

> Sometimes people will eat only one meal a day or have the housekeeping staff come only one time every two weeks, even though they need it more often.
>
> [Fees do not affect residents' choice of services because] the fee is calculated separately and is not based on the number of services per resident [from CHSP]. If a resident needs a service, they will get it. The fee is based on the resident's income.
>
> Most are grateful for the services because they are cheaper with CHSP ... Others ... could use AAA but it is not as reliable as CHSP.

The service coordinators' responses, taken together with participants' answers about ability and willingness to pay, show:

- CHSP services are valuable to participating residents—in addition, the data suggest that, in at least some sites, CHSP services are competitive with other available services in cost, quality and reliability.

- In at least some sites, supportive services are available for residents from other community sources.

- Residents generally endorse the value of paying for services, but are limited in their ability to pay more for the services they need and receive.

6.2 Service Coordination

The preceding discussion has focused primarily on specific types of services used by residents participating in the new CHSP. Although the utilization of specific services is fundamental to the program and its impacts on residents, it is also important to understand the role of service coordination in helping participants obtain and use services needed to help maintain their independence.

The new CHSP places special emphasis on service coordination, provided by professionally trained staff whose time is specifically committed to this activity.

Under HUD's definition,

> Primarily [service coordination] refers to the activity of linking a person to the supportive services or medical services that the individual needs which are provided by private practitioners or agencies in the general community. (CHSP Request for Grant Application OMB No. 2533-0084; p. A-8).

Residents' responses to the survey show the role of the CHSP service coordinator and others in linking the resident to needed services through providing information and helping arrange for the resident to get services. Data in Table 6.8 show that the majority of CHSP participants say that CHSP program staff provide them with information on services and help arrange for and get services for them. CHSP program staff are the most frequently mentioned source of these kinds of assistance.

Staff of other programs also provide information and access to services, though for substantially fewer of the CHSP participants. And, although family members play a role in linking some people to services, this is a much less common source of either information or access to services.

Table 6.8 Sources of Information about Services and Help to Access Services[a]

	Provides information on services (%)		Helps arrange for and get services (%)	
Source	**Elderly**	**Non-elderly**	**Elderly**	**Non-elderly**
CHSP program staff	86.4	68.6	80.4	81.2
Staff of another program	36.3	45.7	37.2	59.4
Family member	14.5	27.1	21.0	5.8
Friend, neighbor or other	4.6	0	3.9	7.2
No one	0	0	0.7	0
Number of cases	413	70	409	69

Source: Baseline survey of CHSP participants.

[a]Respondents were allowed to give multiple responses, so responses do not add to 100 percent.

These data indicate that CHSP is meeting its service coordination goals for most participating residents, helping them learn about and gain access to needed supportive services.

Residents also were asked how often they see their service coordinator and how often they meet with the service coordinator to discuss their service needs. Table 6.9 shows their responses to these questions. Almost two-thirds of elderly and 80 percent of non-elderly residents see the service coordinator at least one day a week. A little more than a quarter of the elderly and 40 percent of non-elderly residents discuss their service needs with the service coordinator at least several times a month. The high degree of contact CHSP participants, especially non-elderly ones, have with the service coordinators probably contributes to the degree of satisfaction the residents report with the service coordinator and the program as a whole (see Section 8).

Table 6.9 How Often Participants See Service Coordinator and Meet to Discuss Service Needs

	Elderly (%)	Non-elderly (%)
See Service Coordinator:		
Every day	16.9%	13.3%

Several days a week	26.5	48.0
About 1 day a week	19.2	20.0
Less than 1 day a week	33.0	14.7
Never	4.4	4.0
Meet with Service Coordinator to Discuss Service Needs:		
About 1 day a week or more	10.6	21.3
2 or 3 days a month	17.2	18.7
About 1 day a month or less	57.6	52.0
Never	14.6	8.0
Number of cases	567	75

Source: Baseline survey of CHSP participants.

Service coordinators' responses to questions about ways they work with residents give a picture of the kinds of help they provide. These include troubleshooting, counseling, problem solving, giving advice on services, arranging services, dealing with loneliness and social issues, and providing assurance to worried residents.

Service coordinators were asked how they help residents get the most out of CHSP. Their responses indicate the variety of things service coordinators do—and the importance of the service coordinator both in helping residents navigate the often confusing array of available care and in overcoming some residents' reluctance to seek or accept assistance.

> We give them assurances that no matter how many ADLs they have they can be more independent through CHSP.
>
> They often don't realize their needs. I encourage them to do something for themselves. Sometimes they feel they can't afford anything and I need to make it clear that they actually can afford the services and that they would benefit from them.
>
> I advocate for them to get on the program and get plugged into Medicaid. I refer them to Medicaid and Food Stamps. I help them understand the service system and schedule, and I individualize it as much as possible.
>
> I encourage them to use the services they need. Encourage them to make peace if they have a conflict with a service provider. Look for other services in the community to

> combine with their CHSP services. Began a support group called WOW (Wonderful Older Women) which meets once a week and is for CHSP women.

These responses make clear that the involvement of service coordinators with the residents they serve is frequent, multifaceted, based on knowledge both of the residents and of the program and services, and imaginative in identifying problems and working with residents to develop solutions. One grantee summed up the importance of the service coordinator as follows:

> The biggest benefit of CHSP is the on-site service coordinator. The services are out there already, but most people are unwilling to go out and get them. It simplifies the confusion of having so many different agencies working with them. Because of the service coordinator, people's level of use of services is greater than before. ....

6.3 Discussion

CHSP receives funding from HUD, the grantee or other agencies (the match), and resident fees. Data on costs and fees show:

- The median cost per participating resident in the first year was about $2,100. Unit costs for such major services as housekeeping and personal assistance are in the range generally charged for such services. Meal costs for some sites are higher than projected in the first applications, for reasons such as low numbers of initial participants and costs of providing meals that meet dietary requirements.

  The evaluation will continue to examine costs over time, to determine whether costs drop or stabilize as programs reach maturity.

- Costs per participant are higher for sites that serve persons with disabilities than for sites that serve predominantly elderly residents. Costs per participant are high for sites serving non-elderly persons with disabilities in several areas, including personal assistance, transportation, and meals.

- It appears that, in at least some sites, fees paid by residents are low, in terms of both CHSP program costs covered by resident fees and the fees that would be expected to be paid by residents.

  This will be examined in subsequent interim reports, as programs develop or ones that cannot meet funding requirements leave CHSP.

- Residents strongly support the principle that those who can afford to pay for services should pay for them. When asked about their ability to pay more for the services they receive, however, fewer than one-fourth of residents say they would be able to pay

more—and some of those would not be willing to pay more. The figures on ability and willingness to pay suggest that perhaps only 15 percent or less of residents would remain in CHSP, if fees were increased above their current levels.

- Service coordinators note that some CHSP-provided services are available at lower fees (or free) from other providers in the community and express concern that fees are a burden for some participants, or discourage participation.

  Other service coordinators note that the quality and cost of CHSP services make them competitive with those of other providers. Also, the structuring of fees and services, so that residents get a coordinated "package" of services for a combined fee (rather than paying for each service independently), is reported by some sites as making the fees affordable. The level of fees charged to residents for CHSP services, compared with fees for similar services from other sources, is a continuing concern for service coordinators and grantees and will be examined further in later rounds of the evaluation.

CHSP provides residents with a set of needed services. In addition, however, the program is organized around the role of the service coordinator, who helps residents identify and obtain an integrated combination of needed services. Responses of both residents and service coordinators underline the importance of service coordination and the ways this helps ensure integrated services and provides frequent interaction with residents to check on their needs and plan for needed services.

- CHSP is the most frequently mentioned source of information on services and help in gaining access to services.

  For frail residents who need assistance to continue living as independently as possible, service information and access is essential. The data make clear that CHSP is helping many frail elderly residents and non-elderly persons with disabilities get needed services.

- CHSP participants typically see their service coordinator at least several days a week and meet with him/her to discuss service needs at least monthly.

These data, together with comments about the value of the service coordinator, make clear the importance of this person and the services she or he provides to participants and the program.

7. DYNAMICS OF PARTICIPATION IN CHSP

Over time, housing residents may become eligible for CHSP, then stay on a waiting list or enter the program, participate for some period, and eventually leave because of death, relocation, or—in some cases—reduced need for assistance.

The study of CHSP participation dynamics—waiting lists, entries, and exits—is important for understanding the operation of the program, its ability to offer supportive services to residents in need, and its effects on residents.

The first year of the new CHSP was a start-up period, as programs hired or assigned staff, did publicity and outreach to residents, assessed residents' eligibility, and provided the array of CHSP services to participating residents. During this period, some residents who entered CHSP subsequently left the program because they chose not to continue receiving services, moved, died, or for other reasons.

This section analyzes data from the first year of new CHSP operations on program dynamics. The topics analyzed are sources and numbers of program entrants, waiting lists for CHSP services, and program exits. Data for the analyses come from grantee annual reports, resident rosters, and transition information collected for the evaluation.

7.1 Sources and Numbers of New CHSP Entrants

The new CHSP accepts residents from several sources. One goal of CHSP is to provide services that make it possible for people to move to congregate housing from a more restrictive environment, such as a nursing home, hospital, or other facility. Thus, in addition to residents who are already living in the development, other persons may move to a development to obtain CHSP services. In addition, development residents who are not eligible for CHSP and persons who are not residents of the development may use CHSP services, if it is determined by the housing manager, service coordinator, and PAC that their participation will not negatively affect the provision of services to eligible residents; these service users pay for any CHSP services used at full cost.

Data on the sources from which participants entered the program are shown in Figure 7.1. As this table shows, the great majority of CHSP participants were already residents of the development when they entered the program.

A smaller number (14 percent) entered from their own home or apartment, the home of a relative, or another HUD development. And a few (3 percent) entered from a more restrictive environment—nursing home, board and care facility, mental health institution, or hospital.

7.2 Waiting Lists for CHSP Services

Grantees' applications for CHSP funding included estimates of the maximum number of participants to be served in the first year of the program and over the 5-year period of program funding.

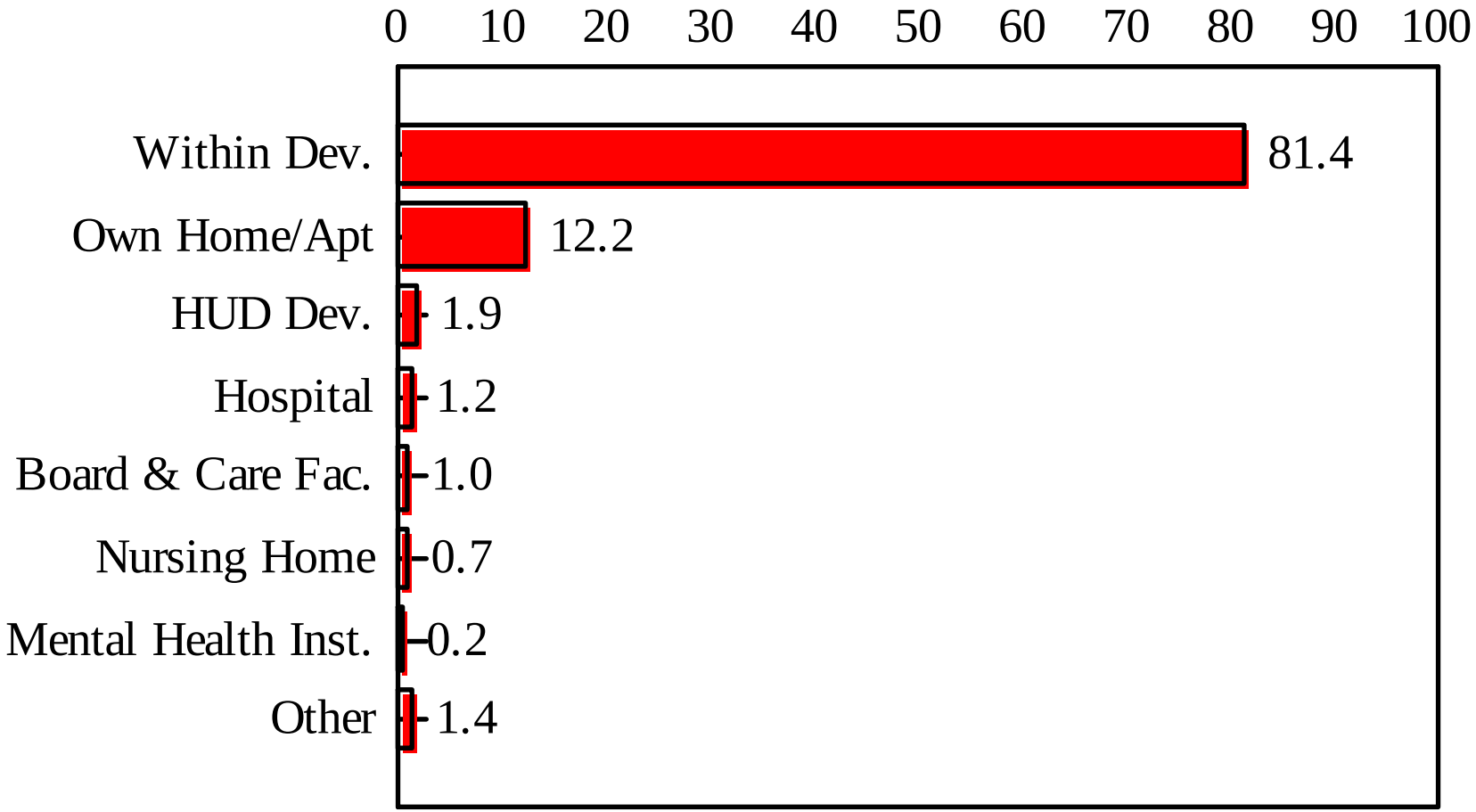
Data on the number of residents enrolled in the new CHSP at the time of data collection in October 1994 and grantees' answers to questions about waiting lists were used to analyze participation and waiting list size.

By October 1994, 15 of the 34 new CHSP projects had reached or exceeded the enrollment targets they set in their grant applications. At least eight of these 15 sites had waiting lists for the program. Most of the waiting lists ranged in size from two or three residents to 15 or 20, but one site, which serves a population made up exclusively of persons with mental retardation or developmental disabilities, reported a waiting list of more than 175 residents, in addition to the 8 residents served by the program.

Overall, there were 740 residents participating in the new CHSP in October 1994. At least 64 more residents were on the waiting list to participate. One site reported 175 residents on the waiting list. If this site is included, the total waiting list is more than 230. Thus, by the end of the first year of new CHSP operations, there were already some residents waiting to join the program. The total number on the waiting lists was a little less than 10 percent of the total being served at that time (except for the one site with a very large waiting list).

Figure 7.1

Sources from Which CHSP Residents Entered Program



Information on source was available for 859 out of 909 participants in Year 1.

Source: Grantees' annual reports.

7.3 The Analysis of Program Exits

Even though CHSP is designed to help frail elderly persons and persons with disabilities to live independently as long as possible, the age and frailty of this population are such that some participants will die or move to a nursing home, a hospital, or other more restrictive living environment. In addition, some residents may leave the program because they no longer need services, cannot afford to pay for services, or are dissatisfied with the program.

For the evaluation, service coordinators provided information on each person who had participated in CHSP at some time during the period from September 1993 (when the grants were awarded) through October 1994. Data were provided for 835 residents who had participated in CHSP during this period.[1]

For each person who had participated, the service coordinator indicated:

- Whether or not they were currently participating in the program; and
- If they were no longer participating, the next location they had gone to after being in CHSP.

  The categories of locations participants had gone from CHSP were:

  - Still in the development, but no longer participating in CHSP (dropped out);
  - Moved—either living in another development or living with family;

[1] Data from the grantees' first annual reports show that, of the 909 people who entered CHSP during the first year of program operations (October 1993 through September 1994), 19 percent (173 persons) left the program. Of these 173, 35 percent (60 people) continued to live in the development but no longer participated in CHSP; the other 65 percent (113 people) had died, moved to a nursing home, moved to live with family, or made some other transition out of the development. The annual report figures give a slightly lower estimate of the proportion of program leavers who stay in the development than do the individual data (35 percent compared with 40 percent). This is probably because service coordinators remember residents still in the facility and may forget some who leave. The differences are small, however, and the overall patterns are very similar.

- Moved to a more restrictive setting—a hospital or a nursing home; or
- Died.

Analyses of data on program exits were done for two groupings of cases:

1. All participants

   These analyses provide an overall picture of how many participants have remained in CHSP and how many have left. They address such questions as:

   - Overall, how many CHSP participants have left the program?
   - Of the total population that entered CHSP, what proportion has remained in the program, compared with the proportions who have left for different reasons (dropping out vs. moving to a more restrictive environment or dying)?
   - What are the age patterns of staying in or leaving CHSP?
   - Is the level of attrition for CHSP higher than would be expected for a population of frail elderly?

2. All persons who have left the program

   By presenting data only for those who have left CHSP, these analyses focus on the relative importance of different reasons for leaving the program. Questions these analyses address include:

   - What are the main reasons for leaving at this stage of CHSP implementation? For example, is dropping out a more common reason than moving to a nursing home or other more restrictive environment?
   - How do patterns of leaving the program differ by age? For instance: are older participants more likely than younger ones to die or move to a more restrictive environment (a hospital or a nursing home)?

Later in the evaluation, after additional rounds of data collection, further analysis will be possible. This will address such questions as:

- What reasons do residents give for having dropped out of CHSP? For instance, what is the relative importance of such factors as not being able to afford services, being dissatisfied with services, and no longer needing services?

- Do the rates and patterns of program exits remain stable or change over time, and what implications do these have for CHSP?

  For instance, it would be expected that, as residents age, more will die or move to nursing homes. If this happens, programs will need to plan for larger numbers of new entrants later in the program.

  If relatively large numbers drop out of the program, service coordinators and grantees will need to determine whether resident selection procedures or service coordination activities should be changed to try to reduce dropouts. And it will be important to ensure that those who leave the program have other sources of needed supportive services.

- What are the cumulative rates of retention and program exits over time? The data in this report cover only the first year of the new CHSP and, in many instances, less than a year, since programs required start-up time and residents were recruited over time. With data from subsequent rounds of data collection, it will be possible to estimate rates of retention and attrition over longer periods of time.

7.4 Findings on Program Exits

Data in Table 7.1 show that 17 percent of persons who participated in CHSP before October 1994 had left the program by that time. The percentage who had left the program ranged from less than 10 percent for the non-elderly participants to nearly 25 percent for those 85 and older.

Table 7.1 CHSP Exit Statistics, October 1993 - October 1994

Age	Percent left CHSP	Number of CHSP Participants[a]
Less than 62	8.3	84
62-74	12.3	154
75-84	14.4	291
85+	23.5	293
Total[a]	17.1	835

[a]Includes 17 respondents for whom age could not be obtained from the programs.

Table 7.2 provides data on patterns of exits from CHSP. The top row of the table shows data for all participants (persons who had participated in the program at some time during the first year). Of this group, 17 percent had left CHSP. These were distributed as follows:

- 7 percent had left CHSP but were still living in the development,
- 5 percent had moved to a nursing home or hospital,
- 3 percent of participants had died, and
- 2 percent had moved to another development or to live with family.

Table 7.2 Patterns of CHSP Exits, October 1993 - October 1994

		Patterns of Exits: CHSP Participants and Persons Who Left CHSP						No. of CHSP Partici-pants
Participant group	Remained in CHSP	Remained in development	Moved to other development	Live with family	In hospital	In nursing home	Died	
All program participants	82.9%	6.8%	0.6%	1.2%	0.3%	5.1%	3.0%	835
Participants who left CHSP	---	39.9	3.5	7.0	2.1	30.1	17.5	143

The bottom row of the table shows data for all persons who had left CHSP. Among this group, 40 percent were still in the development, and the other 60 percent had left the development—32 percent had moved to a nursing home or a hospital, 18 percent had died, and the others had moved to another development or to live with relatives.

The patterns of leaving CHSP differed by age. Among the oldest residents (those 85 or older), 24 percent of those who entered CHSP had left the program. The main reasons for leaving CHSP for this age group were death or moves to a more restrictive environment: of those 85 or older who had left CHSP, 45 percent had moved to a nursing home or a hospital, and 22 percent had died. The numbers of program exits because of death or moves to a more restrictive living environment demonstrate the frailty of many CHSP participants, particularly the oldest ones.

Among the younger elderly residents (those age 62 to 74), 12 percent of those who entered CHSP had left the program, and most of those (63 percent) left the program but not the development.

Fewer of the non-elderly persons who entered CHSP had left for any reason (8 percent had left), and most of those were still in the development. None of the non-elderly had died or moved to a nursing home or hospital during this period.

Data on the proportion of participants who leave the program because of moves to a more restrictive living environment (hospital or nursing home) or death help assess the frailty of CHSP participants and make it possible to compare their attrition with that found in other research.

Among elderly CHSP participants, 7 percent entered a nursing home or a hospital and another 4 percent died; in total, 11 percent of elderly who entered CHSP had left the program for these reasons within a period of approximately one year. The rate was highest for those 85 and over: of the group 85 or older who entered CHSP, 11 percent had entered a nursing home or a hospital and 5 percent had died; in total, 16 percent of the oldest old who entered the program had left for these reasons within the period. (In total, including all reasons for leaving the program, 18 percent of the elderly and 24 percent of the oldest old had left CHSP within the period.)

Findings from earlier research help place these figures in context. The 1988 National Survey of Section 202 Housing for the Elderly and Handicapped found a 13 percent annual rate of turnover of units in the average project (U.S. House of Representatives, Select Committee on Aging, 1989). The CHSP figures show that the percent of elderly who leave the development because of death or a move to a more restrictive living environment in a year is 11 percent, which is similar to the earlier figure of 13 percent. Based on analyses of data for elderly residents of government-assisted housing needing assistance with one or more physical activities of daily living (using data from 1978 and 1982), the estimated proportion institutionalized within two years is around 7 percent (Struyk, Page, Newman, Carroll, Ueno, Cohen, and Wright, 1989).

The percentage of the CHSP elderly who enter a hospital or nursing home within approximately a year is about 7 percent. This is somewhat higher than the one-year rate implied by 7 percent, two-year rate. However, the CHSP ADL eligibility rules sought to limit the participants to a relatively highly impaired group. Overall, the data on the proportions of elderly residents leaving CHSP for different reasons are broadly similar to the figures from earlier research.

7.5 Discussion

These data point to several patterns:

- There is a substantial turnover in participation, resulting both from dropouts and from deaths or moves to more restrictive environments.

  Overall, the data indicate a program exit rate of about 15 percent to 20 percent over a year. If this rate were to continue over time, it would imply that only about 300 to 350 of the original 900 program entrants would still be in the program at the end of 5 years. From a program and service perspective, this would mean: (1) substantial numbers of residents would enter CHSP over time, replacing the ones who leave, and require assessment and other start-up services as well as continuing service coordination and provision of specific services; and (2) many of the new entrants also would leave the program after one or a few years of participation.

- About 40 percent of exits appear to be for reasons other than frailty—as residents leave the program but stay in the development or move to other locations.

  Possible reasons for people leaving CHSP while staying in the development include: post-entrance determination that they were not eligible (either because they improve or because they were not eligible initially); inability or unwillingness to pay for CHSP services; dissatisfaction with services; or other reasons.[2]

  In some cases, there may be a need for service coordinators to make special efforts to ensure that residents who can benefit from CHSP are able to remain in the program. In other cases, there is likely to be a need to help residents obtain access to supportive services from other sources.

- Especially among older participants (those 85 or older), many moves are to nursing homes or other more restrictive environments.

[2]The first follow-up survey of residents will include questions for residents who no longer participate in CHSP. These will ask residents their reasons for leaving the program.

These moves are evidence of the frailty of CHSP participants and are an indication that the program has targeted services to a number of residents who had very high service needs. Over time, as current residents age, it is likely that increasing proportions of residents will die or move to nursing homes or other facilities.

It will be important for service coordinators and PACs to ensure that these exits could not reasonably have been delayed further by provision of services under CHSP. For residents who have declined to the point that CHSP services cannot prevent this move, the service coordinator will need to work carefully with them and any available family members to help with this transition to a less independent level of living.

- Overall, the rate of attrition from CHSP is consistent with findings of other research: approximately 11 percent of elderly nonresidents had died (4 percent) or moved to a higher level of care (7 percent) in a year. In total, including all reasons for leaving the program, 18 percent of elderly participants left the program.

  These numbers are in the same range as the attrition rates found in earlier research on frail elderly residents.

8. PROGRAM IMPACTS, EVALUATION, AND IMPROVEMENTS

The preceding sections have described the experience of grantees, sites, and participants in the first year of the new CHSP. The analyses have shown:

- Despite difficulties some sites experienced in the start-up period, most were providing services by the end of the first year of operation of the new CHSP.
- Approximately 900 residents entered the program during the year, and about 83 percent of these were still participating at the end of the year. Participants who left the program included those who continued to live in the development but no longer participated in CHSP and, especially among the oldest residents (age 75 or older), those who died or moved to more restrictive environments.
- CHSP participants received a variety of services from the program, including meals, housekeeping and other home management, transportation, assistance with personal care, health-related support, and personal emergency response systems.

In addition to these descriptive analyses, data evaluating CHSP operations and services were collected from participants, grantees, and service coordinators.

This section includes analyses of:

- Effects of supportive services on participating residents: participants' assessments of how well the services meet their needs, their satisfaction with services, and the difficulty they would have if they did not receive the assistance.
- Participants' satisfaction with services provided by CHSP. This includes both satisfaction with different dimensions of CHSP services (e.g., quality of interaction, timing, and responsiveness) and overall satisfaction with CHSP.
- Grantee, service coordinator, and participant perspectives on services needed by residents, including both services that are available from CHSP or other sources and additional services needed.
- Impacts of the new CHSP on organizations and the community.
- Grantees' views of CHSP and participants' recommendations for changes in the program.

8.1 Effects of Supportive Services on Participating Residents

Participants were asked, for each supportive service they receive: (1) whether the service meets their needs; (2) how satisfied they are with the service; and (3) how difficult it would be for them to continue living as they are if they did not receive the assistance. The questions cover services from all sources, not only CHSP. Below, data are first analyzed for elderly participants and then for non-elderly persons with disabilities.

8.1.1 Effects on Elderly Participants

Table 8.1 presents elderly respondents' views on services they receive. The large majority of respondents say the help they receive meets their needs (88 percent or more say this about most of these areas of service). Somewhat fewer participants say they get enough help with using the telephone, mental health services, doing housework, getting dressed, getting in or out of the chair or bed, or using the toilet. Several of these service areas, such as transferring and toileting, are ones where assistance is needed very frequently or has to be quickly available on an as-needed basis. (These two services have the smallest percentage saying services meet their needs—70 percent for using the toilet and 77 percent for transferring.) Other areas, such as housework or mental health services, are governed by rules of CHSP or other programs, which place limits on the amounts or types of services residents can receive under the program. (For these services, 80 percent or more say the services meet their needs.) These factors—both high frequency of need and limitations on service availability—may help explain why somewhat fewer service users say the services are enough to meet their needs. Despite the differences among services, the overall finding is that most CHSP participants say the services they receive meet their needs for assistance.

Almost all elderly participants (90 percent or more) report being satisfied with most services. Somewhat fewer participants are satisfied with meals than with most other services, possibly because some older residents do not like the taste or content of meals designed to meet dietary requirements. Other areas in which somewhat fewer residents are satisfied are: personal emergency response systems, assistance with using the telephone, or feeding assistance. These may reflect the fact that feeding and telephone assistance have to be timely to be useful and

Table 8.1 Effects of Services Used by Elderly Participants

Service	Meets needs[a] (%)	Satisfied[b] (%)	Difficult to continue without service[c] (%)	Number of cases
ADL Support Services				
Household management				
Housework	80.8	86.3	67.0	487
Shopping	89.7	92.8	77.0	383
Managing money	93.9	95.5	69.0	274
Using telephone	80.4	85.7	51.0	56
Transferring				
Getting in/out of chair/bed	76.7	90.0	80.0	46
Personal grooming and care				
Washing hair	95.8	97.8	49.2	243
Getting dressed	80.6	95.6	73.5	75
Getting in/out of shower/tub	91.9	97.7	78.0	193
Washing self (bathing)	91.2	97.6	80.2	179
Personal grooming	88.2	95.0	73.4	83
Using toilet	69.2	100.0	92.0	28
Food and eating				
Congregate meals	91.7	80.5	55.3	428
Home-delivered meals	93.6	80.9	68.8	173
Preparing meals	88.8	96.0	74.8	165
Feeding person	94.1	85.7	68.8	19
Other Services				
Transportation	90.8	94.3	65.3	393
Health screening/education	90.9	90.4	37.6	246
Personal emergency response system	94.6	84.7	29.8	360
Mental health services	85.2	90.0	50.0	56
In-home health care	91.1	96.4	64.7	203

Source: Baseline

[a]Response is: help respondent receives is "as much as you need" or "more than you need."
[b]"Somewhat satisfied" or "very satisfied."
[c]"Very difficult" or "impossible."

possibly that they have difficulty understanding or using personal emergency response systems. Even for these areas, however, 80 percent or more of the participants report that they are satisfied with the services they receive.

Taken together, the data indicate that most elderly residents who receive services from CHSP and/or other sources (other programs or informal help from family or others) say the services meet their needs, and they are satisfied with the services.

Finally, many elderly participants say it would be difficult or impossible for them to continue living as they are without the assistance they receive. Two-thirds or more say it would be difficult to continue living as they are without assistance in toileting, getting in or out of the chair or bed, getting in or out of the shower or tub, bathing, shopping for personal needs, getting dressed, meal preparation, personal grooming, money management, home-delivered meals, feeding, and housework.

Between one-half and two-thirds say it would be very difficult for them to continue living as they do without the assistance they get in in-home health care, transportation, or congregate meals. Finally, about half say it would be difficult to continue living where they are without help washing their hair, using the telephone, or mental health services.

8.1.2 Effects on Non-elderly Participants

Table 8.2 shows the same data for non-elderly CHSP participants. Responses are similar to those of the elderly participants. The large majority of non-elderly participants say the help they receive meets their needs, and most are satisfied with the services they receive.[1]

Responses of the non-elderly participants are similar to those of elderly participants, as well, in the proportions saying it would be very difficult or impossible to continue living as they are without the services they receive, although the data suggest that some kinds of personal care assistance (e.g., help in bathing or personal grooming) are more important to the continued functioning of the elderly than to younger participants. This difference probably reflects

[1]Only respondents who could answer questions for themselves were asked how satisfied they are with the services; either respondents or proxies were asked whether services met participants' needs and how difficult it would be for them to continue living as they are without the services.

differences in the needs of the two groups. Many frail elderly need this kind of assistance to help

Table 8.2 Effects of Services Used by Non-Elderly Participants

Service	Meets needs[a] (%)	Satisfied[b] (%)	Difficult to continue without service[c] (%)	Number of cases
ADL Support Services				
Household management				
Housework	78.6	88.0	42.9	57
Shopping	94.5	100.0	68.5	55
Managing money	97.9	–[d]	89.9	47
Using telephone	89.7	–[d]	48.3	29
Transferring				
Getting in/out of chair/bed	–[d]	–[d]	–[d]	5
Personal grooming and care				
Washing hair	81.8	–[d]	40.9	22
Getting dressed	54.5	–[d]	63.6	11
Getting in/out of shower/tub	84.6	–[d]	84.6	14
Washing self (bathing)	93.8	–[d]	50.5	16
Personal grooming	88.9	–[d]	29.6	27
Using toilet	–[d]	–[d]	9	4
Food and eating				
Congregate meals	93.4	95.5	60.7	61
Home-delivered meals	90.0	–[d]	72.5	40
Preparing meals	84.8	–[d]	60.9	46
Feeding person	NA	NA	NA	–[d]
Other Services				
Transportation	96.9	92.0	75.0	64
Health screening/education	85.2	94.1	50.0	54
Personal emergency response system	92.0	82.6	28.0	26
Mental health services	82.1	86.7	60.7	28
In-home health care	81.3	100.0	68.8	16

Source: Baseline survey of residents.

[a]Response is: help respondent receives is "as much as you need" or "more than you need."
[b]"Somewhat satisfied" or "very satisfied."
[c]"Very difficult" or "impossible."
[d]10 or fewer service users responded, because information was provided by proxy, few residents use service, or other reasons.
NA = Not applicable; no residents receive service.

compensate for such problems as difficulty using their hands, balancing, or walking steadily. Many of the non-elderly residents are persons with mental retardation or developmental disabilities, who are typically encouraged to learn and use personal grooming and other life skills.

In summary, many participating residents see the supportive services they receive as being very important or essential to their continued ability to keep living independently. Although some of the services seen as most essential are high-intensity services needed by those with severe physical ADL limitations (e.g., toileting, getting in and out of bed), other services that can be provided on a scheduled basis—such as transportation, housework, and assistance with dressing, grooming, or bathing—also are important to many.

8.2 Participant Satisfaction with CHSP and CHSP Effects on Residents

8.2.1 Participant Satisfaction

Participants were asked how satisfied they are with CHSP and with different aspects of the program. Past research has identified several dimensions of in-home supportive service quality (Eustis, Kane and Fischer, 1993). In addition to technical quality of the services, important dimensions of service quality include quality of interaction (pleasantness, positive attitude), availability of the kinds and amounts of services needed, and timeliness—services are provided at convenient times and providers come at the scheduled time. All of these are related to satisfaction with services.

Table 8.3 shows the percentages of participants who agree with statements about these dimensions of CHSP services, and participants' overall degree of satisfaction with the program.

As this table shows, the large majority of both elderly and non-elderly residents who participate in CHSP report high levels of satisfaction with the amount, quality, and frequency of service and with the program overall. Program participants say they get needed services and get services often enough, see the service providers as having a positive attitude, and report that

Table 8.3 Satisfaction with Aspects of CHSP Services and with Program

	Elderly	Non-elderly
Percent of participants who agree with statements about different aspects of CHSP services:		
Amount of services:		
I get the services I need	93.4	87.9
Provider attitudes:		
People who provide the services have a positive attitude	96.8	94.1
Frequency and timing of services:		
Services are provided on time	96.4	81.8
Services are provided at times that are convenient to me	95.3	87.9
Services are provided on scheduled days	92.9	81.8
I get the services often enough	89.0	84.9
Satisfaction with CHSP:		
Very satisfied	69.9	57.1
Somewhat satisfied	19.8	31.4
Neither satisfied nor dissatisfied	7.6	11.4
Somewhat dissatisfied	2.3	0.0
Very dissatisfied	0.4	0.0
No. of cases[a]	443-471	33-35

Source: Baseline survey of residents.

[a]Only residents who could answer questions for themselves were asked these questions; information from questionnaires completed by a proxy respondent is not included in this table.

services are provided at convenient times and on time. Consistent with this, almost 90 percent say that, overall, they are very satisfied or somewhat satisfied with CHSP.

8.2.2 CHSP Features

In addition to these questions about satisfaction with the new CHSP, participants were asked an open-ended question about what they like most about the program. A number of residents mentioned specific services (e.g., transportation, meals, housekeeping) as the thing they like best about CHSP. In addition, however, thematic analysis of open-ended responses shows several major themes:

- **CHSP provides residents with a sense of security and enhances their ability to live on their own:** "Knowing that help is available." "Peace of mind." "Gives me a chance to be on my own."

- **CHSP provides comprehensive, reliable, and timely service:** "They come on time." "...Help the minute you need it." "They come and do whatever you need when you need it."

- **CHSP staff are high quality and committed to program and participants:** "The thoughtful and considerate care I receive daily." "Service coordinator is there to help you—and has helped—whatever needs to be taken care." "They're good—the people who work for the program are very helpful and always are there when I need them."

In addition to these features of the program and staff, participating residents commented that the program benefited them by establishing or strengthening sociability and relationships with other residents. The meals program is particularly important for this. For instance, one participant reported liking "visiting with all the other residents at meals," and another commented on having meals in the dining room, "It picks [me] up to see other people."

8.2.3 Grantee Perspective on Effects on Residents

In response to a question about the major benefit of CHSP, grantees mentioned a variety of benefits for residents. The major themes were: meeting service needs, in conjunction with housing needs, and providing coordination of services for residents; enabling residents to live in their homes with independence, security, and dignity; and helping reduce isolation and increase sociability of residents. Grantees noted, also, that helping residents has benefits for the

development as well: higher occupancy rates, lower turnover, and better maintenance of housing units. Grantees' statements about CHSP benefits illustrate these themes:

> Keeping people in their homes longer, which is our main goal. It has improved our occupancy rate, which was only 94 percent four years prior to CHSP (now almost 98 percent). It helps keep people living here. It is meeting the non-housing needs of our tenants. HUD is finally recognizing that housing is more than bricks and mortar.
>
> Enabled more independence. ... Instill sense of dignity. Makes senior feel more secure, less isolated. Keeps apartments in better shape and maintains a high value for the real estate because of having guaranteed housekeeping once a week.
>
> Socialization is a major benefit, through the escort service and the meals. We have clients that are so frail that we have to get them an escort to the meals, but it works. They are socializing more now. Keeping people out of nursing homes is a big benefit.
>
> The biggest benefit is the on-site service coordinator. The services are out there already, but most people are unwilling to go out and get them. It simplifies the confusion of having so many different agencies working with them. Because of the service coordinator, people's level of use of services is greater than before. ..... One of the biggest impacts is that through the provision of services residents have been able to stay in their homes. ... It extends people's independence. .... It's good for residents, the building, the owner's investment. Keeping people in their homes reduces turnover and vacancy rates, and services mean residents are healthier and tend to take better care of their properties.

One grantee's descriptions of services provided by CHSP, and their impact on the residents and development, illustrates the beneficial impact CHSP can have on participating residents:

> The Congregate Housing Services Program has made an extraordinarily beneficial impact on the residents, families and staff of [site]. As word spreads to community health and social service agencies about the new supportive services for tenants, collaboration with housing staff has increased to improve care further...
>
> The House Calls and Chore Programs are available round the clock to respond to frail tenants. Availability is key, offering the reassurance that there is someone to call any time "if something happens" (and it does)... It is very clear that having a caring person on site and awake to help with things that require assistance (e.g., toileting, transferring, assistance with medications, cleaning up a mess, etc.) has reduced risks and fears of residents struggling to remain at home.

> A meals program at [site] is a wonderful new addition... The staff were initially uncomfortable with the CHSP requirement that all meals participants had to come in the dining room for meals. The escort service was established to address that difficulty in this large development. Getting tenants out of their apartments has made it possible for them to participate in activities as well as meals. They love it!!

> Escorts are everywhere, ending the isolation of those who had to be visited but never went out...

8.3 Services Needed by Residents

Participating residents were asked what services they need more of, what other services they need, and what services they would like to get from CHSP but cannot afford.

Eighteen percent of elderly participants said they need more of some service than they currently receive. The specific services mentioned by participants include housekeeping (both regular light housekeeping and heavy work, such as major cleaning), laundry, transportation, companion services, counseling, in-home care, and shopping/errands.

Sixteen percent said they need services they do not currently receive. Specific services include transportation, housekeeping and heavy cleaning, home health care, weekend meal delivery, companion service, and other assistance. Five percent said there are CHSP services they would like but cannot afford. Ones they mentioned include heavy cleaning, transportation, and meals, as well as assistance not provided by CHSP (e.g., hearing aid).

Grantees and service coordinators were asked what services elderly residents need or want most. The services most frequently mentioned by the 26 service coordinators interviewed were housekeeping (18, or 69 percent) and meals (14, or 54 percent), with 8 (39 percent) also mentioning transportation. Several service coordinators and grantees commented at more length:

> They want housekeeping because it's in their own territory, their comfort zone. Meal service is alien to a lot of people and community areas are not comfort zones, but once they try it they start to enjoy it and overcome their discomfort.

> They like the housekeeping on an irregular basis for heavy chores such as seasonal cleaning and the like. They also like the transportation and they like learning about the different benefits that exist for them to take advantage of.

Service coordinators who work with non-elderly disabled participants see especially the personal assistance service from CHSP as critical to allowing the residents to live in a group home setting and see the meals as an important vehicle for socialization.

In response to a question about what services are more difficult to arrange or provide, grantees mentioned several areas, including transportation and meals. The problems they describe help clarify why these are the areas with which some residents are dissatisfied or say services do not meet their needs:

> **Transportation:** I think transportation is hard. It's difficult to schedule and you end up waiting around a lot. The scheduling for transportation is really a challenge.
>
> **Meals:** Good meals are always hard to provide. People want to have more choice, but that's too expensive.
>
> **Housekeeping:** Turnover of staff is so high. Coordination and scheduling of services is difficult. Residents like to be there when service is being provided.

8.4 Impacts of the New CHSP on Organization and the Community

Grantees and service coordinators were asked about the effect of the new CHSP. Ten (48 percent) of the 21 grantees said it has affected the degree of coordination among social and housing agencies in the community. Examples include: "[Housing authority and service agencies] now see ourselves more in the same field," and "Improved somewhat—we were more aware of others' goals."

In response to questions about specific effects of the new CHSP, the majority of grantees and service coordinators say it has improved the ability to assess residents, and expanded capabilities to develop care plans, provide services, and arrange and monitor services.[2]

[2]In most cases where the grantee or service coordinator said CHSP had not brought about change in capabilities, a typical comment was that they were already doing that, so they already had the capability.

Comments about the effect of the new CHSP on each capability include:

Resident assessment: "It improved a lot—priorities are always assessed." "Because of staff supervision it has improved." "Positive change—had very little ability to do that before the service coordinator came." "[Had a lot of effect on the management company and maintenance]—it sensitizes people who are used to bricks and mortar approach." Also, although some sites reported problems using the HUD ADLs, one commented: "Regulations are very specific on ADLs, which helps in assessments/ determinations."

Care plan development: "Additional tools for developing care plans." "Care plans are new and only available to CHSP, so it's a new service." "100% enhancement."

Capability to provide services: "This has always been good, but the grant helps us to do it much more affordably." "Grantee's bent wasn't the social work model, but providing and maintaining housing. Now they are a social work provider." "We didn't offer any of these services in-house before. We have found out we can."

Arranging and monitoring services delivered by outside provider: "Developed closer contact with provider." "We are always learning as we get more experience and work as a team." "Now there is an advocate or liaison between the resident and the outside providers." "Learn how to take advantage of what is out there." "Very positive change—had a big problem arranging services before."

Other changes in capabilities: "Recordkeeping. We didn't have a system before, so this has been a huge change. We are hopeful we can develop a recordkeeping module as a model for other CHSP programs." "I am learning to exhibit patience—to interact, not react, when we have clients who are hostile." "Created physician reference form for detailed information on residents during office visits." "Now we are seen as an organization that follows through." "Staff willingness to take on new clientele with more challenging behaviors. Has impacted everyone's lives."

These comments show some of the ways CHSP has had positive effects on service availability, targeting, coordination, and monitoring. Furthermore, the comments on strengthened capabilities help explain why most participating residents report that they get needed services and are satisfied with the services they get from CHSP and other sources.

8.5 Views of New CHSP and Recommendations for Change

8.5.1 Grantees' Views of Program

Although a number of grantees found it challenging to develop and implement the new CHSP and to meet the program's administrative requirements, they generally had positive comments on the program, the partnership with other agencies and providers, and the value of

CHSP to residents. Themes they emphasized included benefits to residents of having CHSP available—new services available, security, service coordination, social interaction; and capability for developments to respond to residents' needs for supportive services, especially as residents age in place. Examples from the grantee interviews and annual reports illustrate these themes:

> We continue to be truly excited about the CHSP concept and the opportunities that this program provides to frail elderly in our complex. Many of the residents that have lived in this facility since it opened about twenty-five years ago also recognize the value of this program. The CHSP program offers our residents additional options that were not available eighteen months ago. We have witnessed the benefits of this program in the last year and look forward to being in the position to continue to offer those services as we see increased numbers of residents age in place.

> This program allows aging in place and comprehensive supportive services. Bar *none*, CHSP is the best HUD program. It is well conceived and the congregate meals are an especially great aspect. The program provides elderly with safety and security. It is a positive option to deal with the issue of housing and comprehensive supportive services for the frail elderly. It is a great program and it is providing the elderly with the services that it promises. The CHSP gets an A+ for concept, philosophy, and its ultimate goals.

> I think that the total well-being of the clients will be improved with this program; for example, those who are isolated because they need assistance to leave their homes will undoubtedly benefit a great deal. The residents have been made aware that we won the grant and are now anticipating the new services; I think this will work to our advantage as they have been thinking about the change. Also I see that the younger residents who now do a lot of care for their less mobile neighbors will benefit in that they will feel less obligated to do these chores. I'm hoping it will be a relief for them.

8.5.2 Recommendations for Changes in the New CHSP

Recommendations for changes in the new CHSP come from responses to questions asked of participating residents, grantees, and service coordinators.

8.5.2.1 Recommendations from Participating Residents

Participating residents were asked about what changes they would most like to see made in the CHSP program. The changes they mentioned include:

Changes in specific services or aspects of services:

Meals: "Meals more varied." "Healthier meals. When you are on a low fat, low salt diet, it's hard with the food they serve."[3]

Transportation: "More availability for transportation for doctor visits and other important appointments." "Transportation on time."

Other services: "Companionship. Someone to spend time with me." "Maybe someone to go to the store shopping with you."

Housekeeping: "Housekeeping and cleaning services better trained and more careful."

Program administration:

Training of staff: "The people who are hired get more training."

Hours of service: "Would like to see someone on emergency call on Sunday." "After 5 o'clock, there is no one to call. They should have someone here 24 hours a day."

Resident fees:

Fees only for services used: "Change back to paying for meals only when we eat."

Overall service costs: "Not to ask for any more money." "Do not want to pay for services not required (e.g., transportation)." "Too much money—needs to be cheaper."

These suggestions reflect individual and site experiences as well as the problems any program faces in providing in-home supportive services for the frail elderly. These problems include the kinds and amounts of service; dissatisfaction with services, especially housekeeping; availability of assistance at night and on weekends; and costs of service. Overall, however (as the data in Section 8.2 show) most participating residents are satisfied with CHSP and with the services it provides. Many responses to the request for suggestions for change are like the following:

[3]Providers are required to meet resident special diet requirements. It may be that some participants are not aware of this requirement or do not ask for special meals, or that the provider has not met a program requirement.

"None. It is a good program. I love it!" "I think it is fine." "Very good program as it is now." "I think the program is excellent, especially for elders."

8.5.2.2 Recommendations from Grantees

Grantees' suggestions of ways to improve the new CHSP include:

- Reduce the number of ADLs required for eligibility:

  The 3 ADLS are too cut and dry—most of the people who fit HUD's requirements would be in nursing homes already.

  Change ADL requirement from 3 to 2. You need to get people living in these housing situations before they get to 3 ADLs.

- Reduce fees, or allow local communities to make choices on how to handle fees:

  It should be left up to grantee discretion to figure out how to charge for services given their particular match and regulatory environment.

  We have found it difficult to reach the 10 percent requirement for participant fees because many of the residents are low income. The fees need to be as low as possible, because people will do without even if it's $2 per month.

- Reduce the size of match required:

  This [CHSP] was a wonderful idea. The match should be lowered to allow more organizations to participate.

- Simplify application and reporting requirements, and have HUD staff available who can answer questions:

  Have HUD people who are knowledgeable about CHSP and accessible to the grantees. Need people who are experienced and prompt in answering questions—-Revamp the fiscal requirements, make the application simpler, and reduce the overwhelming amount of paperwork.

- Facilitate communication and learning among the CHSP sites:

  As the program expands across the country we will be trying to learn from the experience of others doing CHSP. There is nobody to call and network with. We need a clearinghouse or something. Maybe a conference....it should be national.

In summary, the grantees view the CHSP as an important program for their organizational capabilities and for their residents' independence. They would like to see the

program expand to more housing developments and to less frail residents but recognize the financial challenges in doing so. They have learned a great deal in the first year but would like to have the opportunity to learn more from each other.

Although grantees do not always make the distinction, it is important to note that the new CHSP is governed both by statutory provisions, which are not within HUD's authority to change, and regulatory ones, where there are some options. For instance, the requirement that elderly residents have at least three ADL limitations is statutory, as is the required level of matching funds and the requirements to provide congregate meals seven days a week.

Sites have more flexibility in other areas. For example, there is considerable flexibility in the services they provide, except for the requirement for congregate meals and service coordination, and the regulatory requirement that sites obtain HUD approval for including personal emergency response systems under CHSP. Sites differ in how they offer services and how these are grouped. For example, sites may offer services grouped in a "package" of services, or offer them with a set frequency (e.g., weekly housekeeping assistance).

Sites have flexibility in the fees they charge for services other than meals, subject to the requirement that the total fees cannot exceed 20 percent of the resident's adjusted gross income. Some sites report that "packaging" services for a combined fee, rather than charging separately for each services, helps make the fees affordable. Some residents may see this as undesirable, however, because they would prefer to obtain services separately and believe it would be cheaper for them to have that option.

8.6 Discussion

This section has brought together the evaluation results from the baseline data collection. The evaluation results focus on benefits from supportive services provided by CHSP and other sources, satisfaction with the services and with the CHSP program, and gaps in services and ways of improving the program.

These results begin to address several of the key CHSP evaluation issues, particularly service adequacy and quality and effectiveness of CHSP in fostering independence. Also, these results can help identify areas for program improvement during the period of implementation of the new CHSP.

8.6.1 Service and Program Benefits

- Supportive services provide a variety of benefits to participating residents. Both residents and grantees report that services help residents continue living as independently as possible in their own homes.

  In addition to direct benefits from receiving specific supportive services, participating residents and grantees say that services provide residents with broader, more fundamental support: a sense of security, help from committed and caring people, coordinated services that provide an array of needed assistance, and increased social integration.

- Most participants are satisfied with the specific help they receive from CHSP or other sources and are satisfied with CHSP.

  Most participating residents say the services they receive meet their needs and are satisfactory. They also report satisfaction with CHSP on several dimensions of program quality: amount of services, frequency and availability, and provider attitudes. Together, these data point to high levels of participant satisfaction, not only with the specific categories of service but with the way services are delivered.

- Grantees report benefits to the developments as well as to the residents who receive services from CHSP.

  Improved ability to meet needs of residents—including residents who are aging in place—is a benefit to developments. Through CHSP, they are better able to assess residents' care needs, develop care plans, and provide needed services (directly or through other providers). The emphasis on service coordination helps them provide integrated support for residents as well as specific kinds of assistance residents need.

  In addition to improved ability to provide needed supportive services, grantees say that CHSP services contribute to such physical outcomes as better maintenance of units, which is a general benefit to the development.

8.6.2 Recommendations for Change

- In some cases, participating residents say they do not receive the help they need or need more help than they receive. Some participants indicate they need more help for frequent or as-needed activities (e.g., toileting or transferring) and others want

services that CHSP or other programs may limit (e.g., frequency of housekeeping assistance). Some residents also say that fees should be lower or that they should be allowed to choose and pay only for selected types and amounts of services ─ for instance, to pay only for meals they eat rather than paying a fee for meals, or to get housekeeping on request rather than on a regularly scheduled basis.

- At the programmatic level, grantees recommend changes in several areas: reducing the number of ADLs required for eligibility, reducing resident fees or allowing more flexibility to developments and communities in setting fees, reducing the size of the match, and simplifying reporting requirements. In addition, several suggest holding conferences or providing other ways for participating developments to share and learn from others' experience. HUD's ability to respond to the recommended changes varies. For statutory provisions, HUD does not have the option to make changes. For regulatory provisions, there are somewhat more options, and there is considerable flexibility for sites to change things that are matters of local policy or practice.

Overall, the evaluation findings from the baseline indicate a number of benefits from CHSP and a high level of satisfaction with the program on the part of both residents and grantees. At the same time, grantees ask for changes in several basic features of the new CHSP—especially fees and the match requirement—and that the ADL level required for resident eligibility be reduced. These views of the new CHSP have also been expressed in the past. Whether they will change as the new CHSP programs become more fully established in the participating developments will be examined in later rounds of the evaluation.

9. SUMMARY AND CONCLUSIONS

This report presents findings from the baseline survey of new CHSP grantees, service coordinators, and participating residents, and from the grantee first annual reports. Data from these sources provide information on the early period of program implementation, describe the services and residents participating in the new CHSP, and give preliminary evaluations of program effects on residents and grantees. These analyses provide preliminary information on CHSP performance and impact and provide a background for the continuing evaluation of the program over time.

9.1 Grantees and Projects

New CHSP projects are located in a variety of housing types, with more than half being implemented in Public Housing Authority or Section 202 housing. The number of residents participating in CHSP in the different sites ranges from fewer than 10 to more than 100 in one site.

Of the 21 new CHSP grantees, 5 had participated in the old CHSP and 12 also sponsor other service programs for residents. Grantees varied in the speed with which they were able to implement the new CHSP. By the end of 1994, (one year after the program started), 34 of the 44 organizations awarded new CHSP grants had begun providing services; another 7 had not yet started, but planned to start services; and 3 had dropped out of the program.

Reasons for implementation delays reported by the grantees include time required to raise the match and get partnerships firmly in place, hiring the service coordinator, and recruiting and enrolling residents.

Some sites did not achieve the required level of funds from the match and resident fees in the first year of the new CHSP. Overall, the median amounts of total first year CHSP funding were: 51 percent from the match, 9 percent from resident fees, and 38 percent from HUD funding.[1] These figures are close to the program requirements of 50 percent funding from the

[1]The median percentages sum to 98 percent rather than 100 percent because of some variability in the

match, 10 percent from fees, and 40 percent from HUD. In some cases, however, it appears that such problems as delays in resident enrollment resulted in low revenues from fees or slow expenditure of the match.

Despite the initial problems some grantees experienced, the majority (14 of 21) of grantees said they expect the sources and amounts of the match to be very reliable over the 5-year grant period.

9.2 Participant Recruitment

As programs started up, major activities focused on getting information to residents about the new CHSP and the services it offers, identifying and assessing potentially eligible residents, and enrolling eligible residents in the new CHSP. Recruiting and selecting new participants will continue to be important over time, as participants leave the program and new ones can be served.

Most (77 percent) of the CHSP service coordinators undertook publicity and outreach to residents. Written materials (e.g., articles, brochures), informational meetings, and word-of-mouth were all used. These were supplemented by extensive individual outreach to residents and families to reach those who might otherwise not learn about the program or who might be reluctant to participate.

Reflecting the outreach efforts, the majority (69 percent) of participating residents reported that they learned about the program from a staff member of the CHSP project, building, or housing authority. In response to questions about the CHSP application process, most participants reported that it was not difficult for them, although some did not report being actively involved in the selection of services.

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distribution of the percentages for the different sources.

These evaluation results suggest that outreach—especially personal outreach efforts by program staff—has been successful in reaching a number of residents who can benefit from CHSP services and that the application process is not considered difficult by residents. At the same time, the service coordinators note that there are barriers to participation for residents, including residents' reluctance to apply for services and the fees required.

9.3 Participant Characteristics

The new CHSP is targeted to the frail elderly and non-elderly persons with disabilities. Demographic characteristics and functional status of participating residents and comparisons with the population of community-resident elderly and those in nursing homes or board and care homes help assess this aspect of CHSP and describe resident needs for assistance.

9.3.1 Demographic and Social Characteristics of Participants

The majority of CHSP residents (89 percent) are elderly. Further, elderly CHSP residents are concentrated in the oldest age groups: 78 percent are 75 or older, and 39 percent are 85 or older.

The non-elderly residents who participate in CHSP (about 9 percent of all CHSP residents) include persons with mental retardation or developmental disabilities who are living in group homes, as well as a smaller number of persons with mental illness or with physical disabilities, many of whom are living in mixed housing.

Many CHSP participants have aged in place: 54 percent of elderly CHSP residents have lived in their current housing for 5 years or longer. Non-elderly CHSP residents as well have typically lived in their current housing for some time: 33 percent have lived there 5 years or longer.

Having CHSP and other services that allow participants to stay in their own home conforms to older people's preferences to receive services in a home and community setting

without having to move to a new setting to get help. It contrasts with the experience of HOPE IV participants, about one-third of whom had to move to enter the program.

CHSP participants are predominantly female, white, and not currently married (most elderly residents are widowed or divorced/separated; most non-elderly residents have never married). They are similar to other frail elderly in those characteristics.

Although many residents live alone and are not married, most have family living nearby and have frequent interaction with family and/or friends: most have at least one family member who lives within an hour's drive, half or more see family and friends at least one day a week, and more talk with them by telephone that often.

9.3.2 Functional Status and Health

Most elderly CHSP residents have impairments in three or more ADLs (75 percent) and half have impairments in six or more ADLs.

CHSP participants' age and frailty are substantially greater than the general population of U.S. elderly and are more similar to residents of more restrictive living environments— board and care facilities and, in some cases, nursing homes. This points to the need of many residents of federally assisted housing for supportive services and indicates that CHSP services are generally being targeted to a population at risk of needing higher levels of care.

At the same time, a minority of participants report having fewer than three ADL limitations. This may result from such things as residents' self-reports differing from those of a professional service, differences in ADL rating methods used in the sites, and, in some cases, the possibility that some residents are being served who do not fully meet HUD's ADL requirements—either because they report that some residents with two limitations badly need services to avoid premature and unnecessary institutionalization, or for other reasons. As noted in the discussion of recommended changes, some grantees suggest reducing the number of required ADL limitations to two because of the perception that this group is at high risk.

Residents have limitations in a variety of ADLs. For the elderly, the major ADL limitations are light housework, shopping, getting in and out of the tub or shower, preparing meals, and getting in and out of bed. Non-elderly disabled participants also have problems with IADLs (shopping, housework, meal preparation); they are more likely than the elderly to have problems managing money but are less likely to have problems with such personal care tasks as getting in and out of bed or the tub/shower.

Some residents, especially the elderly, also have health impairments. A number of the elderly report such problems as hypertension, heart trouble, or diabetes, and one-third report having had to spend at least one night in the hospital during the past 12 months.

Virtually all residents had at least some health care coverage—through Medicare, Medicaid, private insurance, or a combination of these.

9.4 CHSP Service Provision and Use

9.4.1 CHSP Services Provided

The majority of CHSP projects offer a number of core CHSP services: case management (94 percent), housekeeping (85 percent), meals (82 percent), and personal care (65 percent). In some cases, meals or other services are provided through sources other than CHSP.

Residents make use of these and other services from CHSP and other sources. In particular, large proportions of both elderly and non-elderly CHSP participants receive assistance with housework, shopping, and transportation and participate in congregate meals.

In other ways, elderly and non-elderly CHSP participants differ in the services they receive and the sources of services. The elderly are more likely to get help with personal care, while the non-elderly get more assistance with money management, use transportation more, and are more likely to get health education. The differences in services between the elderly and non-elderly are consistent with the fact that a number of the non-elderly have developmental disabilities and fewer are as physically frail as the elderly. Also, provision of such services as

transportation and health education is consistent with the goals of services to many non-elderly, which involve sustaining or enhancing independent functioning.

For both the elderly and non-elderly, CHSP is the main source of help with housework and congregate meals. For the elderly, family members play the major role in other household management tasks and in such personal assistance as transferring, washing hair, dressing, and feeding. This is consistent with the time demands of many of these needs, as well as the fact that more of the elderly than non-elderly live with another family member or have family nearby. The non-elderly depend more on CHSP than on informal sources or other programs for household management, consistent with their support needs and lower family availability.

In some cases, CHSP has provided services for residents for the first time; others receive services from CHSP that are similar to those they previously received from family, other programs, or other sources. One of the services that is new for many elderly participants is congregate meals—55 to 56 percent of those who get congregate meals under CHSP had not gotten them before.

The fact that many received assistance prior to entering CHSP is consistent with their level of frailty and impairment. The data on past and current services from other sources also suggest that CHSP serves as one of several sources for many people in need rather than the sole provider.

Overall, the data suggest that CHSP has resulted in greater total amounts of assistance to participating residents: few report any reduction in family assistance; and, on average, they receive help from more than one source of assistance. For a relatively small number of participants, it appears there may have been some displacement of prior family assistance by CHSP. However, the effect is small and the greater reliance on CHSP may have benefits for participants and families, since it makes the resident less dependent on family help and thus may free family to provide the kinds of informal support that both residents and families prefer to have provided by families.

9.5 Program Administration

The new CHSP has several important administrative features, including new funding requirements and greater emphasis on service coordination and case management. Analyses of CHSP program administration focused on program costs and funding and on service coordination.

The median cost per participating resident in the first year was about $2,100. The highest per-participant annual median costs were for meals ($820), personal assistance ($646), and case management ($557). Case management and meals also accounted for the largest percentage of total annual costs. The median percentage of total costs for these services were 36 percent for case management and 25 percent for meals. The relative predominance of these areas of cost reflects the fact that these are CHSP services that are used frequently and by large numbers of residents.

Costs per participant are higher for programs serving persons with disabilities than for those serving the elderly. The per participant costs for persons with disabilities appear particularly high for personal assistance, transportation, and meals. Costs per unit of service are not higher for persons with disabilities for meals, but are higher for personal assistance and transportation, reflecting differences in the level of services or equipment needed for the latter services.

Unit costs for such major services as housekeeping and personal assistance are in the range generally charged for such services by outside vendors. Meal costs for some sites are higher than anticipated, for reasons such as low numbers of initial participants and costs of providing meals that meet dietary requirements. Over time, the unit costs for services may drop or stabilize as programs mature.

It appears that fees paid by some residents are low, in terms both of CHSP program costs covered by resident fees and the fees that would be expected from residents. One quarter of residents pay no fees for CHSP services; and, in total, 60 percent of elderly participants pay $25

or less per month (including no fees). The fee structure will be further examined in subsequent interim reports as programs develop or those that cannot meet funding requirements leave CHSP.

Participating residents support the principle that those who can afford to pay for services should pay for them. At the same time, relatively few (less than one-fourth) say they could afford to pay more for CHSP services, and some of those would not be willing to pay more—overall, it appears that only about 15 percent of participants would remain in CHSP if fees were increased above their current levels.

Service coordinators are concerned that fees are a burden for participants or discourage participation—and in some places they report that similar services are available from other sources at lower cost or for free. Some residents also commented that fees are too high or that they have to accept a combination of services rather than picking only the ones they want. It may be, however, that for some needs, the services are competitive. Thus, for example, some service coordinators report that the quality and cost of CHSP services make them competitive with other sources. Also, the structuring of fees and services so that residents get a coordinated "package" of services for a combined fee (rather than paying for each service independently) is reported by some sites as making the services affordable.

9.5.1 Service Coordination

Responses of both residents and service coordinators show the importance of service coordination. The majority of residents (63 percent) say they see the service coordinator at least one day a week, and 85 percent meet with the service coordinator at least one day a month to discuss service needs. The majority of residents say the CHSP staff provide information on services (86 percent of elderly and 69 percent of non-elderly) and help them arrange for and get services (80-81 percent). Overall, CHSP is the most frequently mentioned source of information on services and help in gaining access to services. The CHSP commitment to service coordination and the frequent interactions between participants and the service coordinator are important to the program and participating residents.

9.6 CHSP Program Dynamics

The new CHSP is designed to serve residents who are at high risk of having to move to a more restrictive living environment. Many participating residents are frail and elderly, so mortality is also expected to be relatively high. CHSP projects face challenges in serving these residents and also in handling a continuing influx of new participants who enter the program as others leave.

9.6.1 Entrance to CHSP

During the period from October 1993, when the new CHSP programs started, to October, 1994, a total of about 900 residents participated in the program; at the time of baseline data collection in November-December 1994, approximately 83 percent of these were currently participating.

The majority of residents who entered CHSP were already residents of the development (81 percent). As described earlier, the majority had "aged in place," living in the development for 5 years or more before entering CHSP. Other CHSP participants came to the program from another development, a home outside the development, or another source (16 percent). Only a few (3 percent) moved into the development from a more restrictive living arrangement.

By October 1994, 15 (44 percent) of the 34 new CHSP sites were serving the full number of residents they had projected for the first year of operation, and 8 (24 percent) had a waiting list. The total number of residents on the waiting list was approximately 10 percent as many as the total number of residents being served at this time.

9.6.2 Program Exits

CHSP is designed to provide supportive services to residents who are very frail or have disabilities, with the objective of helping them continue living as independently as possible for as long as they can. At the same time, residents' age and level of frailty is such that some will die, need to enter nursing homes, or otherwise leave the program over time. In addition to these

reasons for leaving, some residents may stop participating because they are dissatisfied or cannot afford services or, in some cases, because they no longer require services.

During the first year of program operations (October 1993—October 1994), 17 percent of the residents who entered CHSP left the program:

- 7 percent had left CHSP but were still living in the development,
- 5 percent (11 percent of those 85 or older) had moved to a nursing home or hospital,
- 3 percent of participants (5 percent of those age 85 or older) had died, and
- 2 percent had moved to another location.

Comparing the non-elderly with elderly residents: fewer of the non-elderly residents who entered CHSP had left (8 percent had left, compared with 18 percent of the elderly), and most of the non-elderly participants who left the program were still in the development. None of the non-elderly had died or moved to a nursing home or hospital during this period.

These data demonstrate that there is substantial turnover in participation, resulting both from dropouts and from deaths or moves to more restrictive environments. Overall, the data indicate a program exit rate of about 15 percent to 20 percent over the first year of the new CHSP. If this rate were to continue over time, it would imply that only about 300 to 350 of the original 900 program entrants would still be in the program at the end of 5 years.

From a program and service perspective, this would mean: (1) substantial numbers of residents would enter CHSP over time, replacing the ones who leave and requiring assessment and other start-up services as well as continuing service coordination and provision of specific services; and (2) many of the new entrants also would leave the program after one or a few years of participation.

About 40 percent of exits appear to be for reasons other than frailty—because residents leave the program but stay in the development or move to other locations. Possible reasons for people leaving CHSP while staying in the development include: later determination that they

were not eligible (either because they improve or because they were not eligible initially), inability or unwillingness to pay for CHSP services, and dissatisfaction with services. In some cases, service coordinators may need to make special efforts to ensure that residents who can benefit from CHSP are able to remain in the program. In other cases, residents will likely need help obtaining access to supportive services from other sources.

Especially among older participants (those 85 or older), many moves are to nursing homes or other, more restrictive environments. It will be important for service coordinators and PACs to ensure that these exits could not reasonably have been delayed further by provision of services under CHSP. If a resident declines to the point at which CHSP services cannot prevent this move, the service coordinator will need to work closely with residents and family members, if they are available, to help with the transition to a less independent level of living.

9.7 Program Impacts, Evaluation, and Improvements

In addition to describing the CHSP projects and residents, the baseline data provide evaluation findings on several topics, especially: (1) benefits from supportive services provided by CHSP and other sources and satisfaction with services and with the CHSP program; and (2) gaps in services and ways of improving the program.

These results begin to address several of the key CHSP evaluation issues, particularly service adequacy and quality and effectiveness of CHSP in fostering independence. Also, these results can help identify areas for program improvement during the period of implementation of the new CHSP.

9.7.1 CHSP Benefits

Supportive services provide a variety of benefits to participating residents. Both residents and grantees report that services help residents continue living as independently as possible in their own homes. In addition to direct benefits from receiving specific supportive services, residents and grantees say that services provide residents with broader, more

fundamental support: a sense of security; help from committed and caring people, coordinated services that provide an array of needed assistance, and increased social integration.

Most participants are satisfied with the specific help they receive from CHSP or other sources and are satisfied with CHSP. Most participating residents say the services they receive from CHSP and other sources meet their needs and are satisfactory. They also report satisfaction with CHSP on several dimensions of program quality: amount of service, frequency and availability, and provider attitudes. Together, these data point to high levels of participant satisfaction not only with the specific categories of service, but with the way services are delivered.

Many residents say it would be difficult or impossible for them to continue living as they are without the assistance they receive. The services that are most frequently cited as essential to continued living at the current level are those involving higher levels of personal care (e.g., toileting, feeding, transfer, getting in and out of the shower or tub, bathing, and dressing), or such instrumental assistance as help in shopping, meals preparation, or money management. Assistance they receive with housework, home health care, and transportation is also noted by many residents as important to their ability to live as they currently do.

At the same time, it is important to note that as many as one-third or more of residents who receive some services say it would not be difficult or impossible for them to continue living as they are without the services. This information, together with the fact that some residents do not appear to meet the ADL eligibility requirements, suggest that CHSP services are not always being targeted to those most in need of help.

In addition to the direct benefits from specific CHSP services, two of the benefits from CHSP are improved coordination of services and increased social participation among residents. Service coordinators have implemented strategies that encourage social participation—such as escorts to help frail, isolated elderly get to meals; support groups of elderly residents; and companion services.

Grantees report benefits to the developments as well as to the residents who receive services from CHSP. Benefits they report include improved ability to assess residents' care needs, develop care plans, and provide needed services (directly or through other providers). Through service coordination they are also able to provide integrated support for residents. Grantees also say that CHSP services contribute to such other benefits to the development as better maintenance of units.

9.7.2 Recommendations for Change

In some cases, residents say they do not receive the help they need or need more help than they receive. Some need more help with frequent or as-needed care (e.g., assistance with toileting or transferring); others want more services for which CHSP or other programs may limit the amounts provided (e.g., housekeeping assistance). Some residents also say that fees should be lower, or that they should be allowed to choose and pay for selected services rather than being charged for a package of services. Sites have some flexibility in the packaging and fees for services other than congregate meals, and can explore alternatives to meet resident needs.

Grantees recommend changes in several areas: reducing the number of ADLs required for eligibility, reducing resident fees or allowing more flexibility to developments and communities in setting fees, reducing the size of the match, and simplifying reporting requirements. In some of these areas, HUD and the sites have opportunities for change. Others involve statutory requirements (e.g., ADL requirements for eligibility, the match, and some fee requirements), and thus cannot be changed by administrative action. In addition, several grantees suggest holding conferences or providing other means for participating developments to share and learn from others' experience.

Overall, the evaluation findings from the baseline indicate a number of benefits from CHSP and satisfaction with the program, on the part of both residents and grantees. At the same time, grantees ask for changes in several basic features of the new CHSP—especially fees and the match requirement—and ask that the ADL level required for resident eligibility be reduced. These views of the new CHSP have been expressed in the past. Whether they will change as the

new CHSP programs become more fully established in the participating developments will be examined in later rounds of the evaluation.

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APPENDIX A:

Description of New Congregate Housing Services Program

APPENDIX A:

Description of New Congregate Housing Services Program

Under the Congregate Housing Services Program (CHSP), HUD provides a combination of housing and community-based supportive services to frail elderly and non-elderly persons with disabilities living in federally assisted housing. The goal of this program is to help residents maintain their independence and to avoid costly and unnecessary institutionalization. This appendix briefly describes the core features of the program and differences between the old and new CHSP.

Originally, CHSP was authorized as a demonstration program under Title IV of the Housing and Community Development Act of 1978 (42 USC 5301). The new CHSP was authorized under Section 802 of the National Affordable Housing Act of 1990 (PL 101-625), as amended by the Housing and Community Development Act of 1992 (PL 102-550). The new and old CHSPs share a commitment to maintaining resident independence and a number of program features; at the same time, the new CHSP differs from its predecessor in important ways.

CHSP services are targeted to residents who, because of their limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), are at high risk of institutionalization.[1] The old CHSP initially set the eligibility requirement at the level of needing assistance in one or more ADLs. Over time, the eligibility requirements were made more stringent; effective in 1987, residents were eligible if they had at least 3 limitations in ADLs (at least one of which must be in eating or preparing food).

[1]An activity of daily living or physical activity of daily living (PADL) is defined as an activity regularly necessary for personal care. An instrumental activity of daily living (IADL) is defined as a regularly necessary home management activity.

Under the new CHSP, residents must need assistance in at least 3 ADLs to be eligible for services. The ADLs used to determine eligibility for CHSP participation include both physical and instrumental ADLs. These are eating or preparing food, bathing, dressing, grooming, getting in and out of bed and chairs, walking, toileting, and household management. In defining these ADLs and setting the eligibility level, HUD sought to specify a level of functional limitation such that residents are at high risk of institutional placement if they do not receive supportive services, but are not so impaired as to create, in effect, a nursing home in the housing facility. Consistent with this aim, the regulations require that a person must be able to perform at a specified minimum level. For example, in order to be eligible for CHSP, residents must be able to feed themselves or receive assistance in feeding themselves from a family member or other person.

A variety of supportive services is provided under CHSP. Under the old CHSP, all developments were required to provide two meals a day for participating residents.[2] Other services that can be provided through CHSP include housekeeping, personal care, personal emergency response systems, and transportation. Medical treatment is specifically excluded, although health education, wellness programs, and preventive health services are allowed. The new CHSP makes an important change in required services: all developments must provide at least one hot meal a day for residents who participate in CHSP; individual participating residents, however, are not required to include meals in the package of services they receive from CHSP.

Service coordination is central to the new CHSP. HUD's definition specifies:

> Primarily [service coordination] refers to the activity of linking a person to the supportive services or medical services that the individual needs which are provided by private practitioners or agencies in the general community. Additionally, the term may cover case management, both formal and informal, in which the individual (or individuals) providing the service coordination is/are responsible for decisions about the way resources are allocated to an individual on the basis of that person's needs, assessment of service needs for that individual, and determination of eligibility for public services.

[2]Initially, participating residents were required to accept and pay for two meals; program changes in 1987 included reducing the number of meals residents were required to take to 7 per week. Current requirements for the old CHSP are the same as for the new CHSP.

(Congregate Housing Services Program Request for Grant Application (DU100G000016992); OMB No. 2535-0084; p. A-8.)

In CHSP, the service coordinator works with the Professional Assessment Committee (PAC) to provide case management. The PAC is made up of volunteer professionals from the community, including at least one professional in medical services and one in social services. The PAC has primary responsibility for eligibility determination and helps the service coordinator tailor services to resident needs. The service coordinator has ongoing responsibility for helping ensure the resident gets needed services and for monitoring the effectiveness of services provided under CHSP. The service coordinator and PAC are required to reassess resident eligibility and needs periodically.

Under the new CHSP, the service coordinator's functions include providing intake and other general case management and referral services; establishing linkages with all service providers and agencies in the community, including preparing a directory of service providers; referring and linking participating residents to service providers; educating residents on such issues as service availability, application procedures, and clients' rights; educating other staff about aging and services, to help them better assist residents; developing case plans in coordination with the PAC or assessment services in the community (this is a function that may be provided); monitoring ongoing provision of services and keeping PAC and provider agency informed about resident needs; setting up volunteer programs of support with service providers in the community; and helping residents build informal support networks with family, friends, and other residents. Further, the program requires that the CHSP service coordinator not have other CHSP responsibilities, such as serving as recreation or activities director, providing supportive services directly, or assisting with other development administrative work unless the person serves part-time as coordinator and part-time in carrying out the other duties. (CHSP Request for Grant Application, p. A-9--A10, p. A-12.)

Under the old CHSP, service coordinator functions were typically performed by the grantee or development manager. In the new CHSP, the importance of service coordination is reflected in the creation of the separate service coordinator position and the requirement that the

person selected for this position have specialized training and experience. The definition of the specialized service coordinator position and the professionalization of this role are intended to improve eligibility determination and case management.

Under the new CHSP, the service coordinator must have, at a minimum, a bachelor of social work or related degree or equivalent work experience; training in the aging process, elder services, disability services, and other related areas;[3] two to three years' experience in social services delivery with the elderly and/or non-elderly disabled persons; demonstrated working knowledge of supportive services in the community; and ability to advocate, problem-solve and provide results for residents served by CHSP. (CHSP Request for Grant Application, p. A-10--A-12.)

The case management provided by the service coordinator and PAC meets several needs, including targeting of services (ensuring the program serves residents who need supportive services to continue living independently and does not provide services to others for whom services are useful or desirable but not essential), tailoring services to the needs of individual participating residents, and ensuring that appropriate and high quality services are provided to residents.

The evaluation of the old CHSP by Dr. Sylvia Sherwood and colleagues found that the program was generally successful in providing services to residents who needed help, but served a substantial number who did not require assistance. Overall, residents were satisfied with the program's services and CHSP did not reduce family or other informal support to residents. CHSP was found to reduce short-term institutional placements, but not rates of permanent institutionalization (Sherwood, Morris and Bernstein, 1984; Sherwood, 1985; Struyk, Page, Newman, Carroll, Ueno, Cohen, and Wright, 1989).

[3] If the person does not already have this training, training requirements must be met within a year.

The tightening over time of eligibility requirements under the old CHSP and the careful definition of ADLs under the 1990 Act are efforts to ensure that CHSP targets services to those who need the services to continue living as independently as possible and who can benefit from CHSP services.

Another important feature of the CHSP is the requirement that residents be clearly involved in choosing the package of services they receive under CHSP. In developing the services plan, under both the old and new CHSP, the PAC must take into account the participating resident's needs and wants and provide at least the minimum supportive services necessary to maintain independence. The resident may elect other services, if available, at cost.

Throughout its history, CHSP has had multiple funding sources. Under the old CHSP, HUD and other programs provided a proportion of the funding. From its beginning, CHSP required that some part of the cost of services be paid by residents who participate in the program. Most grantees used a sliding scale of fees for residents, depending on their income level.

The new CHSP incorporates several major changes in the funding formula. The first is the requirement that grantees or third parties share in the cost of providing CHSP services. The grantees are required to provide at least 50 percent of CHSP costs. This match can be provided in several forms, including cash, imputed value of services or staff provided by a third party (e.g., a partner agency), some in-kind contributions (e.g., value of furniture, supplies or food), and the value of services provided by volunteers.

The second major change is further specification of the requirement for resident fees for CHSP services. In total, 10 percent of a new CHSP grantee's costs must come from resident fees. Fees are required for meals and are optional for other services. Resident fees cannot exceed 20 percent of the resident's adjusted income, but, below that level, there is not a sliding scale for resident fees. If a resident has no income, the fee may be waived, with the grantee and

HUD paying for services for that resident. HUD covers up to 40 percent of costs under the new CHSP.

APPENDIX B:

Evaluation Questions and Data Sources

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
How do grantees propose to meet their share of the matching funds? Which agencies, individuals, or entities provide support? How is sponsorship or matching funds sought? What types of approaches generate the most support? How effective are grantees/owners in maintaining the support over the five year period? How has support changed over the five years (both in dollar amounts and provider agencies)?	• Sources of matching funds • Methods for securing match • Annual match contributions • Dollar amount and match sources each year	• Grantee budgets • Grantee reports • Grantee survey	• Financial analyses of grantee funding
Supportive services plan			
How are the services purchased? Are they provided by project staff or are they contracted out through State or local agencies? Where are services provided for the non-elderly on-site and/or off-site?	• Providers of services • Sources of payment of services • Location of services	• Grantee budgets • Grantee surveys • Program records	• Descriptive analysis of service organization and delivery
How are services delivered? Who coordinates service delivery? When comparing in-house services versus contract-services, what factors contribute to efficient and effective delivery systems? Are the projects that have effective and efficient delivery systems staffed by persons who have had previous experience with providing support services? What does "good" (e.g., on time, within budget, complete, uninterrupted, etc.) service delivery depend on?	• Method of service delivery • Efficiency factors • Effectiveness factors • Staff experience • Definition of "good" service delivery	• Grantee surveys • Service coordinator surveys • Grantee budgets • Participant surveys	• Descriptive analysis of services • Comparative analysis of in-house versus contracted services
Is it effective and cost-efficient to have a	• Cost of congregate meals	• Food budget	• Analysis of grantee food

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
congregate meals program if it is not mandatory for all residents? Is it a plus or a detriment to have such a program in CHSP? Why? Are there differences in meal plans (e.g., diets, costs, etc.) for the elderly and non-elderly group home projects? To what extent do projects use surplus food from USDA? What does this add to the program? Have projects become food stamp sites as required? Do participants use food stamps?	program ● Revenue from congregate meals program ● Types of meal plans ● Participation in meals program ● Use of surplus food ● Food stamp certification ● Use of food stamps	● Grantee surveys ● Service coordinator surveys	programs
2. <u>Community/Environment</u> *Services: Availability, access, sources, cost linkages*			
What services (funded by non-Federal sources for the elderly and non-elderly persons with disabilities) are available in the communities that have CHSP projects? Do project officials attempt to link the CHSP program with other Federal programs (e.g., Home or CDBG rental rehab components)?	● Services for elderly in local area ● Linkage of CHSP with other programs	● Grantee surveys ● Service coordinator surveys ● PAC surveys	● Descriptive and comparative analysis of services for elderly
Funding: Sources, levels			
What are the typical funding sources? How stable are these sources? Do they vary over time? Are grantees able to expand funding sources over time if needed?	● Sources of funds ● Amount of funds by source each year	● Grantee budgets ● Grantee reports ● Grantee surveys	● Financial analysis of grantee funding
B. Implementation/Administration: Resident			

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
Selection, Assignment and Care Plan Development			
1. Participants			
Residents: Role in selection, plan development			
What services are provided? How are service packages tailored to the residents' needs? What role do residents play in determining the services they receive? How do they make choices?	• Services provided • Optional services • Process for selecting services	• Grantee surveys • Service coordinator surveys • Participant surveys	• Descriptive analysis of services
What services are demanded most often by CHSP elderly persons? Which services are demanded most often by CHSP non-elderly disabled? What types of services are provided? How frequently? Which are easiest to provide?	• Number of times each service used • Frequency of service provision	• Grantee surveys • Service coordinator surveys • Program records • Participant surveys	• Descriptive analysis of services

Were eligible frail elderly and disabled persons recruited to reach the program ceiling set by grantees? How was recruiting done? Have additional candidates been added to the project's waiting lists as a result of the recruiting effort? What are the characteristics (include age, marital status, gender, race, ethnicity, etc.) of the eligible candidates for the program on the waiting lists?	• Methods of recruiting
	• Waiting list
	  • Age
	  • Marital status
	  • Gender
	  • Race
	  • Ethnicity
		• Service coordinator surveys
		• Program records
			• Analysis of characteristics of waiting list residents

Service Coordinator: Experience, qualifications, organization of work			
What are the qualifications and duties of the service coordinator? Did coordinators have	• Job description of service coordinator	• Grantee records • Grantee surveys	• Descriptive analysis of coordinator characteristics

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
previous experience serving frail-elderly populations and populations with special needs? How are coordinators chosen?	• Expertise and selection of service coordinator	• Service coordinator surveys • Service coordinator job description	and role
PAC: Membership, operations, role in selection and plan development			
What is the role of the PAC? How do PACs operate? How do PACs interact with other program entities (e.g., sponsors, project managers, service coordinators, service providers, residents)?	• Description of PAC role • Staff views of PACs	• Grantee records • Grantee surveys • Service coordinator surveys • PAC surveys • PAC procedures	• Descriptive analysis of PAC role and operations
What role do PACs play in determining the services received by residents? To what extent do PACs target and tailor the services? How are residents involved in the process? Are PACs involved in determining who is a potential eligible candidate? To what extent are PACs ratifying the project managers' or service coordinators' decisions? Once sponsors or project managers have identified potential residents, are PACs reluctant to reverse the determination?	• Role of PACs in selecting participants • Role of PACs in selecting services	• Grantee records • Grantee surveys • Service coordinator surveys • PAC surveys	• Descriptive analysis of PAC role and operation
What are the qualifications of PAC members (including skills, experience, training)? Does the voluntary nature of the PAC affect membership, attendance, work ethic, and decision making	• Qualifications of PAC members • Impact of voluntary PAC	• Grantee records • PAC surveys • Service coordinator surveys	• Descriptive analysis of PAC role and operations

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
ability?			
Do some sponsors or project managers have agreements with community agencies to perform frailty assessments? How does this procedure differ from the voluntary PAC? Are the outcomes similar or different depending on which entity performs the frailty assessment and tailors and targets the services? What do differences depend on?	• Arrangements for frailty assessments • Differences in types of assessments • Assessment decisions by type • Perceived reasons for different outcomes	• Grantee records • Grantee surveys • Service coordinator surveys • Program records	• Descriptive comparisons of assessments by community agencies and by PACs, including differences in outcomes
Are disabilities definitions and HUD's ADLs applied consistently by those performing assessments? Do assessments differ and why? Do they differ depending on the entity performing the evaluation, the skill mix of the PAC (and/or entity) or the assessment instrument used? Are assessment guidelines specific enough to standardize the process across grantees?	• Perceived application of HUD's ADLs • Assessment guidelines and instruments • Perceived differences in assessments	• PAC surveys • Service coordinator surveys • Program records • PAC procedures • Assessment forms	• Comparison of assessments across grantees
2. <u>Processes</u>			
Identification of eligible residents, selection			
How are priorities assigned and who assigns priorities?	• Priorities for resident selection	• Grantee records • Grantee surveys	• Descriptive analysis of selection priorities and process
How does the grantee identify potential participants in the program? Does the selection process tend to include or exclude any particular	• Grantees' views on identifying participants • Perceived impact of	• PAC surveys • Program records • Grantee surveys	• Descriptive analysis of selection process

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
type of potential residents?	selection process	• PAC surveys	
Care plan development			
Who are the key contributors to the development of the care plan? How involved is the PAC in development of the care plan? Does the local Agency on Aging review the careplan?	• Contributors to care plan • Perceived role of PAC • Perceived role of AAA	• Grantee surveys • PAC surveys • Service coordinator surveys	• Descriptive analysis of care plans and care plan development
3. Initial Outcomes			
Targeting of services: Resident needs, characteristics, resources			
To what extent are residents involved in providing services? What are the characteristics of residents hired to provide supportive services?	• Role of residents in service provision • Number and characteristics of residents providing services	• Service coordinator surveys • Grantee surveys	• Descriptive analysis of resident role in service provision
What are the advantages and disadvantages of serving a population outside the project? How many CHSP projects serve outsiders?	• Services to outsiders • Perceived impact of serving outsiders	• Program records • Grantee surveys • Service coordinator surveys	• Descriptive analysis of services to outsiders
Care Plan: Services: Types, sources, payment			
What are the services offered? How are the services paid for? To what extent do residents pay for the services?	• Services offered • Sources of payment for services	• Program records • Grantee surveys • Service coordinator	• Descriptive analysis of services and payment

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
		surveys	
C. Implementation and Administration: Service Provision, Monitoring, Development and Change in Program, Residents, Process			
1. <u>Participants</u> *PAC* <u>Stability/change in membership, qualifications</u>			
How often do PACs replace members? Why? Are PAC vacancies filled within the allocated time frame? How often are PACs forced to delay assessment because membership dropped below three members?	• PAC turnover • Length of PAC service • Reasons for PAC vacancies • Number and length of times PAC less than three members	• Program records • PAC surveys	• Descriptive analysis of PAC turnover and operations
<u>Functions: Resident evaluation, monitoring/ recordkeeping</u>			
Do PACs (or community agencies) reevaluate residents on an ongoing basis? How often? What prompts reevaluations? Do reevaluations result in changing service plans? How often are service plans updated? What are other outcomes or reevaluations?	• Time of resident reevaluation • Reasons for reevaluations • Reasons for changes in Service plans • Time of service plan updates • Other reevaluation	• Program records • PAC surveys • Service coordinator surveys	• Descriptive analysis of resident reevaluation and service plan change

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
	outcomes		
Do the PACs (or community agencies) fulfill their recordkeeping requirements? Who actually does the work? Are these considered burdensome?	• Record-keeper for PACs • Recordkeeping require-ments and operations	• Program records • PAC surveys • Service coordinator surveys	• Descriptive analysis of PAC recordkeeping
Service Coordinators <u>Relationship/interaction with residents, PACs, service providers</u>			
What is the relationship of the coordinators to the PACs? How do coordinators interact with the PACs: (1) prior to recommending a potential participant to them for assessment; (2) in dealing with the PAC on a referred individual; (3) at PAC meetings; and (4) between meetings?	• Number and type of contacts between service coordinator and PAC members	• Service coordinator surveys • PAC surveys	• Descriptive analysis of service coordinators-PAC interactions and operations
How do coordinators interact with residents? How do coordinators tailor/target services? How do coordinators help residents get the most out of the program? How do they contribute towards delaying institutionalization?	• Number and type of contacts between service coordinator and residents • Coordinators' decisions on services • Coordinators actions to delay institutionalization	• Program records • Service coordinator surveys • Participant surveys	• Descriptive analysis of service coordinator-resident interactions and effects
On average, what is the coordinators' workload? What are the coordinator-to-participant ratios? Is the workload manageable? What do coordinators consider ideal?	• Coordinators' work load • Number of participants per service coordinator	• Grantee records • Program records • Service coordinator surveys	• Descriptive analysis of coordinator workload • Coordinator view of workload

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
What assistance do coordinators get? From whom?	• Types and sources of assistance for coordinators	• Service coordinator surveys • Program records	• Descriptive analysis of coordinator role and assistance
What is the cost of the coordinator function? What portion of program costs does this represent?	• Salary of coordinator • Other coordinator costs • Total program costs	• Grantee budgets and financial reports	• Descriptive analysis of coordinator function costs
What is the turnover rate for coordinators? What are the main reasons for turnover? What effect does turnover have on program management and outcomes?	• Coordinator turnover • Reasons for leaving • Effects of turnover	• Service coordinator surveys • Grantee surveys	• Descriptive analysis of coordinator turnover and effects
Do some coordinators work part-time? Are the service coordinators contract employees? Are there differences in the quality of the services residents receive when coordinators work part-time/full-time, or when they are contract employees?	• Coordinators' contract • Coordinators' work hours	• Grantee records • Service coordinator surveys • Grantee surveys	• Descriptive analysis of coordinator status and hours • Descriptive analysis of service quality
Grantee <u>Approaches to service provision</u>			
What are the main services provided? Are all services provided on-site? What services are used most and which are used very little? How often are service packages modified and for what reasons?	• Services provided • Location of services • Use of services • Date of service package modifications	• Program records • Grantee surveys • Participant surveys	• Quantitative analysis of use of services

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
Financial: Matching funds, costs, commitments			
Do the fees get collected over the term of the grant?	• Fee payment	• Program records • Grantee surveys	• Financial analysis of fee collection
Community/Environment/Service Providers			
Stability/change in services: Availability, cost, quality; levels and model of service; service demands; funding sources and levels			
Does having the ability to obtain services through Medicaid or other community providers at less cost restrict participation in the program?	• Resident service eligibility and use • Perceived number of non-participants due to avail-ability of other services	• Grantee records • Grantee surveys • Service coordinator surveys	• Participation analysis • Analysis of availability and use of other services
Are there service providers in the area without fees or with fees or donations (e.g., Title III Meals, Meals-on-Wheels, Medicaid home-based waivers, etc.)? To what extent, if any, are these services utilized by residents in CHSP or do residents utilize these services instead of utilizing CHSP? What are the benefits to the residents and to program from residents using outside services?	• Listing of area service providers • Use of outside services • Perceived benefits of other services	• Grantee records • Grantee surveys • Service coordinator surveys	• Analysis of services used by participants
2. Processes			
Service Delivery			
Sources, costs, quality			

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
What is the per unit cost of delivering the different types of services? What is the per unit administrative cost of providing the different services? If any, what is the difference in cost of providing services to the disabled and to the elderly in CHSP projects?	• Number using each service • Cost of each service • Administrative cost of each service	• Program records • Budgets and financial records	• Cost analysis of services - Unit service and administrative costs - Elderly vs. disabled service cost comparisons
<u>Integration</u>			
Did residents receive services before enrolling in the program? What type of services did they receive and who was the service provider? Were the residents special needs met prior to the program? If all needs were not met, which ones were met and which were not? How are the services provided by the grantees integrated with services residents already received?	• Number and type of prior services used • Participants' view of services • Use of CHSP and other services	• Participant surveys • Service coordinator surveys • Program records	• Analysis of CHSP and other services used by participants
<u>Evaluation/Monitoring</u>			
Are the grantees monitoring their service contracts according to the plan in the applications? Is service delivery to residents discontinued for a period of time? How frequently? What causes these gaps in service?	• Frequency of service monitoring • Length of service delivery • Cause of stoppage	• Grantee surveys • Program records • Service coordinator surveys	• Descriptive analysis of grantee services - Service contract monitoring - Service continuity
How and to what extent do coordinators monitor residents? Service providers? Service delivery? What are the effects of this involvement?	• Service coordinator monitoring of residents and services	• Service coordinator surveys • Participant surveys	• Analysis of monitoring role and effect of coordinators
Resident Assessment and Service Provision			

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM

Study Questions	Data Elements	Data Sources	Analysis
Resident re-evaluation			
How often are residents re-evaluated? What are the reasons for and outcomes of these re-evaluations?	• Dates for resident reevaluations • Reasons for reevaluation	• Program records • Service coordinator interviews	• Analysis of resident evaluations and outcomes
How do residents rate the services being provided? Are there additional services they would like?	• Perceived quality of services • Perceived need or services	• Participant surveys	• Analysis of resident satisfaction • Analysis of resident service needs and preferences
Service package, levels, payment			
What are the primary sources of payment for services being offered? Does the grantee have any method of periodically assessing the quality and cost of services?	• Payment sources • Limits on use of services • Service assessments	• Grantee records • Grantee surveys • Service coordinator surveys	• Analysis of resident services and payment sources • Analysis of grantee management of services
D. Performance and Impact			
1. Grantee/Program Outcomes			
Increase capability of housing management to serve the needs of residents who are aging in place			
What has been the impact of CHSP on project managers' ability to assess needs of frail residents and provided needed services? How has CHSP affected the project's coordination of services for	• Grantee financial reserve • Grantee income • Grantee service costs • Assessment of frail	• Grantee budget and financial reports • Grantee surveys • Service coordinator	• Financial analysis of grantee • Analysis of resident services

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 1: PROVIDE COMPREHENSIVE DESCRIPTION OF NEW CHSP PROGRAM			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
residents?	residents' needs before and during CHSP ● Factors affecting coordination of resident services	surveys ● Grantee records	- Assessment - Services - Coordination
2. <u>Community/Environment</u> *Housing and service models* Are there models for success from the evaluation? Have some CHSP programs identified methods or services that result in clearly superior performance? Can these actions be replicated by other CHSPs and service providers for the elderly and disabled?	● Indicators of superior performance ● Indicators of access across all or most of CHSPs	● Grantee records ● Grantee surveys ● Site visits	● Comparative analysis of CHSP programs, services, and management ● Quantitative analysis of performance indicators ● Case studies
Service integration-developing partnership between federal and state governments to serve needs of elderly and disabled How have the CHSPs utilized services for the elderly and disabled offered by federal and state governments? How can federal and state governments improve their services based on the results of the CHSP evaluation?	● Utilization of federal and state services available to residents ● Potential service improvements	● Grantee records ● Grantee surveys ● Service coordinator surveys ● Site visits	● Descriptive analysis of use of government services ● Analysis of changes needed in these services

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
A. The CHSP Population and Setting			
1. Residents			
Demographic characteristics			
What is the demographic profile of the program residents (including income, age, marital status, gender, race, ethnicity, etc.)? What percent of the CHSP projects include non-elderly with disabilities? What is the breakdown of the population within all projects by disability type?	• Household composition • Income (sources and amounts) • Age • Disability • Marital status • Gender • Race/ethnicity • Education • Family and other informal support • Current/former occupation	• Participant surveys • Program records • Occupancy records	• Descriptive analysis including measures of central tendency and variance and frequency distributions
Where were the residents living before entering the program (e.g., in the existing project, nursing home, with children, hospital, etc.)?	• Location of participants before current housing • Length of residence • Effect of CHSP on move	• Participant surveys	• Descriptive analysis of residence patterns
Needs/Functional Status/Disability Status			
What types of disabilities are served? What are the service needs of non-elderly disabled and elderly residents? With which ADLs do residents need assistance? How often are residents reevaluated?	• Residents ADLs - HUD ADLs - ADLs/IADLs • Frequency of evaluation	• Program records • Service coordinator surveys • Participant surveys	• Descriptive analysis of resident ADLs, needs • Analysis of evaluation frequency

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE

Study Questions	Data Elements	Data Sources	Analysis
Resources: Economic, social			
What are the income ranges of the residents? What is the extent of their resources? what proportion are able to pay the fees established by the grantee? What options are available to residents who cannot pay the fees. Do the fees collected equal the amount in grantee's budget? In total, what percentage of CHSP program costs are paid by fees?	• Income • Value of assets and savings • Ability to pay fees • Alternatives to payments	• Grantee records • Participant surveys • Program records • Grantee survey	• Descriptive analysis of resident income • Analysis of ability to pay fees, and options for residents who cannot pay fees
Were residents incurring any out-of-pocket cost for services prior to the program? If so, in what instances? Was the pre-program cost to the frail elderly and/or the disabled person greater or less than the CHSP program costs?	• Cost of services received prior to CHSP • Cost of services received under CHSP	• Participant surveys • Program needs	• Descriptive analysis of residence patterns
B. Implementation and Administration: Resident Selection, Assignment and Care Plan Development			
1. <u>Initial Outcomes</u>			
Targeting of services: Resident needs, characteristics, resources			
Are there elderly or non-elderly person with disabilities who reside in housing projects eligible for CHSP, but who are not CHSP project residents, receiving program services	• # of eligible but non-participating residents • Characteristics of non-participating residents (see	• Grantee survey • Grantee records • Service coordinator surveys	• Comparison of information on participants, eligible non-participants, and "outsider" participants

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE

Study Questions	Data Elements	Data Sources	Analysis
at a participating CHSP project? What are these "outsiders" characteristics (including income, age, marital status, gender, race, ethnicity, etc.) How do they get the services?	list of participant characteristics) ● Source and types of services received by non-participants ● Reasons for non-participants ● Reasons for "outsider" participation		
C. Implementation and Administration: Service Provision, Monitoring, Development and Change in Program, Resident, Process			
1. <u>Participants</u> Residents <u>Stability/change in functional status, independence, resources, service utilization, program participation</u>			
Do residents get support from family/friends while in the program? What kinds of support? Did they get this type of support before enrolling in the program?	● Extent and types of social support ● Sources of social support ● Change in social support due to program	● Participant surveys ● Service coordinator surveys ● Program records	● Descriptive analysis of types of support and changes in service types or levels with CHSP participation
Do residents stop participating in this program? How often? For what reason(s)? Are those who leave the program temporarily (e.g., to receive special care due to an accident, ill health, etc.) more apt to have	● # of program dropouts ● Reasons for dropping out ● # of returnees	● Service coordinator surveys ● Program records ● Participant surveys ● Proxy surveys	● Analysis of program exits - patterns - reasons - conditions

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE

Study Questions	Data Elements	Data Sources	Analysis
preexisting or chronic medical conditions?			
What is the average amount of time (per age group) residents remain in the program? What is the turnover rate? What are the reasons for leaving the program permanently? Where do residents go if they leave the program (e.g., nursing home, hospital, family's home, etc.)?	• Time in program • Location of those who left program (nursing home, hospital, family's home, etc.)	• Program records • Participant surveys • Proxy surveys	• Descriptive analysis of program dropout rate and reasons for dropping out, using frequency distributions
Satisfaction			
What is the level of resident satisfaction? Are there particular services that tend to increase resident satisfaction? What factors reduce resident satisfaction and how do grantees deal with these factors?	• Level of satisfaction with housing and neighborhood • Level of satisfaction with life • Level of satisfaction with costs of services • Importance of various services to life satisfaction • Factors that would increase satisfaction	• Participant surveys • Service coordinator surveys • Site visits	• Descriptive analysis of resident satisfaction
Co-payment			
What is the average income of residents? What is the source of income? How much do they pay to participate in the program? What would be the effect of residents or participation if the contribution required of residents was raised or lowered? How would participation be affected and by how much? Does the co-payment act as "vote" for the	• Participant income sources and levels • Costs to participants • Cost as a percentage of income • Effect of cost increases to residents	• Participant surveys • Program records • Service coordinator surveys	• Descriptive analysis - Resident income - Co-payments - Effects of co-payments

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE

Study Questions	Data Elements	Data Sources	Analysis
program or just as a source of income for the program? Does the co-payment make the person a discerning consumer?	• Significance of costs		
Are there residents who elect to pay for services beyond those they are screened for? Why? What is the profile of these residents? Which services are requested most frequently?	• Services eligible for • Services requested • Services received • Reasons for "extra" services	• Program records • Service coordinator surveys	• Comparison of services eligible for and those received • Characteristics of users for "extra" services and reasons for use
To what extent do grantees ask for fee waivers so that the cost of the fee is split between the grantee and HUD for those with some (but not "much") income? Do grantees have trouble raising this additional amount?	• Number of fee waivers requested and granted • Difficulty in raising additional match • Reasons for waivers • Guidelines for granting fee waivers	• Grantee survey • Grantee budgets and financial reports	• Descriptive analysis of fee collection, waivers and materials
What percent of the residents are not able to pay their share of service costs? Is low income the only reason for non-payment? If not, what are other reasons? How many residents leave the program because of fees?	• Resident fee payment • Reasons for inability to pay fee • Fee as reason for leaving program	• Service coordinator surveys • Program records • Program exit information	• Analysis of resident share of service costs - Non-payment - Reasons
What effects does non-payment by residents have, if any, on residents, on the service distribution system, on the operation of the program? Under what circumstances? How? To what extent?	• Frequency of non-payment by residents • Perceived effects of non-payment	• Program records • Grantee surveys	• Financial and program analysis of fee non-payment

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE

Study Questions	Data Elements	Data Sources	Analysis
A. Performance and Impact			
1. Resident Outcomes			
Increase or maintain ability to function			
Have residents, in their estimation, increased or maintained their ability to function as a result of the program? If not a result of the program, to what do residents attribute their independence?	• Level of functioning (baseline and follow-up) • Resident assessment of impact of program on functioning • Resident assessment of other impacts on functioning	• Participant surveys	• Analysis of resident perception of service efforts in functioning, ability to maintain independent living
How often are residents confined to bed or restricted in their activities? Did residents increase or decrease their use of services over the course of the program? Are residents satisfied with the services they receive while in the program?	• How often are activities restricted • Satisfaction with quality and costs of services • Changes in service use over time	• Participant surveys • Proxy surveys • Service coordinator surveys	• Descriptive analysis of service use, activity restriction days, satisfaction with services
Foster independent living			
How does the program contribute towards the person's ability to maintain independence? What program features are most significant for maintaining independence?	• Rate of moves to more restrictive environment • Resident perception of - reasons for independence - service needs		• Analysis of rate of institutionalization of program participants • Descriptive analysis of importance of services and other services
Do residents believe that services allow them to remain independent? If yes, to what			

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
extent? If not, to what do they attribute their ability to remain independent? Do residents believe their needs are met?			
Delay or prevent premature institutionalization			
How predictive of institutionalization are HUD's ADLs? How does their prediction ability compare with other ADL measures? What proportion of residents became institutionalized over time? What are the effects on institutionalization of residents' needs, resources (e.g., family), and types and intensity of services.	• Participant institutionalization • Participant ADLs	• Program records • Proxy surveys • Service coordinator surveys • PAC surveys	• Causal analysis of impact of ADLs on institutionalization using regression techniques
Resident satisfaction			
Has the level of resident satisfaction changed over time? What are the key reasons for high or low levels of resident satisfaction?	• Resident satisfaction • Housing characteristics-neighborhood characteristics • Relations with other tenants	• Participant surveys • Site visits	• Descriptive analysis of resident satisfaction - Levels - Reasons - Change
2. <u>Service Costs</u>			
How much does it cost to maintain an individual in the program per month (rural/urban)? What service components are most cost-effective in preventing premature	• Monthly participant cost for services • Monthly total program cost for participants	• Program records • Participant surveys	• Analysis of per-person service costs • Descriptive analysis of effects of services

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 2: ASSESS EFFECTIVENESS IN MAINTAINING INDEPENDENCE			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
institutionalization? What ones are not cost-effective?	• Impact of individual services on institutionalization		

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 3: COMPARE NEW CHSP WITH HOPE FOR ELDERLY INDEPENDENCE			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
The CHSP Population and Setting			
Grantees			
Characteristics: Type, location			
Are any PHAs operating both CHSP and HOPE for Elderly Independence projects and are these in the same PHA servicing area?	• Location of CHSP and HOPE projects by type of project	• CHSP grantee application • Grantee surveys • HOPE evaluation	• Comparative analyses of new CHSP and HOPE for Elderly Independence
Implementation/Administration: Resident Selection, Assignment and Care Plan Development			
Participants			
PAC: Membership, operations, role in selection and plan development			
How do the CHSP PACs differ from the HOPE for Elderly Independence Demonstration Program PACs?	• Grantee views of PACs • PAC membership • Perceived role of PACs in selection and plan development	• Grantee surveys • PAC surveys • HOPE evaluation	• Comparative analysis of new CHSP and HOPE
Initial Outcomes			
Targeting of services: Resident needs, characteristics, resources			
Are there outsiders located in an area where	• Demographic data on HOPE	• HOPE evaluation	• Descriptive analysis of

CHSP Program Evaluation
Data Elements, Data Sources, and Analysis

OBJECTIVE 3: COMPARE NEW CHSP WITH HOPE FOR ELDERLY INDEPENDENCE			
Study Questions	**Data Elements**	**Data Sources**	**Analysis**
the HOPE for Elderly Independence CHSP and Programs are operating?	grantees		HOPE projects

APPENDIX C:

Evaluation Methods

APPENDIX C:
Evaluation Methods

1. INTRODUCTION

The new Congregate Housing Services Program (CHSP) provides a combination of housing and community-based supportive services to frail elderly residents and non-elderly persons with disabilities who are residents of federally assisted housing.

The main purposes of the program are:

- To promote and encourage maximum resident independence within a home environment, and
- To improve the ability of management to assess the service needs of eligible residents and provide or ensure the delivery of needed services.

The U.S. Congress mandated an evaluation of the new CHSP in Section 802(l) of the National Affordable Housing Act of 1990. This evaluation is being conducted by the Research Triangle Institute (RTI) under a contract from the U.S. Department of Housing and Urban Development (HUD), Office of Policy Development and Research (PD&R).

The overall objectives of this evaluation are:

- To provide a comprehensive description of the new CHSP;
- To assess the effectiveness of the program in maintaining the independence of elderly and disabled persons by providing a range of supportive services; and
- To compare the new CHSP with the HOPE for Elderly Independence (HOPE 4) Demonstration Program, another HUD program with a similar mission.

Table C.1
Evaluation Issues

Implementation and Administration	Performance and Impact
1. Grantee and project characteristics; ability of grantees to maintain match	1. Impact of co-payment agreements
2. Role and performance of Professional Assessment Committees (PACs)	2. Role and impact of service coordinators
3. Targeting of CHSP services	3. Effectiveness of CHSP in fostering independent living; comparison with HOPE for Elderly Independence
4. Provision, quality, and cost of services	

The evaluation focuses on two sets of issues: (1) implementation and administration of the new CHSP and (2) performance and impact of the program (see Table C.1). It is designed to address a set of specific questions under each of the major issue areas. Appendix B provides the full matrix of evaluation questions and data sources.

To conduct the five year (1993-1998) evaluation, RTI is collecting data from a variety of sources: residents who participate in the program, service coordinators, representatives of PACs, grantee staff, grant applications, program reports and records, HUD officials, and secondary data sources. Data collection and analysis are organized into four phases. These phases, and the major data sources for each, are summarized in Table C.2.

Data from the successive phases will be used to describe CHSP projects, the types of housing in which the projects are located, and CHSP operations, services, and residents over time; to analyze the implementation of the program as grantees move from planning and start-up to full implementation and then maturity; and to assess the impact of the program on

Table C.2
Overview of CHSP Evaluation Project

Activity/Product	Phase 1	Phase 2	Phase 3	Phase 4
Data Collection and Analysis				
Grantees Telephone survey		First survey of grantees, SCs, and PACs	Surveys of SCs and PACs	Follow-up survey of grantees
Other data collection and analysis	Data abstraction from grant applications and reports to HUD	Analysis of grantee reports	Analysis of grantee reports	Analysis of grantee reports
	Secondary data on community context		Site visits to 4 grantees	Site visits to 6 grantees
Residents		First (baseline) survey of residents	Second (first follow-up) survey of residents	Third (second follow-up) survey of residents
Comparisons		HOPE for Elderly Independence grantees and participants; participating residents vs. CHSP waiting list	HOPE for Elderly Independence grantees and participants	HOPE for Elderly Independence grantees and participants
Reports	First Interim Report	Second Interim Report	Third Interim Report	Final Report

residents, grantees, and their communities. In each phase, comparisons with HOPE for Elderly Independence will be used to increase understanding of CHSP and to assess its effects.

This second interim report presents data from the baseline (Phase 2) collected for the period from initial program implementation starting in October 1993 through the time of Phase 2 data collection in November and December 1994. RTI collected and analyzed data from four major sources in Phase 2:

- Baseline interviews with grantees and service coordinators;
- Baseline questionnaires administered to residents participating in CHSP;
- Data on participating residents and on residents who had entered and left CHSP prior to the baseline data collection, provided by the service coordinators at participating sites; and
- Annual reports requested by HUD's Office of Elderly and Assisted Housing and submitted by grantees to local HUD field offices.

Table C.3 summarizes the data from these sources.

Table C.3 Data Sources and Modes

Data Source	Number of Respondents	Data Collection		Topic Areas
		Period	Method	
Grantee	21 grantees (for 34 active programs)	November to December 1994	Telephone interviews	• Grantee agency • Program staffing • Services in development • Matching funds • Grant application • Program design and implementation • Impacts of CHSP
Service Coordinator	26 service coordinators (for 34 active programs)	November to December 1994	Telephone interviews	• Participant selection and enrollment • Care plans • Service provision • Impacts of CHSP
Resident	667	November to December 1994	Group, individual and proxy interviews	• CHSP neighborhood • Health and use of medical services • Physical functioning • Services received through CHSP and other sources • Social activities and help from families
Annual Reports	42 (34 active in Year 1)	November 1994 to January 1995	Requested from grantees	• Project type • Participant mix by age, race/ethnicity • Service levels and costs • CHSP entries/exits • Narrative report

2. EVALUATION METHODS AND OPERATIONS

The remainder of this appendix describes the approaches taken in conducting the CHSP evaluation to date, including instrument development, data collection, data processing, and analysis.

2.1 Development of Data Collection Instruments

Prior to developing the data collection instruments, the data collection protocols were discussed by the project team. The decision was made to have a resident survey instrument that could be self-administered or administered by an interviewer if the respondent was too physically or visually impaired to complete it on his or her own. Since RTI must also compare the CHSP with the HOPE for Elderly Independence Program (HOPE 4), the RTI Project Director then met with the Westat Project Director (the HOPE 4 evaluation contractor) and others to discuss the survey content, using a draft developed by Westat as the basis for the discussion. After the initial meeting, RTI staff developed a data matrix that contained all of the evaluation questions and listed the data elements and possible sources of data to be included in the questionnaire. This matrix, together with the Westat resident questionnaire, served as the basis for the development of the resident and grantee surveys. It is included in Appendix C of this report.

Upon completion of the first draft, the baseline resident and grantee survey instruments were reviewed for aging (especially ADL) issues by Dr. Catherine Hawes and for housing issues by Dr. William Rohe. Again, the instruments were checked against the data matrix to ensure all evaluation questions were covered. Next the resident questionnaire was pretested by RTI's cognitive laboratory staff to ensure it would be appropriate for a frail elderly population. Changes were made based on the input of the survey methodologists and the cognitive lab staff, and the revised version was pretested again. A second revision was made to the survey instrument, and it was pretested.

Finally, a reconnaissance visit was made to one of the sites that was operating a CHSP program to pretest the resident baseline survey. Concurrently, several sites were telephoned to pretest the grantee baseline survey. After reconnaissance, the instruments were revised again to improve the flow and shorten the length and then submitted to the HUD GTR for review. Proxy versions of the resident survey were then drafted and the follow-up versions of resident and grantee

instruments were developed. The final version of the resident instrument, as approved by the HUD GTR, was then translated into Spanish so that Spanish-speaking residents would also be able to participate in the survey.[1]

Once the survey instruments were finalized, RTI staff developed data abstraction forms. These forms were used by the service coordinators to provide additional information on the CHSP participants, such as financial information, type of disability, and monthly fees. A separate form was developed to obtain information on transitions out of the program. These forms were pretested during a pretest of the grantee interviews. Each service coordinator who was interviewed during the pretest was mailed a form to complete and provide feedback. The forms were revised prior to data collection, based upon input from these service coordinators.

2.2 Grantee Data Collection

Several types of data were collected from each CHSP grantee: qualitative data from telephone interviews with grant administrators, service coordinators, and PAC representatives; financial and narrative data from quarterly and annual reports submitted by grantees to HUD; and program documents RTI requested directly from grantees.

Telephone interviews. Five social sciences professionals divided up the 44 CHSP projects and, for each project, set up an individual interview with the grant administrator, the service coordinator, and the PAC chairperson or other representative. These interviews were completed in November and December 1994. In 10 sites, the program was not yet implemented, or the grantee was preparing to withdraw, so not all the interviews could be completed; however, we obtained 100% response for the grantee, service coordinator, and PAC interviews with all 34 active sites.

[1]There was one CHSP development whose residents were primarily Russian speakers. However, after discussions with the site's service coordinator and the HUD GTR, the decision was made, that because it would be easier for respondents and ultimately less expensive, we would use Russian translators at the site to interpret the survey instrument, instead of having it translated.

Quarterly and annual reports. Quarterly reports for the first two quarters were requested from grantees via the HUD field offices, but less than half were received in time for analyses, and many programs were just beginning to provide CHSP services. Annual reports were requested by fax or mail directly from the grantees as part of the data collection effort in November-December 1994, and reports for all 34 active programs were received in time for Phase 2 analyses. RTI also received program documents from nearly all the active programs in response to the same request.

2.3 Resident Data Collection

Information about residents participating in CHSP was collected from the residents using the resident questionnaire and from the service coordinators at each site using the data abstraction forms. **Exhibit C.1** shows the sequence of events for CHSP resident data collection.

The resident data collection process began with a telephone contact to each of the service coordinators to determine the correct address and contact information for the service coordinators and grantees of each site. On occasion, the mailing address for service coordinators was not the same as the location of the CHSP site. Therefore, both site location and mailing address information were collected on all the sites. The location information was used to make field interviewer assignments. After this information was compiled, a mailing of the CHSP Resident Roster was made to each of the service coordinators.

Service coordinators were instructed to complete the roster, including the name, age, gender, address, telephone number, primary language and expected questionnaire format on each resident currently enrolled in CHSP at their site. The process for completing the form was explained during the initial telephone contact. A set of detailed directions was also included in the mailing to facilitate thorough completion of the form. All forms were completed and returned to RTI prior to training the field interviewers.

Recruitment and Training of Field Interviewers. Field Interviewers were recruited using RTI's extensive data base of experienced field interviewer staff. Potential interviewers were identified according to site location, availability, experience, and reputation. Twenty field

interviewers (FIs) were ultimately recruited and trained. During recruitment of FIs, a time for telephone training was set up so that three telephone training sessions could take place and incorporate all field staff. The training session was set for four hours with a break scheduled at the halfway mark. A copy of the training agenda is included in **Exhibit C.2.** Training took place on October 31, 1994, through November 2, 1994.

During training, FIs were instructed to make an initial visit to the site in order to introduce themselves to the service coordinator (SC) and to become familiar with the site. Specific instructions concerning the initial visit and the interviewing process were covered during the training session. The general responsibilities of FIs were also covered and included reading the training materials; participating in the entire telephone training session; arranging appointments with the SCs; completing the assigned number of sites and resident interviews in a thorough, efficient, and timely manner; maintaining confidentiality; completing any necessary control forms; distributing and collecting data abstraction forms to and from the SC; editing all completed interviews and forms; submitting all appropriate time and expense reports; returning all interviewing materials as instructed; and reporting regularly to field supervisors as scheduled.

RTI field supervisors were assigned to each field interviewer during the training. Interviewers were also instructed to maintain a positive, professional relationship with the service coordinator and the residents. Responsibilities in establishing this relationship were identified as: recognizing residents' planned activities and needs for quiet time or rest when scheduling work; putting the service coordinator at ease about the purposes of the study and the use of the information; explaining the confidentiality requirements mandated for all interviews; maintaining communication with the service coordinator; and acknowledging the service coordinators' need to perform their normal duties in addition to providing needed information.

FIs were further instructed to determine, with the assistance of the service coordinator, which residents would participate in a self-administered group session, which residents would need individual interviews, and which would need proxy interviews. Monitoring of the group sessions was done in a way that FIs were available at all times to assist any residents who needed help. Also, FIs were instructed to observe the residents to see if anyone was having particular problems

and to offer assistance as needed. Finally, FIs were given instructions for editing the questionnaires thoroughly while participants were still present to discuss any issues identified.

Administration in the Field. Prior to training, each FI was mailed all the materials needed to monitor and/or conduct the interviews at the CHSP sites assigned; a Contact Record (CR), for each site assigned; and a computerized Assignment Control Form (ACF), that listed each resident selected for participation. The CR was used for documenting contacts with the service coordinator. For each phone call or in-person contact attempt made, the date, day of the week, time of the attempted contact, whether it was a call or visit, and the result of the contact were recorded. The results of the contacts were recorded using preassigned result codes. The Assignment Control Form was used regularly to document the status of cases. FIs were required to report to their supervisor each week using the information recorded on the ACF, which was returned with the completed questionnaires. Bar-coded labels also were generated that included identification numbers for each resident. These were attached to the questionnaire completed by the residents or the proxy of the resident. The identification numbers included an identifier for the site number and the resident. This bar-code system was used to facilitate eventing the data as it was received at RTI after completion.

During the initial site visit, field staff were instructed to meet with the service coordinator; become familiar with the site; verify with the SC that all the residents listed on the ACF represented a true picture of the resident enrollment in the CHSP; verify that interview status indicated on the ACF for each resident was correct; ask the SC to identify a space to hold the group sessions; schedule the group session(s) with the SC; and schedule time for proxy and individual interviews, if necessary. Any residents who had enrolled after rosters were generated at RTI were also added to the roster. Additionally, FIs were instructed to leave data abstraction forms with instructions for completing each form with the SC. Information on residents who left the CHSP program was recorded on one form and included all residents who were ever enrolled or received services through CHSP. The other form was used to record archival data about income, occupation, services received, etc.

Each field interviewer was assigned to one of two field supervisory staff at RTI. A schedule of weekly calls was created so that all field staff talked to their supervisory staff once a week. Calls included information about work accomplished, problems that arose, materials and supplies, and any other concerns the FIs may have had. Upon completion of the assignment, the weekly phone calls were discontinued, although the monitoring of data received was continued until all data expected from a field interviewer was received. Upon receipt of the field data, the information was entered as an event into the control system to monitor progress of the data collection, and the process for editing and keying the data received was begun.

Resident Data Control System. Prior to actual data collection, the information collected on the resident roster forms was used to generate a resident data base. The information gathered during the telephone interviews with service coordinators was entered into a project database, which contained one record for each of the sites or projects in the CHSP. Variables include the project site, project name and address information, grantee name, grantee address information, service coordinator, and site status information. The project database is linked to the resident database by the project identification number. The resident data base also contains one record for each of the CHSP participants in each of the projects. Variables include the resident ID, the project ID, demographic information about the resident, roster information and status information. The survey data was also merged onto the resident database after data collection was completed.

The CHSP database continues to be accessible to all project employees who have been issued a password. The control system was designed to check for correct ID and data information, update resident events, update project events, and produce a report that lists warnings and errors that have been detected during the execution of the program. Any errors detected were resolved and the post event program run again to update the changes. This process allowed for up to date calculation of data received by the data entry unit at RTI. This feature was particularly helpful in coordinating efforts between field interviewers and field supervisors.

The control system was also used to generate status reports. It allowed for both flexibility and consistency among staff members involved in monitoring data collection. All staff working on the project had access to up-to-date data on the status of data collection using this system.

Resident Data Response Rates. Data collection began in November 1994 and lasted for approximately six weeks. Data were collected from 774 participating residents. After cleaning the data and reconciling the information in the control system database with the transition forms and resident information forms, a total of 667 completed survey instruments remained. A total of 183 of these were completed in a group session, 528 were completed in an in-person interview, and 139 were completed by a proxy respondent (the service coordinator). The refusal rate was sufficiently low that weights were not used. A response rate of 96.2 percent was achieved for the resident survey. Transition forms and resident information forms were received from the 34 active sites.

2.3 Data Processing and Analysis

During the baseline survey period, we collected and processed data from several sources: grantees, service coordinators, PAC representatives, residents, annual reports, and other documents. Each data file we created contained a unique identifier used to link the data from each source. In each instance, the identifier contained a site-specific identifier so that data from individual sites would remain together. After the data were cleaned and all differences and inconsistencies in the data reconciled, the files were ready for use in analyses. Some site-level data were merged with resident-level data, and annual report data were merged with Phase 1 data from the grant applications and communities. Additional variables were also created.

For instance, for resident-level analyses, a variable to count the number of ADL impairments was created. This variable used the question on difficulty in performing a task and included the responses of a lot of difficulty and some difficulty to define an impairment. The date of birth was used to calculate age and create an age variable for each resident.

For grantee-level analyses of annual report data, numerous ratios were constructed, such as the per-resident and per-unit costs of services, the proportions of residents of certain ages or

racial/ethnic backgrounds, and the proportions of residents who entered and left the program during the first year.

RTI used the quantitative data from the resident survey and the annual reports to construct most of the descriptive tables that characterize the programs as well as the residents who participate in these programs. Most of the data reported here come from frequencies (individual or joint), means, medians, ranges or sums on variables of interest.

For the analyses of telephone interview data from the grantees, service coordinators, and PAC representatives, the staff who conducted the interviews wrote them up electronically within a half-day of completing the interview. The electronic completed interviews were then read into AskSam, a qualitative analysis software package. Two analysts then coded fields and themes in AskSam and generated a variety of reports by topic and by the interviewees' responses to related questions. Frequencies on categorical variables were tabulated as well. The flexibility of this software facilitated our identification of recurrent themes as well as the use of quotes in this report.

Qualitative analysis techniques were also used in identifying important themes in the narratives of the annual reports and the comments from residents on the resident survey.