Evaluation of the HOPE for Elderly Independence Demonstration

FINAL REPORT

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FOREWORD

One of the Department's goals is to help frail, elderly persons meet their housing needs. Aging in place is favor by a vast majority (85 percent) of America's elderly, who, according to a survey by the American Association of Retired Persons, say they want to stay in their current homes and never move. The Department instituted the HOPE for Elderly Independence Demonstration Program (HOPE IV) to help low-income, frail, elderly persons maintain the highest possible quality of life in the least environment—preferably their own homes.

HOPE IV is a tenant-base program, administered by public housing authorities (PHAs) for persons who where not previously receiving HUD assistance. In addition to providing Section 8 housing assistance, the program provides case management and non-medical support services. HOPE IV allows applicants to remain in their home as long as it is in the PHA area and meets HUD's Section 8 quality standards. To understand the effects of the Program, HOPE IV elderly were compared to a similar population receiving Section 8 assistance.

The evaluation shows that the HOPE IV Program was appropriately targeted to clients at risk of being institutionalized and who could be served by community-based options. In many cases, managed services were new to the persons in the HOPE IV program, and in almost all cases the services received through the program resulted in greater total amounts of assistance. The level of assistance necessary to maintain independence corresponded to the level of frailty and impairment of the participant.

At the end of the two- year period of the study, the HOPE IV participants and the comparison group members differed in several respects. The HOPE IV participants were frailer than the comparison group and a higher percent received increasing amounts of services. The HOPE IV participants' disabilities increased appreciably, while the control group's did not. Attrition rates were slightly higher for HOPE IV participants than the comparison group— 40 percent versus 38 percent respectively.

The impact of the HOPE IV program was most noticeable in the quality of life and care of the participants. Despite increased frailty and worsening health conditions, 90 percent of the participants were satisfied with the HOPE IV Program. In addition, about half of those in the program said they were satisfied with their lives, liked their neighborhoods and living arrangements, were confident and had few worries, had good appetites, and were in control of their lives. This suggests that even the frailest elderly, who are also low-income, and have few or no support systems, are able to live independently in a service rich environment that includes case- management.

Although studies indicate that there is a large number of low-income, elderly waiting for housing assistance, PHAs in this first group of grantees found it difficult to fill the HOPE IV slots. Many grantees took over a year to get the programs started. The largest problem was finding qualified participants, adequate housing and linking housing and services. However, after overcoming initial implementation problems, PHAs were successful in serving persons at risk of institutionalization.

This evaluation will be very valuable as the Department looks for new and better ways to meet housing needs of America's elderly.

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and Monitoring

EXECUTIVE SUMMARY

This is the final report from the evaluation of the HOPE for Elderly Independence Demonstration (HOPE IV) program conducted by Westat, Inc., for the U.S. Department of Housing and Urban Development (HUD).[i] HOPE IV combines HUD Section 8 rental assistance with case management and supportive services to low-income elderly persons (62 and older) with limitations in three or more personal care and home management activities, such as bathing, dressing, and housekeeping. The purpose of HOPE IV, administered by local Public Housing Agencies (PHAs), is to expand access to Section 8 rental assistance by a frail elderly tenant population and help participants avoid nursing home placement or other restrictive settings when home and community-based options are appropriate. In addition to rental assistance, as vouchers for private-market housing, HUD pays 40 percent of the supportive services costs, the grantees pay 50 percent, and participants, except for those with very low incomes, pay 10 percent.

A key feature of HOPE IV is the establishment of a Service Coordinator position within the PHA with responsibilities for the design and implementation of an integrated system of case management, personal care, and home management services for frail elderly Section 8 tenants. Of particular importance is the coordination of traditional Section 8 staff activities with the new case management and services components of HOPE IV. In addition, the Service Coordinator is responsible for forging relationships with other agencies and organization in the community with resources and responsibilities for programs on aging, including purchase-of-services arrangements with existing providers. Supporting the Service Coordinator is a Professional Assessment Committee (PAC) responsible for screening applicants for frailty and documenting need for services, in accordance with the HUD HOPE IV regulations. The PAC must include at least one medical professional and at least two other members with various health or social services backgrounds.

During the first round of HOPE IV funding (February 1993), the focus of this evaluation, HUD awarded grants to 16 agencies for demonstration projects ranging from 25 to 150 persons for a five-year period. The grants collectively totaled $9.9 million for the supportive services component and an additional $29.6 million for rental assistance.

This report presents findings from the four phases of the evaluation:

Phase 1 describes the design and implementation of HOPE IV in each of the 16 grantee agencies, including staffing, funding, arrangements with service providers, recruitment, assessment, and placement of participants in Section 8 scattered-site housing with case management and supportive services. The evaluation collected information for this phase through grantee site visits, telephone interviews with staff, and a mail survey.

Phase 2 consisted of a baseline survey of HOPE IV participants and captured a broad range of information, including demographic and housing characteristics, frailty and functional status, social interaction, and other measures of well being, receipt of services, satisfaction with the HOPE IV program, and other information. The baseline survey also screened 5,000 elderly Section 8 tenants who were not in

[i] Westat was awarded a five-year contract in July 1993 to evaluate the HOPE IV program.

HOPE IV for levels of frailty similar to program participants and selected and surveyed 523 of them as the study's comparison group.

Phase 3 consisted of interviews with the HOPE IV Service Coordinators and the Professional Assessment Committee (PAC) members and provided important information on full implementation and operation of the demonstration, as a follow-up to the Phase 1 data collection.

Phase 4 assessed the impact of HOPE IV by administering a follow-up survey after two years to program participants and the comparison group to show changes in key outcome indicators, including access to needed services, levels of physical functioning and social well-being, and the quality of life and care. In addition, Phase 4 captured a range of information on persons who left HOPE IV and Section 8, including the reasons for leaving (e.g., death, severe frailty, improvement in functional status, or relocation), and subsequent placement and care arrangements (e.g., nursing home placement or participation in another program for the frail elderly).

The following summary presents an overview of the major findings from the evaluation.

Overview of Findings

Benefits and Outcomes

- Participants in the HOPE IV program received a significantly higher level of supportive services than the comparison group, and this disparity in access to care remained over time. For example, at follow-up, nearly one-third (32 percent) of the comparison group reported receiving no services at all despite high levels of frailty, versus seven percent of the participants.

- In addition, receipt of services had a significant correlation with a range of positive outcomes, across multiple domains of functioning. For example, service recipients scored significantly higher in four major mental health dimensions (anxiety, depression, loss of behavioral/emotional control, and psychological well-being), social functioning (quantity and quality of social activities), vitality (energy level and fatigue), and other measure of social well-being.[ii]

- However, there were no statistically significant differences between the participants and the comparison group members in the rates of nursing home placement, mortality, or remaining in Section 8. This finding is consistent with the assumptions in the research design and the results of prior studies that show the impacts of similar programs address quality of life and care, rather than changing such overt outcomes as death, institutionalization, or otherwise having to leave one's home due to frailty.

- Over the two-year period, 40 percent of the participants left the HOPE IV program, including Section 8. This consisted of 15 percent who died, nine percent who went into a nursing or related care home, nine percent who moved to another location, and

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

seven percent who left HOPE IV and Section 8 for other or unspecified reasons. Sixty percent of the participants remained in assisted housing, including seven percent who left HOPE IV but retained their Section 8 rental assistance.

- Over the same two-year period, 38 percent of the frail elderly comparison group left Section 8, including 13 percent who died, eight percent who went into a nursing or related care home, nine percent who moved to another location, and eight percent who left for other or unspecified reasons.

- An overwhelming 85 percent of participants at baseline, and an even higher 91 percent at follow-up, reported they were very satisfied with HOPE IV; 11 percent, and six percent, said they were somewhat satisfied. Only one respondent indicated active dissatisfaction with the Program at either point in time, while a very few were uncertain or did not say.

HOPE IV Grantee Characteristics

- The 16 HOPE IV grantee communities presented a rich range of environments for HOPE IV program operations. They were located in several geographic regions and distributed across urban, suburban, and rural areas. Grantee communities exhibited some racial, ethnic and cultural diversity, and also presented some distinctive housing characteristics and situations.

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

- Nine of the grantee sites were located in communities that had relatively small racial and ethnic minority populations. Seven grantees served areas with relatively high concentrations of (or at least "pockets" of) minorities, including Mexican-Americans, blacks, and Asians. Of these seven sites, one was in a border community with a large Mexican-American population, and virtually all the HOPE IV participants at that site were of Mexican-American or Mexican origin. Another of these seven sites was in an area with a significant representation of American Indians, but this population tended to be served by tribal institutions and not the PHA.

- Only four grantees were experienced in provision of supportive services to the elderly when they applied for HOPE IV funds; two others were experienced in providing supportive services to non-elderly populations. Six grantees had limited backgrounds in provision of supportive services to the elderly, and four had little or no prior experience with such programs.

- Ten of the 16 grantees applied for HOPE IV because, in spite of their PHA's relative inexperience in this area, they recognized the growing needs of the elderly population in their communities and saw HOPE IV as a way to address these needs. For four grantees, submitting a HOPE IV application represented a natural extension of past work in efforts combining housing and provision of supportive services to the elderly. Two grantees said they apply for all available Section 8 funds as part of a general strategy of increasing the number of rental vouchers and certificates in their area.

- In all 16 communities, HOPE IV filled an unfilled or incompletely filled niche in the service system for the frail elderly. For example, five grantees indicated there were no real alternatives to HOPE IV in their communities except nursing home placement at the time of the inception of the program.

- Four grantees reported either that the limited home care available in their area was too costly for the frail elderly population, or that publicly funded community-based, long-term care programs in their community were under budget pressures and had impossibly long waiting lists.

- The 16 grantees represented a broad spectrum of PHAs in terms of size, from small (about 100 units of assisted housing) to very large (about 10,000 units). Beyond HOPE IV, each of the 16 grantees had an existing Section 8 rental assistance program that ranged from about 100 certificates and vouchers to about 5,000 certificates and vouchers.

- There was substantial variety as to which departments and individuals within the PHA were assigned to oversee and operate the HOPE IV program. For example, in four sites, Section 8 program managers were responsible for daily operations; at three sites, community service directors or special programs coordinators administered HOPE IV activities; and at two sites, directors or assistant directors of other types of divisions ran the HOPE IV program (e.g., Leasing, Housing Assistance).

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

- Very few of the HOPE IV grantees found generating a matching funds commitment a serious barrier to application. As required by HUD, all grantees had collaborated with local AAAs or other agencies in developing their winning HOPE IV applications, and these "partner" agencies are the primary source of the match, either as in-kind services or dollars donated for services.

- Executive Directors of 40 PHAs with characteristics similar to those of the 16 grantees were interviewed to determine why they had not applied to the HOPE IV program. Their reasons fell into three main categories: (1) a perception that the program was not

needed in the community or was of low priority relative to other needs; (2) limited PHA staff experience or familiarity with key requirements for operating such a program; and (3) there were insufficient time and personnel available to prepare the application or implement a program if it were to be funded.

HOPE IV Program Implementation and Participant Recruitment

- Application for and participation in HOPE IV had a noticeable impact on the grantees' orientation toward the frail elderly population. For all grantees, at the very least, HOPE IV represented a new, unique opportunity to complement Section 8 housing with delivery of supportive services for the frail elderly. From the perspective of community service providers, HOPE IV represented the first chance to link human and service delivery for the low-income frail elderly population in a far more systematic and coordinated fashion.

- Although the Section 8 programs at most of the grantee PHAs at first experienced difficulties meeting new demands imposed by HOPE IV, grantees responded by making formal and informal changes in their organization and orientation. For example, one PHA reduced by 50 percent the case load its Section 8 staff carried when involving frail elderly tenants. Another provided formal training for Section 8 staff on the status and needs of the frail elderly using the resources of a local university.

- As a consequence of implementation difficulties, by the end of calendar year 1995, nearly two years after the HOPE IV grants were awarded to the 16 PHAs, only about one-half (583) of the participants who were expected to enroll in the program were in place. For 11 of the 16 grantees, that enrollment represented at least three quarters of all their allotted units, while four had approximately half or fewer of their units filled at the time of the December 1995 Service Coordinator interviews. Only one grantee reported no participants at the end of 1995, although all had started their programs by this time. New participants enter the HOPE IV program through initial enrollment or to fill slots of persons who have left the program for various reasons.

- Focusing a portion of the Section 8 program on the frail elderly required the addition of new functions and forced a change in several aspects of typical Section 8 operating procedures. Grantees, only able to fill a few HOPE IV units through existing Section 8 waiting lists and usual recruitment methods, relied on referrals from the AAAs and other community agencies, combined with extensive outreach efforts. In most cases, this strategy worked. However, recruitment suffered at several sites where the PHA/AAA partnership failed to develop as expected. In many places, the pace of recruitment sped up considerably after information about the HOPE IV program reached the network of elderly service providers and spread, through word-of-mouth, to the elderly population at large.

- Once potential participants learned of the HOPE IV program, considerable recruitment work remained, including home visits to conduct assessments and complete HUD Section 8 forms. HOPE IV participants, more of whom than expected had to move to

qualify for the program, also often relied on the grantee to locate suitable housing and assist with the move. Responding to these and other needs placed considerable additional demands on program staff, usually the Service Coordinator. Attrition, due to last minute decisions not to enter the program, hospitalization, nursing home admissions, and moving out of the area, also absorbed staff resources.

- Frail elderly participant respondents, on the whole, found the process of entering the HOPE IV program fairly easy. At baseline, 82 percent agreed that it was easy to provide the necessary financial information for entering the Program, 84 percent indicated that the program and its requirements were clearly explained to them, and 78 percent of the respondents reported having actively participated in deciding which services they would receive.

- However, ADL assessment was the one area for which there was a slightly lower level of satisfaction: 67 percent disagreed, and 21 percent agreed, with the statement that the process used to determine the need for assistance was complicated. The participants' perception that entering the HOPE IV program was a relatively easy process should be seen in relation to the enormous efforts grantee PHAs and Service Coordinators expended in recruiting and assessing applicants as described above.

- Since recruitment was continuous, as program implementation proceeded, a conflict often developed for Service Coordinators between focusing energy and attention on "front end" activities, such as marketing, recruitment and assessment, and paying closer ongoing attention to the ever-shifting and often extensive needs of the already enrolled HOPE IV participants.

- The Service Coordinator's role soon became overburdened as most grantees dealt with intensified demands on staff time by expanding the Service Coordinator's duties. Ten of the 16 grantees applied for supplemental service coordination funds from HUD (under the July 1994 NOFA); most intend to use the money to support and extend their Service Coordinators' activities.

- Service Coordinators, or a small team, including the Service Coordinator and a nurse or geriatric social worker, perform the frailty assessments and design the service plan. The PACs review the results and make usually minor recommendations for changes. All but one grantee use an established frailty assessment tool and crosswalks its ADL categories with HUD's ADL definitions, which are somewhat different from most by including home management, also called Instrumental Activities of Daily Living (IADLs).

- In response to a question on the adequacy of the HOPE IV definition of ADL limitations, eight of the Service Coordinators said the HUD definition of frailty identified the correct group of elderly for the program, and eight said it did not. Six of the latter eight said that the criteria were overly strict and excluded many persons who needed the HOPE IV services. Two of the Service Coordinators said that adding *degree of difficulty* within the ADL eligibility categories would enhance their ability to assess true need, for example, by distinguishing between some difficulty and a lot of difficulty in performing an activity.

- The size of the PACs ranged from three to 13, with an average of 6.6 and a median of six. Concerning the medical professionals, four of the PACs had a physician, 14 included at least one nurse, and 10 included other health care professionals. All of the PACs had at least one social worker, and 14 had at least one other social services professional, such as staff from the Area Agency on Aging.

- Grantees deliver a common cluster of services that includes case management; linkage services such as transportation; personal care; and homemaker and chore services. Other services (advocacy, social and behavioral support, and recreation and socialization), although recognized as needed by some grantees, are much less commonly offered.

- Only one grantee directly delivered supportive services to HOPE IV participants. The others contract out the actual delivery of services. Several also contract for service coordination, and a few for PAC functions, as well.

- Despite the HUD requirement that HOPE IV participants should contribute 10 percent of the cost of their supportive services, unless this exceeded 20 percent of their adjusted monthly income at baseline and follow-up, nearly half of participants reported paying nothing above rent toward the cost of HOPE IV program services. At baseline, 12 percent of those who paid a portion of their service costs (roughly six percent of all respondents) said this presented a problem for them since entering the HOPE IV Program. At follow-up, the corresponding percentage was 16 percent (or about eight percent of HOPE IV respondents). However, telephone interviews conducted in the Fall of 1993 and 1994 all revealed that HOPE IV program personnel at some grantee sites were reluctant to press the payment issue with participants, most of whom they felt were too poor to be asked to contribute.

Participant Demographic and Housing Characteristics

- The vast majority of HOPE IV participants are widowed, white females, consistent with the profile of frail elderly Americans overall. In addition, approximately half of the participants are age 75 and over, have less than a high-school education, and receive incomes under $8,000 per year.

- Over half of the participants, however, are between 62 and 74 years old, but with few exceptions and in spite of their relatively young age, these persons have similar levels of frailty as their counterparts above age 75.

- Most HOPE IV participants have at least three factors that are highly correlated with frailty and risk of institutionalization in national studies—low-income, low-level of education, and living alone. Advanced age, very low-income, and minority status are the other factors associated with risk, all of which can be found in some of the HOPE IV population.

- Over 40 percent of the participants moved as a function of the HOPE IV program, either to meet Section 8 Housing Quality Standards or the rental housing requirement.

- Seventy percent of participants indicated they were very satisfied with their living arrangements, while another 19 percent reported they were just somewhat satisfied. Only five percent stated they were somewhat or very dissatisfied with their current living environment. Concerning safety, 88 percent of participants reported they felt safe most of the time, while 10 percent felt safe only some of the time or rarely.

Functional Status

- HOPE IV participants are much frailer than non-institutionalized elderly persons in the general population, and they are considerably less frail than elderly persons in community-based programs for nursing home eligibles or persons receiving nursing home care.

- Levels of frailty, however, vary considerably among participants, confirming the need for case management to tailor supportive services to individual participant requirements.

- During the two-year period between the baseline and follow-up survey, the percentage of participants and comparison group members reporting an ADL limitation increased for all activities of daily living. However, the comparison group reported fewer increases than the participants.

- Compounding the risks of frailty and need for HOPE IV services, only about half of the participants have someone who could take care of them for any length of time during a protracted illness, and just one quarter say this person could help out indefinitely.

- The majority of participants described their overall health as fair or poor, and over one-third said their health had worsened during the past year. In addition, most participants reported multiple chronic health conditions, including arthritis, hypertension, heart disease, and respiratory problems.

- Even though HOPE IV participants are considered very frail and reported having many medical conditions that they say worsened in the past year, about half report they are satisfied with their lives, like their neighborhoods and living arrangements, are confident, have good appetites, have control over their activities, and have few worries.

Informal Assistance, Social Support, and Service Utilization

- Many HOPE IV participants are not isolated, participate in activities outside the home, and enjoy their social contact. However, the patterns of both in-person and

telephone contact showed that most participants have either a great deal of contact or little contact at all, with surprisingly few cases in between.

- At baseline, 82 percent of both the HOPE IV and comparison group respondents reported seeing another person -- whether a family member, friend or neighbor -- on a regular basis at least once a month. Eighteen percent of both groups said they saw no one monthly except for service personnel or others living in their households. The percentages for both groups were identical at follow-up: 82 percent of both participants and comparison group members said they had regular in-person social contact with another person at least once monthly, 18 percent indicated they did not.

- Concerning social interaction via the telephone, overall, at baseline, participants had an average of 20.1 monthly phone contacts and comparison group members an average of 23.2 such contacts. At follow-up, the average number of such contacts declined slightly for both groups: to 18.8 for participants and 21.7 for comparison group members. While these numbers point to small relative declines in overall frequency of telephone contact for both groups between baseline and follow-up, on average, both groups had telephone contact with another person roughly two out of three days in a month. As with in-person contacts, the two groups were characterized by a bi-modal pattern of either very infrequent or quite frequent telephone contacts with children both at baseline and at follow-up.

- Forty-two percent of participants and 44 percent of comparison group members at baseline were satisfied with their then current level of social activity; somewhat less than half of both groups would have liked to be doing more socially. At follow-up, the percentage of those satisfied with their current level of social activity rose to 56 percent for both participants and comparison group members. Forty percent of participants and 38 percent of comparison group members reported a desire for more social activity.

Services

- At baseline, 80 percent of participants and 49 percent of comparison group members reported they got housekeeping services (a difference of 31 percent between groups); at follow-up, the percentages had risen very slightly, to 84 percent, and 51 percent, respectively (a difference of 33 percent between groups).

- Transportation was the second most frequently received service for both groups at both points in time. At baseline, 46 percent of participants and 32 percent of comparison group members got transportation services (a between-group difference of 14 percent); at follow-up, the percentage of participants receiving transportation services increased slightly, to 50 percent, while the percentage of comparison group members getting these services dropped slightly, to 24 percent (a between-group difference of 26 percent).

- Home-delivered meals are the third category of services for which there are differences between the groups: 38 percent of participants at baseline and 40 percent

of participants at follow-up received home-delivered meals; the corresponding percentages for the comparison group were 24 percent, and 27 percent, a between-group difference of 13 percent -14 percent.

- Predictably, the percentage of HOPE IV participants who reported receiving each type of service for one year or more rose substantially between baseline and follow-up. At the time of the baseline interview, participants were only just entering the HOPE IV Program, so most reported receiving most types of service for less than six months. The exceptions, particularly services the participants said they had been receiving for over one year, probably represented non-HOPE services or services provided through other channels prior to their entrance into the Program.

- By contrast, the percentage of comparison group members reporting they had received services for over a year rose only slightly between baseline and follow-up. At baseline, a sizeable percentage of comparison group members had already indicated they had been getting their services for over one year. This is understandable, in light of the fact that most had been residing in their housing for quite some time, and so presumably had had the time to establish a service network.

- Most comparison group members receiving case management had less frequent contact with their case managers than did HOPE IV participants with their Service Coordinators and probably did not enjoy the same quality of personal relationship. On the other hand, most comparison group members had been receiving these services for an extended period.

- The Service Coordinators arrange both for services paid for by HOPE IV and other community programs with their own financial base, such as services from the Area Agencies on Aging, Medicaid, or other entitlements for which HOPE IV participants may be eligible. When asked if they link participants with non-HOPE IV community services or programs, 12 of the 16 Service Coordinators said they did, while four said they did not. When asked to identify these other services and programs, eight of the 12 Service Coordinators mentioned medical, day health, or other long-term care services, such as those provided through Medicaid or the Visiting Nurse Association. Four of the 12 mentioned mental health services, while the rest mentioned individual programs such as adult protective services, Food Stamps, home weatherization, fuel assistance, and clothing banks.

The report that follows consists of eight chapters. Chapter 1 provides a description of the HOPE IV demonstration and a summary of the evaluation design. Chapter 2 presents the key characteristics of the HOPE IV grantees. Chapter 3 gives a summary of HOPE IV program implementation, including barriers and how the grantees overcame them. Chapter 4 summarizes the demographic and housing characteristics of participants in the HOPE IV program. Chapter 5 describes the frailty, health status, emotional well-being, and cognitive functioning of the participants at baseline and again after the two-year follow-up survey. Chapter 6 identifies the nature and intensity of participants' social supports, formal and informal systems of care, and satisfaction with the HOPE IV program, initially, and after two years. Chapter 7 presents the rates and reasons participants left HOPE IV, and the multivariate analysis of program impact. Chapter 8 presents a summary of the findings and conclusions from the evaluation,

including the policy implications for HUD. The methodology for the evaluation is described in detail in the first and second interim reports.

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

List of Tables

TABLE OF CONTENTS
(continued)

List of Tables (continued)

List of Figures

1. INTRODUCTION

With a substantial increase in the number of elderly persons in the United States, especially in advanced age groups associated with frailty, communities across the country have experienced a rise in demand for a range of services to support an aging population. While most elderly persons continue to live independently in their own homes, the rising number of persons throughout the United States who are reaching advanced age heightens the need for provision of assistance with many personal care and home management activities, such as bathing, dressing, and meals preparation. This increase in the numbers of frail elderly creates demands on various community agencies to develop new forms of assistance geared to the special needs of this population. For Public Housing Agencies (PHAs), adapting the Section 8 rental assistance program to the needs of frail elderly tenants means providing a range of services that goes well beyond providing affordable housing.

1.1 The HOPE for Elderly Independence Demonstration Program

The HOPE for Elderly Independence Demonstration (HOPE IV) program is designed to explore how the U.S. Department of Housing and Urban Development (HUD) can support the needs of a frail, low-income elderly population by combining Section 8 rental assistance with case management and supportive services to enhance the quality of life and avoid unnecessary or premature institutionalization. To be eligible for HOPE IV, a person must be at least 62 years of age; have an income that generally does not exceed 50 percent of the area's median;[iii] reside in or be willing to move to a rental dwelling meeting HUD's Section 8 Housing Quality Standards; not be a current participant in Section 8 or other housing assistance programs; and be frail, according to HUD's definition.

For HOPE IV program purposes, frailty is defined as needing assistance in at least three of the following activities: 1) eating (may need assistance with cooking, preparing or serving food, but must be able to feed self); 2) bathing (may need assistance in getting in and out of shower or tub, but must be able to wash self); 3) grooming (may need assistance in washing hair, but must be able to take care of personal appearance); 4) dressing (must be able to dress self, but may need occasional assistance); and 5) home management activities (may need assistance in doing housework, grocery shopping, laundry, or

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

getting to and from one location to another, but must be mobile, alone or with the aid of assistive devices such as a wheelchair). A Professional Assessment Committee (PAC), in conjunction with a Service Coordinator, determines eligibility; develops a case plan for services; and regularly monitors each participant's condition and care. HUD pays 40 percent of the program costs; the grantee pays 50 percent; and the participant pays 10 percent, except where this exceeds 20 percent of the person's income.

This report and the evaluation on which it is based focus on the first round of funding, during which HUD awarded grants to 16 agencies for projects ranging in size from 25 to 150 persons for a five-year demonstration period. Collectively, these first-round grants total about $10 million for the supportive services component and approximately $30 million for rental assistance.

1.2 Conceptual Design

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

According to this conceptual framework, outcomes of the demonstration are likely to be influenced by both the content and the volume of services delivered to participants. These, in turn, depend on the efficiency and effectiveness of program operations. Characteristics of the participants (such as age, physical frailty, mental health, gender, education, and the availability of other formal support services outside the program) may influence outcomes as well. Finally, the degree to which program participants have access to informal support must also be considered.

HOPE IV embraces what for many grantee PHAs is a new Section 8 tenant population. To even begin to meet the special challenges of serving a frail elderly constituency, most HOPE IV grantees have had to adapt their normal Section 8 operating procedures and initiate an array of new services and linkages with other agencies in the community. Beyond specifying minimum age, income, and frailty requirements, HOPE IV allows considerable flexibility in local implementation. This means that relatively little is known in detail about who the first Program participants are. Therefore, one purpose of

this report is to present a portrait of the HOPE IV participants, including their demographic and housing characteristics, health, frailty, mental health, and patterns of receipt of informal assistance and social support. It also describes the participants' satisfaction with various aspects of the HOPE IV program, including the process of entering the Program, services received, and perceptions of HOPE IV program benefits. Finally, the evaluation measures the impact of HOPE IV across many domains of well-being.

This is the final report on the results of a five-year evaluation of the HOPE IV program. The overall evaluation design, as shown in Figure 1-1, occurred in four phases that combined a process evaluation of Program implementation at the 16 HOPE IV grantee sites with a quasi-experimental design to assess Program impact.

Phase 1, Analysis of Program Design, which began in late 1993, consisted of abstracting grantee applications and surveying the 16 first-round HOPE IV grantee agencies. The aim was to describe the PHA grantees, participant recruitment, services, case management procedures, and the organizational and demographic environment in which the grantees operate. Phase 1 also included a survey of PHAs that did not apply for HOPE IV to determine their reasons for non-participation. The results of this phase are summarized in the first Interim Report, released by HUD in March 1995.

Phase 2, Baseline Participant and Comparison Group Surveys, marks the beginning of the evaluation of HOPE IV program impact. The conceptual framework for the quasi-experimental design, illustrated in Figure 1-2, is based on the assumption that the ability of frail elderly people to live independently can be enhanced with certain basic supportive services. These services can and often are delivered informally by family, friends, and neighbors, but formal delivery of services by community-based agencies may be needed. By helping to provide a variety of community-based support services, HOPE IV aims to reduce inappropriate or premature institutionalization, increase the length of the participants' lives, and promote their quality of life and care. According to this conceptual framework, the outcomes of the demonstration are likely to be influenced by participant demographic characteristics (frailty, income, age), the combination and volume of services delivered to participants, the efficiency and competence of program operations, and the quantity and quality of informal social support received from family and friends.

Figure 1-1

Figure 1-2

To test this model and thus assess the impact of HOPE IV program participation on the outcomes of interest, a comparison group was selected of frail, low-income, elderly Section 8 tenants who are not receiving supportive services through the HOPE IV Program. The idea was that the basic comparison would be between HOPE IV participants receiving a combination of Section 8 rental assistance and an individualized, case-managed package of supportive services, and a similar group of frail, low-income elderly receiving Section 8 housing assistance but not HOPE IV supportive services. This allows the evaluation to occur within the context of Section 8.

These comparison group members came from the grantees and other similar PHAs located in the same States. Comparison group selection procedures, however, only allowed for screening comparison group respondents on reported frailty and age. This left open the possibility that some comparison group members might be receiving supportive services similar to those provided by HOPE IV under other auspices, such as Area Agencies on Aging or other community service agencies.

Consequently, in addition to presenting a portrait of HOPE IV participants, the tables in this report compare the participants and comparison group in selected domains most germane to establishing the viability of the evaluation's quasi-experimental design. These include, most centrally, basic demographic and housing characteristics; levels of frailty; receipt of informal social support; and receipt of supportive services, any or all of which could importantly affect the ability to discern Program benefits according to the conceptual model presented above. Knowing the degree to which the two groups are alike on these characteristics at baseline helped guide the analysis of HOPE IV program impact over the two years between the baseline and follow-up surveys. For example, we found that many comparison group members did receive case management and supportive services similar to HOPE IV. This caused us to modify the evaluation's design to explore how well the comparison group was able to sustain these supports over the two-year period between the baseline and follow-up surveys, relative to participants.

Phase 3 of the evaluation, the **Analysis of Service Coordination and Professional Assessment**, began in December 1995 and focused on telephone surveys of Professional Assessment Committee (PAC) members who determine participant functional status and the Service Coordinators who arrange for and oversee service delivery.

Phase 4, the **Follow-up Survey to Ascertain Program Impact**, began in August 1996 and consisted of follow-up surveys of participants and comparison group members approximately two years after the first interviews, to show relative changes in functional status and quality of life and care. In

addition, the evaluation collected exit information for persons no longer in their respective programs (HOPE IV or Section 8). The information on those who have exited includes the reasons for leaving (e.g., death, severe frailty, improvement in functional status, or relocation), subsequent placement and care arrangements (e.g., nursing home placement or participation in another program for the frail elderly), and date of exit.

1.3 The Organization of this Report

Following the Executive Summary and Introduction, Chapter 2 presents data on key characteristics of the 16 HOPE grantees and the areas they serve, including the size and scope of their current housing assistance programs and prior experience providing services to frail elderly populations.

Chapter 3 summarizes what the evaluation learned about the implementation of the HOPE IV Program. This chapter discusses various ways in which, and the pace at which, participants were recruited, screened, and assessed for the HOPE IV Program. It also explores the organization of service provision, including the types of services delivered; the role of the Service Coordinator; and the different arrangements developed between the grantees and community social service agencies for providing supportive services to HOPE IV participants. In addition, it presents the consumer perspective on the implementation process, including the level of satisfaction with the recruitment, assessment, and services delivery components of HOPE IV.

Chapter 4 presents data on the demographic and housing characteristics of the participants from the 16 HOPE IV grantees. This includes age, gender, race/ethnicity, income, marital status, living arrangements, and educational attainment. These characteristics not only describe the participants in this new demonstration, but also identify persons with particular risk factors, such as very low levels of education, extreme poverty, advanced age, and living completely alone. In addition, this chapter describes the types of housing that participants occupy, whether they had to move to meet HUD Housing Quality Standards, and their levels of satisfaction with their housing and neighborhoods. Comparison group respondents are juxtaposed to the HOPE IV respondents to confirm the degree of baseline similarities.

Chapter 5 presents important indicators of service needs using measures of functional limitations, health, mental health, and cognitive status. These indicators relate to the HOPE IV eligibility

criteria and provide a basis for assessing program impact over time. Comparing measures of frailty for the participants and comparison group is also important to establish the viability of the quasi-experimental design. Baseline and follow-up differences show important changes in these measures of well-being.

Chapter 6 describes the frequency and kind of informal assistance and social support participants receive from family and friends and compares this to the support received by the comparison group. As discussed above, the availability of informal and other non-HOPE IV support ultimately may be germane to explaining outcomes related to preventing or delaying unnecessary institutionalization. Chapter 6 also compares the participants' and comparison group respondents' perceptions of the quality and adequacy of their social activities and the availability of help in emergencies. As indicated in the conceptual model, the nature and frequency of social interaction and social support may itself prove to be an important outcome measure. The chapter also gives the participants' initial views and impressions of different aspects of the HOPE IV program. Finally, this chapter describes the changes that occurred according to these measures over the two-year period between the baseline and follow-up surveys.

Chapter 7 uses multivariate analysis to combine and present data from the separate chapters to show the benefits and impact of HOPE IV, relative to the comparison group.

Chapter 8 summarizes our conclusions from the evaluation activities.

2. KEY CHARACTERISTICS OF HOPE IV GRANTEES AND THEIR COMMUNITIES

This chapter provides background information on the 16 HOPE IV grantees and the communities in which they were located. The first section presents demographic, housing and social characteristics of the HOPE IV communities, as well as distinctive community features underlying the need and desire for the HOPE IV program in the context of community-based, long-term care. The second section discusses the grantees' experiences and motivations in applying for the HOPE IV program and contrasts these with the reasons given by 40 similar PHAs for their decision not to apply for the Program. The third section presents selected organizational and staffing characteristics of the grantee PHAs as well as information on their prior experience delivering supportive services to elderly and non-elderly and collaborating with elder service agencies. The chapter concludes with general lessons learned from the grantees' experiences as to community and organizational factors that should be considered in designing housing and supportive services programs for a frail elderly constituency.

2.1 Characteristics of HOPE IV Communities

The 16 HOPE IV grantee communities presented a rich range of environments for HOPE IV program operations. They were located in several geographic regions and distributed across urban, suburban, and rural areas. Grantee communities exhibited some racial, ethnic and cultural diversity, and also presented some distinctive housing characteristics and situations.

Several characteristics of the HOPE IV grantee communities are summarized in Table 2-1, including geographic region, race/ethnicity, degree of urbanization, and other distinctive community features. In the last column, Table 2-1 identifies one or more reasons the grantees cited for needing the HOPE IV program in their particular locale. According to the grantees, community needs for the frail elderly included:

- No prior effort to combine affordable housing and supportive services for elderly persons (11 grantees);
- No alternative community-based, long-term care program in the area (three grantees); and
- Little or no PHA experience serving elderly persons (two grantees).

Table 2-1: Key Socio-Demographic Characteristics of HOPE IV Communities

(1) Site	(2) Number of HOPE IV Units	(3) Region	(4) Race/ Ethnicity	(5) HOPE IV Service Area/ Service Population	(6) Distinctive Community Characteristics	(7) Need for HOPE IV
A	150	West	Small percent minority	Suburban county	■ Suburban area adjacent to a large city	■ No alternatives for frail low income elderly
B	120	Southwest	Predominantly Hispanic (Mexican-American)	Urban (must live within city limits)	■ Border town ■ Poor ■ Rundown housing ■ Some problems in inter-generational families	■ No prior efforts linking Section 8 and services
C	25	New England	Small percent minority	City (both suburban and rural)	■ Bedroom community ■ Many retirees on limited incomes	■ Previous to HOPE IV, public housing only viable option
D	150	Midwest	Urban portion has large Black population	County (includes both city (urban) and rural	■ Many elderly own their own homes	■ No prior organized effort to combine Section 8 and services
E	85	Mid-Atlantic	Virtually no minority	County (mainly rural)	■ Few apartments ■ Dispersion of dwellings	■ No past program systematically linking housing and services
F	75	Southwest	10-11% Hispanic, 2-3% Black	City (suburban)	■ Retirement center ■ Growing elderly population ■ Rising rental costs	■ No previous effort of any kind to link housing & services for elderly
G	40	Midwest	Small percent minority (if any)	County (rural)	■ Older than average population ■ Large nursing home population ■ Dispersion of population	■ No alternatives for low income frail elderly

Table 2-1: Key Socio-Demographic Characteristics of HOPE IV Communities (continued)

(1) Site	(2) Number of HOPE IV Units	(3) Region	(4) Race/ Ethnicity	(5) HOPE IV Service Area/ Service Population	(6) Distinctive Community Characteristics	(7) Need for HOPE IV
H	75	West	Urban portion 7-8% minority, rural portion considerably more (Black and Hispanic migrant workers)	Bi-county (2 urban areas with rural in-between)	■ Advertised as retirement center ■ Retirees on limited incomes with rising rents	■ No past program linking housing and services for elderly
I	70	Mid-Atlantic	Large minority (Hispanic and Black) population in urban county	Two counties (one urban, one rural)	■ Lack of stable housing for many elderly ■ Dispersion of rural population	■ No past program linking Section 8 and services for frail elderly
J	25	Midwest	Small percent (if any) minority	City (rural)	■ Large, dispersed elderly population ■ Lack of transportation a problem ■ Mixed strength of family ties of elderly	■ No prior efforts systematically linking housing and services for elderly ■ Most of PHA's assisted housing stock services families
K	50	Southwest	43% minority in elderly service system, 34% Hispanic (Mexican-American), rest Black, small percent Asian	City (urban)	■ Lack of decent, affordable housing (Desire for housing may be more prominent than desire for services)	■ No prior efforts linking housing and services
L	75	West	Very small percent minority	Small city	■ Remote, not near a major metropolitan area	■ No prior PHA orientation toward serving elderly.

Table 2-1: Key Socio-Demographic Characteristics of HOPE IV Communities (continued)

(1) Site	(2) Number of HOPE IV Units	(3) Region	(4) Race/ Ethnicity	(5) HOPE IV Service Area/ Service Population	(6) Distinctive Community Characteristics	(7) Need for HOPE IV
M	25	Midwest	Substantial number of elderly Native Americans, although tend to participate mainly in tribal programs	Rural	■ Growing elderly population ■ Growing aging-in-place Section 8 population	■ No community-based long-term care ■ No prior efforts systematically linking housing & services for elderly
N	50	New England	Probable substantial minority population	City (urban)	■ Lack of affordable housing for elderly ■ High percentage of elderly living alone	■ No prior efforts linking Section 8 and provision of services ■ Long waiting lists for PHA-assisted housing
O	150	New England	Virtually no minority	State (multiple localities)	■ Increasing proportion of elderly in the population ■ Dispersion of elderly	■ Allows extension of other efforts linking housing & services.
P	95	Midwest	Significant proportions Blacks, Hispanics (Mexican-American, South American); some Native Americans	Large city (urban)	■ Increasing proportion of elderly in population ■ Large group of poor elderly with poor health more frailty than usual	■ No prior effort linking Section 8 and services for elderly.

2.1.1 Geographic Diversity and Urbanization

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

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

2.1.2 Racial, Ethnic, and Cultural Diversity

Nine of the grantee sites were located in communities that had relatively small racial and ethnic minority populations. Seven grantees served areas with relatively high concentrations of (or at least "pockets" of) minorities, including Mexican-Americans, blacks, American Indians, and Asians. Of these seven sites, one was in a border community with a large Mexican-American population, and virtually all the HOPE IV participants at that site were of Mexican-American or Mexican origin. Another of these seven sites was in an area with a significant representation of American Indians, but this population tended to be served by tribal institutions and not the PHA.

The racial/ethnic composition of HOPE IV participants is discussed in greater detail in Chapter 4. The first 16 grantees served a predominantly white population in their HOPE IV programs. In terms of race, 90 percent of the demonstration program participants were white. In terms of ethnicity, Hispanics (of any race) accounted for about 10 percent of HOPE IV program participants. A single site accounted for most of the Hispanic participants.

In the one HOPE IV site with a predominantly Hispanic participant population, the PHA had to be aware of salient cultural issues in the operation of its demonstration program. For example, in this

community the majority of HOPE IV applicants spoke Spanish as their primary or only language. Therefore, most interactions between the PHA and HOPE IV applicants and participants had to be conducted in Spanish. Furthermore, the PHA's jurisdiction is a city on the border between the United States and Mexico. The city is very poor and ties with Mexico are extremely fluid—that is, people may move back and forth across the border as they change residences over the years. Some of their family members may reside in Mexico, others in the United States, and this may shift over time. The service coordinator reported that, "Many of [the HOPE IV participants] still think they are living in Mexico." This fluidity of movement raised questions of access to, eligibility for, and continuity of supportive services. Most of these elderly people were not United State citizens and may have been unfamiliar with American service organizations or bureaucracies. While they were legal residents, they may have believed that they were not entitled to receive help. They may have feared that acceptance of formal help would have brought about a loss of control over their own lives. Combined with cultural factors was a dearth of appropriate housing for the frail elderly. A substantial effort was thus required to earn the trust of the frail elderly in this community and convince them of the benefits of enrolling in a subsidized housing and supportive service program.

2.1.3 Housing Costs, Quality, and Tenure

Six grantees noted "unmanageable housing costs" as a particular problem for the elderly in their area. At least four of these grantees thought desire for stable and decent housing would be the main factor motivating participation in the HOPE IV program at their sites, but also expressed concerns about the availability of a large enough stock of housing that would be both acceptable to the participants (e.g., due to location and environment) and could meet Section 8 Housing Quality Standards. Two other grantees indicated that a high percentage of elderly in their service area owned their own homes, making them ineligible for HOPE IV, even though they were low-income and frail.

2.1.4 Other Distinctive Community Characteristics

During site visits and phone calls, grantees identified some special and distinctive aspects of their community that they believed might affect the operation of the HOPE IV program. These aspects went beyond the basic demographic data supplied in their HOPE IV applications. The grantees provided a variety of responses, which enriched the understanding of the communities in which the HOPE IV demonstration was operating.

At one site, the PHA director pointed out that, due to its location in the temperate Southwest, the community was becoming a retirement center. One consequence of this mobility was that many of the retirees were without family support and could easily become socially isolated. Also, low or fixed incomes among the elderly tended to restrict mobility or leave elders in unaffordable or otherwise unsuitable housing. Some elderly persons, especially widows, were finding it difficult to make ends meet on Social Security and small pensions, especially when low incomes were combined with relatively high rents.

At another site, the HOPE IV program served a two-county area which encompassed two urban zones "with a rural area in between." This area was being advertised as a retirement community, attracting a large number of older persons and placing an upward pressure on the cost of housing. In addition, the PHA's elderly constituted a heterogeneous group. Many elderly in the urban part of the service area were retirees who came to work at a nuclear facility during or right after the Second World War. The rural portion of the area, however, had a concentration of aging black and Hispanic migrant farm workers who settled there permanently. Thus, the service needs of subgroups within the elderly populations were quite diverse and complex. Another implication of rapid growth in the elderly population was higher rent burdens, as demand for suitable elderly housing increased and relatively little new rental housing was being developed.

In virtually all of the predominantly rural sites, the PHA representatives expressed worries about the anticipated difficulties of delivering services to a widely dispersed population. Concerns were raised about the cost and physical challenges of providing services in large service areas and about the availability and accessibility of transportation for the rural elderly.

At one rural site, PHA representatives indicated that, despite the stereotypical image of tightly knit rural families, some elderly people did not have strong family support networks. One of the goals of the HOPE IV program was to serve frail elderly persons who lacked an effective family support system. Although some elderly persons in rural sites had very strong and supportive family ties, other elderly persons lived without any family nearby, were estranged from their families, or even lived in situations of abuse or neglect. Interestingly, respondents in one urban site made similar observations about the prevalence of tension, at times escalating to elder abuse, in situations in which elders were living with their children or grandchildren. "They (elders) want out. Their in-laws want them out. But the older people are too proud to admit it." According to several HOPE IV grantees, the isolated or abused elderly represented special challenges to their demonstration programs. For example, substantial

outreach was needed to identify such persons. Also, several grantees mentioned that neglectful or abusive family members interfered with the application process.

2.1.5 Other Community-Based, Long-Term Care Options in the HOPE IV Grantee Communities

The evaluation questions also asked about the range of other long-term care options for the frail elderly available in the HOPE IV communities. Of special interest was knowing what other alternatives existed for the frail, low-income older population, as well as where HOPE IV fit on the continuum of care.

In all 16 communities, HOPE IV filled an unfilled or incompletely filled niche in the service system for the frail elderly.

- Five grantees indicated that at the time of the inception of the program, there were no real alternatives to HOPE IV in their communities except nursing home placement.
- Four grantees reported either that the limited home care available in their area was too costly for the frail elderly population, or that publicly funded, community-based, long-term care programs in their community were under budget pressures and had impossibly long waiting lists.
- Four grantees indicated the HOPE IV supportive services component would be an expansion of existing AAA efforts, although complicated in some cases by different frailty eligibility criteria for HOPE IV and the AAA home care program.
- Three grantees in two different States noted that Medicaid or Medicaid/Medicare waiver programs had been established in their communities to deliver intensive supportive services in community-based settings to frail elderly persons who would otherwise qualify as nursing home eligible.

In one of these three communities, a Medicaid and Medicare waiver program is operated under the aegis of the State Department of Housing and Community Affairs and is modeled after the On Lok Program in San Francisco.[iv] Funds that would have been used to cover nursing home expenses for these extremely frail and medically needy individuals are used instead to sustain them in a community-based setting by providing an interlocking network of medical and other necessary services. All three of

[iv] On Lok is a private, nonprofit organization which serves primarily an elderly Chinese-American community in San Francisco, California. On Lok operates residential and day programs. On a capitated basis, On Lok uses Medicare reimbursements under a unique waiver to address the long-term health care needs of older persons as an alternative to fee-for-service and nursing home care.

these grantees with State Medicaid or Medicaid/Medicare waiver programs saw HOPE IV as serving individuals less frail than persons eligible for the waiver program. Depending on availability, persons assessed as too frail for HOPE IV might be channeled into the waiver program, or as they aged or exhibited further decline, HOPE IV participants needing an added level of care might "graduate" into the more service-intensive waiver program rather than entering a nursing home. Follow-up data suggest that a small number of HOPE IV participants in these communities did enter these waiver programs.

2.2 The Decision to Apply for HOPE IV

The invitation to participate in the HOPE IV program was extended to the nation's over 3,000 PHAs in HUD's Notices of Funds Availability (NOFA), as two competitions for Federal fiscal years 1992 and 1993. A total of 28 agencies received awards, 16 of them as part of the 1992 competition. This section of this chapter explores the reasons why the successful applicants for the 1992 competition applied for the program and summarizes reasons why some of the others that also saw either year's NOFA did not submit applications.

Grantees and the Application for HOPE IV

2.2.1 Factors Motivating the Grantee Applications

Why did the grantees decide to expend the time and effort required to apply for the HOPE IV Program? The reasons fall into two clusters. Ten grantees indicated that in spite of their PHA's relative inexperience with programs of this sort, they had come to recognize the growing needs of the elderly populations in their communities, and saw the HOPE IV Program as a way to address these needs. In most cases, PHA personnel had not come to this recognition on their own. Rather, their views had been influenced by contacts, conversations and meetings with advocates for the elderly or representatives of community agencies delivering services to the elderly.

The following excerpts from site visit reports illustrate these points:

> ...there was a need for long-term care... No agencies were providing a program similar to HOPE IV. The Area Agency on Aging (AAA) saw that, within its jurisdiction, [name of community] had a lot of elements already in place that would be needed to apply for HOPE

> IV. According to the PHA, the existing Section 8 population was aging and needed more supportive services.
>
> ...the Executive Director of the PHA saw the NOFA and decided to apply. Agency staff are aware that there is a high proportion of elderly people in the county. The PHA receives frequent requests for housing assistance and services from people who are concerned about their increasingly frail parents, and they [the PHA] are unable to provide suitable assistance.
>
> [Name of place] has a large, scattered, elderly population that the PHA would like to serve. Several years ago, the managers of PHA-assisted housing expressed an interest in dealing with the problems and service needs of their elderly tenants.
>
> The PHA director became interested in HOPE IV because he came to realize that the elderly are the fastest growing segment of the population and nothing had been done for them before in the housing arena...The general impetus to do something to address the needs of elders in [name of community) came several years ago, through the Mayor's Committee on Aging and the Senior Center Director going "one-on-one" with the city council.

The second major cluster of grantees reported that applying for HOPE IV funds represented a natural extension of their past work in efforts combining housing and provision of supportive services to the elderly.

A theme that emerged strongly is that although initial contacts may already have been forged between the PHA and the AAAs or other service delivery agencies, the HOPE IV NOFA gave them just the opportunity for collaboration, or more intensive collaboration, that they needed. The timing was right. "We had been waiting for something like this to come down the pike," said a representative from one grantee site. "The PHA had already established informal linkages with the AAA when the NOFA appeared," read another site visit report. A third report stated:

> A survey had been done three years ago, revealing the housing needs of the elderly. A coalition of aging groups had been formed on the initiative of the Mayor's Advisory Board on Aging and the Department of Human Services. But before HOPE came onto the scene, there was no mechanism to facilitate this coalition's working jointly with the PHA.

Several of these grantees suggested that without a pre-existing base, which made it reasonably easy for them to put together the application, they would probably not have applied for HOPE IV funds.

In one way or another, a groundwork for inter-agency collaboration had already been laid in these communities. The HOPE IV NOFA provided the necessary catalyst for activating the process. Another site visit report said:

> The PHA found it could help persons with considerable disabilities stay at home, avoiding the need to move into restricted settings such as nursing homes. For this reason, the PHA knew the HOPE IV concept would work for the scattered site Section 8 frail elderly tenants.

One PHA director admitted that his PHA applied for all HUD-sponsored programs to provide affordable housing. In this locale, the process was simplified for HOPE IV because Section 8 eligibility screening criteria had already been incorporated into an existing ADL assessment tool that could be used to screen participants for frailty. In this case, as well, prior experience in putting together applications of this sort, plus a fortuitous coalescence of local conditions, supported the decision to apply for HOPE IV funds.

2.2.2 Putting Together the Application

In at least 13 grantee sites, someone at the PHA, although not necessarily the PHA director, took the initiative to produce the HOPE IV application. The "typical" scenario was that someone at the PHA saw the NOFA and immediately set about notifying the partner agencies and arranging for their representatives to meet as soon as possible. For example, one PHA reported, "We faxed the AAA [in another town] the NOFA over the weekend and arranged for them to come down to meet with us early the next week." Virtually all the sites emphasized that time was of the essence; the turnaround time was so short that they had to act quickly or not at all.

At one site, the initiative for pursuing the application came instead from the city department of human services and a community-based coalition for long-term care, whose representatives then contacted the PHA community services director "who immediately said yes."

At most of the 16 HOPE IV sites, the PHA assumed lead responsibility for putting together the application, but with significant help from representatives of AAAs and other community service organizations. In all cases, some collaboration from non-PHA agencies was needed to gather and assemble the required information. At one site, the application was drafted by the PHA and AAA and reviewed by a committee of community agencies. The application was also critiqued by the HUD field office, which provided technical assistance to the local PHA in their application effort. This was the only time a grantee described having received assistance from HUD in their application efforts.

At one grantee site, the application for HOPE IV was written by an outside consultant and someone from the community elder services agency, with little if any direct involvement from the PHA. The PHA program coordinator had little experience or apparent interest in supportive services for the elderly. He indicated that the main person with an interest in the program and connections to aging

network had left the PHA. Interestingly, this is one of two sites where implementation of the HOPE IV program was delayed for several years.

Respondents tended to concur that the HOPE IV application process required inter-disciplinary expertise in both housing and aging issues, and expertise in submitting grants. "I knew how to put together the housing piece," said one PHA director, "but I could never have done the supportive services piece without help from the AAA." At one large grantee site, several PHA employees participated in the application-writing effort, including the PHA's specialized grants writer, who teamed with an accomplished grant-getter from the community long-term care agency. "To win this sort of thing," they said, "you need to have sophisticated people working together." In the smaller, rural sites where expertise was generally lacking, the respondents described the process of preparing the application as a "seat of the pants" operation.

Virtually every grantee indicated that there was a limited amount of time in which to prepare the application between the NOFA and the due date. Although these grantees were obviously able to overcome the time limitation barrier, they acknowledged that under other circumstances the time constraints might have been enough of a deterrent to have stopped them from applying. Several sites indicated that they had relied on a lot of "volunteered" time above and beyond regular work time to put the package together.

One grantee commented that projecting service needs to design a services package was "part fortune-telling." Respondents at this site felt it would have been better to have required a gross projection of needs for application purposes and then allowed the grantee to design the actual service package once more detailed local information was available. Another grantee indicated that challenges for them in preparing the application included selecting the counties to participate (in a State-administered site), deciding on the appropriate target population, and meeting the matching funds requirement.

2.2.3 The 50 Percent Match Requirement

Requiring matching may serve as a barrier, especially in financially troubled communities. The ability to raise the match can signal that the community can assemble the resources. Being able to gather the necessary resources also reflected the PHA's ability to work with community agencies that delivered services to the frail elderly.

Very few grantees indicated that generating the matching funds commitment had presented a serious barrier to application. Several added, however, that it remained to be seen whether service delivery would flow as smoothly in this respect over the entire five-year demonstration period. At least two grantees indicated that, if necessary, they planned to dip into their operating reserves to cover any shortfall in the match.

The "partner" AAA agency, donating in-kind services or dollars for services, was the primary source of the match for most HOPE IV grantees. Other sources tapped for the HOPE IV match included: Medicare, Medicaid, and various types of State programs (including a State-funded homecare program, a State Homelessness Prevention Program, and Social Security Block Grant monies).

2.2.4 Grantee Ties with Community Agencies Delivering Services to the Elderly Before and After Application

The HOPE IV application instructions required applicants to document that local AAAs and other key community agencies delivering services to the elderly had been involved in the application process. Collecting the information to document service needs and service plans generally required some degree of inter-agency collaboration. However, as will be seen, that collaboration did not necessarily indicate a strong history of common efforts. In many cases, the HOPE IV application marked the first time that PHA personnel had worked with personnel from these community agencies.

The evaluation team decided it would be important to find out more about the true strength and nature of the PHA's pre-existing ties with these service delivery agencies, as well as the impact on this relationship of winning the grant. Program implementation might be less problematic and move more quickly in sites with a history of successful collaboration. The team also thought that winning the award might in itself solidify ties and perhaps even lay the groundwork for other collaborative efforts.

Twelve of the 16 grantees indicated that before applying for HOPE IV they had only limited experience with the agencies in their communities that delivered services to the frail elderly. Several grantees stated that prior to HOPE IV, there had been no formal mechanism available to them for making such a linkage. In a number of cases, the ties that existed had been episodic, transitory, or mainly through one individual rather than formal agreements between agencies,

Four grantees described a history of collaborative efforts across agencies both at the local PHA and AAA level and across divisions at the State level. One grantee reported a pattern of cross-cutting ties, with representatives of the AAA performing functions on housing commissions and PHA representatives sitting on advisory committees on aging. Not surprisingly, these same grantees stated that applying for HOPE IV came as a natural extension of previous efforts linking housing and services for frail elderly in their communities.

However, where there had been little if any contact between the PHA and service agencies prior to applying for the demonstration monies, HOPE IV provided the means of creating or building up these linkages. This appears to have been an easier process in communities with a strong network of community-based, long-term care services where the PHA could be "assimilated" into an existing network.

PHAs That Did Not Apply for HOPE IV Funding

One component of the original evaluation design was a non-grantee telephone survey of PHAs that had requested HOPE IV application materials from the HUD regional offices, but had not followed through by submitting an application. After consultation with HUD, it was decided that it would be exceptionally difficult and costly to develop a sampling frame of these agencies. In locating sites for comparison group members, Westat had already identified a group of PHAs that had not applied for the HOPE IV program and were similar to the grantees in a variety of important characteristics. Consequently, with HUD's approval, these became the frame in selecting the PHAs for the non-grantee survey. The majority of the PHAs interviewed were medium-sized, suburban, or rural agencies.

In this section, we summarize the results of interviews with Executive Directors of 40 PHAs that chose not to apply for HOPE IV grants. The purpose of these interviews was to identify reasons for not applying. For accuracy's sake, "non-grantees" have been renamed "non-applicants." Of these 40 PHAs, 16 had considered applying for HOPE IV, whereas 24 had not.

2.2.5 Comparing HOPE IV Grantees and Non-Applicants

The perspectives of the grantee PHAs that prepared successful applications for the HOPE IV program were considerably different from those of non-applicants, some of whom did not even consider applying. For the 16 grantees, a number of factors came together to encourage application, even in the

face of obstacles. As seen, one major reason for applying for HOPE IV given by the grantees was their perception of a need for a program of this sort to serve the low-income, frail elderly in their communities. Many of the grantees were made aware of the needs of the frail elderly only through contacts with representatives of elderly service agencies or advocates for the aging. Joint participation in the application process then increased the PHA grantees' knowledge of the unmet needs of this frail elderly constituency, and at the same time, built up or strengthened their linkages to their partner elderly service agencies. It was a cumulative process, and timing was also important.

By contrast, the non-applicant's reasons for deciding not to apply can be classified into three categories: (1) perceptions that the program was not needed in the community or was considered of low priority; (2) PHA staff felt they were not experienced or familiar with key activities required for operating such a program, especially those involving coordination with other agencies; (3) limited time, staff, or resources were available to develop the proposal or implement the program if it were to be funded.

Despite differences between the grantees and non-applicants, certain key features of the decision process were similar for both groups. For both grantees and non-applicants, the PHA had to determine whether HOPE IV was a high enough priority to warrant the time and attention required to complete an application. In making this decision, agencies considered whether there was a large enough low-income, elderly population within their areas needing supportive services as well as housing and if existing programs could adequately meet those needs.[v] Furthermore, a favorable climate of opinion in the community was required to provide support for such a program. The 16 successful grantees considered HOPE IV to be high enough in priority to warrant applying for the program, whereas half of the non-applicants did not.

Potential applicants also had to evaluate their experience and expertise in areas related to the program's basic features. Most grantees were able to devise an approach to generating matching funds and had at least some ties to social service delivery organizations or individuals they could build upon to develop a program. Many non-applicants—both those that decided that the program was too low in priority to warrant serious consideration and others—found it daunting to devise a method for obtaining matching funds or to form ties with social service agencies to serve elderly clients.

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[v] It is not possible to judge the objective accuracy of the non-applicant's assessment of the lack of need for a program like HOPE IV in their communities. Nor do we really know how much consideration they gave to assessing this situation. In this case, however, what is important is their perception of lack of need or of the adequacy of existing resources in addressing that need, as well as their perception that groups other than the frail elderly had more pressing needs.

Despite difficulties, grantees also successfully conquered a third obstacle to preparation of an application: the availability of staff time, expertise, and other resources to write the proposal and manage the program. Resource constraints were a stumbling block to 10 of 40 non-applicants, even when priorities and experience were not particular problems.

2.3 Grantee Governance

The following section describes the organization, structure, and institutional setting for the first 16 HOPE IV grantees. The grantees represented a mix of PHAs in terms of the variety and amount of housing assistance they managed, staff size, and relationship to the general purpose government (i.e., State, county, or municipal government). The grantee agencies implemented a variety of different staffing arrangements for administering a HOPE IV program, which are also discussed in this section.

2.3.1 Assisted Housing Units

The 16 grantees represented a broad spectrum of PHAs in terms of size, from small (about 100 units of assisted housing) to very large (about 10,000 units). Each of the 16 HOPE IV grantees administered a Section 8 existing (certificate and voucher) rental assistance program. The size of the grantees' Section 8 programs ranged from about 100 to about 1,000 certificates and vouchers. Most of the grantees also operated a conventional Low Rent Public Housing program. Altogether, the grantees managed or assisted about 40,000 units of low- and moderate-income housing, which includes over 12,000 public housing units, over 20,000 Section 8 rental assistance certificates and vouchers, and the balance among other housing assistance programs. About one-third of the grantees' assisted housing units served elderly persons. Five grantees operate or assist nearly 3,000 units of project-based, congregate or other supportive housing for the elderly.

2.3.2 Grantee Staffing

To implement a HOPE IV program, the grantees had to undertake a variety of staffing, organizational, and administrative changes. As will be discussed in detail in Chapter 3, the PHAs made substantial changes in their rental assistance program operations to accommodate HOPE IV applicants and certificate recipients. Characteristics of the Professional Assessment Committees (PACs) and of the HOPE IV Service Coordinators also are discussed in Chapter 3, which focuses on the grantees' experience with implementing a HOPE IV program. Below, four types of HOPE IV staffing issues are discussed:

- Overall staffing levels,
- Arrangements for hiring or contracting for HOPE IV service coordination,
- Assignment of HOPE IV administrative responsibilities, and

- Relevant experience of PHA staff in the delivery of housing and supportive services.

Overall Staffing

The 16 PHAs represented a wide range of staff sizes. Staff sizes ranged from two to over 400 full-time equivalent or FTE. Most of the grantee PHAs maintain very small staffs: nine had staffs of fewer than 25 FTE.

HOPE IV Service Coordination

HOPE IV rules required that grantees designate one or more Service Coordinators for the demonstration's participants. Generally, the grantees followed one of two different staffing scenarios for service coordination. Either the PHA hired its own Service Coordinator, adding one or more individuals to its staff or designating a current employee for this purpose, or the PHA contracted with an elderly supportive service organization to provide one or more Service Coordinators.[vi]

PHA Staff Devoted to HOPE IV

In general, the executive directors of the 16 grantee agencies demonstrated an interest in and commitment to the HOPE IV program, even when they delegated the management of day-to-day HOPE IV operations. Executive directors tended to be most active in day-to-day HOPE IV operations in the smallest HOPE IV sites. At PHAs with more than a dozen staff members and a greater differentiation of divisional and staff functions, the primary responsibilities for HOPE IV operations tended to be assigned to particular departments and individuals. However, in all these sites, executive or associate directors performed oversight functions for HOPE IV.

There was, nevertheless, substantial variety as to which departments and individuals were assigned to operate the HOPE IV program. For example, in four sites, Section 8 program managers were responsible for daily operations; at three sites, community service directors or special programs coordinators administered HOPE IV activities; and at two sites, directors or assistant directors of other types of divisions ran the HOPE IV program (e.g., Leasing, Housing Assistance). At most grantee agencies, HOPE IV operations cut across several program or divisional lines. For example, in one agency, HOPE IV operations were assigned to the Section 8 and Community Services divisions. For a

[vi] Chapter 3 of this report addresses additional issues concerning Service Coordinators.

few grantees, setting up HOPE IV operations in multiple agency divisions seemed to be more difficult than coordinating with social service delivery agencies in the wider community.

Background of PHA Staff

PHA directors and other HOPE IV staff were asked about their own professional background in providing supportive services, especially services for elderly persons, and their familiarity with the needs of the frail elderly. Most of the PHA directors described themselves as "veterans" of roughly 20 years in the housing arena, but only a few of them had very much experience managing the delivery of supportive services in conjunction with the housing they managed. Other PHA staff assigned to the HOPE IV program reported varying levels of interest and expertise in providing supportive services. Some grantee PHAs have special divisions or programs devoted primarily or exclusively to service delivery.

At one site, a new Special Programs Coordinator with a double background in Public Administration and Social Services was hired on a consultant basis by the PHA just prior to the start of the HOPE IV Program. Her role was to develop a service niche within the PHA for HOPE IV and Family Self-Sufficiency (FSS) participants. Both HOPE IV and FSS shared the common thrust of combining housing with supportive services, all as an integral part of the PHA's new orientation. This new coordinator was hired, in part, because the executive director recognized that he and representatives of the community's social services agencies "spoke a different language." With her double background, the Special Programs Coordinator presumably could speak both languages and, thus, would be able to translate across the divide. She worked closely with the agency's HOPE IV Service Coordinator, but did not take on actual case management functions in order to preserve a clear division of labor between the PHA and the contracted service provider.

2.3.3 Relationship of PHA to General Purpose Government

Level of Government

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

The two State-level grantees were distinctive in that their HOPE IV programs operated in multiple counties. One grantee was a state housing finance agency, a public benefit corporation created in 1981 to serve as the PHA for the entire State, operating a full range of housing finance and assistance, and generally serving localities without their own PHA. The agency is run centrally and has no delegated functions. What this meant for HOPE IV was that the State-level grantee passed through Section 8 rental assistance and supportive service funds to the designated local communities, and maintained ultimate jurisdiction over HOPE IV program operations.

The other State-level grantee was a State housing and community development agency, a division of the State's Department of Community Affairs. Two counties in the State were selected as HOPE IV sites. The HOPE IV Service Coordinators for the two counties were based in their respective county offices. Within the state agency, the Bureau of Housing Services, responsible for the Section 8 program statewide, was the focus for the HOPE IV demonstration. The agency's programs are operated through four regional supervisors, each responsible for about one-quarter of the State's 21 counties. Regional supervisors oversee county field offices and handle the Section 8 program and other special projects. This state agency maintains strong control of financial operations at the state level. Section 8 applications from anywhere in the State are sent to a central office; the Section 8 hearing officer is also located in the central office. The central office processes paperwork for payments and makes payments to participating landlords directly from the State treasury. Agencies at the county level handle such activities as new leases, yearly renewals, and changes in payments or income for tenants. In addition to Section 8, certain other programs—such as special needs, transitional housing, and homelessness prevention—are handled centrally, while others are administered at the county level.

Independent and Line Agencies

Most of the grantees were independent authorities, governed by their own boards of directors. Ten local-level grantee PHAs were independent agencies, and the remaining four local-level grantees were line agencies. However, in operational terms, the 10 independent authorities encompassed a range of legal, financial, and administrative arrangements vis-a-vis city and county governments. For example, one PHA was an independent authority, but its board of directors was appointed by the mayor. Furthermore, the PHA conformed to city practices and procedures. Another PHA was technically independent, but its employees were city staff. The board at a third PHA was appointed by the County Commissioners, but the PHA received no funds from the county. A fourth PHA was a legally independent agency whose finances were managed by the county.

The four line agencies were part of their respective city, county, or State governments. One of these PHAs had been incorporated into the Community Services Department of the city since 1971. Another was independent until 1984, when "management problems" led the city manager to dissolve the housing authority board of directors and directly incorporate the PHA within the city's Division of Community Development. In the third case, the arrangement in which the PHA was formally made part of the city was only about seven months old when the HOPE IV site visit was conducted in November 1993. Prior to that, the PHA had been attached to the Chamber of Commerce.

2.3.4 Grantee Supportive Service Experience Prior to HOPE IV

Prior to HOPE IV, 10 of the 16 grantees had little experience with directly providing or procuring supportive services of any kind, whether to the frail elderly or any other population. Six of the 16 grantees were notable exceptions, with extensive histories of direct service provision or cooperation with service providers, either to the elderly or to other groups.

This section of the report summarizes three aspects of the grantees' experience in the area of supportive services.

Grantee PHA Experience Delivering Elderly Services

Among the 16 HOPE IV grantee PHAs, four had considerable prior experience in providing supportive services specifically to the elderly. A strong foundation for HOPE IV had already been laid in prior PHA expertise with these programs. It is not surprising that PHAs with an established record of combining housing and supportive services to the elderly should be among the HOPE IV grantees. More surprising is that of the remaining 12 grantees; eight had only limited experience providing supportive services to the elderly, while four grantees may be considered true neophytes in this area at the time they received the HOPE IV funds.

The four most experienced grantees presented a range of prior experience in delivering supportive services to the frail elderly. One such grantee PHA was funded under the Older Americans Act (OAA) to deliver supportive services to all elderly in the county, not just those residing in PHA-related housing. One of these four grantees receives funds from HUD to operate a Congregate Housing Services Program (CHSP) and a second administers a similar State-funded program combining

congregate housing and supportive services. CHSP is a program much like HOPE IV; the key difference is that CHSP operates within existing public housing, Section 202 Supportive Housing for the Elderly, or other existing project-based, assisted housing. One of these four grantees was also involved almost 20 years ago in a pioneering venture combining Section 8 housing assistance and delivery of supportive services to deinstitutionalized mentally ill persons, many of whom were also elderly and disabled.

Eight of the 16 HOPE IV grantees reported prior or current involvement in much smaller scale efforts to provide supportive services or other special programs for the elderly in PHA-assisted housing. Not all of these efforts had yet resulted in the delivery of services, and none of the eight approached either the scope or the service intensity of the HOPE IV program. Five grantees mentioned efforts geared toward elderly residents of public housing complexes. These programs were unlike HOPE IV in three main ways: 1) services were typically not coordinated by a Service Coordinator; 2) the offered services included a larger complement of recreational, educational, and health promotion activities (e.g., parties, classes, wellness programs, blood pressure screening, nutrition counseling) rather than supportive services designed to help a frail or disabled person maintain a private residence; and 3) in most cases, participation in the services portion of the program was entirely voluntary. For three of these eight grantees, efforts for the elderly were extremely limited in scale. For example, about 10 years ago, one grantee supported a pilot project to convert a motel into a supportive housing complex for 20 elderly residents. Another had at one time worked with service agencies to organize educational forums on topics of importance to elderly residents of public housing.

Four of the HOPE IV grantees had little or no prior experience with programs combining provision of housing and supportive services, even by these modest standards. This does not necessarily reflect a dearth of supportive services for the elderly in these communities. Rather, it illustrates a previous lack of direct involvement by the PHA in these efforts. In several HOPE IV communities where the PHA has not previously been involved in such activities, strong networks existed for provision of community-based, long-term care services to frail elders.

Grantee Experience Providing Supportive Services to Other Groups

In addition to the four agencies noted as having had extensive experience with service delivery to the frail elderly, two other grantees had had extensive experience in combining housing and supportive services for other populations. To the extent that such experience was transferable, these grantees were probably better prepared than the remaining 10 grantees for dealing with the requirements of managing the HOPE IV program. The director of one of these agencies had consistently shown a commitment to programs combining housing and supportive services and had supported various mechanisms for coordination of service delivery across agencies and programs. The other grantee PHA had been involved in programs for delivering supportive services to a wide range of groups, including the homeless, single room occupancy (SRO) residents, family self-sufficiency program participants, public

housing residents in employment and training programs, and elderly residents in a small scale project to deliver supportive services at one public housing facility.

Prior Collaboration with Elder Service Agencies

Somewhat distinct from their experience in delivering supportive services to frail elderly was the HOPE IV PHA grantees' history of collaborating with the agencies in their communities that deliver services to the elderly.

The extent of formal or informal linkages between the 16 grantee PHAs and elderly service organizations prior to the HOPE IV program varied substantially:

- Four grantees reported prior formal experience contracting with elderly service organizations at both the local and State levels;
- Eight grantees reported only "informal working relationships" or transitory individual contacts with elderly service organizations; and
- Four grantees reported "little or no" prior experience of any kind with elderly service organizations, although they emphasized the existence of a strongly developed network of services for the frail elderly in their communities.

Only a minority of the HOPE IV grantees had had any prior experience of formal cooperation (e.g., contracts, cooperative agreements, letters of agreement/or understanding) with elder service agencies. Several grantees said that, prior to HOPE IV, there had been no formal mechanism available to them for making this linkage. For some grantees, working together on the HOPE IV application was the first opportunity they had for collaboration. Even in communities with a strongly developed network of elderly service providers, there seems to have been little formal collaboration between the PHA and these service agencies prior to HOPE IV.

Notwithstanding this overall picture of limited past collaboration, HOPE IV provided a means of forging or strengthening the linkages between the PHAs and AAAs. In one community lacking either a strong pre-existing service network or prior contact between the PHA and the AAA, collaboration created by joint participation in the HOPE IV application process had already stimulated another joint venture in combining housing and supportive services for the frail elderly even before the HOPE IV program began in earnest at that site.

2.4 Summary: Implications for Designing PHA Programs for the Frail Elderly

The HOPE IV program filled an unfilled or incompletely filled service niche in all 16 HOPE IV communities, which represented most regions of the country and a wide range of types of communities. The diversity of characteristics presented by the 16 HOPE IV grantees provided an opportunity to consider the influence of community and PHA context on designing and establishing PHA programs for the frail, low-income elderly. Two general lessons can be offered, incorporating recommendations and observations from the 16 grantees:

- *Grantee PHAs must adapt their programs to fit the needs and circumstances of the low-income, frail elderly in their communities. This requires detailed, firsthand knowledge of various aspects of this population (e.g., housing conditions, economic circumstances, family support, and lifestyle).*

This apparent truism cannot be stressed too much. Any basic program model, however sound, must be shaped to fit the particular environment. Intimate, working knowledge of community conditions as they affect the frail, low-income elderly is more useful than abstract projections or generic demographic data. This detailed knowledge permits a realistic assessment of what will be required to establish a viable program for the target population in a given community, including many of the likely obstacles to be overcome.

For example, in establishing a program in a largely Mexican-American border community, PHA staff had to address a range of linguistic, cultural, and residential issues. The needed adaptation extended well beyond translating materials into Spanish; it required appreciating inter-generational dynamics of Mexican and Mexican-American families, as well as how best to approach overcoming cross-cultural differences in assumptions underlying receipt of services. In most communities, knowledge of how local housing conditions affect the low-income elderly—including the quality and availability of appropriate housing stock, the proportion of renters versus owners, and current and future rental market conditions—is vital to the ability to design a viable housing program for this constituency. Similarly important was knowing the basic economic circumstances of the low-income, older population.

Considering what they might have done differently to ease the process of program implementation, the HOPE IV grantees offered similar advice to PHAs starting a program like HOPE IV. "Really know your frail elderly population, not just the State level data" said one grantee. "Be sure you

have the necessary 1-bedroom availability," recommended another. A third grantee provided an example of what can happen when the PHA identifies a high level of need for housing and supportive services, but not the particular circumstances, on the part of the frail elderly. This PHA noted that in making projections, the application team had failed to take into account how many low-income elderly in their community own their own homes and would thus be reluctant to move into rental housing to satisfy the requirements of the program. Another grantee indicated: "If we had thought harder about what was needed (for a participant) to fulfill all the specific requirements of the (HOPE IV) program, we probably would have requested fewer vouchers."

Surprisingly few of the 16 HOPE IV grantee PHAs had extensive prior experience either delivering supportive services to the frail elderly or formally collaborating with elderly service agencies in their communities. However, most had some, albeit limited, experience with service delivery to the elderly or at least informal prior contacts with AAAs. Another factor mitigating the lack of PHA experience is that most of the grantees with little or no history of PHA/AAA collaboration were located in communities with a strong network of supportive services for the frail elderly:

- *Extensive experience in service delivery to the frail elderly and a history of prior formal collaboration between the housing agency and the elderly service agencies are not absolutely necessary for establishing a program such as HOPE IV. However, it is advisable to start with some foundation for inter-agency collaboration based on previous contacts or a strong pre-existing elderly service delivery network. Beyond that, it is wise not to take much about the PHA/AAA relationship for granted.*

Prior collaboration between the PHA and the AAA did not necessarily guarantee smooth implementation of the HOPE IV program. However, failure to agree in advance on a clear division of responsibilities between agencies did sometimes cause problems. With hindsight, grantees stressed that in launching the PHA/AAA partnership, it was necessary to go well beyond the "on paper relationship" presented in the HOPE IV applications.

3. PROGRAM IMPLEMENTATION

This chapter describes the design, implementation, and operation of the HOPE IV Program at the 16 first-round grantee sites. It examines commonalties and variations across the sites in how participants were identified, recruited, screened and assessed, how long this took, and why. The chapter also explores the functions of the Professional Assessment Committees (PACs) and Service Coordinators, as well as the organization of delivering services, including which services are delivered and by whom, which functions are contracted and which are handled directly by the grantees. We also briefly consider the grantee's sources of funds for operating the HOPE IV program, including HUD and other sources, and how the funds are allocated among different uses, including the various categories of services. In addition, this chapter includes an analysis of participant satisfaction with these aspects of the HOPE IV program, including assessment procedures and services received.

The sources of data for this chapter include: abstractions and close reading of the narrative portions of the HOPE grant applications; reconnaissance visits and calls to the grantees; analysis of documents provided by the grantees (including the instruments they use for assessing frailty); grantee mail survey returns; follow-up telephone interviews with the grantees conducted in November and December 1994 (about a year after the initial round of reconnaissance calls and visits), as well as structured interviews with PAC members and Service Coordinators at the end of calendar year 1995, and a meeting with Service Coordinators in Washington, DC, on March 31 and April 1, 1998. This chapter provides considerable detail on HOPE IV implementation in order to orient and assist other PHAs interested in developing housing and support services programs for a frail elderly tenant population.

3.1 Effects of HOPE IV on Section 8

Application for and participation in HOPE IV had a noticeable impact on the grantees' orientation toward the frail elderly population. For all grantees, at the very least, HOPE IV represented a new, unique opportunity to complement Section 8 housing with delivery of supportive services for the frail elderly. From the perspective of community service providers, HOPE IV represented the first chance to link human and service delivery for the low-income, frail elderly population in a far more systematic and coordinated fashion. In the fall of 1993, respondents both from the grantee PHAs and their partner AAAs repeatedly expressed their excitement at having been provided a rare opportunity to take this

"double-pronged" approach to addressing the failures of the service delivery system. One year later, though considerably wiser about the obstacles to implementing a joint venture in provision of housing and supportive services to the frail elderly, they remained, on the whole, still very enthusiastic about the HOPE IV program and even more committed to addressing the needs of this group.

A related theme has to do with how participation in the HOPE IV program affected various aspects of regular Section 8 Program operations at the grantee sites. Virtually all grantees recognized that the Section 8 program in their PHA changed perceptibly as a result of their involvement in HOPE IV. Eight of the 16 grantees went so far as to characterize these changes as "dramatic," "major," or even "revolutionary."

Grantees said that prior to HOPE IV the Section 8 programs in the grantee sites had, either consciously or inadvertently, discounted the frail elderly as a service population. In a number of places, this had taken the form of steering elderly away from Section 8 and toward other types of housing such as elderly congregate housing or public housing projects. At some sites, the frail elderly and their needs had previously been "invisible" to the PHA. For example, at one grantee site it was only with the advent of the HOPE IV program that the PHA discovered the reasons why so many elderly, especially frail elderly, had been letting their Section 8 vouchers or certificates expire. The PHA had assumed this had happened largely through lack of interest. In fact, the Service Coordinator discovered this phenomenon reflected the physical inability and psychological unwillingness of elderly prospective Section 8 tenants, especially frail elderly, to search for and locate apartments and make the necessary arrangements with the landlord in the time allotted. At another PHA, participation in the HOPE IV Program had begun to move Section 8 away from an almost exclusive focus on young families with children by creating an awareness in the community that the PHA can provide the elderly more than housing.

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

Although the Section 8 programs at most of the grantee PHAs at first experienced difficulties meeting new demands imposed by HOPE IV, grantees responded by making formal and informal changes in their organization and orientation. For example, one PHA reduced by 50 percent the case load its Section 8 staff carried when involving frail elderly tenants. Another provided formal

training for Section 8 staff on the status and needs of the frail elderly using the resources of a local university. Virtually all grantees reported that day-to-day interaction greatly improved the ability of PHA Section 8 personnel to work collaboratively with HOPE IV Service Coordinators and others in participant recruitment and assessment of eligibility for both Section 8 and HOPE IV services. In many cases, Section 8 forms and procedures were altered to accommodate telephone screening and home visits for application purposes.

Participant recruitment, screening and assessment were the aspects of HOPE IV program operations most immediately affected by the lack of prior experience of the grantee Section 8 programs in handling the requirements of running a combined housing and supportive services venture. However, the initial unpreparedness of the Section 8 program is not the only reason why recruitment and enrollment took longer than expected. Even under the best of circumstances, the process was much lengthier and more labor-intensive than any of the grantees or their colleagues at the service delivery agencies had anticipated. The reasons why are given in the following section on recruitment of participants into the HOPE IV program.

3.2 Participant Recruitment

Grantees varied considerably in when they began active recruitment and placement of HOPE IV participants. Many grantees had to await development of an entirely new infrastructure within the PHA, and linkages with other service providers, before beginning recruitment. Table 3-1 summarizes the grantees' recruitment activities as part of the HOPE IV program implementation.

By the end of 1993, only one-half of the 16 grantees had begun active participant recruitment. While the HUD grantees in July 1992 reported a number of administrative problems with the awards process that delayed start-up of the program, only three grantees were at or near full enrollment in December 1994, and these had been actively engaged in recruitment for an average of 14-15 months.

As of December 1994, the 16 grantees had recruited only approximately 40 percent of all HOPE IV participants specified in the awards. Full implementation of the program did not occur until several years after the awards, given the difficulties of HOPE IV implementation. For example, in August 1995, upon completion of the baseline participant and comparison group survey, only about 550

of the 1,260 authorized units were filled. By the close of calendar year 1995, Service Coordinators reported a total of 586 participants.

Table 3-1

Table 3-2

3.2.1 Attrition from the HOPE IV Program

In a program such as HOPE IV, attrition of participants due to moving, hospitalization, nursing home placement, or death is to be expected over the five-year course of the demonstration. Chapter 7 provides a detailed analysis of program exits for both participants and the comparison group. However, shorter-term attrition, occurring either just prior to or relatively soon after lease-up, was also a factor affecting HOPE IV program implementation. Eight grantees noted cases of prospective participants dropping out of the program before lease-up, most often because they could not bring themselves to move, or else could not find an apartment that could qualify under Section 8 or whose landlord would accept Section 8 tenants. Two grantees noted problems with participants who either refused to accept supportive services after enrolling in HOPE IV or dropped out of the HOPE IV program as soon as they got "what they wanted" (e.g., transportation services). In a few cases, after lease-up, participants were either evicted or "just moved out" following disputes with the landlord. Other cited reasons for attrition include: relatives moving in with program participants, thereby disqualifying them from the program; onset of severe illness; entry into nursing homes; moving out of the community; and death. Two grantees mentioned participants who transitioned out of the program because their health and functional status improved; others noted that participants had been transitioned into Medicaid-waiver community-based programs.

Several implications for HOPE IV program operations can be drawn from these findings on participant attrition. First, depending on when in the process participants or applicants dropped out of the program, the hours spent on outreach, recruitment, and assessment represent "lost" staff time. HOPE IV grantees attempted to deal as best they could with this problem. Some grantees reported they had gotten better at identifying the "warning signs" of applicants who seem likely to drop out of the program and learned to ease off in recruiting these individuals. To decrease the number of HOPE IV participants who declined services after lease-up, one grantee pre-screened applicants for willingness to accept supportive services.

Second, notwithstanding their efforts to minimize time spent recruiting participants who never enrolled or quickly dropped out of HOPE IV, most grantees acknowledged that some of the unexpected early attrition from the program was probably inevitable. The needs of low-income, frail elderly are very extensive, complex, and changeable. Prospective participants could not always honestly anticipate their reactions to enrolling in the HOPE IV program, or foresee how their participation will require changes in their lives, such as moving to a new housing environment. In this as in other aspects

of program implementation, grantees learned that operating a program for the frail elderly required more time and patience than managing other types of programs.

As Table 3-2 shows, during the two-year period between the baseline and follow-up surveys, 40 percent of the participants left the HOPE IV program, including Section 8. Another seven percent left HOPE IV but retained their Section 8 rental assistance, 15 percent died, nine percent went into a nursing or related care home, nine percent moved to another location, and seven percent moved for other or unspecified reasons. The "Other" category consists of two percent who became ineligible due to failure to meet HUD housing quality standards or other compliance problems, two percent who left for other reasons such as declining/refusing services, and three percent who left for unspecified reasons. This relatively high turnover rate required that the HOPE IV Service Coordinators continue their intensive recruitment and placement activities, while, at the same time, providing on-going case management to current participants. Chapter 7 provides an in-depth summary of both participant and comparison group exit patterns, in conjunction with other benefits and outcome measures.

Table 3-2.
Program Status After Two Years

Status at Follow-Up	Participants (n=543) (%)
Remained in HOPE IV	53
Left HOPE IV, remained in Section 8	7
Left HOPE IV and Section 8	40
Died	15
Nursing home	9
Moved to other locations	9
Other	7

3.2.2 Factors Affecting Participant Recruitment

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

According to the grantees, it typically took several months from the time recruitment was initiated to when the **first** HOPE IV participant began to receive services. In all but one case, grantees reported that participants were screened into the program at a slower rate than they had projected.

However, most grantees reported that, following a very slow start, the process definitely picked up speed over time.

- *Time was lost pursuing recruits from Section 8 waiting lists, which proved a uniformly poor source of HOPE IV participants.*

The PHAs had to drastically adapt their usual Section 8 recruitment methods to fill the HOPE IV slots. Many of the grantees indicated that, because of the popularity of the Section 8 Vouchers and Certificates among the low-income population and the low-turnover rate, the PHA's Section 8 waiting lists had been closed for two or three years prior to the inception of the HOPE IV program. Recruitment for Section 8 had consisted of opening the waiting list for very brief periods once every several years. Newspaper notices and other announcements were more than adequate to add new names to the Section 8 waiting lists. Prior to HOPE IV, the PHAs then simply went down these lists to fill any new Section 8 units that became available. However, very few grantees were able to fill many of the HOPE IV units through these usual methods.

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

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

Difficulty Developing Linkages with Service Providers

Although relying on the AAAs and other community care agencies worked well as a source of HOPE IV participants at a number of sites, three grantees who had originally counted on their local

AAAs to fill all or most of their HOPE IV slots were disappointed when these agencies referred only a few eligible persons. In one of these sites, the PHA successfully adapted to this unexpected situation by quickly finding other sources of recruits. At the other two sites, the AAA's failure to refer names of prospective participants, reflecting a more general breakdown in the relationship between the PHA and the AAA, caused HOPE IV recruitment to literally cease for some time.

- *Adapting to the expanded needs of the HOPE IV participants in comparison to other Section 8 tenants took time and required rearrangements of resources and staff time either within the PHA or in relation to the "partner" agencies.*

Unlike in the typical Section 8 program, considerable recruitment work still needed to be done after potential participants learned of the HOPE IV program. Under the traditional Section 8 program, the prospective tenant is usually expected to initiate the application for housing assistance, including coming into the PHA and completing the required forms and performing other intake steps in the process. Persons who were unable to apply on their own had effectively been deprived of access to Section 8.

While HOPE IV provides a combination of rental assistance under Section 8 and supportive services, responsibility for these two aspects of the program in many cases remained separate within the PHA organization. To successfully recruit the frail elderly into the HOPE IV program, PHA or other agency staff often have to perform, or assist in performing, intake functions that historically were not their responsibility. PHA personnel or HOPE IV Service Coordinators had to telephone and make sometimes multiple home visits to elderly persons to help them complete the necessary paperwork. Grantees have developed methods for prescreening potential candidates for financial eligibility and ADL limitations. The PHA Section 8 programs that did take on the new responsibilities of recruitment, pre-screening and arranging for moves frequently experienced severe strains on the traditional system. For example, one Section 8 director indicated that the caseload for Section 8 staff in the HOPE IV program had to be half that for the traditional program.

Changes Needed in PHA Infrastructure

At some sites, the PHAs relied on their subcontractors or other "partner" agencies to carry out or help carry out these activities, in some cases depending entirely on the Area Agencies to locate and determine eligibility of HOPE IV participants. At one site, the Area Agency on Aging added Section 8

income and other eligibility items to their own intake and frailty assessment instruments and performed these combined assessments for the PHA. However, when the anticipated level of cooperation in the inter-agency relationship either failed to develop or broke down, PHA over-reliance on the AAA or other partner agency had devastating consequences for participant recruitment as well as other aspects of program implementation.

- *An unexpectedly high proportion (42 percent) of HOPE IV participants had to move to qualify for the program. This made the recruitment and enrollment process lengthier and far more complicated and labor-intensive than was anticipated.*

Moving, stressful for anyone, raises very special financial, logistic, health, and emotional issues for low-income frail elderly. They may lack the financial resources to pay for the move, or be unable to afford security deposits or utility deposits on their new units. At a few sites, some potential HOPE IV participants lived in their own homes or trailers, albeit in substandard and dilapidated condition (several were described as literal "tarpaper shacks"). Although the elderly persons were willing to sell or otherwise divest themselves of these properties to participate in the HOPE IV program, accomplishing the transfer required considerable legal skill and paperwork which these persons could not usually handle themselves.

If, as often occurs, the unit that the potential participant currently occupied did not meet Housing Quality Standards, it took considerable time and effort to find an apartment that did meet these standards, was physically safe and appropriately outfitted for a frail elderly person, and was located in a neighborhood where the elderly person wanted to reside. Several grantees stressed that neighborhood identifications were very strong in their communities, and most eligible HOPE IV participants were reluctant to move out of their current neighborhoods. Said one Service Coordinator: "People in this town just don't move from the South Side to the East Side."

Even if a suitable residence could be found in a desired location, the landlord might refuse or be reluctant to rent to elderly Section 8 tenants. Six grantees reported having a hard time convincing landlords to accept HOPE IV participants. Three of these grantees emphasized that very tight housing markets in their communities made Section 8 rents unappealing to most landlords. Another grantee, initially spared from having to deal with this problem, anticipated difficulties with landlords in the future, as the vacancy rates for one-bedroom market in the community fell and rents continued to rise.

Handling the multiple factors associated with moving participants had myriad unanticipated ramifications for program staff and how they spent their time. First, knowing they would need to move, generally made applicants more tentative about participating in the HOPE IV program at all, and it was a major reason why some people backed out of the program, often not until the last minute, when lease-up was imminent. Months of sustained effort by program staff were lost in this way.

Because finding an appropriate unit for a HOPE IV participant was time-consuming, several grantees had to request multiple extensions beyond the usual 60-day time frame allowed by the Section 8 program for locating a unit. Some Service Coordinators organized groups of volunteers to help move participants, and one went so far as to move HOPE IV participants in her own truck. Program staff have expedited legal matters for prospective participants or helped them obtain emergency funds, furniture, or household goods, all in an effort to facilitate a change of residence. One Service Coordinator took pictures of available units and brought them back to homebound HOPE IV applicants because "I don't believe anyone should live somewhere they have not seen." In addition, HOPE IV program personnel at several sites met with landlords and managers of senior apartment complexes to provide education about the benefits of the program and encourage rentals to HOPE IV participants. Also, Service Coordinators and other HOPE IV staff were called upon to act as intermediaries between HOPE IV applicants and their prospective landlords.

These and other activities to promote housing opportunities were developed in ad hoc fashion, motivated by a much-higher-than-expected proportion of persons having to move to participate in the HOPE IV program. Dealing with this situation consumed considerable staff time and energy and prolonged the recruitment period well beyond original expectations. The single anomalous grantee that recruited participants more quickly than expected was the exception that proved the rule. Program personnel at this site recognized that the relative speed and ease of recruitment at their site was due in large part to the high proportion of HOPE IV participants who were able to lease in place.

- *The process of recruiting frail elderly persons into a program such as HOPE IV was inherently more complex, delicate, and potentially traumatic to the participants than was expected.*

Both moving and becoming the recipient of formal support services can be emotionally as well as physically traumatic for frail older persons. This is true even when prospective participants recognized the need for a change in their living situation and care arrangements--and, by all reports, many

did not. Some participants entered the program following the death of a loved one and were still deeply grieving their loss. Even when the participant did not have to physically move to qualify for the HOPE IV program, becoming accustomed to the idea and reality of receiving help with activities of daily living could be difficult. Given that enrollment in the HOPE IV program often raised complex and delicate issues for the participants, many grantees concluded that the process had a dynamic of its own which could not be rushed. The staff at one grantee site made a conscious policy decision to slow down the pace of recruitment and enrollment after their first five new participants were hospitalized within several weeks of entering the HOPE IV program. "We decided we'd rather maintain a slow but steady pace and make sure that the process is handled smoothly and the participant is properly set up with services. We wanted to be sure we were taking proper care of the participants after they entered the program. These are some pretty frail people." Although this was the only grantee who reported having consciously slowed the pace of recruitment, several echoed the general thought that a very careful, "slow but steady" approach was the correct one to take with a frail, elderly population, even though this usually meant substantially prolonging the anticipated recruitment period.

- *"Word of mouth," both among service providers and the elderly themselves, was often the best source of recruitment into the HOPE IV program. However, it took awhile for knowledge of and accurate information about the program to spread into the relevant segments of the grantee communities.*

HOPE IV was a totally new demonstration program with several unique features and special eligibility requirements. A number of grantees reported that, especially at first, they had a difficult time explaining the program's requirements both to prospective participants and their families and to workers at community agencies that delivered services to the frail elderly. One result of early failure to clearly communicate the details of all the requirements of the HOPE IV program was receiving a number of referrals of clearly ineligible applicants.

At many sites, program staff (usually Service Coordinators) had to spend considerable time marketing the HOPE IV program to various segments of the community and "talking it up" with their colleagues in the elderly service provider network to "get the word out." This was typically not a one-shot process, as it usually took several repetitions before the different audiences got a good enough grasp of the requirements of the HOPE IV program and its target population to supply appropriate referrals. It was important that other service providers develop a clear sense of how HOPE IV fit into the larger

service delivery structure for the elderly in their community. It also took time before "word" of the Program filtered into the elderly community-at-large, where it sometimes became a source of self-referral.

Changes in Recruitment Strategies

For the most part, there were good reasons why recruitment and enrollment of HOPE IV participants was both slower and more demanding of staff time, resources, and creativity than was initially expected. In the grantees' estimation, few if any of the factors affecting the process, or their far-reaching impact on program implementation, could have been foreseen. As a result, only two grantees made any major initial additions to their basic recruitment strategy when starting HOPE IV. One grantee implemented a plan to air public service announcements and send letters to recipients of Supplemental Security Income (SSI) and Food Stamps, in an effort to broaden their recruitment base. Another grantee succeeded in recruiting more minorities and others previously outside the existing service loop by placing ads on Spanish-speaking radio shows and in local newspapers that catered to isolated rural populations. Six other grantees made changes in recruitment that represented shifts in relative emphasis rather than real additions to the basic recruitment strategy. These changes included: intensified marketing, devoting more energy to recruiting participants from "naturally occurring retirement communities," and reducing emphasis on medical facilities as a referral source.

3.2.3 Participants' Initial Sources of Information on HOPE IV and Experiences Entering Programs

Table 3-3 shows the distribution of the participants' initial sources of information on the HOPE IV Program. Just under half of the respondents first found out about HOPE IV either from their local Area Agency on Aging or the housing authority. Another 17 percent first heard about HOPE IV from relatives, especially their children. Friends and neighbors accounted for another 10 percent of respondents' sources,

Table 3-3.
Initial Sources of Information on the HOPE IV Program
(n=543)

Source	Participants (%)
Housing authority	25
Area Agency on Aging or other local agency	22
Relative	17
Friend or neighbor	10
Landlord	7
Service worker	6
Newspaper article or radio announcement/ brochure or flyer	5
Hospital/Physician	2
Church/Synagogue	1
No response	5

followed by a range of individuals, including landlords, service workers, doctors, and hospital discharge planners. Interestingly, only about five percent of respondents first heard about the Program from impersonal sources, such as ads, radio announcements, or brochures. This confirms the idea that some form of "word-of-mouth" is the key to the recruitment process.

Respondents, on the whole, found the process of entering the HOPE IV program fairly easy. At baseline (the only time these questions were asked), 82 percent agreed that it was easy to provide the necessary financial information for entering the Program, 84 percent indicated that the program and its requirements were clearly explained to them, and 78 percent of the respondents reported having actively participated in deciding which services they would receive. ADL assessment was the one area for which there was a slightly lower level of satisfaction: 67 percent disagreed, and 21 percent agreed, with the statement that the process used to determine the need for assistance was complicated. The participants' perception that entering the HOPE IV program was a relatively easy process should be seen in relation to the enormous efforts grantee PHAs and Service Coordinators expended in recruiting and assessing applicants as described above.

3.3 Assessing Frailty

3.3.1 The Professional Assessment Committees (PACs)

Professional Assessment Committees (PACs) were charged with assessing the frailty of prospective HOPE IV program participants. According to program regulations, PACs could be comprised of volunteers brought together by grantees specifically for the HOPE IV program or already existing teams contracted from other service agencies in the community. In either case, PACs should have been made up of three to seven members and must have included at least one medical professional. The evaluation included interviews with one PAC member from each of the 16 grantees covering a range of structural and functional questions.

Although many PAC members were not technically "staff" of the HOPE IV program, the PACs clearly played an important role, especially in the participant assessment process. New PACs were formed specifically for purposes of the HOPE IV program in six sites. Ten grantees made use of already established PACs in community agencies to perform their assessments; and, in some cases, contracted

with local service agencies to initiate and fulfill this function. The size of the PACs varied from three to 13 members, and all had either a nurse or a physician, sometimes both.

HOPE IV grantees reported that the full PACs do not actually conduct the participant assessments. In most cases, either the Service Coordinator alone or a small team consisting of the Service Coordinator and a nurse or geriatric social worker performed the assessments, made an initial determination, and then presented the results along with a service plan to the full committee for review. The most common rationale for this division of functions was that PAC members were typically too busy to devote their time to all the intricacies of the case and could provide a more useful and focused service as an oversight body. In marginal or borderline participant cases, the PAC requested more detailed information on a particular person or took more time in its deliberations. However, by all reports, the PACs very rarely seriously questioned and only occasionally overruled the Service Coordinator's recommendations. More often, the PACs suggested minor changes to the service plan. Between bimonthly or monthly PAC meetings, Service Coordinators informally consulted individual PAC members on specific cases.

During initial interviews, several grantees suggested that managing the PAC process had become extremely cumbersome and time-consuming for Service Coordinators. The number of cases the PAC could review at its monthly meetings limited the number of participants who could be enrolled in the HOPE IV program each month. A few grantees developed procedures to expedite the approval process by sending PAC members relevant materials to go over in advance of the meetings. Several grantees questioned the need for the entire PAC to review each case, and at least one grantee dealt with this by organizing the PAC into subcommittees. Another grantee indicated that the PAC's ongoing functions had become less clear, since the grantee has enrolled all their participants. Program staff felt that PAC meetings were only needed a few times a year.

One unanticipated twist in the assessment process was that 12 of the 16 grantees developed mechanisms for pre-screening applicants prior to conducting the full ADL assessment. At most of these sites, potential HOPE IV participants were pre-screened by phone for basic ADL limitations and presence of medical conditions; in some cases, pre-screening also involved questions about financial and residential eligibility and/or level of family support. In at least two sites, assessment became a two-phase process, including a preliminary assessment on a brief instrument developed by the grantee specifically for HOPE IV purposes, followed by a more complete formal assessment on a standard statewide

instrument. Consistent with HUD requirements, the final determination of eligibility for the HOPE IV program, including Section 8, was performed by PHA staff.

PAC Membership and Meetings

To qualify for HOPE IV funding, applicant agencies had to demonstrate prior experience either in providing services for the frail elderly or working closely with community agencies that delivered care. The purpose of this requirement was to minimize the need for start-up activities by building on existing community capacity. For this reason, the geographic areas in which the HOPE IV programs operate sometimes had a range of services and an existing infrastructure for coordinating assessment of clients and delivery of care to the elderly. One vehicle for such coordination could be a team of service professionals who assess frailty and service needs, determine eligibility for various programs, and coordinate the provision of services for a range of participants.

The PAC survey inquired about the existence of such central assessment bodies in the HOPE IV communities and the extent to which they also functioned as the HOPE IV PAC. Of the 16 PAC members interviewed, 12 said that the Professional Assessment Committee was specially formed for the purposes of HOPE IV, while only 4 said the HOPE IV PAC employed a team that was already in existence at the time the program began.

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

For 11 of the PACs, all the members are volunteers (except for the Service Coordinator), and not paid under the HOPE IV program. Concerning frequency of meetings, six of the PACs meet once per month, three meet every two months, one meets quarterly, and three meet twice a year.

To ascertain the level of commitment of the PAC members, especially given their volunteer status, the survey included questions on the regular attendance of meetings by members. Nine respondents said one member usually was absent from each meeting, four said two members usually

missed each meeting, and one said three usually were absent. Two of the respondents said their PACs usually had no members absent from their regular meetings. When asked if these absences had caused any problems, all but one said they did not.

PAC Roles and Responsibilities

Within the general requirements of the HOPE IV regulations, local PHAs had considerable flexibility in the design of the demonstration. Beyond assessing needs and determining eligibility, PAC members also could play a role in designing the program. Nine of the PACs, or individual members of them, did participate in designing the HOPE IV program, while five did not. Two of the respondents said they did not know if the PAC or its members were involved in the original design of the PHA's HOPE IV program.

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

Five of the PACs played a large role in reassessing participants, and four had a large role in coordination of services. Nearly half of the PAC respondents, however, said their role in these activities was small, occasional, or none at all. Concerning level of effort, half of the PAC members spent between two and three hours per month on these responsibilities, while four spent 15 or more hours per month performing these activities.

When describing the nature of their interaction with the HOPE IV Service Coordinator, eight of the PAC respondents mentioned activities associated with the initial assessment and determining service needs, seven mentioned activities concerning the ongoing monitoring of the participants' well being and services, and four cited administrative activities, such as recordkeeping and reporting issues.

PAC's Role in Assessment and Reassessment

When asked how the PAC uses the HUD ADL definitions when assessing participants, 12 of the respondents said they adhere closely to these criteria, while four said they use HUD's ADL definitions only as guides in conjunction with other criteria and assessment procedures in place in the community.

All but two of the PAC respondents thought that the HUD ADL definitions could be applied consistently in assessing applicants to the HOPE IV program, and 12 of the 16 thought that these ADL definitions identified the right individuals to receive HOPE IV services.

Of the four who did not think these ADL definitions identified the right persons for the program, two said that the definitions were too broad to ascertain need and required additional detail. One said that persons with less than three ADL limitations should be eligible, and the other cited inconsistencies with standard ADL and IADL assessment instruments as a problem. In applying these eligibility criteria, seven of the respondents said the PAC had reversed the determination of participant eligibility made by the Service Coordinator or the PHA, but only on a few occasions.

Five of the PACs reassess participants every six months, while two do so once per year. Four PACs conducted their reassessments of disability and service needs on an as-needed basis. Some of the PACs reported that they had not done reassessments due to the limited amount of time for which participants had been enrolled. When asked what usually prompts reassessment, eight PAC members said changes in the health and disability status of the participants, while five said it was a regularly scheduled process covering a fixed time period.

Recordkeeping Requirements and Overall PAC Performance

Ten of the PAC members said that they had encountered no problems in meeting record keeping and reporting responsibilities of the HOPE IV program. Of the four PACs reporting problems, two mentioned difficulty keeping track of multiple funds, one said service providers sometimes did not provide timely reports, and one indicated general difficulty in assembling assessment and services data for the PAC meetings.

The survey also asked if the PAC had changed its role since it began meeting. Nine of the PAC members said there had been no change in the role; three said the role had expanded as a result of general experience gained since it began or from the addition of new members with different specialties; while two said their role had decreased after the initial influx of applicants at the beginning of the program.

Concerning expansion of the PAC's role, respondents mentioned working better together to focus on the purpose of HOPE IV, especially concerning the issue of participant eligibility. They also

said that since the start of the program, the PAC has become better educated about the services available in the community, and the providers, in turn, have enhanced their involvement in the HOPE IV demonstration and increased their effectiveness through the coordinating functions of the program.

When respondents reported a decreased role for the PAC, it was due to a reduction in the number of assessments as fewer new participants entered the program. While reassessments occurred for those continuing in HOPE IV, this involved a reduced level of effort compared to the initial assessment of frailty and service needs.

Half of the respondents said that the PAC has performed very successfully so far, while the other half said it has performed fairly successfully. None of those interviewed, however, felt that the PAC had performed unsuccessfully. When rating the importance of the PAC, seven respondents said it was very important, while nine said it was fairly important. None of the respondents said that the PAC was unimportant.

Views of Overall HOPE IV Program

The final section of the survey asked for the PAC member's opinion about the overall impact of the HOPE IV program, the major benefits, and suggestions for improvements. Eleven of the 16 PAC members said the HOPE IV program has had a significant impact on the frail elderly in the community, while five said the impact was moderate. None of the respondents said that the HOPE IV program has had little impact. When asked to elaborate on the major benefits of the HOPE IV program in the community, 10 of the PAC members mentioned availability of services, while eight mentioned the ability of the frail elderly to live independently in their own homes.

Regarding improvements that the PAC members recommended for the HOPE IV program, six respondents suggested expanding the program to cover additional persons or continuing it beyond the five-year period, while three PAC members said that the ADL definition should be changed to allow additional elderly persons with documented needs into the program. Two respondents said the participant fees should be eliminated, one due to the limiting effect on needed services and the other due to enforcement difficulties. Three respondents said that improvements in administrative areas would be helpful, including assistance in addressing the matching funds requirements and having computers to handle the records and reports.

3.3.2 ADL Assessment Tools Used by the Grantees

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

HOPE for Elderly Independence: HUD Activities of Daily Living (ADL) Definitions

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

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

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

The HUD ADL definitions differ from those most commonly used in the field of geriatric functional assessment. As distinct from HUD's definitions, most grantees used ADL measures developed by Sidney Katz and his colleagues, which consist of bathing, dressing, transferring between bed and chair, using the toilet, continence, and eating.[vii] These activities often fall under the category of personal care. The grantees also measured Instrumental Activities of Daily Living (IADLs), based on definitions

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

developed by M. Powell Lawton and Elaine Brody.[viii] IADLs cover more complex activities, including handling personal finances, meal preparation, shopping, traveling, doing housework, using the telephone, and taking medication. Studies of the elderly often categorize these IADLs as home management activities. However, for HOPE IV program purposes, HUD includes home management activities in its definition of ADLs.

Use of Assessments

On the whole, eligibility determination was not based on a rigid process of ADL limitation scoring and thresholds. Instead, the assessment instruments and procedures used by the grantees reflected a desire for a holistic assessment as an informed basis for selecting persons most likely to benefit from the program. The grantees ensured that the participants met the HUD ADL requirements, but there were many more domains of measurement that served as a basis for determining need for HOPE IV services.

Fifteen of the 16 grantees relied on existing standard assessment instruments used by elderly service provider agencies in their States and communities. These instruments collect ADL limitation data for determining HOPE IV eligibility in accordance with HUD guidelines. To further help identify a participant's service needs, the instruments also collected data concerning such areas as cognitive ability (e.g., memory and basic intellectual capability), physical functioning (e.g., lifting, bending), use of assistive devices, mental health (e.g., depression and social interaction), physical and social environment, and formal and informal support (e.g., receiving care from family or paid providers). Some instruments also contained sections on medical history and chronic health conditions. In general, the grantees converted their own terms and measures to the HUD criteria. Most of the assessment instruments employed a severity scale, which measured the relative level of difficulty experienced by the person in performing a given activity. For example, there may be five levels of severity for each activity of daily living, ranging from complete independence to total dependence.

3.4 Supportive Services Packages

Table 3-4 presents a summary of the types of supportive services the grantees provided as part of the HOPE IV program, as well as a description of their service delivery arrangements. While the services

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

offered by the grantees should have responded to the requirements in the HUD NOFA, there was flexibility in the specific package of services they could decide to offer. In addition to case management, which is required under the HOPE IV program, supportive services listed as allowable in the NOFA included personal care and grooming, transportation, meals, housekeeping, laundry, counseling, non-medical supervision, wellness programs, preventive health screening, monitoring of medication consistent

Table 3-4

Table 3-4 (Continued)

Table 3-4 (Continued)

Table 3-4 (Continued)

Table 3-4 (Continued)

Table 3-4 (Continued)

with State law, and other requested supportive services essential for achieving independent living, if approved by HUD.

The first column of Table 3-4 shows the supportive services that grantee PHAs presented in their HOPE IV applications. This list reflects the grantees' projections of needs of HOPE IV participants. PHA staff and AAA representatives recognized that the services the HOPE IV participants would actually receive would depend on assessments and periodic reassessments of individual needs. Grantees were aware that services would have to change as participant needs shifted over time and Service Coordinators became more familiar with the participant population. A subsequent survey of Service Coordinators in all 16 grantees updated this listing of HOPE IV services. As of December 1994, 10 grantees reported they had made no changes to the basic service package outlined in their application. Six of the 16 grantees did alter their service packages, either by adding new services or adapting or expanding existing ones. However, the changes made since the inception of service delivery (shown in italics in column 1 of Table 3-4) were not dramatic. Three grantees added new services, including medication monitoring (Site F), supplying an emergency response button allowing participants to connect quickly with sources of help in the event of an emergency (Site P), and providing occupational therapy evaluations as a means of establishing the need for making physical adaptations (such as addition of handrails) to the participant's dwelling unit. Three grantees adapted or diversified their meals services, by providing a liquid nutritional supplement (Ensure) on weekends (Site H), adding diabetic meals (Site M), and delivering hot meals to HOPE IV participants (Site N).

HOPE IV services may be divided into four basic groups: case management, linkage, personal care, and homemaker services. Grantee service packages tend to include all four of these categories of services. A fifth, "catchall" category consists of a range of types of services (e.g., social and behavioral support, socialization, legal assistance) provided only by a very few grantees.

3.4.1 Contracted and Non-Contracted Service Functions

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

Table 3-4 (column 2) shows that 15 of the 16 grantees contracted for some or all of these functions through agreements with existing community agencies. For most of the grantees, supportive service delivery was unfamiliar terrain, and it made sense to connect with a community agency where one existed that was familiar with service delivery to the frail elderly population. Moreover, most PHAs had already involved these agencies in the process of writing the application and designing the service plan.

Table 3-4 (column 3) shows that 15 grantees contracted for at least some of their supportive services. Eight grantees retained service coordination functions in the PHA, and eight subcontracted for service coordination. Just two grantees contracted for PAC functions, as well. Table 3-4 (column 4) indicates that for seven of the 16 grantees, the PHA kept service records on individual HOPE IV participants, and for the remaining nine grantees this was the responsibility of the AAA or other subcontractor agencies.

Only one grantee directly performed all functions of professional assessment, service coordination, provision of supportive services, and keeping individual service records. This occurred under a long-standing, anomalous arrangement in which the PHA was contracted by the Area Agency to provide supportive services to all the frail elderly in the county, regardless of whether they were residents of PHA-assisted housing.

3.4.2 Sources and Uses of Services Funding

As documented in their applications to HUD, HOPE IV grantees anticipated employing a number of different financial resources to support their projects and fund their service packages. Figure 3-1 presents a summary of the sources and uses of the approximately $4.6 million in total funds in first-year project budgets. As the highlighted section of the first chart shows, the largest single source of funding is the HUD grant itself. However, State resources, participant fees, applicant (grantee) resources, and other sources (including other Federal sources, such as Medicare) together accounted for over 60 percent of the total. These figures indicate that grantees succeeded, on average, in assembling matching funds in excess of 150 percent of HOPE IV grant funding.

Overall, across all 16 grantees, about 70 percent of all funds were budgeted for services related to care of the person and the home, and for meal and nutrition services, treated here as a separate category to parallel the service groupings used in the application budgets. Services involving care of the person and the home, which included housekeeping, bathing, laundry, shopping and other services,

accounted for about half of total costs. Meals and nutrition services represented the next largest

Figure 3-1

proportion of the budget (17 percent). Administration and case management accounted for 16 percent, transportation eight percent, and other costs 6 percent.

Figure 3-2 shows considerable variation in the total amount budgeted for supportive service per person across the 16 grantee sites. This variation partly reflects different strategies employed by grantees in claiming matching funds. For example, some grantees claimed services provided through Medicare and Medicaid as match, while others did not. Another factor contributing to the variation in per person costs across grantees is the wide range in the amount received from HUD for HOPE IV services when this is figured on a per participant basis. This amount varies among grantees from $961 to $2,549 per participant, with an average of $1,574.

Figure 3-2 also shows the components of the total per person service cost, using the same five categories of services as in Figure 3-1: home and personal care, meals and nutrition, administration and case management, transportation, and other services. Although there are some basic similarities, a number of interesting differences are also apparent in the relative distribution of costs to different service categories. All 16 grantees budgeted a relatively large share of funds for personal and home care services, which is consistent with the large share of all HOPE IV services this category represents. Similarly, 15 grantee applications budgeted some amount, although a more variable percentage of the total, for meals and nutrition services. However, only seven grantees budgeted for transportation. In addition, Figure 3-2 shows that the per person amount and relative proportion of funds devoted to administration and case management varied widely across grantees. This may have reflected the degree to which administration was centralized in the PHA through direct service provision or shared with subcontractors.

3.5 Service Coordinators

As seen, the role of the Service Coordinator became even more pivotal to most aspects of the HOPE IV implementation than was originally anticipated. This section explores different aspects of the Service Coordinator's roles and functions as they developed over the course of program implementation.

3.5.1 Basic Characteristics of HOPE IV Service Coordinators

Table 3-5 presents basic information about the Service Coordinators at the 16 grantee sites as of 1993. Column 2 shows when the original Service Coordinator was hired.

Figure 3-2

Reliance on Existing Service Networks and Proportion of Time Devoted to HOPE IV

Table 3-5 (column 3) shows that grantees were about evenly divided between those who hired a new person for the Service Coordinator position and those who hired someone already part of an existing service delivery network. There was some relationship, in turn, between grantees relying on an existing network (column 3) and the Service Coordinator spending only a portion rather than all of his or her time on HOPE IV (column 4), at least at the outset. There may have been program start-up benefits, as well as cost savings, in hiring Service Coordinators who were part of an existing network and thus already familiar with the case management system. But as the HOPE IV caseload expanded, Service Coordinators who had to divide their time between HOPE IV and other activities said they were being pulled in both directions and usually forced to spread themselves too thin. In fact, the two grantees that did not hire a Service Coordinator especially for HOPE IV and relied entirely on the services of a case manager from other community agencies, progressed the slowest in recruiting participants into the program. At two other sites, where the Service Coordinator either devoted only 50 percent time to HOPE IV or divided time between HOPE IV and the Congregate Housing Services Program (CHSP), the grantee agencies requested additional funds to support full-time Service Coordinators for the HOPE IV program.

Organizational Placement of the Service Coordinator

HUD guidelines gave the HOPE IV grantees considerable flexibility in the organizational placement of the Service Coordinator. In communities with an existing agency capacity to conduct functional assessments and develop service plans, it usually made sense for the PHA to contract with an agency such as the Area Agency on Aging to perform the Service Coordinator activities. PHAs with limited experience delivering services to frail, older populations felt that service coordination functions were best handled by community agencies with a proven track record. Another motivation for having the Service Coordinator be an employee of the AAA was that the PHA lacked personnel who could provide appropriate supervision in case management. Column 5 of Table 3-5 shows that about half of the grantees directly employed the Service Coordinator, with the remainder subcontracting with the Area Agency on Aging or others for the performance of this function. As previously shown in Table 3-4, in many cases in which the Service Coordinator was an AAA employee, his or her services were part of a total package contracted by the PHA for the HOPE IV participants.

Several HOPE IV grantees that subcontracted Service Coordinator functions emphasized in early interviews that even though the Service Coordinator was technically an employee of the AAA, this

was a somewhat artificial distinction, since that person was still considered to be working for the HOPE

Table 3-5

Table 3-5 (Continued)

Table 3-5 (Continued)

IV Program. HOPE IV funds were still paying all or part of his or her salary. At one grantee site, the AAA offices were located in a different town than the community being served by HOPE IV. The PHA made it a condition of their agreement with the AAA that the Service Coordinator be stationed directly in the HOPE IV community. Although it took time and effort on both sides to work out the situation to everyone's satisfaction, the "outstationing" of the Service Coordinator in the HOPE IV community greatly enhanced communication between the PHA and the AAA. The grantee PHA community services representative said that she and the Service Coordinator were in and out of each other's offices almost every day. At the same time, both PHA and AAA staff agreed it was important that the Service Coordinator was supervised by area agency personnel who really knew the workings of the county case management system.

Several HOPE IV grantees regarded the increased frequency of interaction and greater ease of communication between the PHA and AAA, brought about largely through the Service Coordinator, as one of the largest "side benefits" of participation in the HOPE IV program. Few grantees had anticipated how important Service Coordinators would become in mediating the physical, cultural, and organizational distance between grantee PHAs and social service agencies. Grantees emphasized that day-to-day interaction at the individual level between the HOPE IV Service Coordinator and PHA staff was the single most important factor in paving the way to better and more comfortable working relations. One grantee said that the PHA and AAA came to speak the same language, thanks to the Service Coordinator. Another grantee indicated that the Service Coordinator had become the "human link" between the two organizations, helping the flow of information in both directions. Without "a real live person" performing this role, this grantee suggested, this connection would never have been sustained. Bridging the inter-agency relationship is just one of several "unanticipated" functions that HOPE IV Service Coordinators assumed in the course of defining their roles.

Table 3-5 (column 6) shows that, as of the time of the first interviews, all Service Coordinators performed common "core functions" that included prescreening participants; conducting ADL assessments and presenting the results to the PAC; case planning and case management; and documentation and reporting. However, most grantees had broadened this list substantially to include at least some additional activities, such as recruitment, outreach, help with housing, additional program management responsibilities, and tracking of services and service costs.

3.5.2 The Overloading of the Service Coordinator Role

By Fall of 1993, it was clear that the Service Coordinator role in most HOPE IV sites had become overburdened. Not only were Service Coordinators performing their originally intended functions of assessment and case management, but, as seen earlier in this chapter, they had stepped in to fill a vacuum by absorbing a variety of unanticipated functions into the role. Many had become involved in recruitment and marketing of the HOPE IV program to different lay and professional groups in their communities, were providing potential participants with help filling out their Section 8 paperwork and even, in some cases, helping them locate appropriate housing. Some Service Coordinators had even taken the initiative to assist participants in moving into their new housing and in convincing landlords to take Section 8 tenants.

- *Since recruitment was continuous, as program implementation proceeded, a conflict often developed for Service Coordinators between focusing energy and attention on "front end" activities such as marketing, recruitment and assessment, and paying closer ongoing attention to the ever-shifting and often extensive needs of the already enrolled HOPE IV participants.*

Also, because many HOPE IV participants were much poorer and needier than expected, the sometimes desperate circumstances of these very low-income, frail elderly impelled many Service Coordinators to extend their role well beyond even the most expansive job description. Grantees in both rural and urban communities reported that at the time of application to the HOPE IV program, some participants lacked such basic necessities as food, money to pay for moving or for utility deposits, furniture, clothing, and household furnishings. One Service Coordinator conducted several functional assessments of HOPE IV applicants living in their cars. Another reported that elderly persons were discharged from nursing homes with "nothing but the clothes on their back." In response to these pressing needs, Service Coordinators took on such unanticipated advocacy functions as helping participants obtain Supplemental Security Income (SSI) or Food Stamps; finding sources of emergency funds, food or medical care; and "begging from Goodwill" to get furniture or household items with which the participant can create the rudiments of a household. None of these additional activities fit within even the broadest interpretation of "case management" as envisioned under the HOPE IV program guidelines. But, humanitarian reasons aside, they had to be done if participants were to be enrolled in the program.

Also, for those Service Coordinators who tend to be maximally responsive to their HOPE IV clientele, the Service Coordinator role was not only functionally overburdened, but also very emotionally

and physically demanding. Several grantees expressed concerns about Service Coordinator burnout. Said one Service Coordinator: "This is just so much more intense than any other case management I've ever done." Her colleague from the county long-term care agency concurred: "This is a whole different type of case management than we're used to. [The Service Coordinator] is always running here and there to put services together for her HOPE IV clients." The grantees were largely unprepared for what this would mean in real terms, and, once again, it was mostly the Service Coordinators who shouldered the added burdens.

HUD Supplemental Service Coordinator Funding

Consequently, HUD's July 6, 1994, NOFA, which offered HOPE IV grantees the opportunity to apply for supplemental funds for service coordination, came at an opportune time. It supplied a vehicle for relieving pressure on the Service Coordinator and making needed changes to the role at the HOPE IV sites. Table 3-6 shows that all but one of the 16 grantees were familiar with the NOFA, and nine of the 16 applied for the funds, often at the urging of their regional offices. All those who applied did receive the funds. Of the seven grantees who did not apply for the supplemental funds, only three did not perceive a need for additional Service Coordinators. The remaining grantees failed to apply for a variety of miscellaneous and circumstantial reasons.

Service Coordinator Survey Results

By the time we spoke to the Service Coordinator, in the survey administered in the Spring of 1995, we were able to add questions to clarify the uses to which the service coordination funds had been put or would be put. The survey included questions on the presence of more than one person performing Service Coordinator functions. Twelve of the 16 Service Coordinators each reported they were the only person serving in this capacity, while four PHAs had more than one. Two additional PHAs planned to hire another Service Coordinator, one of whom would work approximately half-time. Nine Service Coordinators reported job responsibilities that extended beyond the HOPE IV program, all but one involving similar case management functions for clients in other community programs for the frail elderly.

Use of Time

Because of the potential for considerable variation in how Service Coordinators actually allotted their work time, we were interested in determining the number of hours worked per week and specific functions performed by the Service Coordinators. Eleven of the 16 Service Coordinators spent 30 hours or more per week in HOPE IV-related activities, while five worked part-time. Concerning the adequacy of this coverage, one of the part-time and four of the full-time Service Coordinators said they needed additional time to carry out their responsibilities.

Service Coordinators most frequently reported their major activities to be: 1) interacting with participants, 2) performing frailty assessments and 3) outreach and recruiting of persons into the program. The least frequently reported Service Coordinator activities were determining Section 8 eligibility, interacting with other personnel in the PHA, interacting with Area Agency on Aging personnel, and interacting with other community agencies. This is consistent with the 1993 grantee interviews where the Service Coordinators stressed the enormity of the participants' needs and the intensive participant contact and attention this required.

In addition to an initial assessment of frailty, the regulations called for periodic reassessment of the participant's ADL limitations and service needs. Three Service Coordinators reported that they conducted reassessments every three months, six said they occurred every six months, and two reported a frequency of every 12 months. The remaining five conducted reassessments on an as-needed basis.

Developing a Service Plan

The HOPE IV program regulations emphasized the importance of participant involvement in determining service needs and arranging for the delivery of necessary care. Eight of the 16 Service Coordinators said that participants at their sites were very active in developing their service plans, five responded that participants were somewhat active, and two said that participants were somewhat passive in determining their own service plans. All but four of the Service Coordinators felt that the degree of involvement was just about right, while most of the others would have liked to see more involvement. All but three of the Service Coordinators also said that at least one HOPE IV participant had actively disputed a service plan or refused to receive certain services. These appeared to be isolated instances, however, where the participants were reluctant to allow service personnel unfamiliar to them into their homes or felt more comfortable having family members deliver their care.

Relationship to PAC

The particular functions performed by the PAC, and the PACs' relationship with the Service Coordinator varied among the HOPE IV grantees.

Ten of the Service Coordinators reported they took the lead in assessing frailty, determining HOPE IV eligibility, documenting service needs, or convening and running the PAC meetings. Only three said that their role was limited to collection of assessment information that the PAC then used to make its own decisions. The remaining three Service Coordinators said they worked in relatively equal partnership with the PAC in determining eligibility and service requirements.

When asked to describe the primary role of the PAC, half of the Service Coordinators emphasized eligibility determination and half planning for needed services. Nine of the Service Coordinators said the PACs were performing very successfully, while seven said they performed somewhat successfully. None of the Service Coordinators said the PACs were performing unsuccessfully.

Interactions with Participants

Service Coordinators reported that routine checks and friendly visits constituted the most frequent type of interaction they had with the participants. Answering complaints about services was the second most frequent basis for interaction. When asked to describe the overall quality of their interaction with the HOPE IV participants, all reported it to be very good or very friendly. One Service Coordinator, however, also stated that it was difficult for only one person to monitor the care of all the participants in the PHA's HOPE IV program.

Eight of the Service Coordinators expressed the view that formal case management functions (such as functional assessment and determination of service needs), were of greatest value in realizing the benefits of the HOPE IV program, while four of them said that general checking up on the participants and providing friendly visiting were most important. Four of the Service Coordinators said that helping participants to secure rental assistance was the most valuable component of the program.

Barriers and Suggestions

With respect to the main barriers confronted by the Service Coordinators, five mentioned inadequate time to perform their functions, while three said that participant reluctance to request assistance or accept services due to pride was the greatest barrier they had to overcome. Only two of the Service Coordinators reported poor service quality as the greatest barrier to success of the HOPE IV program. Individually, other Service Coordinators reported isolation of participants, lack of funding to move belongings into a new apartment, difficulty working with both Section 8 and HOPE IV services staff, and insufficient funds for services, as the greatest barriers to program success. Only two of the Service Coordinators stated that there were no barriers at all to implementation of HOPE IV.

In response to a question on the adequacy of the HOPE IV definition of ADL limitations, eight of the Service Coordinators said the HUD definition of frailty identified the correct group of elderly for the program, and eight said it did not. When asked for an explanation for the negative responses, six of the eight said that the criteria were overly strict and excluded many persons who needed the HOPE IV services. Two of the Service Coordinators said that adding degree of difficulty within the ADL eligibility categories would enhance their ability to assess true need, for example, by distinguishing between some difficulty and a lot of difficulty in performing an activity.

Overall Assessment

The Service Coordinators recommended several enhancements to improve the HOPE IV program. Seven Service Coordinators suggested expanding the funding for the HOPE IV program to allow increasing the number of participants, staff, and geographic areas where the program operates. Three others recommended expanding eligibility to current housing assistance recipients, a group now ineligible for the HOPE IV program. Another three suggested increased flexibility in the ADL limitation criteria in order to open the program to additional persons and simplify the eligibility determination process, citing uncertainties in interpreting HUD's frailty criteria. Finally, two Service Coordinators suggested relaxing the participant fees, especially when levels of frailty required additional services that the participant might not be able to afford.

3.6 Program Participation

This section of the chapter compares participants' views of different aspects of the HOPE IV Program at baseline and follow-up. Section 3.6.1 discusses their relationship with their Service Coordinators, Section 3.6.2 covers co-payment of service fees, and Section 3.6.3 summarizes participant's overall assessment of and satisfaction with HOPE IV and compares these to the Service Coordinator's own assessment of HOPE IV.

3.6.1 How HOPE IV Participants View and Assess Their Service Coordinators

As seen, the HOPE IV Service Coordinator played a pivotal role vis-a-vis the participants in a variety of ways: as the person who helped to assess their eligibility and facilitate their entry into the Program, developed and revised an individualized service plan, and monitored and coordinated the smooth delivery of services. In many ways, the Service Coordinator came to represent the HOPE IV Program.

Knowing this, it is interesting to see how the Service Coordinators and their functions were perceived by the HOPE IV participants at two different points in time: just as they were entering the Program, and then, after roughly two years of participation in HOPE IV.

In brief, participants at both points in time were highly satisfied with their Service Coordinators. The overwhelming majority of participants, at baseline (82 percent) and an even higher percentage (91 percent) at follow-up, reported they were very satisfied with their Service Coordinator. Another nine percent at baseline and four percent at follow-up said they were somewhat satisfied. Only a handful of individuals at either point in time (five at baseline, only one at follow-up) expressed active dissatisfaction with their Service Coordinators. Moreover, the relatively few respondents at baseline or at follow-up who said they would like something more from their Service Coordinators indicated wanting more of the same services already being provided.

While satisfaction with their Service Coordinators remained high, the level and nature of contact between participants and Service Coordinators does appear to have changed between baseline and follow-up as part of the natural evolution of the relationship. Overall, at follow-up, participants reported less frequent in-person contact with their Service Coordinators, with more indicating that "it worked both ways" as to who usually initiated contact. Both at baseline and at follow-up, case management functions

headed the participants' list of the activities the Service Coordinator performed for them. However, in the two years between surveys, the emphasis shifted from providing help in obtaining services and housing to providing information and explanation of services and help in qualifying for services. At follow-up, participants also gave greater salience to the Service Coordinator's role as someone who monitored their needs and visited and socialized with them. Interestingly, though, at both points in time the most valued activities were help in obtaining and scheduling services and help in securing housing and rental assistance—from the participants' perspective, these two functions appear to have been the bedrock of the HOPE IV Service Coordinator's role.

At baseline, over three-quarters of all HOPE IV participants, or, as shown in Table 3-6, 76 percent of the 374 respondents who answered this question, reported seeing their HOPE IV Service Coordinator once a month or more since entering the Program. Somewhat more of these respondents (42 percent) reported contact of twice a month or more than indicated seeing their Service Coordinator once a month (34 percent). At follow-up, of the 264 participants responding, a total of only about half reported in-person contact of once a month or more, with most (39 percent) of these respondents indicating contact of once a month. At baseline, a total of 23 percent of the 374 respondents reported in-person contact with their Service Coordinators less than once a month, ranging from several times a year to once a year. At follow-up, the percentage of respondents indicating less than monthly in-person contact rose to nearly one-half (47 percent), with 20 percent indicating contact only once a year. Between baseline and follow-up, participants' average frequency of contact with Service Coordinators fell from nearly 23 times a year to 11 times a year, or from nearly twice a month to just under once a month.

Table 3-6
Frequency of In-Person Contact Between Participants and Service Coordinators

Amount of Time	Baseline *(n=374)** (%)	Follow-Up *(n=264)** (%)
2 or more times/month	42	13
1 time per month	34	39
4-11 times/year	6	13
2-3 times/year	11	14
Once a year	6	20
Total	100	100

*Excludes non-respondents.

A decline in the frequency of the participants' contact with their Service Coordinators between baseline and follow-up is not surprising. In the Service Coordinator Survey, many respondents described a pattern in which more intense contact when participants first entered the program was followed by more routine, less frequent contact once they were settled in their housing, with a service plan in place. The decline in frequency of in-person contact probably also reflects that many Service Coordinators shifted from in-person to telephone contact as their most common means of staying in touch

with their elderly clients. Several Service Coordinators reported that with rising numbers of participants to serve, they had increasingly turned to the telephone for most routine contacts, reserving in-person visits for more pressing or unusual circumstances (e.g., a dramatic deterioration in the participant's health or frailty that would necessitate an immediate change in service plans).

At baseline, 44 percent of the HOPE IV respondents indicated their Service Coordinator usually initiated contact with them, 28 percent said they usually contacted their Service Coordinator if they needed something, and about 20 percent reported that it worked both ways. The remaining respondents gave "don't know" or "not ascertained" responses. At follow-up, interestingly, 28 percent of participants said their Service Coordinator usually initiated contact, 14 percent said that they usually did so themselves, and nearly half (46 percent) said that it worked both ways. An increased percentage of participants saying it worked both ways may indicate that greater mutuality had developed between Service Coordinators and their clients in the two years since Program entry. That is, as they had gotten to know one another better, mutual expectations had been clarified, so participants felt freer to initiate contact on an as-needed basis.

At baseline, the HOPE IV participants' volunteered statements about what their Service Coordinator did for them were consistent with the Service Coordinator acting primarily as a case manager. However, their views of their Service Coordinators' primary functions were also influenced by their relatively recent entry into the Program. At baseline, the respondents' six most frequent answers to an open-ended question about what their Service Coordinator did for them were: (1) Helps to obtain, schedule and organize services (293 mentions); (2) Helps to get housing/rental assistance (180 mentions); (3) Helps persons to qualify for the HOPE IV program (172 mentions); (4) Monitors needs and checks in on respondent (77 mentions); (5) Provides information and explains services (63 mentions); and (6) Visits, socializes and talks with the respondent (60 mentions). Other miscellaneous, somewhat idiosyncratic responses included helping the participant perform activities (33 mentions), bringing the participant things (24 mentions), and providing emergency financial assistance (eight mentions). About seven percent of respondents reported either that their Service Coordinator did nothing for them (four percent) or they did not know or could not say what she or he did (three percent).

At follow-up, the rank order of the responses had shifted, as follows: (1) Provides information and explains services (86 percent of 286 respondents); (2) Helps with qualifying for services (85 percent of 286 respondents); (3) Helps to obtain and schedule services (83 percent of 286 respondents); (4) Helps with getting housing or rental assistance (80 percent of 286 respondents); (5)

Checks in on or monitors respondents' needs (79 percent of 286 respondents); and (6) Visits, socializes and talks with respondent (61 percent of 286 respondents.) A much smaller percentage of the 286 respondents answered that the Service Coordinator brings them things (18 percent), helps them with performing activities (12 percent), or helps with emergency financial assistance (eight percent).

These shifts in the participants' views of the Service Coordinators' activities probably reflect changes in the Service Coordinators' role between baseline and follow-up. The three activities most frequently named at baseline—helping to obtain and schedule services, helping to obtain housing and rental assistance, and helping the participant to qualify for HOPE IV—are all functions strongly associated with enrolling the participants in the Program. Thus, it is understandable that these would no longer head the list. By follow-up, participants were giving more prominence to the Service Coordinator as a provider of information on and help in qualifying for services, as well as someone who monitored their needs and visited and socialized with them. This characterization is consistent with the Service Coordinators' own reports of how their role and interactions with the participants had changed over time.

However, as a caveat, it may also be true that some of the differences in responses between baseline and follow-up reflect the changed form of the question. At baseline, the question was posed in an open-ended manner: respondents had to volunteer responses as to what their Service Coordinators did for them. At follow-up, respondents were read a list of possible Service Coordinator activities (derived from the baseline responses) and asked to say whether or not their Service Coordinator performed any or all of them. Thus, at follow-up, respondents were presented with a range of possible responses from which to choose that might not have occurred to them independently as volunteered responses.

At baseline, of the 455 (84 percent) of all respondents who answered the question concerning which of the Service Coordinator's activities was most beneficial to them, the largest number (159 respondents) named helping to obtain and schedule services, followed by helping to get housing and rental assistance (123 respondents), and helping to qualify for the HOPE IV program (40 respondents). As seen above, these were also the three most frequently named Service Coordinator activities. At follow-up, participants also answered that the single most beneficial service provided by their Service Coordinators was help with obtaining and scheduling services (42 percent) and help with getting housing or rental assistance (33 percent). As seen earlier, Service Coordinators largely agreed as to their most beneficial activities vis-à-vis participants: about half named basic case management functions, four marketing and friendly visiting, and four helping to secure rental assistance.

Only about one-quarter of participants at baseline and 14 percent of participants at follow-up indicated they would have liked something more from their Service Coordinator. At baseline, the largest number of these respondents expressed a desire for more services (35 mentions), more cleaning services (25 mentions), and more contact with their Service Coordinator (21 mentions). At follow-up, of the 41 participants responding to this question, the largest number would have liked their Service Coordinator to provide additional services (19), refer them to other services (17), or provide more and better information on the HOPE program (14).

3.6.2 Paying for HOPE IV Supportive Services

HOPE for Elderly Independence program regulations stated that HOPE IV participants should contribute 10 percent of the cost of their supportive services, unless this exceeded 20 percent of their adjusted monthly income. However, telephone interviews conducted in the Fall of 1993 and 1994 revealed that HOPE IV program personnel at some grantee sites were reluctant to press the payment issue with participants, most of whom they felt were too poor to be asked to contribute. In this light, it is interesting that both at baseline and follow-up, nearly half of participants reported paying nothing above rent toward the cost of HOPE IV program services. At baseline, 12 percent of those who paid a portion of their service costs (roughly six percent of all respondents) said this presented a problem for them since entering the HOPE IV Program. At follow-up, the corresponding percentage was 16 percent, or about eight percent of HOPE IV respondents.

At baseline, when considering all the services they were then receiving through HOPE IV and any other source, excluding rent, 40 percent of respondents indicated they paid nothing, 33 percent that they paid between $1 and $25 per month, 11 percent between $26 and $50 per month, and nine percent reported paying over $50 each month. In terms of how this amount compared to what they paid prior to entering the HOPE IV program, over half of the respondents (55 percent) indicated they previously received no such services, and another 12 percent gave "don't know" answers. Of the remaining 32 percent of respondents who answered the question, 13 percent said what they paid at the time of the interview was a lot less (10 percent) or a little less (three percent) than before; eight percent said that the amount was about the same; and 11 percent said that they were now paying somewhat (five percent) or a great deal (five percent) more. It is not clear to what extent greater or lesser monthly costs reflect differences in the types and amounts of services received before and after entering HOPE IV. Of the 242 respondents who answered a question comparing HOPE IV services with those they received prior to entering the Program, 22 percent said they were receiving all the same services, 12 percent most

of the same services, 33 percent some of the same services, and about 30 percent none of the same services as before.

At follow-up, the percentage of participants who reported paying nothing per month for all services, excluding rent, rose from 40 percent to 50 percent. Thirty percent (as compared to 33 percent at baseline) reported paying between $1 and $25 per month, 15 percent (as compared to 11 percent) between $25 and $50 a month, and five percent (as compared to nine percent) over $50 for supportive services. Thus, the most notable change between baseline and follow-up is the increased percentage of those reporting they paid nothing per month for all (HOPE and non-HOPE) services.

When asked a hypothetical question regarding their willingness to contribute more money each month for their current services should HOPE IV rules be changed to require this, at baseline, 40 percent said they would, and 54 percent indicated they would not be willing to do so. The vast majority (85 percent) of the latter indicated they would pay no more than $1-$25 more per month. Fifty-nine percent of the participants not then paying for their HOPE IV services reported they would be unwilling to pay anything. However, 33 percent of those not paying anything for HOPE IV support services said they would be willing to contribute something, with over four-fifths of the latter giving the amount at between $1 and $25 per month. It should be noted that even though it was posed hypothetically in an effort to allay fears about losing program benefits, some respondents may still have interpreted these questions as a test of their loyalty to the program. Consequently, these responses should be interpreted cautiously. Because of these ambiguities of interpretation coupled with the possibility that re-asking the question might again cause unnecessary anxieties for the frail elderly respondents, we decided to delete these questions from the follow-up instrument.

3.6.3 Participants' Overall Assessment of HOPE IV

Participants were enthusiastic supporters of the HOPE IV program at baseline, and even more so at follow-up. Participants said they would change little, if anything, about HOPE IV, and considered the Program essential to helping them remain in their own homes. An overwhelming 85 percent of participants at baseline, and an even higher 91 percent at follow-up, reported they were very satisfied with HOPE IV; 11 percent, and six percent, said they were somewhat satisfied. Only one respondent indicated active dissatisfaction with the Program at either point in time, while a very few were uncertain or did not say.

Table 3-7 presents what respondents said they liked most about HOPE IV. At baseline, the highest percentages named help with housing and rent (30 percent) and receipt of specific services (26 percent). Fifteen percent indicated that the humane, caring attitude of program and service personnel is what they liked most about HOPE IV, while 18 percent felt they could not really choose among the various aspects of the HOPE IV program, because "everything about it is good." At follow-up, the single largest percentage (37 percent) of participants now reported that they liked everything about the Program, with the next highest percentage (28 percent) naming help with housing as what they liked best, followed by specific services (16 percent), and the staff's humane attitude (14 percent). It may be that over time, as intended, more participants had come to view HOPE IV as a total package, rather than a series of discrete services. Interestingly, Service Coordinators responding along similar lines when asked what they believed participant's would consider the most beneficial aspects of HOPE IV, said the combination of the availability of someone to contact for assistance, the services themselves, and the rental subsidy.

Table 3-7
Single Thing Participants Like Most About HOPE IV Program

	Baseline *(n=543)* (%)	Follow-Up *(n=286)* (%)
Help with housing	30	28
Specific services (e.g., housekeeping, meals, home health aide)	26	16
Humane/caring attitude	15	14
Everything/services in general	18	37
Enabling independent living	4	2
Miscellaneous (safer environment, lowering financial burden)	3	1
Non response	4	2

At baseline, about 85 percent of the participants said they would make no changes to the HOPE IV program; at follow-up, the number rose to 94 percent. At baseline and at follow-up, most of the very few who could think of something they would have wanted to change indicated wanting the Program to improve existing services. Ninety percent of participants at baseline, and 96 percent at follow-up, indicated that HOPE IV had been very important for allowing them to continue living in their own homes; at baseline, seven percent, and at follow-up, two percent, felt the Program had been somewhat important in this respect. At both points in time, only a handful of individuals (10 at baseline, three at follow-up) answered that the Program had made no difference one way or the other.

3.7 Conclusions on HOPE IV Program Implementation

Implementing the HOPE IV program presented a number of distinctive, initially unanticipated challenges to the 16 first round grantees. Since it took time for the grantees to recognize and respond to these challenges, some of which only emerged once the program was operational, implementation overall proceeded somewhat more slowly and less smoothly than might first have been expected. Nonetheless, grantees adapted to these unexpected pressures, albeit some more quickly than others.

Despite having faced many common obstacles, the 16 grantees varied considerably in how quickly and effectively they were able to effect program implementation. Various factors influenced these differences in speed and depth of implementation, including: when the grant agreement with HUD was signed; when the Service Coordinator was hired; whether the relationship between the PHA and the AAA or other partner agency developed as planned; the level of PHA support for HOPE IV and degree of flexibility of Section 8 staff in adapting to the needs of the frail elderly; and the creativity, stamina, and time commitment to the HOPE IV program of key staff, especially the Service Coordinator. Also important were local community conditions, such as the strength of the existing service delivery network for the elderly; the local housing market and housing conditions; and the economic, physical and mental health status of the low-income, frail elderly populations.

Participation in the HOPE IV program had multiple, mainly unanticipated effects on various aspects of the grantee PHAs, including their Section 8 programs. Participation in this pioneering venture in combined provision of Section 8 housing and supportive services broadened the grantees' conceptions of their service populations to more fully encompass the frail elderly. In general, at the outset, grantee PHAs were not prepared, either organizationally or psychologically, for the demands of running a program like HOPE IV. Typical Section 8 recruitment techniques, such as reopening waiting lists, were only minimally effective in drawing new participants into the program. Thus, the PHAs were forced to turn to new outreach approaches, such as distributing flyers, making presentations to community groups, or sponsoring radio spots. In addition, processes such as screening and assessment took much longer and were more labor-intensive than was anticipated.

Many grantees came to rely heavily on the resources of their "partner" AAA and other community service agencies for names of potential recruits, and, in some cases, also for doing much of the leg work necessary to screen, assess, and enroll participants in the HOPE IV Program. Where the

PHA and AAA were able to develop an effective working relationship, this strategy of reliance on the AAA helped to expedite the recruitment process. However, for the grantees where a good PHA/AAA relationship unexpectedly failed to develop, the PHA was left in a difficult position, and recruitment suffered as a result. The pace of recruitment was also affected by a number of other unanticipated factors, including the unexpectedly high percentage of HOPE IV participants requiring assistance in locating and moving into their housing as well as the high level of need among participants. In effect, it took awhile for the grantees to recognize that participant recruitment and assessment would be ongoing throughout the course of the HOPE IV implementation process. Even those few grantees that managed to recruit all or most of their participants early on, recognized that they would need to replace slots lost through attrition, which proved to be more extensive than expected even relatively early in the process. For the majority of the grantees, it took several years to even approach full enrollment in the program, with nearly continuous replacement of lost slots operating simultaneously. The need to devote ongoing energy and attention to "front-end" tasks of recruitment and assessment created a strain on program operations, felt mainly by the Service Coordinator.

In fact, Service Coordinators came to play an important and more expansive role in the HOPE IV program than was ever envisioned in the original program design. Grantees shaped different conceptions of the Service Coordinator role, which changed and developed in response to changing demands of program implementation. Some grantees emphasized client contact and "hands on" case management, while others stressed administrative duties and linkage among service delivery agencies. However, no matter what the relative emphasis, for all but a few grantees serving a small number of HOPE IV participants in small communities, the Service Coordinator role rapidly became overloaded with too many intense, competing demands. In addition to performing the core activities of frailty assessment, PAC review, and service planning and monitoring, Service Coordinators stepped into the vacuum to assume a variety of unanticipated functions associated with participant recruitment and program start-up. These included marketing, helping participants locate and move to new housing units, and assistance in obtaining essential non-HOPE services and basic necessities. Many Service Coordinators also came to play an important role in bridging the distance between the PHA and AAA or other service delivery agencies, and they took on greater than expected management and administrative duties. As implementation progressed, Service Coordinators were further torn between devoting their energies to ongoing "front-end" activities of outreach, recruitment, and assessment, and responding to the often intense and changeable service needs of HOPE IV participants already in the program.

HUD's July 1994 NOFA offering additional service coordination funds answered a very real need for most of the HOPE IV grantees and helped provide additional staff support. Prior to the NOFA, HOPE IV grantees had responded to these pressures in various, ad hoc ways. As Table 3-8 shows, nine of the 16 grantees applied for funds under the NOFA, and most used the money to increase the percentage of time Service Coordinators devoted to the HOPE IV program or help fund new Service Coordinator positions.

In response to the latitude HUD purposely gave the HOPE IV grantees in designing their individual programs, the 16 grantees presented variation in a number of program implementation areas, which can be summarized as follows:

- **Instruments used to assess frailty:** All but one grantee used an "established" frailty assessment tool and crosswalked its ADL categories with HUD's ADL definitions. One grantee used an instrument specifically designed to measure ADLs as HUD defined them for HOPE IV Program purposes. Most instruments assessed a range of factors beyond functional status, including social support, physical health, and mental health.

- **Types of Services:** Most grantees provided a common cluster of services that included case management, linkage services such as transportation, personal care, and homemaker and chore services. Other allowable categories of services (social and mental health, socialization and recreation, and advocacy) were less prevalent, although grantees recognized unmet needs for counseling, legal, and financial services. Since service delivery began, a few new services were added (emergency

response systems, medication monitoring, household adaptation), and meals services were changed to accommodate special or unmet nutritional needs (diabetic meals, hot dinners, and a liquid supplement for weekends).

- **Sources and Uses of Supportive Services Funds:** The HUD grant is the single largest source of funding for HOPE IV supportive services. However, all other sources combined (State and grantee resources and participant fees) account for 60 percent of the total. Grantees assembled matching funds in excess of 150 percent of the HUD grant. Seventy percent of funds were projected to be devoted to care of the person and the home and meal and nutrition services. The remainder went to administration and case management (16 percent), transportation (eight percent), and other services (six percent). The per person amount budgeted for services in grantee applications varied widely, from just over $2,000 to nearly $10,000, including both Federal and non-Federal shares. Some of this variation may be explained by differences in how matching funds were claimed and in the amount of the HUD grant figured on a per participant basis.

- **Contracted and Non-Contracted Services:** Only one grantee PHA directly delivered supportive services to HOPE IV participants. All others contracted out the delivery of services, half also contracted for service coordination, and a few for PAC functions, as well.

The variety in program implementation presents an interesting range of program characteristics to explore, but also raises issues of consistency and comparability across sites, possibly complicating the ability to assess program effects.

4. DEMOGRAPHIC AND HOUSING CHARACTERISTICS OF THE HOPE IV PARTICIPANTS

4.1 Demographic Characteristics

HOPE for Elderly Independence, as a new service for many Public Housing Agencies, brings frail elderly tenants and an accompanying system of case management and supportive services into Section 8 rental assistance programs. To be eligible for HOPE IV, participants must meet the program's age, income, and frailty guidelines, but within these criteria there are many other possible combinations of demographic characteristics. Of particular interest are those factors that prior research shows are highly correlated with risk of institutionalization and need for services. While the disability measures in Chapter 5 are the most predictive in this regard, demographic characteristics are important as well. These include advanced age, living alone, very low income, minority status, and low levels of educational attainment.

4.1.1 Age, Race/Ethnicity, and Gender

The baseline survey found that the vast majority of HOPE IV participants are white females, many of whom are of advanced age. Table 4-1 shows that over half of the participants are at least 75 years of age and 16 percent are over the age of 85. Of particular interest, however, is the fact that nearly half of the participants are under the age of 75, a group not often at high risk of institutionalization. For example, only 16 percent of elderly nursing home residents are less than 75 years of age.[ix]

Table 4-1.
Demographic Characteristics:
Age, Race/Ethnicity, and Gender

Characteristics	Participants *(n-543)* (%)	Comparison Group *(n=523)* (%)
Age		
62-74	51	47
75-84	34	34
85 and over	16	20
Race		
White	90	81
Black	3	9
Other	3	5
Unknown	4	5
Hispanic origin*	10	13
Gender		
Female	80	84
Male	20	16

*Hispanics can be of any race.

During interviews with the HOPE IV grantees, the Service Coordinators, who have major responsibility for outreach and

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

recruitment, stated that scattered-site rental housing, even with case management and supportive services, required participants to be far less frail than the nursing home population. These Service Coordinators also saw the HOPE IV program serving an elderly population who had fewer needs than persons in many other community-based, long-term care programs, such as those operated under various Medicaid waivers as alternatives to nursing home placement. For example, of those participating in the Long Term Care Channeling Demonstrations, a home- and community-based, long-term care alternative for persons who are nursing-home eligible, only 27 percent were under the age of 75.[x] These HOPE IV participant age characteristics are also consistent with the program regulations, which set a level of frailty, for eligibility purposes, that are far less severe than for either nursing home residents or those participating in home and community-based alternatives. We also found, when analyzing HOPE IV participant data on frailty according to age, as discussed in Chapter 5 below, that the youngest group reported rates of limitation in activities of daily living that were similar for those over age 75. We also found that this age profile varied somewhat among grantees. For example, the percentage below age 75 ranged from 30 percent to 75 percent, but the relatively small numbers of participants at some grantees requires analysis of participant data as a whole.

Unlike age, the race and Hispanic origin of participants were often a function of the grantee location. For example, the majority of first round HOPE IV grantees were not in locations with high concentrations of minority elderly. This was especially true for those grantees that had recruited a substantial number of their participants in time for inclusion in the baseline survey. There were exceptions, however, for some HOPE IV sites had few if any black or Hispanic participants, despite sizable numbers of these groups among the overall elderly population in the grantee's locale.

Nearly all the participants were white (90 percent), while only three percent were black. Those of Hispanic origin, who can be of any race, comprise 10 percent of participants, virtually all from a single grantee PHA in an area with a high concentration of Mexican-American elderly.

Eighty percent of the participants were female, mirroring the profile of America's population of low-income, frail elderly, overall. This pattern generally held across all the grantee sites. Federal statistical agency data show that most poor, frail elderly in this country are female, and the HOPE IV participants reflect this national trend. For example, according to the Census Bureau, of persons age 65

[x] Mathematica Policy Research, The Evaluation of the Long Term Care Demonstration: Final Report, U.S. Department of Health and Human Services, 1986, p.41.

and over who are below the poverty threshold and have a severe disability, 78 percent are women and 22 percent are men.[xi]

Table 4-1 also shows the extent to which the participant and comparison groups have similar demographic characteristics. Regarding age, the rates for each of the three age cohorts are almost the same. Concerning race/ethnicity, the Hispanic rates are 10 percent and 13 percent for the participant and comparison groups. The participant group had fewer blacks than the comparison group, at three percent and nine percent, respectively. This reflects a lower rate of black participation in HOPE IV than the study design anticipated and will be controlled for statistically. Given that most frail elderly are, in fact, women, screening solely on the basis of frailty and age yielded a gender profile of participant and comparison group members that is nearly the same, at 80 percent versus 84 percent.

4.1.2 Marital Status and Living Arrangements

Most of the participants have been widowed for many years and are living alone. As Table 4-2 shows, less than 10 percent of participants were married at the time of the survey, while over 60 percent were widowed and another 30 percent were divorced, separated, or never married. Of all participants, over 36 percent had been widowed for more than 10 years and nearly half for more than five years. Only six percent had been widowed during the past two years. Consistent with these figures, the vast majority of participants (86 percent) lived alone. Only 13 percent lived with 1 other person, and virtually none (one percent) were in households with more than two persons. Consistent with HOPE IV's focus, persons

Table 4-2.
Demographic Characteristics:
Marital Status and Living Arrangements

Characteristics	Participants *(n=543)* (%)	Comparison Group *(n=523)* (%)
Marital status		
Widowed	61	58
Divorced	21	24
Married	9	10
Separated	4	4
Never married	5	4
Years widowed		
Not widowed	39	42
1 to 2 years	6	2
3 to 4 years	6	2
5 to 10 years	13	11
Over 10 years	36	42
Living arrangements		
living alone	86	79
2 persons	13	18
More than 2 persons	1	3
Moved to qualify for HOPE IV		
Yes	42	NA
No	57	NA
Unknown	1	NA

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

who are frail and live alone are at considerable risk, often relying on outside help for performing basic life activities, such as personal care and home management.'

Over 40 percent of the participants moved as a function of the HOPE IV program, either to meet Section 8 Housing Quality Standards or the rental housing requirement. This figure is somewhat higher than the approximately one-third of Section 8 tenants (of all ages) who move to quality for rental vouchers or certificates. Many HOPE IV applicants lived in rental housing not meeting Section 8 requirements; in some cases, the applicants owned their residences. These individuals either chose to forego enrollment in the HOPE IV program by not moving, or they relocated into qualifying housing as HOPE IV participants. Conversely, nearly 60 percent of participants already lived in rental housing meeting HUD Housing Quality Standards.

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

Table 4-2 also confirms similarities between the study groups at baseline in terms of marital status and living arrangements of the participant and comparison groups, which are nearly the same. This table also shows there is a high level of consistency regarding many other demographic factors when selecting comparison group members solely on the basis of age and frailty.

4.1.3 Education, Income, and Housing Costs

Many studies of the elderly show that age, alone, is a poor predictor of service needs, except at the far end of the spectrum, such as over 85 years. Other factors, such as education and income, however, are highly correlated with frailty and risk for loss of independence. Table 4-3 presents information on the education, income, and rental payments of HOPE IV participants. *Nearly half of those*

in the program have not completed high school, and while all are poor as a HUD requirement, there is substantial variation within this low-income group. For example, nearly 20 percent have annual incomes under $6,000 and almost half receive $8,000 or less. Monthly tenant contribution to rent (including utilities), which varies as a function of income, is quite low. More than half of the participants pay $200 or less a month in rent, and over three-quarters pay $300 or less.

Table 4-3.
Demographic Characteristics:
Education, Income, and Tenant Contribution to Rent

Characteristics	Participants *(n=543)* (%)	Comparison Group *(n=523)* (%)
Education level		
No formal schooling	7	10
Not a high school graduate	42	52
High school graduate	30	21
Some college	13	12
College graduate	5	4
Unknown	3	2
Income		
Less than $6,000	18	26
$6,000 to $8,000	31	39
$8,001 to $10,000	24	20
More than $10,000	23	15
Unknown	4	0
Monthly tenant contribution to rent		
Less than $100	16	9
$100 to $200	39	65
$201 to $300	23	18
More than $300	13	7
Unknown	9	2

Table 4-3 shows that the comparison group also had substantial numbers with less than a high school education, low income, and low tenant contribution to rent. The rates for these items, however, were somewhat higher than for participants in the HOPE IV program.

4.2 Housing Characteristics and Satisfaction

This section describes the homes and neighborhoods in which the HOPE IV participants live and the attitudes of these persons about their environment. It also shows changes between the baseline and follow-up surveys in terms of these satisfaction measures. Also, for those participants who moved within a year of starting the program, either to qualify for HOPE IV or in response to the new housing choices the program provided, this section also compares participant attitudes about the old versus the new neighborhoods.

4.2.1 Satisfaction and Safety

Participants not only were quite satisfied with their current living environment but also felt safe most of the time. Table 4-4 shows that 70 percent of participants indicated they were very satisfied with their living arrangements, while another 19 percent reported they were just somewhat satisfied. Only five percent stated they were somewhat or very dissatisfied with their current living environment. Concerning safety, 88 percent of participants reported they felt safe most of the time, while 10 percent felt safe only some of the time or rarely. As a program model that is often new to both public housing agencies and a frail, elderly tenant population, HOPE IV participant satisfaction and perception of safety are extremely important indicators for continuation and expansion of the concepts embodied in the demonstrations. The comparison group reported similar rates of satisfaction and feelings of safety, despite having lived in their neighborhoods far longer than participants (see Table 4-7). These rates held for the follow-up survey, with both participants and comparison group members reporting slight increases in satisfaction and safety.

Table 4-4.
Housing Characteristics:
Satisfaction and Safety of Current Living Environment

Characteristics	Participant *(n=543)* (%)	Comparison Group *(n=523)* (%)
Satisfaction:		
Very Satisfied	70	64
Somewhat satisfied	19	23
Neither satisfied nor dissatisfied	4	4
Somewhat or very dissatisfied	5	9
Unknown	1	0
Safety:		
Feel safe most of the time	88	84
Feel safe some of the time	7	11
Feel safe rarely or never	3	4
Unknown	2	1

4.2.2 Physical Features

With the physical features of buildings, we begin to see some differences between the participants and comparison group that may be a function of length of time receiving Section 8 assistance and corresponding differences in building design. The impact analysis controls for these

Table 4-5.
Housing Characteristics:
Physical Features

Characteristics	Participants *(n=543)* (%)	Comparison Group *(n=523)* (%)
More than one story building	69	50
Stairs required for entry	41	50
Unit is above first floor	34	27
Unit above first floor without an elevator	13	7
All rooms are on same floor	98	96
Interior modifications made	17	16
Difficult to enter home	14	19
Difficult to get around home	8	12

differences and others associated with long-terms residence in a community, including self-reported access to care. Table 4-5 shows that over two-thirds of the HOPE IV participants live in a building with more than one floor versus about 50 percent for the comparison group. Section 8 rental assistance allows flexibility in the type of rental housing; thus some HOPE IV participants and comparison group members live in a single-family home, such as a rented house with more than one story. This is the exception, however, for 98 percent of the participants and 96 percent of the comparison group members have all their rooms on one floor.

Concerning accessibility, 41 percent of participants and 50 percent of the comparison group must climb at least one stair to enter their building. Also, 13 percent of participants and eight percent of the comparison group reported living in a rental unit above the first floor without a (working) elevator in their building.

According to the grantees, an issue of considerable importance during implementation of the HOPE IV program was locating rental units that not only met Section 8 Housing Quality Standards, but also were relatively free of physical barriers, given the tenant's level of frailty. Modifications were made to units; 17 percent of participants reported interior modifications to their housing units, including installation of grab bars and modifications to the bath and shower to facilitate use by persons with disabilities. Concerning the consequences of physical barriers, 14 percent of the participants reported difficulty entering their home, while eight percent said it was difficult to get around inside their unit. Between the baseline and follow-up surveys, these rates changed only slightly.

4.2.3 Participant Use of Community Services within Walking Distance of Home

Participants reported that the services within walking distance of their homes that they most frequently used were dry cleaners or laundromats (21 percent), grocery stores (22 percent), drug store or pharmacy (15 percent), and beauty parlor or barber shop (14 percent), as Table 4-6 shows. Less than one-quarter of the participants, however, use any one of these essential services within the proximity of

Table 4-6.
Housing Characteristics:
Use of Community Services within Walking Distance of Home

Community Services	Participants *(n=388)* (%)	Comparison *(n=523)* (%)
Dry cleaners/laundromats	21	17
Grocery stores	22	22
Drug store/pharmacy	15	18
Beauty parlor/barber shop	14	13

their own home, suggesting that they require transportation and escort services to other locations. Comparison group figures are similar. These figures provide some context for the supportive services information presented in Table 6-7, below. For example, transportation is the second most frequently used service for both participants and the comparison group, after housekeeping. Changes between the baseline and follow-up survey suggest an increasing demand for supportive services such as transportation. For example, participant use of grocery stores within walking distance of their homes dropped from 22 percent over two years to 12 percent. The corresponding change for the comparison group was 22 percent to 14 percent.

4.2.4 Length of Time in Current Home

Nearly half of the participants had moved into their current home within one year of enrollment, either in conjunction with the HOPE IV program, or for other reasons. In contrast, only seven percent of the comparison group had lived in their current home for less than one year (Table 4-7). Nearly 30 percent of participants had lived in their home from one to four years. However, only one-quarter of participants had been there at least five years versus 64 percent for the comparison group. Only 11 percent of participants had lived in their homes for more than 10 years, versus 30 percent for the comparison group. Length of time in current residence may be highly correlated with access to care, and the analysis controls for these differences in assessing the impact of HOPE IV.

Table 4-7.
Housing Characteristics:
Length of Time in Current Home

Characteristics	Participants *(n=543)* (%)	Comparison Group *(n=523)* (%)
Less than 6 months	32	3
6-11 months	17	4
1-4 years	27	28
5-10 years	13	34
More than 10 years	11	30

Participants who had moved within one year of enrolling in HOPE IV identified their reasons for relocating. The evaluation includes this information to help determine if participants felt they had to move in order to enroll in the HOPE IV program, or if other factors explained why they relocated. HOPE IV is a combination of two types of benefits, the first consisting of Section 8 rental assistance, and the second covering supportive services. Given the long waiting periods for receiving Section 8, in many cases more than two years, grantee locales had a substantial unmet demand for affordable, rental housing. At the same time, given the requirements of HOPE IV, applicants may have had to choose between

staying in their current home and foregoing HOPE IV services, or giving up their residence in order to meet the rental housing and housing quality standards of Section 8, which also apply to HOPE IV. For these reasons, the study sought to distinguish between participants who moved primarily as a function of HOPE IV program requirements and those who reported another primary reason. Of the nearly one-half of participants who had lived in their home for less than one year, 42 percent said they moved as a function of HOPE IV, while 14 percent cited Section 8 rental assistance, and 43 percent said they moved for reasons unrelated to program participation, such as proximity to children, safety, and cost. Given the benefits of remaining in place for this frail elderly population, the impact analysis will explore the relationship between housing stability and various outcome measures, such as nursing home placement and life satisfaction (see Chapter 7).

4.2.5 Characteristics of New Neighborhood

When asked to compare their old and new neighborhoods, most participants who had moved within one year of enrollment in HOPE IV reported their present location to be the same or more favorable than their previous neighborhood in terms of convenience to transportation and services, safety, visitation by family and friends, and noise levels. Only half, however, said they knew as many or more neighbors in their new area than the old one, possibly as a function of how recently they moved (see Chapter 6 for a summary of social interaction with family and friends).

Table 4-8.
Housing Characteristics:
How Does Present Neighborhood Compare to Previous Neighborhood?

Characteristics	Participants *(n=543)* (%)
New neighborhood is the same or more convenient to transportation and services	64
Feel as safe or safer in new neighborhood	85
Visited the same or more often in new neighborhood	75
New neighborhood is as quiet or quieter	80
Know as many or more neighbors in new neighborhood	51

5. FUNCTIONAL STATUS AND HEALTH

5.1 Frailty of HOPE IV Participants

HOPE IV regulations require that participants not only qualify for Section 8 rental assistance by virtue of their low-income, but also need assistance in personal care and home management, as defined in 1.1, above. These activities cut across two primary measures of frailty frequently used in research: limitations in *Activities of Daily Living (ADL)* and *Instrumental Activities of Daily Living (IADL)*. ADLs include five very basic activities essential to independent living: eating, dressing, bathing, transferring (between bed and chair), and toileting (getting to and using the toilet as opposed to continence).[xii] IADLs go beyond ADLs in level of complexity and include handling personal finances, meal preparation, shopping, traveling about the community, doing housework, using the telephone, and taking medications.[xiii]

To ensure consistency with the considerable body of prior research on the frail elderly, the HOPE IV study design collected data in terms of these standard ADL/IADL measures, as well as the additional activities in the HOPE IV regulations. By doing so, this report can present a functional profile of the HOPE IV participants relative to both the HUD program regulations and other studies of frailty among the elderly, especially in relation to participants in other community-based, long-term care programs. The following tables and accompanying narrative begin with the traditional ADL/IADL measures and end with a presentation and discussion of frailty in terms of the HOPE IV program regulations. The tables present data for the baseline and the two-year, follow-up survey to show changes in functional status and health over time for the participant and comparison groups.

5.1.1 Activity of Daily Living Limitations

Table 5-1 identifies the number and percentage of HOPE IV participants reporting difficulty in performing each of the five ADLs, including those who are unable to do so, as well as those who have some or a lot of difficulty. In addition, the table shows how many report multiple ADL difficulties, as a composite indicator of frailty. *Nearly three-quarters of the participants reported difficulty performing at*

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

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

least one ADL, with individual activity limitation rates ranging from a high of 55 percent for transferring between bed and chair to a low of 14 percent for feeding oneself.

Table 5-1.
Frailty Characteristics:
Activity of Daily Living (ADL) Limitations

	Participant (%)		Comparison Group (%)	
Activities	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Limitation in				
Bed/chair transfer	55	67	64	61
Bathing	46	57	47	53
Dressing	45	56	48	51
Using toilet	32	46	36	50
Feeding self	14	21	12	16
Multiple ADL limitations				
One or more	74	79	86	79
None	26	21	14	21
One	19	15	26	16
Two	17	12	23	15
Three	17	12	18	16
Four	13	28	14	20
Five	7	13	6	11

During the two-year period between the baseline and follow-up survey, the percentage of participants reporting an ADL limitation increased for each of the five activities, while the ranking remained the same for both periods. However, the low-prevalence ADL limitations experienced the greatest change. For example, the limitation rate for feeding one's self increased by one-half, from 14 percent to 21 percent, while the rate for transferring increased by just over one-fifth from 55 percent to 67 percent. The comparison group reported fewer increases than the participants. For example, the limitation rate for feeding one's self increased by one-third, from 12 percent to 16 percent, while the limitation rate for transferring actually decreased by five percent.

The ADL scale is hierarchical, and certain activities are more indicative of frailty than others. For example, difficulty feeding one's self, while of relatively low prevalence, represents the most severe

limitation.[xiv] Therefore, when interpreting the figures in the tables, it is important to realize that low rates of difficulty actually represent those activities for which the elderly need the greatest level of assistance.

As a measure of severe frailty, 37 percent of the participants and 38 percent of the comparison group reported limitations in three or more ADLs at baseline. At follow-up, these rates increased to 53 percent versus 47 percent, respectively, for the participant and comparison groups. Overall, participants who reported at least one ADL limitation increased from 74 percent to 79 percent, versus a decrease from 86 percent to 79 percent for the comparison group.

The analysis tested for several possible explanations for these patterns. First, differential exit rates for the participants and comparison groups, according to ADL limitations, could explain these differences between the baseline and follow-up periods. For example, one hypothesis is that HOPE IV allows more frail elderly participants than comparison group members to remain in the Section 8 program over time. This did not occur, however, for the baseline ADL limitation profile of those who stayed and those who left their respective programs was nearly identical for both groups.

This means that the differences in frailty over the two years, and between the two groups, were a function of actual changes in the ADL limitation status of participants and comparison group members, rather than differential retention and exit rates based on frailty. As Chapter 7 shows, this may be a function of the relatively high level of case management and supportive services the comparison group members were also receiving, from sources other than HOPE IV. The multivariate analysis in Chapter 7 controls for receipt of services, in conjunction with other factors such as ADL limitations, to show the impact of HOPE IV on a range of participant outcomes.

Given the large percentage (approximately half) of participants who were under the age of 75, it is reasonable to ask if this group reported a relatively low level of ADL limitations. When analyzing HOPE IV participant measures of frailty as presented in Table 5-1, however, the percentage reporting multiple Activity of Daily Living limitations was similar for the three age cohorts: less than 75 years, 75 to 84 years, and 85 and above. The exception was for participants reporting a limitation in all five ADLs, where the activity limitation rates for the oldest age group were more than twice as high as the youngest cohort (14 percent versus six percent). Those reporting difficulty with all five ADLs, however, comprise only about seven percent of all participants at baseline.

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

HOPE IV participants are considerably more frail than the elderly population as a whole, in terms of the ADL difficulty criteria in Table 5-1. Measures of ADL difficulty address very basic life activities essential for independent living, affecting a relatively small percentage of the overall elderly population. For example, among all non-institutionalized elderly age 65 and over, only 11 percent reported a limitation in at least one ADL, ranging from about nine percent for dressing to approximately one percent for feeding oneself.[xv] By contrast, nearly three out of four of HOPE IV participants reported difficulty performing at least one ADL.

When describing physical frailty, other community-based, long-term care surveys or programs often identify the number of persons receiving (or needing) help from another person to perform the activity, as opposed to just having a difficulty or a limitation. These studies use the term ADL dependencies to describe this measure, which identifies a more severe limitation than simply reporting difficulty performing the activity. Using this constructed definition, approximately 30 percent of HOPE IV participants reported receiving help from another person for at least one of the five ADLs. Among the comparison group, 39 percent reported receiving help from another person to perform at least one ADL. For those remaining in their respective programs at follow-up, 34 percent of the participants reported receiving the help of another person for at least one ADL, versus 36 percent for the comparison group. To put these figures in perspective, only about eight percent of the total household population age 65 and over reported receiving such help from another person in performing at least one of these five ADLs. [xvi]

While HOPE IV participants are considerably more frail than the elderly population overall, they are much less frail than persons who receive, or are eligible for, nursing home care. Approximately 92 percent of nursing home residents age 65 and over had at least one ADL dependency, in this case involving the assistance of another person among six activities, including continence (e.g., using a catheter or bedpan), ranging from a high of 91 percent for dressing to a low of 40 percent for eating.[xvii] Involving a similar clientele needing skilled nursing care, the recent Program for All-Inclusive Care for the Elderly (PACE) demonstrations focus on elderly persons who are eligible for nursing home care but choose to receive services in the community. Between 79 percent and 95 percent of participants in the

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

[xvi] Wiener, J.M., et al, "Measuring the Activities of Daily Living: Comparisons across National Surveys," *Journal of Gerontology: SOCIAL SCIENCES, Vol. 45, No. 6 (1990).*

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

PACE program had at least one ADL dependency.[xviii] Also targeting a nursing home eligible elderly population, The Long Term Care Channeling Demonstration program participants had an ADL dependency rate of approximately 84 percent.[xix]

The purpose of these ADL comparisons, as summarized in Table 5-2, is to show where the HOPE IV participants lie along a continuum, from the elderly household population in general, through those who receive or qualify for nursing home care.

Table 5-2.
Frailty Characteristics:
Comparing HOPE IV with Other Long-Term Care Programs for the Frail Elderly

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

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

5.1.2 Instrumental Activities of Daily Living Limitations

While ADL limitations focus on personal care needs, the Instrumental Activities of Daily Living (IADL) scale covers a higher level of functioning associated with care of the home. IADL limitations pertain to many of the frailty criteria in the HOPE IV regulations, including need for assistance in preparing meals, shopping, doing light housework, and managing money. In terms of these four IADLs, 92 percent of the HOPE IV participants reported difficulty performing at least one at baseline, ranging from a high of 83 percent for light housework to a low of 33 percent for managing money, as Table 5-3 shows. The baseline IADL difficulty rates in Table 5-3 measure the relatively complex domains of functioning that HOPE IV participants require for independent living in scattered site rental housing, with the help of case management and supportive services to perform these activities. Comparison group members reported very similar rates for all the IADL limitation measures.

To put these figures in perspective, 18 percent of the total household population, age 65 and over, reported at least one IADL limitation, in this case from a list of six activities including the above four, as well as using the telephone and getting around the community.[xx] Also, by way of comparison, virtually

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[xviii] Branch, L.G., et al, "The PACE Evaluation: Initial Findings," *The Gerontologist*, Vol. 35, No. 3 (1995).

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

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

all nursing home residents and participants in the PACE and Channeling demonstrations had at least one IADL difficulty, consistent with the relatively high level of physical and cognitive functioning that IADLs require.

Table 5-3. Frailty Characteristics: Instrumental Activity of Daily Living (ADL) Limitations				
	Participant (%)		Comparison Group (%)	
Activities	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Reports difficulty in:				
Preparing meals	56	66	60	61
Doing light housework	83	85	85	81
Shopping	76	87	76	79
Managing money	33	43	35	41
Total IADL limitations:				
One or more	92	93	94	90
None	8	7	6	10
One	14	8	15	10
Two	23	18	21	18
Three	30	31	33	32
Four	24	36	24	29

Between the baseline and follow-up periods, participants reported increased limitation rates for three of the four IADLs, with light housekeeping remaining essentially the same at its relatively high level. The percentage of participants reporting difficulty with all four IADLs increased from 24 percent to 36 percent. Comparison group rates changed only slightly between the baseline and follow-up periods. And as was the case for ADL limitations, participants experienced an increase in their level of frailty to a greater extent than did the comparison group.

As a partial explanation for these differences, the IADL limitation rate was somewhat higher among the comparison group who left Section 8 than participants who left HOPE IV. For example, 53 percent of comparison group members who stayed reported three or four limitations, versus 67 percent for those who left. Among participants, 51 percent of those who stayed reported three or four limitations, versus 60 percent for those who left HOPE IV.

Another possible explanation for the increase in IADL limitation rates for participants, relative to the comparison group, is that the latter group has lived in their Section 8 assisted housing, often with case management and services, for far longer than the participants. This may have resulted in a relatively high level of stability among the comparison group, that HOPE IV participants, as new recipients of assisted housing and supportive services, have yet to realize. While changes in ADL and IADL limitation rates are, themselves, important outcome indicators, their main value is in controlling for service need when analyzing

impact in terms of nursing home placement, changes in well-being, and the other measures presented in Chapter 7.

5.1.3 Analysis of HOPE IV Eligibility

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

For the purposes of analyzing grantee adherence to the HOPE IV eligibility criteria, the evaluation defined the five HUD ADL items as: (1) eating, including meals preparation; (2) bathing, including getting in and out of tub or shower; (3) grooming, including washing one's hair; (4) dressing; and (5) home management, including housekeeping, shopping, managing money, and various activities associated with moving about one's environment, such as transferring between bed and chair, and getting to and using the toilet room. Defining each of the five activities in this way, 96 percent of participants reported difficulty at baseline with at least one of the five, and over 70 percent reported difficulty performing at least three (see Table 5-4). When counting all 12 of the activities mentioned in the HOPE IV regulations and included in the participant survey instrument, 96 percent report difficulty performing at least one, and nearly three-quarters reported difficulty performing at least three. (See Table 5-5.)

Table 5-4. Frailty Characteristics: HUD ADL Difficulties (5 activity categories)				
	Participant (%)		Comparison Group (%)	
Activities	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Difficulty:				
Eating/meals preparation	60	68	62	63
Bathing/in & out of tub/shower	78	82	88	79
Grooming/washing hair	58	65	66	60
Dressing	45	56	48	51
Home management	93	94	97	93
Total limitations:				
One or more	96	96	98	95
None	4	4	2	5
One	11	7	4	10
Two	13	13	14	12
Three	20	14	23	17
Four	23	16	26	17
Five	29	44	31	38

The activity of daily living difficulty information in Tables 5-4 and 5-5, suggests that between 19 percent and 28 percent of the participants have fewer than three ADL difficulties, contrary to the HOPE IV program regulations. As one explanation for this disparity, prior research in measuring ADL difficulties shows that frail elderly persons, especially women, self report fewer difficulties than occurs during professional assessments of the same individuals. For example, in their work with the *Women's Health and Aging Study*, sponsored by the National Institute on Aging, Westat and Johns Hopkins University researchers found that frail elderly women in the community under report their level of ADL difficulties compared to the functional assessments and physical performance tests conducted by study team professional staff.[xxi] In addition, this study found that such under reports of functional capacity come, in part, from various adaptive behaviors on the part of the frail elderly (e.g., changing how they approach an activity) to compensate for a limitation in functioning. The study also found that respondents were quite

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

unaware that this decline in functioning had occurred, which may explain some of the under reporting. These findings are consistent with others in the literature on frailty among the elderly.[xxii]

[xxii] Rubenstein, et al., "Systematic Biases in Functional Status Assessment of Elderly Adults: Effects of Different Data Sources." *Journal of Gerontology*, 1984, 39:686-69.

Table 5-5.
Frailty Characteristics:
HUD ADL Difficulties (12 activity categories)

Activities	Participant (%)		Comparison Group (%)	
	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Reports difficulty:				
Feeding self	14	21	12	16
Preparing meals	56	66	60	61
Washing self	46	58	48	54
Getting in and out of shower/tub	70	75	76	67
Using toilet	32	46	36	50
Personal grooming	31	34	30	31
Washing hair	52	62	62	58
Dressing	45	56	48	51
Bed/Chair transferring	55	67	64	61
Housework	83	85	85	81
Shopping	76	87	76	79
Managing money	33	43	35	41
Total limitations:				
One or more	95	96	98	95
None	5	4	2	5
One	8	4	3	7
Two	6	4	4	6
Three	7	6	8	3
Four	9	11	12	10
Five	11	7	13	8
Six or more	54	63	58	60

As another possible explanation for under reporting, the high level of participant satisfaction with the HOPE IV program and fear of losing the benefits, as Chapter 6 discusses, may discourage participants to report ADL limitations. Participants may be unwilling to admit difficulties that either suggest criticism of the HOPE IV program (for not meeting all their needs) or that imply they need nursing home or other restricted forms of care that participants want to avoid.

In addition, as the first interim report on the HOPE IV evaluation states, grantees showed considerable variation in how they interpreted the program eligibility requirements and measured ADL difficulties using their own assessment instruments and procedures. For example, one PHA staff person stated during the grantee interviews that persons with two ADL imitations and a portion of a third were particularly difficult to assess for eligibility. In this case, the HOPE IV applicant had an ability to perform

some aspects of an ADL but also had difficulty with other components of it. Also, consistent with the design of the Westat participant questionnaire, most grantee assessments categorized ADL difficulty according to several levels, ranging from inability to perform an activity at all to just having some difficulty with it. Some grantees assigned numeric scores depending on the particular activity and the level of difficulty, and they used these as a basis for determining HOPE IV eligibility. These procedures varied from site to site, which may explain some of the inconsistency between the evaluation survey findings and local practice in ascertaining HOPE IV eligibility. This also confirms the viability of using the standard frailty measures in the evaluation's survey instruments to ensure consistent data for this study.

As was the case for the ADL and IADL limitation measures, participants experienced greater increases in frailty between baseline and follow-up than did the comparison group, according to the two HUD ADL listings in Tables 5-4 and 5-5. While participants reported increases in difficulty performing all the activities, the comparison group actually reported decreases in several, including getting into and out of the tub or shower and performing light housework. Both of these, however, remain among the activities with the most difficulty for both participants and comparison group members.

5.1.4 Functional Limitations

Moving beyond ADL and IADL limitations in degree of complexity, functional limitations provide yet another measure of frailty among the elderly. For persons who must live independently in the community, especially when personal care workers are not present for considerable periods throughout the day and night, measures of functional limitation are extremely important indicators of physical ability. These include such activities as getting around inside the home, climbing stairs, bending, reaching, grasping, going in and out of the house, getting in and out of a car, seeing, and hearing. Table 5-6 lists these activities with the number and percentage of HOPE IV participants reporting difficulty in performing them. *The most severe functional limitations were in climbing stairs, bending down to pick up clothing (63 percent at baseline), getting in and out of a car (57 percent), and reaching up for light objects (56 percent)*. Also, 43 percent had difficulty hearing a normal conversation and 42 percent of participants reported difficulty seeing ordinary newspaper print even with glasses or contact lenses. To put these figures in perspective, the corresponding rates from the total household elderly population age 65 and over are 16 percent with difficulty seeing words and letters, 14 percent with difficulty hearing a normal conversation, and 31 percent

who have difficulty climbing stairs without resting[xxiii]. As with ADL and IADL limitations, these data show that the HOPE IV participants are considerably more frail than the elderly household population as a whole.

Table 5-6.
Frailty Characteristics:
Functional Activity Limitations

Activities	Participant (%)		Comparison Group (%)	
	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Walking up or down stairs	82	84	89	84
Bending down to pick up clothing	63	69	74	68
Getting in and out of a car	57	66	63	68
Reaching up for light objects	56	57	63	62
Hearing a normal conversation	43	46	49	44
Seeing ordinary newspaper print	42	34	44	33
Walking between rooms	38	47	41	46
Going in and out of home	38	52	47	55
Grasping faucets/knobs/stove pots	29	37	33	37
Confined to a wheelchair	7	4	6	8

During the two-year period from the baseline to the follow-up surveys, changes in functional limitation rates differed markedly between the participant and comparison groups. For example, participants reported increases in eight of the 10 items in Table 5-6, while the comparison group reported fewer increases (five) and lower rates of changes for each of them. While the comparison group reported more functional limitations at baseline than did the participants, these differential rates of change are important to explain as part of the evaluation.

As was the case with the ADL and IADL measures, the comparison group appeared to have a more stable disability profile over the two-year period than did the participants. Again, this may be a function of the relative stability among the comparison group, whose members have lived in their current housing and received care far longer, on average, than the participants, all of whom are new to both assisted housing and supportive services.

[xxiii] McNeil, J.M., *Americans with Disabilities: 1991-92*. U.S. Bureau of the Census, Current Population Reports, P70-33, U.S. Government Printing Office, Washington, DC, 1993, p 20.

Another possible explanation is that the relatively high level of case management and services allowed very frail elderly HOPE IV participant to remain in Section 8 housing, despite their disability, to a far greater extent than did the comparison group. To begin testing these two hypotheses, we compared the baseline functional limitation status of those participants and comparison group members who remained through follow-up and those who left. For two specific functional limitations, the participant and comparison group differences over time were, indeed, influenced by differential exit rates based on frailty.

For example, among participants, there was no difference in the percentage reporting a difficulty seeing, between those who stayed in HOPE IV and those who left, at 42 percent, each. For the comparison group, however, 39 percent of those who stayed reported a difficulty seeing, versus 55 percent for those who left. A similar, but less pronounced, pattern exists for persons reporting a difficulty hearing. Among participants, 42 percent of those who stayed in HOPE IV reported difficulty hearing, versus 45 percent for those who left. However, among the comparison group, 45 percent of those who stayed reported difficulty hearing, versus 57 percent for those who left. This suggests that HOPE IV may be associated with retention of frail elderly with at least these two functional limitations to a greater extent than for the comparison group.

For the bulk of the functional activities, however, these differential patterns of exits based on frailty do not appear. The multidimensional model in Chapter 7 simultaneously controls for the many factors that may explain these participant and comparison group differences, in order to isolate and separately assess the impact of HOPE IV.

5.2 Health Status

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

5.2.1 Self-Assessed Health Status

Table 5-7 confirms the relatively poor overall health on the part of both participants and the comparison group at baseline and follow-up. It presents a profile of the self-reported health status according to five categories, poor to excellent. For interpretation purposes, the National Center for Health Statistics often summarizes this information into two categories: good to excellent or fair to poor health. In these terms, *39 percent of participants and 34 percent of the comparison group reported good to excellent health,*

while 59 percent of the participants and 64 percent of the comparison group members stated their health was fair to poor. Concerning changes in health status over the past year at baseline, participants reported they were better off than a year ago in only 19 percent of the cases, while 44 percent stated their health was the same. The corresponding figures for the baseline comparison group are 14 percent and 47 percent, respectively, for health status that was better or the same. Particularly important is the fact that over one-third of the participants and more than 40 percent of the comparison group indicated their health was worse now than it was a year ago. Between baseline and follow-up these patterns changed only slightly.

Table 5-7.
Health Characteristics:
Self-Assessed Health Status

Characteristics	Participant (%)		Comparison Group (%)	
	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Current health status:				
Excellent	6	4	4	3
Very Good	10	11	12	9
Good	23	21	18	20
Fair	35	41	39	41
Poor	24	21	25	25
Unknown	2	1	1	1
Change in past year:				
Better	19	14	14	12
Same	44	48	43	47
Worse	35	37	42	40
Unknown	1	1	1	1
Gained or lost a lot of weight during past year without trying to	39	26	39	34
Ate fewer than two meals per day at least once during past week	23	13	24	20

Also showing the correlation between frailty and poor health, of all baseline participants who said their health was excellent, less than one quarter (24 percent) reported three or more ADL limitations (as defined in Table 5-1). At the same time, of all baseline participants who said their health was poor, over half (52 percent) reported three or more ADL limitations.

Nearly 40 percent of the baseline HOPE IV participants and comparison group members said they had gained or lost a lot of weight during the past year without trying to do so. In addition, about one-quarter of both the baseline participants and comparison group said they had eaten fewer than two meals per

day at least once during the past week. Substantial gain or loss of weight by the elderly is often an indication of health or emotional problems. For example, in its recent review of the literature on malnutrition among the elderly, the Administration on Aging found that skipping meals was indicative of a high risk of many problems, beyond malnutrition and weight loss, including chronic medical conditions and general food insecurity, such as inability to afford, shop for, and prepare meals.[xxiv] A national study by the Urban Institute, *Hunger Among the Elderly*, found that unintended weight loss is a strong predictor of poor health and nutrition, disease, and mortality among the elderly.[xxv] Living alone, a characteristic common among HOPE IV participants, is also highly correlated with skipping meals, poor quality diets, and overall inadequate nutritional intake. For example, the Institute of Medicine found that social isolation and malnutrition were strongly interrelated, with one contributing to the severity of the other.[xxvi]

Information on skipping meals is significant, even in the presence of HOPE IV, because in-home services that deliver meals and assist with food preparation often cover only one meal per day, with no service on the weekends.

Between the baseline and follow-up periods, the participants faired better than the comparison group according to these two measures of nutritional well-being. The percentage of participants reporting substantial weight loss or gain fell from 39 percent to 26 percent, versus 39 percent to 34 percent for the comparison group. In addition, fewer participants than comparison group members reported skipping meals at follow-up, 13 percent versus 20 percent.

5.2.2 Health Conditions

Consistent with their overall health status, participants and the comparison group reported having had many chronic health conditions. However, the prevalence rates changed very little over time, given the long-term nature of these medical impairments. Table 5-8 shows the range of these health conditions (based on what their doctor or other health professional had told them) and the extent to which at least one had worsened during the past year. Seventy-one percent of participants reported having had

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[xxiv] Codispoti, M.S. and Barlett, B.J., *Food and Nutrition for Life: Malnutrition and Older Americans*, (Administration on Aging, U.S. Department of Health and Human Services, Washington, D.C., 1995).

[xxv] Burt, M.R., *Hunger Among the Elderly: Local and National Comparisons, Final Report of a National Study on the Extent and Nature of Food Insecurity among American Seniors*. Washington, D.C.: The Urban Institute, 1993.

[xxvi] Berg, R.L. and Cassells, J.S. (eds.), *The Second Fifty Years: Promoting Health and Preventing Disability*, (Institute of Medicine, National Academy Press, Washington, D.C., 1990).

arthritis and more than half said they had high blood pressure. Forty-five percent of participants indicated having had a heart condition, and 42 percent reported having had pneumonia or other respiratory disease. About half of the participants said they had other conditions, the most frequent of which were a digestive disease, bone or joint problems, cataracts or other eye problems, cancer, circulatory problems, and back problems. Nearly 50 percent of participants said that at least one condition had worsened during the past year, most frequently arthritis and respiratory conditions.

Table 5-8.
Health Characteristics:
Health Conditions

	Participant (%)		Comparison Group (%)	
Conditions	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Arthritis	71	77	80	78
Hypertension	53	56	56	57
Heart Disease	45	48	48	49
Respiratory	42	38	45	40
Osteoporosis	24	26	24	24
Diabetes	19	19	25	26
Stroke	18	18	18	21
Arteriosclerosis	14	16	14	16
Broken hip	11	15	12	13
Parkinson's Disease	2	2	2	3
Other	53	74	53	64
Worsened in past year	46	51	54	53

5.2.3 Frequency of Falls

HOPE IV requires that, despite their frailty, participants must be able to live independently in the community, given the tenant-based and scattered-site nature of their rental assistance. Even with the case management and personal assistance HOPE IV provides, participants will spend considerable time alone in their home. For a frail elderly population, the risk of falls is always present and a potential source of injury. As Table 5-9 shows, over 40 percent of participants reported having fallen during the past year. Of all participants, 18 percent said they fell once in the last year, while over one-fifth reported falling more than once during this period. Among all participants, nine percent sustained a broken bone, and six percent received a head injury as a result of falls. Twenty-two percent sought medical care as a result of falling, and nine percent were hospitalized for more than one day due to a fall. The baseline comparison group rates were nearly identical for all these items, confirming the similarity of the two groups in this area as well. The

percentage of each group reporting a fall during the past year remained essentially unchanged between baseline and follow-up.

Table 5-9.
Health Characteristics:
Frequency of Falls

Characteristics	Participant (%)		Comparison Group (%)	
	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Fallen during past year	42	43	40	40
Number of times:*				
Once	18	20	16	14
Twice	8	8	8	7
More than two	13	9	14	14
Unknown	3	6	2	5
Type/degree of injury:*				
Broken bone	9	9	7	8
Head injury	6	6	8	4
Sought medical care	22	21	22	20
Hospitalized over 1 day	9	7	6	7

* Percent of all persons.

5.2.4 Medical Care Access and Use

Despite their high level of frailty and overall poor health, the majority of the HOPE IV participants, at baseline, were not confined to bed or a chair at all during the past month, saw a doctor four times or less during the past year, and did not need to use a hospital emergency room or stay in a hospital overnight at all during the last 12 months. However, nearly half of the participants had used a hospital emergency room at least once, and over 40 percent had stayed overnight as a hospital in-patient over the past year. The latter is a rate twice that for the elderly household population as a whole.[xxvii] About one-quarter of participants saw a medical doctor once during the past year, another 37 percent saw a doctor two to four times, and 17 percent saw one more than four times. Just eight percent of participants, however, stayed at least one night in a nursing home during the past year. (See Chapter 7 for nursing home placement rates for those who left HOPE IV and Section 8.)

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

Disability days, that is the number of days a person stayed in bed or a chair most of the time due to a health problem, represent a common health status measure. *Sixty percent of the participants reported no disability days at all, and virtually all the participants (95 percent) reported having a usual source of health care.* However, 36 percent of participants stayed in bed or a chair most of the day at least once during the past month due to a health problem, including four percent for one to three days, six percent for four to nine days, and eight percent for 10 to 29 days. Of particular importance is that nearly one fifth (18 percent) of participants reported staying in bed or a chair most of the time for the entire month prior to the survey due to a health problem. This group reported lower levels of well-being regarding other measures as well. For example, they had a mean of 2.9 ADL limitations, compared to 1.9 for participants overall (using the measures in Table 5-1), and nearly 80 percent of this group reported fair to poor health, compared to 58 percent for all the HOPE IV participants.

Table 5-10.
Health Characteristics:
Health Care Utilization

	Participant (%)		Comparison Group (%)	
Characteristics	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
During past year:				
Used hospital emergency room	48	38	42	40
Was overnight hospital patient	42	31	34	36
Stayed in a nursing home	7	7	6	5
Saw a doctor:				
Did not see a doctor	17	19	16	18
Once	26	32	30	32
2 to 4 times	37	38	37	38
More than 4 times	17	9	15	10
Don't know	3	2	2	3
During past month:				
Stayed in bed or chair most of the time due to health problem:				
No days	61	73	60	64
1 to 3 days	5	4	8	4
4 to 9 days	6	4	7	4
10 – 29 days	8	3	6	6
30 days	16	11	14	17
Don't know	3	4	5	5

Has usual source of medical care	95	96	94	96

For nearly every health indicator, as Tables 5-7 through 5-10 present, the baseline participant and comparison group profile is almost identical. Prior research shows the consistently strong correlation between frailty and various other measures of health status. Having only screened comparison group members for similarity with participants based on age and limitations in activities of daily living, it is not surprising that other measures, such as health status, are similar as well.

Changes between the baseline and follow-up surveys, however, occurred differentially among the participants and comparison group members, for several of these health characteristics. For example, use of a hospital emergency room decreased from 48 percent to 38 percent for participants versus a drop of only two percent for the comparison group. The percentage of participants with an overnight hospital stay dropped from 42 percent to 31 percent versus a slight increase for the comparison group. Finally, fewer participants stayed in bed or a chair most of the time at baseline than at follow-up (16 percent versus 11 percent). For the comparison group, the rates increase slightly from 14 percent to 17 percent.

5.2.5 Mental Health, Quality of Life, and Cognitive Status

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

In spite of their poor health and frailty, most of the participants report the quality of their lives to be relatively high, although this was not the case for all. Table 5-11 presents five measures of life satisfaction. Over one-third of the HOPE IV participants responded at baseline that they were, in general, very satisfied with the way their life is going, and 45 percent indicated they were somewhat satisfied with life. Almost one-fifth, however, said they were not satisfied. Most participants (56 percent) said they had a great deal of choice about what they do and when they do it, and over half reported they were very confident about their ability to deal with daily living. Almost half said they do not worry at all about whom to turn to for help, and over 50 percent reported their appetite as good. However, 17 percent said they worry at lot of the time about not knowing whom to turn to for help, and 45 percent said their

appetite was only fair to poor. Consistent with the patterns in physical measures presented thus far, the comparison group reports similar baseline rates of life satisfaction for all these items.

Table 5-11. Measures of Life Satisfaction				
	Participant (%)		Comparison Group (%)	
Quality of Life Measures	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
Life satisfaction:				
Very satisfied	36	32	32	28
Somewhat satisfied	45	50	47	52
Not satisfied	19	16	18	18
Unknown	1	1	3	2
Amount of choice:				
A great deal	56	48	50	55
Some	34	43	37	35
None	8	7	10	9
Unknown	1	2	2	2
Confidence:				
Very confident	51	48	49	47
Somewhat confident	40	39	43	44
Not confident	7	10	6	6
Unknown	2	2	2	3
Amount of worry:				
A lot	17	11	18	18
Some	35	32	34	28
Not at all	47	55	47	52
Unknown	1	2	1	2
Appetite:				
Good	54	61	53	57
Fair	32	32	35	34
Poor	13	7	12	9
Unknown	1	1	1	0

Between baseline and follow-up, these patterns remained very similar. Both participants and comparison group members, overall, continued to report high levels of well-being. Chapter 7 explores similarities and differences in these patterns for subgroups of participants and comparison group members.

Participants describe themselves as generally happy, peaceful and calm, and many said they were full of life most or all of the time. However, only a few participants reported having lots of energy, and many felt worn out or tired most or all the time. Table 5-12 provides several measures of vitality and mental health using positive and negative indicators about participant feelings. Thirty-seven percent of participants said they felt full of life most or all the time during the past 30 days, and about 60 percent said they were a happy person or felt calm or peaceful most or all of the time during that period. Few of the participants (14

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

Table 5-12.
Measures of Vitality and Mental Health

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

Between baseline and follow-up, both participants and comparison group members reported similar, but often relatively small, changes in well-being. For example, those who reported feeling full of life dropped from 37 percent to 27 percent for participants and from 33 percent to 28 percent for the comparison group. While simple frequencies show little change over time and few differences between the participants and comparison group members, the analysis in Chapter 7 shows that there is a significant positive correlation between HOPE IV participation and receipt of services and between receipt of services and positive responses to these measures of well-being.

Cognitive functioning is an important determinant of risk for institutionalization and ability to function independently in a community-based, long-term care program such as HOPE IV. Generally, participants and comparison group members had few incorrect responses to questions that served as

indicators of mental status. Table 5-13 presents the rates of incorrect responses to six questions, as a measure of cognitive status: the current year, season, date, day of the week, state of residence, and county of residence. At baseline, 63 percent of the participants and 66 percent of the comparison group members answered all items correctly, while 30 percent of participants and 23 percent of the comparison group made one incorrect response, virtually all of which was reporting the incorrect date. The remaining seven percent of participants and 10 percent of the comparison group had either two or three incorrect responses.

Table 5-13.
Cognitive Status

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

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

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

Measures of mental health and cognitive status are extremely difficult to interpret, and researchers are only beginning to develop methods for scoring and aggregating responses to such questions to ascertain overall well-being.[xxviii] The major application of these measures occurs in Chapter 7 when scoring and analyzing data from the baseline and follow-up interviews to determine changes over time, between the participants and comparison group members, and the relationship between positive scores and participation in HOPE IV.

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

6. INFORMAL ASSISTANCE, SOCIAL SUPPORT, AND SERVICE UTILIZATION

This chapter treats two main topics: the extent, sources, and patterns of informal assistance and social support received by the HOPE IV participants and comparison group members and their utilization of services. The first part of the chapter, focusing on social support, compares the frequency with which HOPE IV participants and comparison group members saw or spoke on the telephone with relatives, friends, and neighbors at baseline and at follow-up. It also describes the HOPE IV participants' and comparison groups' satisfaction with the amount and quality of their social activity, as well as the availability and accessibility of help in emergency situations, at baseline and follow-up. The second part of the chapter describes the patterns of service utilization of both groups at baseline and follow-up. It compares the specific supportive services received, how often and for how long they were received, as well as both participants' and comparison group members' satisfaction with these services and assessment of which additional services they believed they still needed. In addition, the latter part of the chapter considers the extent to which the comparison group was receiving case management services similar to those provided to HOPE IV participants.

6.1 The Importance of Informal Assistance and Social Support

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

To ascertain the level and kinds of social support they were receiving both at baseline and follow-up, HOPE IV participants and comparison group respondents were asked in each round about the

frequency and patterns of their informal social contacts with relatives, friends, and neighbors. These data will allow us to compare the two groups at both points in time and to assess the impact, if any, of program participation on the HOPE participants' social contacts.

6.1.1 Frequency and Nature of In-Person Social Contacts

On the whole, both the frequency and pattern of social contacts reported at baseline as well as at follow-up are remarkably similar for HOPE IV participants and comparison group members. At baseline, 82 percent of both the HOPE IV and comparison group respondents reported seeing another person—whether a family member, friend, or neighbor—on a regular basis at least once a month. Eighteen percent of both groups said they saw no one monthly except for service personnel or others living in their households. The percentages for both groups were identical at follow-up: 82 percent of both participants and comparison group members said they had regular in-person social contact with another person at least once monthly, 18 percent indicated they did not.

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

As presented in Table 6-1, at baseline, most HOPE IV respondents and comparison group members showed a bimodal pattern of seeing a child either less than once a month or several times a week or more. Forty-seven percent of HOPE IV and 51 percent of comparison group respondents saw a child less than once a month. By contrast, 26 percent of HOPE IV respondents saw a child three or more times a week, and 12 percent saw a child on a daily basis. The same figures for the comparison group

were 17 percent, and 18 percent, respectively. Thus, the main, relatively minor, difference between the two groups at baseline was that a slightly higher percentage of comparison group members than HOPE IV participants saw a child every day. This might reflect that HOPE IV was targeted to the frail elderly with more limited support available from family members or others living in close proximity.

Table 6-1.
Monthly Frequency of Different Types of In-Person Social Contacts for HOPE IV and Comparison Group Respondents at Baseline and Follow-Up

Baseline Times per month regularly sees . . .	Participant *(n=541)*				Comparison Group *(n=523)*			
	Child (%)	Other relative (%)	Friend or neighbor (%)	Anyone (%)	Child (%)	Other relative (%)	Friend or neighbor (%)	Anyone (%)
Less than once (0-<1)	47	74	57	21	51	70	55	20
A few times (1-3)	4	5	3	3	4	4	3	3
Once or twice a week (4-7)	12	7	4	9	10	7	6	8
Several times a week (8-27)	26	10	14	31	17	10	15	24
Every day (28+)	12	4	22	37	18	9	22	45
Follow-Up	Participant *(n=286)*				Comparison Group *(n=323)*			
Less than once (0-<1)	43	76	56	19	45	70	61	19
A few times (1-3)	6	6	3	3	4	4	2	3
Once or twice a week (4-7)	15	6	5	10	13	7	4	9
Several times a week (8-27)	19	7	13	29	19	9	14	26
Every day (28+)	17	6	24	39	20	10	19	43

The same basic bimodal pattern of contact with children characterized both groups at follow-up. The percentage of those with less than monthly contact declined slightly, from 47 percent to 43 percent for participants, and 51 percent to 45 percent for comparison group members. At the opposite end of the spectrum, the percentage of those reporting daily contact with children rose from 12 percent to 17 percent for participants and 18 percent to 20 percent for comparison group members. Again, the already small disparities between the two groups lessened between baseline and follow-up. *Moreover, there is no indication that participation in HOPE caused a decline in average frequency of in-person contact with children between baseline and follow-up.*

Neither group had frequent contact with relatives other than children at either baseline or follow-up. At baseline, 74 percent of HOPE IV respondents and 70 percent of comparison group members reported seeing a relative other than a child once a month or less. At follow-up, the percentages were 76 percent and 70 percent, respectively. At the opposite end, at baseline, somewhat more comparison group members (nine percent) than HOPE IV respondents (four percent) reported seeing such a relative every day; at follow-up, slightly higher percentages of both groups (six percent of participants, and 10 percent of comparison group members) indicated having daily in-person contact with a relative other than a child.

For both groups, at both baseline and follow-up, the distribution of in-person contact with friends and neighbors is somewhat more skewed than is contact with children. At baseline, 57 percent of HOPE IV and 55 percent of comparison group respondents did not see a friend or neighbor at least once a month, while 22 percent of both groups did so every day. At follow-up, 56 percent of participants and 61 percent of comparison group members indicated seeing a friend or neighbor less than once a month, while 24 percent or HOPE IV participants and 19 percent of comparison group members reported daily contact with a friend or neighbor. While the patterns are quite similar for both groups at both points in time, it is interesting that there was a small increase in the frequency of such contact for HOPE IV participants between baseline and follow-up.

Not only is the pattern of in-person social contact again remarkably similar for the two groups at follow-up, but it appears that the already minor differences between participants and comparison group members in intensity of informal contacts dwindled even further in the two years between baseline and follow-up. At baseline, 21 percent of participants and 20 percent of comparison group members reported no regular in-person informal monthly contact, while 45 percent of comparison group members and 37 percent of HOPE IV participants said they saw another person on a daily basis. At follow-up, 19 percent of participants and comparison group members said they did not see anyone at least once a month. However, the percentage of those reporting that they saw someone on a daily basis rose slightly (from 37 percent to 39 percent) for participants and declined slightly (from 45 percent to 43 percent) for comparison group members. Again, what deserves most emphasis is the striking similarities between the two groups at both baseline and follow-up.

In a question designed primarily with the follow-up survey in mind, HOPE IV participants were also asked if the frequency of their in-person contacts had changed since they entered HOPE IV. For obvious reasons, no similar question was posed to the comparison group. Since most respondents had

been in HOPE IV for just a brief while (a few months at most) at the time of the baseline interview, it seemed unlikely we would notice any change at that point. As shown in Table 6-2, for the most part, at baseline, participants indicated no change in frequency of contacts since they began in the HOPE IV program: 65 percent of contacts with children, 69 percent of those with another relative, and 59 percent of contacts with friends and neighbors had remained the same. Moreover, as Table 6-2 shows, for the smaller percentage of cases for which changes were reported at baseline, there were more increases than decreases in contact.

Table 6-2.
Changes in Frequency of In-person Contacts Since Entering HOPE IV Program at Baseline and Follow-Up

	Since entering HOPE IV, percentage of contacts that have . . .		
Baseline Contacts with . . .	Decreased (%)	Stayed the same (%)	Increased (%)
Child	11	65	24
Other family member	10	69	21
Friend/neighbor	10	59	31
Overall	10	64	26
Follow-Up			
Child	5	85	10
Other family member	1	88	11
Friend/neighbor	3	76	21
Overall	3	83	14

The more important question is whether this pattern of sustained or increased in-person contact was maintained over the next two years. In fact, as shown on the lower portion of Table 6-2, at follow-up, the participants' responses were even more clear-cut. Participants indicated that 85 percent of contacts with children, 88 percent of contacts with other family members, and 76 percent of contacts with friends and neighbors had stayed the same since they entered the HOPE IV program. Of those reporting a change, it was once again in the direction of increased contact with all three categories of persons. Only a tiny percentage of contacts had declined. *Thus, participation in HOPE IV did not lessen (and in a small percentage of cases even increased) the frequency of informal in-person social contact.* It appears that no "substitution effect" was operating; that is, receipt of formal services through HOPE IV did not cause children—or others— to visit the participants less often.

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

Thus, HOPE IV participants were also queried both at baseline and at follow-up about what they usually do when their children, other relatives, and friends and neighbors come to visit. Their answers covered a broad span of activities, from helping with housework to running errands, eating out, or attending social functions together. While there does seem to be a division of activities according to the type of visitor, *at both baseline and follow-up, the most frequently named activity by far across all categories of visitors was spending time informally talking and visiting with the participant.* However, at baseline, children were next most likely to take the participant shopping or go shopping for the participant; at follow-up, children were next most likely to take the respondent shopping or help with household activities. By contrast, at baseline, after informal talking and visiting, the next most frequently named activities with other relatives were to attend social functions with the participant, or go out to eat with or go shopping for the participant. At follow-up, other relatives were next most likely to help with the household or take the respondent shopping. For friends and neighbors, at baseline, playing games with the participant and going out to eat together ran a far second and third to informal socializing; at follow-up, taking the participant shopping and going out to eat together were named as the second and third most frequent activities. Again, it should be emphasized that spending time chatting and visiting informally was named much more frequently than any other single activity across the board.

At follow-up, the vast majority of HOPE IV participants reported no change in the nature of their activities with their visitors since entering the Program. Ninety percent said they do the same activities with their children, 95 percent do the same things with other relatives, and 87 percent do the same things with friends and relatives who come to visit.

6.1.2 Telephone Contact

In an increasingly mobile society, when elderly persons may live far from family and friends, keeping in touch by telephone is another important form and source of social contact. The frequency of telephone contact with relatives and friends was very similar for HOPE IV participants and comparison group respondents, both at baseline and follow-up. Both at baseline and at follow-up, about three-quarters of both groups reported speaking to someone on the phone on a regular basis, while roughly one-quarter said they did not. At baseline, 37 percent of participants and 39 percent of comparison group members, and at follow-up, 30 percent and 36 percent, respectively, indicated they spoke with someone on the phone every day.

In terms of average monthly frequency of phone contacts, at baseline, participants had somewhat more contacts with their children than did comparison group members. HOPE IV participants had an average of 10.3 and comparison group members an average of 9.7 such telephone contacts each month. By contrast, on average, comparison group members at baseline had more telephone contacts with relatives other than children (5.2 versus 3.6 times per month) and with friends (8.3 versus 6.2 times per month). At follow-up, the pattern of phone contact with children was reversed. Participants reported 9.4 telephone contacts with children per month, a decline from 10.3 since baseline; comparison group members reported an increase, from 9.7 to 11.5 such contacts, during that same period. As was true at baseline, at follow-up, comparison group members continued to have somewhat more frequent telephone contact with other relatives (an average of 4.3 versus 3.0 contacts each month), but HOPE IV participants now reported slightly more frequent phone contact with friends than did comparison group members (6.4 versus 5.7 times per month).

Overall, at baseline, participants had an average of 20.1 monthly phone contacts and comparison group members an average of 23.2 such contacts. At follow-up, the average number of such contacts declined slightly for both groups: to 18.8 for participants and 21.7 for comparison group members. While these numbers point to small relative declines in overall frequency of telephone contact for both groups between baseline and follow-up, on average, both groups had telephone contact with another person roughly two out of three days in a month.

As with in-person contacts, the two groups were characterized by a bimodal pattern of either very infrequent or quite frequent telephone contacts with children both at baseline and at follow-up. As shown in Table 6-3, at one end of the spectrum, a little over half of both groups reported less than monthly phone contact with their children. At the other end of the spectrum, at baseline, a total of 38 percent of HOPE IV participants and 36 percent of comparison group members reported phone contact with children several times a week or more, with 22 percent of participants and 20 percent of comparison group members indicating daily phone contact. At follow-up, an even higher percentage of both participants and comparison group members (41 percent) reported phone contact with their children several times a week or more. Between baseline and follow-up, the percentage of those indicating daily phone contact with children declined slightly, from 22 percent to 15 percent, for participants, but remained the same (20 percent) for comparison group members.

Table 6-3.
Monthly Frequency of Telephone Contacts for HOPE IV and Comparison Group Respondents at Baseline and Follow-Up

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

As seen in Table 6-3, for both groups, phone contact with other relatives as well as with friends and neighbors is less frequent than with children and declined slightly between baseline and follow-up. At baseline, 74 percent of participants and 70 percent of comparison group members reported less than monthly phone contact with relatives other than children. At follow-up, the corresponding percentages are 76 and 74, respectively. Overall, the pattern of phone contacts with friends and neighbors is similar to that for other relatives, except that a somewhat higher percentage of both groups reported daily phone contact with friends and neighbors both at baseline and follow-up.

6.1.3 Informal Contacts: A Summary

At baseline, comparison group members tended to have slightly more frequent in-person interaction with their children, while participants had slightly more frequent telephone contact with theirs. In the second interim report, in interpreting these findings, we reasoned that more frequent telephone contact might be compensating for less frequent in-person contact, especially when physical distance

would make it impossible for a child to make frequent in-person visits to an elderly parent. We also considered the possibility that shifts in patterns of contact had occurred as a result of the moves many participants had made in order to enter the Program. Two years later, comparison group members, on average, still had slightly more frequent in-person contact with their children than did participants, but the differences between the two groups had narrowed (10.1 as against 9.0 times per month). However, although the frequency of phone contacts had declined for both groups since baseline, at follow-up the comparison group had slightly more frequent telephone contact with children (an average of 20.8 as against 18.9 contacts per month) than did the participants. *Overall, both the frequency and pattern of in-person and telephone contact with children is even more similar for both groups at follow-up than it was at baseline. This may be due to a "normalization" of social contacts with children after an initial period of adjustment to the HOPE IV Program for some participants. Similarly, not only was there remarkable similarity between groups in both in-person and telephone contacts with all groups at both points in time, but there was remarkably little change between baseline and follow-up.*

6.1.4 Level of Satisfaction with Social Activities

Because of varying perceptions of what constitutes a satisfactory level of social contact, different individuals may express rather different degrees of satisfaction with the same frequency of visits and telephone calls. For example, some elderly respondents may feel quite satisfied with seeing a child once or twice a month, whereas others may be unhappy with anything less than daily visits. Similarly, getting out of the house twice a month may be quite satisfactory for some, but not nearly enough for others. To gauge this more subjective aspect of social support and sociability, HOPE IV participants and comparison group respondents were asked both at baseline and at follow-up about the quality of their social ties and how they assessed their current level of social activity.

Considering their frailty, both at baseline and follow-up, HOPE IV participants and comparison group respondents enjoyed fairly full social lives, with which most were reasonably satisfied. Overall, both groups were slightly more socially active and more satisfied with their social lives at follow-up than they were at baseline. At baseline, 42 percent of HOPE IV respondents and 37 percent of comparison group members had participated in some kind of social activity outside their home in the two weeks prior to the interview. At follow-up, 46 percent of participants and 42 percent of comparison group members had done so. Forty-two percent of participants and 44 percent of comparison group members at baseline were satisfied with their then current level of social activity; somewhat less than half of both groups would have liked to be doing more socially. At follow-up, the percentage of those

satisfied with their current level of social activity rose to 56 percent for both participants and comparison group members. Forty percent of participants and 38 percent of comparison group members reported a desire for more social activity.

At baseline, about half of both HOPE IV participants and comparison group members said they saw their relatives and friends about as often as they wanted, and another third of both groups was only somewhat unhappy about how little they saw relatives and friends. About 10 percent of both groups said they were very unhappy with the frequency of their social contacts, and only a small number of participants (barely one percent) reported they had no one to see. At follow-up, the pattern had shifted slightly relative to baseline: a somewhat lower (45 percent) percentage of both groups indicated seeing their friends and relatives as often as they want, while a slightly higher percentage (43 percent of participants and 41 percent of the comparison group) said they were somewhat unhappy about how little they saw their relatives and friends. About 10 percent of both groups again reported being very unhappy with how little they saw friends and relatives.

Along a slightly different dimension*, both at baseline and at follow-up, neither HOPE IV nor comparison group respondents reported high levels of loneliness, and almost all in both groups had at least one confidante. In fact, both groups reported feeling somewhat less lonely at follow-up, while the already high percentage of HOPE IV participants with a confidante rose slightly between baseline and follow-up.* At baseline, although 20 percent of the HOPE IV respondents and 17 percent of comparison group members said they felt lonely quite often, 41 percent and 42 percent of both groups said they felt this way sometimes and another 38 percent of HOPE IV respondents and 40 percent of the comparison group almost never felt lonely. At follow-up, the percentage of those reporting frequent feelings of loneliness declined for both groups; only 13 percent of both HOPE IV participants and comparison group members reported feeling lonely quite often. A slightly higher percentage, roughly half of both groups, now said they feel lonely sometimes, and 35 percent and 38 percent, respectively, indicated they almost never feel lonely. At both points in time, the vast majority of both groups reported having someone they trust and in whom they can confide. At baseline, about 87 percent of HOPE IV respondents and 91 percent of comparison group members said they had such a person. At follow-up, the percentage of participants reporting they have someone whom they trust and in whom they can confide rose to 92 percent for participants and remained more or less the same (90 percent) for comparison group members.

Thus, at both points in time, the HOPE IV respondents and comparison group members were quite alike in having a confidante and reporting relatively infrequent feelings of loneliness. Moreover, the

already very small differences between the two groups at baseline disappeared by follow-up. Again, this may reflect that after two years in the HOPE IV program, most participants had the time to adjust to their new social surroundings and the opportunity to establish contacts with neighbors.

Overall, it seems clear that, over the long run, participating in the HOPE IV Program has not had a negative effect on the participants' social lives and social well-being. If anything, this aspect of their lives may have been enhanced by participation.

6.1.5 Getting Help in an Emergency

Enjoying reasonably frequent social contact, not feeling lonely very often, and having a confidante do not necessarily mean that HOPE IV participants or comparison group members could have been reached quickly during an emergency, or that someone would have been available to take care of them during protracted illness or convalescence. Both sets of surveys also addressed this important issue of accessibility and availability of help in emergencies. At baseline, for somewhat less than half of HOPE IV respondents and comparison group members a relative, most often a child, would be the first person they would have called in case of an emergency. For a slightly higher percentage of participants (46%) and comparison group respondents (51%), a relative—again, overwhelmingly, a child—would be the second person they would have called under these circumstances. At follow-up, slightly higher percentages of both groups indicated that a relative—again, most often a child—would be the first (45% of participants and 56% of comparison group members) and second (49% of participants and 52% of comparison group members) person they would have called in an emergency. At baseline, about a third of both groups indicated the first number called would be 911; at follow-up, this was true of about 30 percent of participants and roughly one quarter of comparison group members. For both groups, both at baseline and follow-up, calling a friend or neighbor was the third, albeit much less frequent response, for both the first and second person they would call. All other answers were spread thinly over several categories, including physician, nurse, apartment manager, HOPE IV Service Coordinator, and others.

As shown in Table 6-4, in terms of how long it would have taken the first person they called to reach their home in an emergency, at baseline, about 82 percent of responding participants and 83 percent of responding comparison group members reported that someone could have been there within 15 minutes. Ninety-five percent of both groups indicated someone could have reached them in 30 minutes or less. At follow-up, the percentages of respondents in both groups who said someone could have gotten to their home within 15 minutes rose slightly, to 88 percent and 86 percent, respectively, and the percentages

of those saying someone could have reached them in a half hour or less, rose to 97 percent for both groups. Thus, at both points in time, nearly everyone had someone who could have reached them within 30 minutes.

Table 6-4.
Time Required to Reach HOPE IV Participants' and Comparison Group Members' Homes in an Emergency

	Participant		Comparison Group	
Amount of Time	Baseline *(n=465*)* (%)	Follow-up *(n=260*)* (%)	Baseline *(n=463*)* (%)	Follow-up *(n=296*)* (%)
1 – 15 minutes	82	88	83	86
16 – 30 minutes	13	9	12	9
31 – 45 minutes	1	0	0	0
46 minutes to 1 hour	0	0	0	1
Over 1 hour	4	3	4	3
Total	100	100	100	100

*Excludes don't know and non-responses.

Although the vast majority of HOPE IV participants and comparison group members could have been reached relatively quickly in an emergency, only about one-quarter of the participants and one-third of the comparison group respondents had someone who would have been able to provide sustained help during an illness or other emergency. At baseline, slightly less than half (47 percent) of the HOPE IV and just over half (52 percent) of comparison group respondents said they had someone who could have taken care of them or helped them at home if they were sick or needed assistance. At follow-up, those who reported having someone who could have taken care of them fell a bit, to 42 percent for participants, and remained more or less the same (53 percent) for comparison group members. Moreover, both at baseline and at follow-up, just about one-quarter of HOPE IV participants and one-third of comparison group members indicated this person could have helped as long as needed. Most of the others replied that the person would have been able to assist just for a week or less, or only "now and then."

6.2 Service Utilization

This section of the chapter compares the service utilization of HOPE IV participants and comparison group respondents at baseline and follow-up. More specifically, it compares the two about the specific supportive services they received, how long they had been getting each service, how often they received it, and how satisfied they were with the service. In addition, this section examines the extent to which comparison group members were receiving some type of informal or formal case management, as well as the source of any such case management services, how long they had been receiving these services, and how often they received them. *Since comparison group selection did not permit screening out frail elderly Section 8 tenants who might be receiving services similar to those*

provided under HOPE IV, comparing the two groups on service utilization as well as receipt of case management is critical to the quasi-experimental study design.

Service categories are defined as follows in the survey instruments: (1) housekeeping services, such as help with laundry, dishes, running errands, or housecleaning; (2) transportation services, such as providing a car, van, or escort to take the respondent shopping or to appointments; (3) home-delivered meals, or sending someone to prepare meals in the respondent's home; (4) in-home health services, such as a nurse or health aide who checks on the respondent's health, provides medications, or bathes the respondent; (5) personal care services, including assistance with grooming, dressing, eating, toileting, or getting around in the home; (6) meals at a senior center or other site; (7) recreational services, such as participating in activities at a senior center or having someone conduct friendly visits with the respondent in her home; and (8) counseling services, or help with mental health or emotional issues from a professional. An example would be provision of counseling on loss of a spouse.

6.2.1 Services Received

Table 6-5 presents the supportive services received by HOPE IV participants at baseline and at follow-up, in order of relative frequency, along with the percentage getting each type of service at both points in time. Table 6-6 presents the same information for comparison group members. At both baseline and follow-up, the highest percentage of both groups received housekeeping services, but there was quite a disparity in the percentages of each group actually getting the service. At baseline, 80 percent of participants and 49 percent of comparison group members reported they got housekeeping services (a difference of 31 percent between groups); at follow-up, the percentages had risen very slightly, to 84 percent, and 51 percent, respectively (a difference of 33 percent between groups). Transportation was the second most frequently received service for both groups at both points in time. At baseline, 46 percent of participants and 32 percent of comparison group members got transportation services (a between-group difference of 14 percent); at follow-up, the percentage of participants receiving transportation services increased slightly, to 50 percent, while the percentage of comparison group members getting these services dropped slightly, to 24 percent (a between-group difference of 26 percent). Home-delivered meals are the third

Table 6-5.
Services Received by HOPE IV Participants
(in order of relative frequency)

Service	Percent Receiving Baseline *(n=543)*	Percent Receiving Follow-Up *(n=286)*
Housekeeping	80	84
Transportation	46	50
Home delivered meals	38	40
In-home health	29	37
Personal care	25	33
Miscellaneous other (food stamps, emergency beeper)	16	16
Meals at senior center	13	10
Recreational	14	14
Counseling	6	5

category of services for which there are differences between the groups: 38 percent of participants at baseline and 40 percent of participants at follow-up received home-delivered meals; the corresponding percentages for the comparison group were 24 percent and 27 percent, a between-group difference of 13 percent - 14 percent. Apart from somewhat different relative rankings for other services, the other main difference between the groups at both points in time was that a somewhat higher percentage of HOPE IV participants received most other types of service, with roughly equal percentages getting personal care and in-home health services.

Table 6-6.
Services Received by Comparison Group Members (in order of relative frequency)

Service	Percent Receiving Baseline *(n=523)*	Percent Receiving Follow-Up *(n=324)*
Housekeeping	49	51
Transportation	32	24
In-home health	29	36
Personal care	26	31
Home delivered meals	24	27
Miscellaneous other (food stamps, emergency beeper)	13	10
Recreational services	10	8
Meals at senior center	10	7
Counseling	4	7

However, even though a higher percentage of participants received most types of services, comparison group members getting services received them with greater average frequency. This was even truer at follow-up than at baseline. As shown in Table 6-7, at baseline, HOPE IV participants and comparison group respondents who got transportation and home-delivered meals did so with roughly the same average frequency of about six times a month for transportation and about 21 days a month for home-delivered meals. Those in both groups who received recreational services also got them equally often (10 times per month). However, comparison group respondents received personal care, in-home health, and housekeeping services with greater average frequency than HOPE IV participants. The only services participants received more often than the comparison group, on average, were meals at senior centers (14.3 versus 11.5 times a month) and counseling (3.9 versus 2.0 times a month). At follow-up, as shown in Table 6-8, the only services that participants got more frequently than comparison group members were home-delivered meals (a minor difference of less than one day per month) and meals at a senior center (14.9 versus 12 times per month). Comparison group members, on average, received transportation, personal care, and in-home health, housekeeping, and recreational services more often than participants. For several key support services, namely, personal care (a difference of three days per month), in-home health (a difference of 1.4 days per month), and housekeeping (a difference of 3.9 days per month), the between-group differences were considerable.

Table 6-7.
HOPE IV Baseline: Length of Receipt, Average Monthly Frequency of Receipt, and Satisfaction with Specific Services

Participants *(n=543)* Service	% Receiving	For How Long (%) Less than 6 months	6 months to 1 year	Over 1 year	Average Frequency (days per month)	% Very Satisfied
Transportation	46	42	24	3	5.9	66
Home-delivered meals	38	56	26	16	21.1	69
Meals at senior center	13	45	26	26	14.3	71
Personal care services	25	64	21	15	12.7	88
In-home health	29	57	17	24	7.2	85
Housekeeping	80	61	21	17	8.0	79
Counseling	6	34	17	49	3.9	63
Recreational services	14	42	23	33	10.0	81
Comparison Group *(n=523)*						
Transportation	32	8	10	80	6.1	73
Home-delivered meals	24	16	17	65	21.0	76
Meals at senior center	10	6	10	84	11.5	80
Personal care services	26	18	15	67	15.7	85
In-home health	29	20	19	57	8.1	90
Housekeeping	49	18	16	65	11.0	78
Counseling	4	24	14	62	2.0	52
Recreational services	10	12	8	81	10.0	79

Predictably, the percentage of HOPE IV participants who reported receiving each type of service for one year or more rose substantially between baseline and follow-up. At the time of the baseline interview, participants were only just entering the HOPE IV Program, so most reported receiving most types of service for less than six months. The exceptions, particularly services the participants said they had been receiving for over one year, probably represented non-HOPE services or services provided through other channels prior to their entrance into the Program.

By contrast, the percentage of comparison group members reporting they had received services for over a year rose only slightly between baseline and follow-up. At baseline, a sizeable percentage of comparison group members had already indicated they had been getting their services for over one year. This is understandable, in light of the fact that most had been residing in their housing for quite some time and so, presumably, had had the time to establish a service network.

It is clearly a result of Program participation that, at follow-up, a higher percentage of participants than comparison group members reported receiving every category of service except counseling for one year or more. Nevertheless, the differences between the two groups at follow-up are not great, as shown in Table 6-8. The vast majority of both participants and comparison group members reported they had been receiving most categories of services for one year or more. *This suggests that there had been few discontinuities or disruptions in service for either group during the two-year period between surveys.*

Table 6-8.
HOPE IV Follow-Up: Length of Receipt, Average Monthly Frequency of Receipt, and Satisfaction with Specific Services

Participants *(n=286)* Service	% Receiving	For How Long (%) Less than 6 months	6 months to 1 year	Over 1 year	Average Frequency (days per month)	% Very Satisfied
Transportation	50	1	6	92	4.5	72
Home-delivered meals	40	2	4	92	22.7	67
Meals at senior center	10	4	4	93	14.9	75
Personal care services	33	2	5	92	14.1	88
In-home health	37	6	10	80	8.2	90
Housekeeping	84	2	5	92	8.8	86
Counseling	5	20	7	73	-	-
Recreational services	14	5	3	90	7.7	87
Comparison Group *(n=324)*						
Transportation	24	9	5	86	5.4	71
Home-delivered meals	27	7	6	85	21.8	78
Meals at senior center	7	4	9	83	12.0	70
Personal care services	31	11	6	83	17.0	89
In-home health	35	11	10	79	9.6	86
Housekeeping	51	9	6	83	12.7	84
Counseling	7	18	0	82	3.0	68
Recreational services	8	16	4	80	9.1	88

To summarize, the major difference in service utilization between the two groups, both at baseline and at follow-up, is that a higher percentage of HOPE participants than comparison group members were receiving most categories of services, with markedly higher percentages of participants than comparison group members getting housekeeping and transportation services. Also, a moderately higher percentage of participants than comparison group members were receiving home-delivered meals, both at baseline and at follow-up. However, the percentages of those receiving two key categories of supportive services—in-home health and personal care—were nearly identical for both groups at both

points in time. Moreover, while the participants enjoyed an apparent advantage in terms of the percentage receiving most services, comparison group members who did get services received them, on average, more often than participants.

Another way of looking at services is to compare the total number and average number of services received by participants and comparison group members at baseline and follow-up. These data are presented in Table 6-9. As shown, the largest differences between the two groups are in the percentages of those indicating they received no services at all. At both baseline and follow-up, a negligible percentage of HOPE IV participants reported receiving no services. By contrast, one-quarter of comparison group members at baseline and nearly one-third at follow-up indicated they did not receive any services whatsoever. Between baseline and follow-up, the average number of services received by participants increased from 2.7 to 2.9, whereas the average for comparison group members remained stationary at 2.0. *Thus, there do seem to be differences between the groups with regard to the average number of services received and the much higher percentage of comparison group members getting no services at all. The segment of the comparison group not receiving any services is the closest we come to a "clean" comparison group of frail, elderly individuals with Section 8 rental assistance, but no supportive services.*

Table 6-9.
Number of Services Received at Baseline and Follow-Up

Number of Services Received	Percent of Participants		Percent of Comparison Group	
	Baseline *(n=543)*	Follow-Up *(n=286)*	Baseline *(n=523)*	Follow-Up *(n=324)*
0	4.0	7.0	26.0	32.0
1 – 2	46.0	39.0	37.0	30.0
3 – 4	37.0	35.0	29.0	28.0
5 +	13.0	19.0	9.0	10.0
Average Number	2.7	2.9	2.0	2.0

6.2.2 Case Management

In addition to providing frail, low-income elderly individuals with Section 8 rental assistance, the other key element of HOPE IV program design is delivery of an individually tailored, case-managed package of supportive services. What is expected to make a difference is not only receipt of services, but also the way service delivery is monitored, to be maximally responsive to changing needs; case management is a critical piece. Thus, to properly evaluate the impact of the HOPE IV program, it is

important to know the extent to which comparison group members receiving supportive services were also getting case management similar to that provided to HOPE IV participants.

In the baseline survey, we asked comparison group respondents whether any person or agency provided them with information about available services and how to access them as well as whether anyone helped them to arrange for and obtain needed services. Nearly half (45 percent) responded that some person or agency provided information, and a similar percentage (44 percent) indicated that they had help arranging for and obtaining needed services. The results of the baseline survey to date (as presented in the Second Interim Report) had suggested that a considerable percentage of comparison group members were receiving supportive services like those provided to HOPE IV participants. Consequently, to be in a better position to compare the two groups, we added several more questions on case management to the comparison group follow-up survey.

At follow-up, about 40 percent of comparison group respondents said that a person or agency currently provided them with information about services and that some person or agency helped them arrange for and get services. As shown in Table 6-10, for the vast majority (84 percent or 106) of these respondents, the source of that help was a professional case manager who worked for an agency rather than a friend or relative. Thus, about one-third of the comparison group respondents at follow-up were receiving professional case management similar to that provided to HOPE IV participants by their Service Coordinators.

Table 6-10.
Comparison Group Source of Help with Case Management
(n=127)

Source of help is:	(%)
. . . a relative, friend, or neighbor	13
. . . someone who works for an organization	84

With respect to frequency of contact with professional case managers, as shown in Table 6-11, most comparison group members receiving professional case management services indicated seeing their case manager either once a month or more (44 percent) or once a year (39 percent), with very little in between. By contrast, for participants (whose corresponding percentages at follow-up are shown in parentheses), the distribution of in-person contact with

Table 6-11.
Frequency of In-Person Contact Between Comparison Group Members and Professional Case Managers*
*(n=87)***

	%
2 or more times/month	16 *(13)*
1 time per month	28 *(39)*
4 – 11 times/year	8 *(13)*
2 – 3 times/year	9 *(14)*
Once a year	39 *(20)*

*Comparable percentages for participants at follow-up are given in parentheses.

**Excludes non-response and don't know responses.

Service Coordinators was less skewed, with a higher percentage (52 percent) indicating monthly contact or more, and a much lower percentage (20 percent) reporting contact of only once a year. As far as how long these comparison group members had been getting help from this same person or agency, of the 98 respondents to this question, 13 percent said they had been receiving case management from this source for less than one year, 14 percent that they had been getting it for one year, and 11 percent, for two years. Thus, at follow-up, just over one-third of these respondents had been getting professional case management services for as much or less time than the HOPE IV participants. *However, fully 61 percent of these comparison group respondents reported having received these services from the same source for three years or more, with one-half of this group saying they had gotten case management from the same person or agency for eight or more years, a few for as many as 15 or 20 years.*

At follow-up, comparison group respondents receiving professional case management were read a list of services and asked to indicate which ones their case managers performed for them. The identical question was posed to HOPE IV participants concerning their Service Coordinators' activities. Table 6-12 presents the comparison group's responses, in order of relative frequency; participant's responses to this question at follow-up are given in parentheses. As shown, the highest percentages of comparison group members named help with providing information and explaining services (83 percent), obtaining and scheduling services (78 percent), and qualifying for services (76 percent). These are the same activities most frequently named by HOPE IV participants, though in different order. But whereas 80 percent of participants indicated help with getting housing or rental assistance as a key Service Coordinator function, only 37 percent of comparison group respondents gave this response. This difference is undoubtedly related to the specifics of the HOPE IV Service Coordinator's role as someone providing linkages both to housing and supportive services. In fact, it is noteworthy that as many as 37 percent of comparison group members reported this as something their case manager did for them. Beyond this, the main differences are that higher percentages of HOPE IV participants indicated their case manager/Service Coordinator monitored their needs and conducted

Table 6-12.
Comparison Group: Services Provided by Professional Case Manager (in order of relative frequency)*
(n=106)

	%
Helps with providing information and explaining services	83 *(86)*
Helps with obtaining and scheduling services	78 *(83)*
Helps with qualifying for services	76 *(85)*
Checks in and monitors needs	51 *(79)*
Visits, socializes, and talks	47 *(61)*
Helps with getting housing or rental assistance	37 *(80)*
Brings things	16 *(18)*
Helps with performing activities	9 *(12)*
Helps with emergency financial assistance	9 *(8)*

*Comparable percentages for participants at follow-up are given in parentheses.

friendly visits. *Taken together, the data suggest that most comparison group members receiving case management had less frequent contact with their case managers than did HOPE IV participants with their Service Coordinators, and probably did not enjoy the same quality of personal relationship. On the other hand, most had been receiving these services for an extended period.*

With respect to which of their case managers' services comparison group respondents believed to be most beneficial, as shown in Table 6-13, help with obtaining and scheduling services far outranked all the others, with 62 percent of respondents favoring this response. Participants, whose corresponding percentages are shown in parentheses, also considered this the single most beneficial Service Coordinator activity. However, for participants, help with obtaining housing or rental assistance ran a much closer second. Again, this difference likely reflects the fact that HOPE IV integrated provision of housing and case managed supportive services.

Table 6-13.
Comparison Group: Case Manager Services Reported as Most Beneficial (in order of relative frequency)
(n=103)

	%
Helps with obtaining and scheduling services	62 *(46)*
Helps with getting housing or rental assistance	17 *(36)*
Checks in and monitors needs	7 *(7)*
Helps with qualifying for services	5 *(4)*
Provides other assistance	3
Provides information and explains services	2 *(1)*
Brings things to help with emergencies	2
Visits, socializes, and talks	1 *(5)*
Provides financial assistance	1

6.2.3 Satisfaction with Services

Both at baseline and at follow-up, the vast majority of HOPE IV participants and comparison group members were happy with the amount and types of services they were receiving. As shown in the last column in Tables 6-7 and 6-8, both groups reported similar, extremely high levels of satisfaction with individual services both at baseline and at follow-up.

Apart from indicating their level of satisfaction with individual services, HOPE IV participants and comparison group members were also asked if they needed more of any of their current services, or felt they could use services they were not getting at the time of either survey. At baseline, 82 percent of HOPE IV participants and 77 percent of comparison group members responded that they did not need any more of their current services. Of the 16 percent of participants and 18 percent of respondents who indicated they would have liked more of their then current services, the greatest number of participants (44) and comparison group members (36) expressed a desire for more housekeeping

services. Among participants the next largest number (15) said they wanted more transportation or escort services, while the second largest number of comparison group members (11) indicated a desire for more financial assistance.

Similarly, 75 percent of participants and 71 percent of comparison group respondents at baseline reported they did not need any services other than those they were then getting. Transportation, housekeeping, and personal care services ranked highest on the list of additional services desired among the one-quarter of HOPE IV participants who would have liked additional services. The same three services were named, but with different relative rankings, by the 29 percent of comparison group members who said they wanted additional services. Housekeeping led the list by far, mentioned nearly three times as often (72 mentions) as transportation (28 mentions) and personal care (24 mentions).

At follow-up, the percentage of those saying they did not need any more of the services they were currently receiving rose from 82 percent to 89 percent for participants, and from 77 percent to 81 percent of comparison group respondents. Of the roughly 10 percent of both groups expressing a desire for more of these services, most in both groups wanted more housekeeping. Seventy-eight percent of both participants and comparison group respondents said they did not need additional services. Of the roughly 20 percent of both groups who did want additional services at the time of the follow-up surveys, transportation was the service most frequently named by the participants (12 mentions), while comparison group members again indicated the strongest desire for housekeeping (27 mentions), followed by transportation (15 mentions), and home companion services (14 mentions).

Table 6-14 presents the one service participants and comparison group members considered most important in allowing them to continue to live in their own homes. At baseline, housekeeping services headed the participants' list, noted as most important by 40 percent of those who responded to the question, followed by rental assistance (24 percent), home health aide services (14 percent), and Meals on Wheels (10 percent)—all core in-home services designed to maximize the participants' ability to remain independent. At follow-up, rental assistance (36 percent) and housekeeping services (32 percent) still headed the list, but in reverse order; the percentage of those ranking rental assistance first rose by 12 percent, from 24 percent to 36 percent. Interestingly, the percentage of responding participants saying that all services helped equally rose from five percent to 14 percent between baseline and follow-up. By contrast, as shown in Table 6-12, those in the comparison group who answered this question responded that housekeeping and home health aide services were most important to maintaining their independence. At baseline, a slightly higher percentage ranked housekeeping first (28 percent versus 25 percent); at

follow-up, this was true of home health aide services (29 percent versus 24 percent). Rental assistance ranked third both times.

Table 6-14. Service Seen as Most Helpful for Maintaining Independence for Participants and Comparison Group				
	Participant		Comparison Group	
Service	Baseline (percent) *(n=521)*	Follow-Up (percent) *(n=266)*	Baseline (percent) *(n=445)*	Follow-Up (percent) *(n=282)*
Housekeeping	40	322	28	24
Rental assistance	24	36	18	22
Home health aide	14	10	25	29
Meals on wheels/meals program	10	4	7	6
All help equally	5	14	6	8
Miscellaneous others (e.g., transportation, food stamps)	7	4	16	11

It is interesting that, especially at follow-up, a noticeably higher percentage of HOPE IV participants than comparison group members considered rental assistance the one service most important to allowing them to remain in their own homes. One possible reason may be that, as long-time Section 8 tenants, comparison group members did not regard rental assistance in the same way as participants did, for whom it was provided as one key element of an integrated HOPE IV service package. Since most comparison group members' needs for supportive services had presumably developed after they became Section 8 tenants, they did not regard rental assistance as paramount in facilitating their continued independence. Instead, they gave primacy to housekeeping and home health aide services, without which they might well have not been able to remain in Section 8 housing.

7. HOPE IV BENEFITS AND OUTCOMES

7.1 Outcome Measures

This chapter presents the results of the impact analysis, using a combination of measures presented thus far to show the benefits and outcomes of HOPE IV. The simple frequencies in the previous chapters, while quite informative from a descriptive perspective, may not control for all the relevant factors influencing outcomes. As we stated in the second interim report, many of the comparison group members, as a possible consequence of their high levels of frailty and long-term residence in their current housing, also received case management and services, similar to but from sources other than HOPE IV. Given the assumptions underlying HOPE IV–that the frail elderly need case management and supportive services to effectively participate in the Section 8 rental assistance program–it is not surprising that many (but not all) of the comparison group were receiving relatively high levels of care. Indeed, prior demonstrations that initially selected comparison group members who were not receiving case management and services found that, over time, many of these individuals developed linkages with other care providers (see Chapter 5).

This required changes to the evaluation design in two important ways. First, the evaluation explored the extent to which comparison group members were able to sustain this relatively high level of case management and supportive services over the two years between the baseline and follow-up surveys, relative to HOPE IV participants. Second, the analysis tested the relationship between participation in HOPE IV and receipt of services, and, separately, the relationship between receipt of services and a range of positive outcomes. In this way, the evaluation shows the extent to which case management and supportive service correlate with positive outcomes for Section 8 tenants, regardless of the source of support. Simply showing differences between the participant and comparison group members in terms of these outcomes, over time, fails to distinguish between comparison group members who receive services and those who do not. This also is one explanation for the overall similarities we found between the participants and comparison group members, according to the measures of well-being in Chapters 5 and 6. The analysis in Chapter 7 controls for this important difference in receipt of services, within and between the two groups.

The primary purpose of HOPE IV is to allow a frail elderly tenant population to participate in Section 8 scattered-site rental housing through the provision of case management and supportive

services. PHA staff reported that prior to HOPE IV, the frail elderly often did not come into Section 8 and went, instead, to congregate housing or other programs specifically for the elderly. In addition, when existing Section 8 tenants become frail, through aging in place, they often leave for nursing homes or other restrictive settings due to the absence of care to address their limitation in basic life activities.

7.2 Reasons for Leaving HOPE IV

A major research question HUD wanted this evaluation to answer was the extent to which participation in HOPE IV allowed frail elderly tenants to participate in Section 8 housing and avoid unnecessary or inappropriate nursing home placement. To answer this question, the evaluation collected detailed information on the HOPE IV participants and frail elderly Section 8 comparison group members who remained in, or exited from, their respective programs over a two-year period, and why, including mortality, nursing home placement, and moving to other locations. Table 7-1 shows the retention and exit patterns for the participants and comparison group members, according to these categories.

Table 7-1.
Program Status After Two Years

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

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

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

Over the same two-year period, 38 percent of the frail elderly comparison group left Section 8, including 13 percent who died, eight percent who went into a nursing or related care home, nine percent who moved to another location, and eight percent who left for other or unspecified reasons.

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

Only being between ages 75 and 84 and the number of IADL limitations were included by the stepwise inclusion procedure indicating that none of the other variable had a statistically significant effect on remaining in HOPE IV or Section 8. Being between ages 75 and 84 and each additional IADL reduced the probability of remaining in HOPE IV and Section 8, respectively, by about 37 percent (odds ratio = 0.63 Wald Chi-Square=9.01, $P < 0.001$) and 14 percent (odds ratio = 0.84, Wald Chi-Square=10.02, $P < 0.001$). The above analysis included HOPE IV participants who left the Program but remained in Section 8. The rationale for including this latter group is that these persons did not actually exit, given the primary purpose of HOPE IV to sustain the frail elderly in Section 8 private market, scattered-site housing. We note that excluding from the analyses the 40 persons who remained in Section 8, but not in HOPE IV, altered the model in the obvious way: the HOPE IV participants were associated with an approximately 34 percent reduction in the probability of remaining in the program at follow-up (odds ratio = 0.66, Wald Chi-Square=10.28, $P < 0.001$); excluding these persons did not appreciably change the other effects (see the Changes in Quality of Life measures, below).

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

The most likely explanation for this pattern is that frail, older clients receive more services than others do, and these clients tend to exit to nursing homes regardless of the services they receive. However, the analysis found that even after controlling for the number of ADL and IADL limitations, the percentage of clients moving to a nursing home or care facility was correlated with the number of services received. For example, among persons with a combination of seven or more ADL and IADL limitations, only about five percent of the 41 persons who received no more than one service (at the time of the baseline) moved to a nursing home or related care facility, but the comparable rate was about 11 percent for the 92 who received two to three services.

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

7.3 Changes in Quality of Life

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

We found that the quality of life and care was significantly higher for HOPE IV participants than comparison group members for many domains of well-being. Specifically, participants in the HOPE IV program received a significantly higher level of supportive services than the comparison group, and

this disparity in access to care remained over time. For example, at baseline, over one-quarter (26 percent) of the comparison group reported receiving no services at all, despite levels of frailty that were similar to participants, and this figure remained at a relatively high level (32 percent) over the two years between baseline and follow-up (the two percentages are not statistically different). The corresponding figures for participants receiving no services were three percent and seven percent, respectively, over the two years. These differences remained significant when controlling for differences in ADL limitation and other factors influencing need for services.

Most important, receipt of services had a significant association with a range of positive outcomes, across multiple domains of functioning. For example, service recipients scored significantly higher in four major mental health dimensions (anxiety, depression, loss of behavioral/emotional control, and psychological well-being), social functioning (quantity and quality of social activities), vitality (energy level and fatigue), and other measure of social well-being.[xxix]

Table 7-2 presents the results of the multivariate regressions of *Number of Services* (column 1) and a range of *quality of life measures* (columns 2 through 8) on several independent predictors. The key predictor for *Number of services* is HOPE IV *Participation* (line 2). The key predictor for the quality of life measures is the *Number of services*. All models include indexes of frailty, *Number of ADL limitations* (line 5) and *Number of IADL Limitations* (line 6) among the predictors. The analysis set high scores, and therefore positive numbers, to represent the most beneficial outcomes. Negative scores are associated with non-beneficial outcomes, such as a decline in mental health status. We did this for the predictor variables as well, e.g., number of services (0-7), participation in HOPE IV (no=0, yes=1), etc. This helps facilitate understanding of the values in the table by having a positive number refer to positive outcomes and negative numbers referring to negative outcomes.

In constructing this multivariate model, the evaluation explored many other potential independent variables to control for during the analysis, including age, income, and gender. We excluded these from the model because they contributed very little to the explanation of outcomes. We used repeated measures regression methods to examine differences between HOPE IV participants and comparison group members, and we constructed separate regression models for the numbers of services received (column 1), the level of satisfaction with where respondents live (column 2), self-reported levels of vitality (column 3) and mental health (column 4), health status (column 5), and three other measures of well-being: life satisfaction (column 6), confidence in dealing with daily living (column 7), and amount of worry about who to turn to for help (column 8). Table 7-2 presents the parameter estimate (and parameter standard error estimates) for all models in the table. A key finding is that, other things being equal, participants received 0.813 +/- 0.132 more services than the comparison group members ($p < 0.001$) (line 2, column 1).

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

Table 7-2. Multivariate analyses of selected measures. (Repeated measures mixed models for dependent variable in terms of effects listed)

EFFECTS[2]	DEPENDENT MEASURES[1]							
	(1) Number of Services	(2) Satisfaction with Neighborhood	(3) Vitality	(4) Mental health	(5) Health	(6) Life satisfaction	(7) Confidence	(8) Help availability
Intercept	2.360*** (0.234)	0.471*** (0.080)	2.483*** (0.084)	1.779*** (0.082)	3.106*** (0.105)	1.27*** (0.069)	1.157*** (0.061)	2.748*** (0.077)
1. Number of Services	_[3]	0.030* (0.014)	0.027 (0.014)	0.039** (0.014)	0.047** (0.018)	0.000 (0.012)	0.020 (0.010)	0.021 (0.013)
2. Participation	0.813*** (0.132)	_	_	_	_	_	_	_
3. Period	0.072 (0.103)	0.090* (0.034)	-0.179*** (0.038)	-0.033 (0.034)	0.046 (0.045)	-0.066* (0.032)	0.073* (0.028)	0.071 (0.037)
4. Participation by Period Interaction	0.070 (0.103)	_	_	_	_	_	_	_
5. Number of ADL Limitations	0.142** (0.054)	-0.049 (0.027)	-0.142*** (0.028)	-0.044 (0.027)	-0.183*** (0.034)	-0.0.58* (0.023)	-0.057** (0.020)	-0.012 (0.026)
6. Number of IADL Limitations	0.267*** (0.062)	0.025 (0.030)	-0.200*** (0.032)	-0.126*** (0.030)	-0.094* (0.039)	-0.085** (0.027)	-0.150*** (0.023)	-0.076* (0.029)
7. Number of ADL + IADL Limitations	0.071 (0.150)	0.025 (0.076)	0.138 (0.079)	0.100 (0.074)	0.062 (0.096)	0.001 (0.066)	0.056 (0.057)	-0.027 (0.073)
8. Feeling safe	_	0.721*** (0.043)	0.177*** (0.045)	0.162*** (0.043)	0.096 (0.045)	0.208*** (0.037)	0.008 (0.033)	0.158*** (0.041)
Common correlation [4]	0.47***	0.26***	0.37***	0.47***	0.45***	0.29***	0.31***	0.37***

[1] Scores for satisfaction with neighborhood, vitality, mental health, health, life satisfaction, and confidence are transformed for the model.
[2] Statistical significance at levels 0.05, 0.01, and 0.001 were indicated by *, **, and ***, respectively.
[3] Not included in model
[4] Common correlation is defined as the ratio of the common covariance divided by sum of common covariance and residual variance. If repeated measurements at baseline and follow-up were independent, its value would be 0, if they were identical, its the value would be 1.

In addition to showing this overall beneficial impact of HOPE IV on the receipt of services, we know from Table 6-9 that the distribution of these services varied considerably within the participant and comparison groups. For example, while virtually all of the participants (93 percent) reported receiving at least one service, almost one-third of the comparison group (32 percent) reported receiving no services at all, at the time of the follow-up survey.

The evaluation also explored the extent to which this pattern may have changed over the two-year period between the baseline and follow-up surveys. To do this, the analysis used the variable *Period* (line 3) to distinguish between the two points in time and assigned a value for this variable of "0" for baseline and "1" for follow-up. The coefficient of the variable, *Period*, shows the extent of change over the two-year period for all the outcome variables in columns 1 through 8. For example, looking at *Period* (line 3) and *Number of Services* (column 1), we note that the regression on the indicator variable (*Period*) was not significant, confirming that there was no general change in the number of services between baseline and follow-up. The *Period* variable also allows us to show changes in the other outcome variables over the two years. For example, we see that as the *Period* (line 3) changed the Vitality score (column 3) decreased (that is, the level of vitality worsened) between baseline and follow-up. However, the receipt of services (line 1) countered this pattern.

The analysis also confirms our assumptions that that the number of ADL and IADL limitations are predictive of need for care, for these are significantly and positively correlated with the number of services the participants and comparison group members receive. The table shows that each addition in the *Number of ADL Limitations* (line 5), using the five-item Katz scale, corresponds to an increase in the average *Number of Services* (column 1) by 0.14 +/-0.05 ($p < 0.01$). Each addition in the *Number of IADL Limitations* (line 6) increased the average *Number of Services* (column 1) by 0.27 +/-0.06 ($p < 0.001$). We also include a separate line for the combined effect of ADL and IADL limitations (line 7). While most of the predictive power of ADL and IADL limitations is already accounted for in the separate measures in lines 5 and 6, we include the sum to control for any additional effect that combinations of these factors may contribute.

Satisfaction with Neighborhood (column 2) depends primarily on *Feeling Safe* (line 8), although the regression parameters for *Number of Services* received and *Period,* showing changes

between baseline and follow-up, were also statistically significant[xxx]. Thus, feeling safe and receiving more services, at baseline, were associated with increased satisfaction with neighborhood, but the number of ADL and IADL limitations, and their sum (line 7), were not significantly related to this measure of satisfaction. However, in the model that retained the number of ADL limitations as the sole indicator of frailty, this variable became a significant predictor of the neighborhood satisfaction index (model not shown). We also explored satisfaction with neighborhood using two other models (not shown). In one of these other models, we replaced the variables for services received with indicator variables for participation in HOPE IV and the interaction between *Participation* and *Period* (line 4). In this model, neither of the two indicator variables exhibited a statistically significant relationship with satisfaction with neighborhood indicating that participation in HOPE is not directly related to neighborhood satisfaction. In the other model, we simply dropped the variables for the numbers of ADL and IADL limitations, and their sum, retaining only the variables for *Number of Services* received, *Period*, and *Feeling Safe*. In this model, there no longer was a statistically significant relationship between the *Number of Services* received and *Satisfaction with Neighborhood. Taken together, these models suggest that, to the extent that HOPE participants experienced increased satisfaction with their neighborhood, they did so because, at a given level of service need—as this is determined by the number of ADL limitations—participants received a greater number of services than comparison group members.*

The pattern of results for the other outcome measures in Table 7-2 was largely similar to the results for *Satisfaction with Neighborhood*. *Feeling Safe* was associated with improvement in every outcome variable, and the *Number of IADL Limitations* is associated with a worsening in all of them. The *Number of ADL Limitations* is associated with a worsening in measures of *Vitality, Health, Life Satisfaction, and Confidence* in daily living. This further confirms the value of ADL and IADL measures as indicators of need for care. There was no systematic difference between baseline and follow-up interviews in that, other things being equal, some outcomes were more positive at baseline, some at follow-up, and others did not change significantly. The *Number of Services* was always associated with improved outcomes, and the parameter measuring this effect was statistically significant for *Mental Health*, and *Health*—that is in three out of seven models (including *Satisfaction with Neighborhood*). Except for the variable measuring *Life Satisfaction*, participation in HOPE IV was not significantly associated with positive outcomes in models in which *Number of Services* received was replaced by indicator variables for *Participation* and the *Participation by Period* interaction (models not included, see

[xxx] Here, and subsequently, we will refrain from interpreting numeric relationships expressed by regression coefficients when either the dependent variable, or the predictor, or both are somewhat arbitrarily selected scales - as for example is the scale for satisfaction with housing etc.

discussion in last paragraph). This means that we cannot measure the impact of HOPE IV by direct association with the outcome variables. We must, instead, measure impact indirectly through association with increases in levels of service.

One variable that was also highly correlated with these outcomes, among the comparison group, was having a case manager who helped identify and arrange for the delivery of services the person needed. All HOPE IV participants have a case manager (Service Coordinator) as part of the demonstration program. However, there also was an extremely high correlation between having a case manager and the number of services the comparison group received. When one variable is essentially a proxy for another, it is not practical to include both in a regression model. For this reason, case management was not included among the predictors in the analyses presented in the table.

This relationship between having a case manager and the number of services the comparison group members receive is, itself, an extremely important finding. One assumption underlying the design of HOPE IV is that the combination of case management and services, rather than one or the other, constitutes the most effective approach to addressing the needs of a frail, elderly tenant population. It appears reasonable to interpret the significant beneficial relationship between receipt of services and positive outcome measures in Table 7-2, which covers both HOPE IV participants and comparison group members, as a benefit due to receipt of case management.

8. FINDINGS AND CONCLUSIONS

This chapter highlights the major findings of the four phases of the HOPE IV evaluation and presents a number of policy implications for HUD and DHHS concerning a frail elderly tenant population.

8.1 Rationale for the Research Design

The evaluation addressed both the implementation of this community-based, long-term care program as part of an integrated public housing agency initiative, and the impact on the well being of frail elderly Section 8 tenants. The research design placed considerable emphasis on describing and evaluating the implementation process for several reasons. First, the primary purpose of the demonstration and, therefore, the evaluation is to determine if the PHAs could increase the number of frail elderly receiving the traditional services and benefits of Section 8 by including a package of case management and supportive services, in conjunction with the housing assistance. As we see from Chapter 3, effectively enrolling participants in HOPE IV occurred only after making considerable changes in the infrastructure and attitudes of the PHA. Once this happened, recruitment, assessment, and placement of participants in the housing and services program was very labor intensive. All the grantees overcame tremendous obstacles to the design and implementation of the HOPE IV program, apart from issues of impact, and it was extremely important to document and assess the various ways in which this occurred.

Another reason for stressing implementation as well as impact was a change in the prospect for Administration and Congressional support for continuation of the HOPE IV program after the demonstrations ended. Except for the two rounds of demonstrations, there are no plans to continue HOPE IV. For this reason, the purpose of the evaluation changed somewhat, from supporting a move from demonstration to full implementation, to more generally informing PHAs about how to enhance the provision of assisted housing under Section 8 to a frail, elderly tenant population. By thoroughly describing and evaluating the design and implementation process, PHAs will have the benefit of several implementation models from which to choose, as well as candid assessments of what to expect when developing similar initiatives of their own.

Evaluating the impact of HOPE IV was, indeed, an important part of the evaluation. The challenge, here, was to avoid simply repeating the many prior assessments of community-based, long-

term care programs for the frail elderly and, instead, cast the evaluation within the context of PHAs and Section 8. Previous research has thoroughly explored the impact of home versus institutional care on the well-being of the elderly. We know from these studies that there are many benefits highly correlated with participating in home-care alternative to nursing home placement, especially concerning quality of life measures. What this new evaluation contributes is studying such an impact on a very specific client population--frail elderly tenants in Section 8 scattered-site housing. It was for this reason that the comparison group was as similar as possible, except for participation in HOPE IV. By screening and selecting other frail elderly Section 8 tenants, we accomplished this goal.

Consistent with our assumptions, the participant group reported receiving more services than the comparison group. Somewhat surprisingly, however, the comparison group receives more services than might have been expected. For example, both groups reported similar rates for receipt of personal care at baseline (25 percent and 26 percent, respectively); but participants exceeded the comparison group rates in housekeeping (80 percent versus 49 percent, respectively), transportation (46 percent versus 32 percent), and home delivered meals (38 percent versus 24 percent). In addition, all participants benefit from HOPE IV's important case management component; by comparison, just under half (46 percent) of comparison group members reported receiving some kind of formal case management at baseline. This level sustained itself between baseline and follow-up for the comparison group (41 percent).

A relatively high level of receipt of services by the comparison group is itself an important finding suggesting that, at a given point in time, a certain segment of frail, elderly Section 8 tenants in locations similar to those of the HOPE IV grantees receives substantial service support. The comparison group may have had to be receiving relatively high levels of personal care and other services in order to continue to live independently in Section 8 scattered-site rental housing as frail elderly tenants. HOPE IV is but one of many community-based, long-term care programs available for the frail elderly, and the services of Area Agencies on Aging and others may be supporting frail elderly Section 8 tenants at a relatively high level. Another factor that might help to account for this comparatively high level of formal support among comparison group members is that they have lived in their current homes much longer than the HOPE IV participants; nearly one-third of the comparison group members have lived in their residence over 10 years, compared to just 11 percent of the participants. Having been in their communities for a long time may have allowed the comparison group to develop linkages with community resources that ensured a considerable level of formal services support.

This relatively high level of formal support by both groups also may be a function of similar attitudes about willingness to receive such help. For example, both HOPE IV participants and comparison group members were similarly receptive when asked a series of questions about their attitudes toward receipt of services from different sources and preferences for getting help from family and friends or government and community agencies. These questions were asked to determine if there might be differences between the two groups on variables related to the propensity to participate in programs that would otherwise have no direct bearing on premature institutionalization or other major outcomes of interest to the study. The similarity of the participant and comparison group responses regarding the willingness to accept services further confirms the viability of the comparison group design.

One issue is whether the comparison group continued to receive the type and level of support received by the otherwise very similar HOPE IV participants. In light of this, one important finding from the follow-up interviews was the relative ability of HOPE IV participants and comparison group respondents to sustain this support over the two years. We see that this did occur, for the average number of services and the percentage with a formal case manager changed very little over the two years. However, we see from Chapter 7 that HOPE IV participants received more services and had better outcomes than the comparison group.

8.2 Characteristics of HOPE IV Grantee Communities

The first 16 PHAs selected for the HOPE IV Program are a diverse group:

- **Geographic Location**: The grantee sites are located in the West, Midwest, Southwest, Mid-Atlantic, East, and New England. They are situated in large urban areas, small cities, suburbs, predominantly rural areas, and areas with a rural and urban mix.

- **Community Contexts**: HOPE IV grantees have had to adapt the basic program model to a variety of contexts in implementing the program at the individual sites. Some grantee communities are retirement centers with rising rents and limited affordable housing; others are rural communities that lack good transportation. One border-community site has almost all non-English speaking, Hispanic participants facing linguistic and cultural barriers.

- **Other community programs for the frail elderly**: In all 16 communities, HOPE IV provides an opportunity to extend the service base and incorporate a much-needed housing component. Most HOPE IV communities have no real alternative to nursing homes for those who can no longer maintain themselves at home. Programs that

provide in-home supportive services to the frail elderly can address only a portion of the demand. Three grantee communities have Medicaid or Medicaid/Medicare waiver programs that allow frail, medically needy elderly who would otherwise qualify for nursing home placement to remain in a community setting. However, these programs are directed at persons who are frailer than those in the HOPE IV program.

8.3 Grantee Characteristics

The HOPE IV Program represents a unique opportunity for the PHA and community agencies, often for the first time, to work together to systematically link provision of Section 8 housing and delivery of a coordinated, case-managed and individually tailored package of supportive services to the frail elderly. The grantees and their "partners" were excited by the possibilities this program offered.

The HOPE grantee agencies vary in their governance, prior experience serving frail elderly, and relationships with existing community service delivery systems.

Governance

- Four of the PHAs are part of city government. Ten are independent legal entities, although often closely attached to city or county governments. Two grantees are State agencies that distribute HOPE IV funds to selected localities in their States.
- All 16 PHA Executive Directors or their direct designees provided oversight to HOPE IV program operations. However, Executive Directors played a day-to-day role in HOPE IV only at three or four small PHAs. Elsewhere, routine management functions were delegated to a variety of PHA personnel.
- Design and implementation of HOPE IV often required substantial structural changes within PHA to establish new staff roles for the Service Coordinator and supportive services components of the program.

Prior PHA experience with programs on aging

- Most grantee PHAs had little or no previous involvement in ventures linking housing and supportive services to a frail, elderly population. Prior efforts had almost all been small scale and directed at elderly residents of public housing or other congregate facilities. Four grantee PHAs, however, had considerable experience in provision of supportive services to the elderly before HOPE IV.
- Despite limited experience, grantees successfully created linkages with Area Agencies on Aging and other community service providers in assembling their HOPE IV applications and designing their service packages.

8.4 Applying for HOPE IV Funding

Grantees decided to expend the time and effort to apply for the HOPE IV Program for two primary reasons:

- They recognized the growing needs of the elderly populations in their communities and saw HOPE IV as a way to address these needs. This recognition often came about through interaction with service providers or advocates for the elderly.
- HOPE IV represented a continuation of past efforts to combine housing and supportive services to the elderly.

Most often, a PHA staff member took the initiative to coordinate the production of the HOPE IV application, with significant help from representatives of AAAs and other community service organizations. Prior efforts to establish coalitions of agencies serving the elderly facilitated the application process. Grantees indicated that limited time to prepare the application presented an obstacle, which under other circumstances might have deterred them from applying. The 50 percent matching funds requirement did not present a serious barrier to application.

8.5 Reasons PHAs Did Not Apply for HOPE IV Funding

Non-applicant PHAs gave three primary clusters of reasons for not applying for HOPE IV funding:

1. They perceived the program was not needed in the community or was of low priority, relative to other needs;
2. PHA staff felt they would have had difficulty coordinating with other agencies for service delivery and/or obtaining and sustaining the matching funds commitment; and
3. Time and personnel were insufficient to prepare the application or implement the HOPE IV program if funded.

8.6 Variations in Program Implementation

HUD allowed HOPE IV grantees some latitude in designing their programs. The 16 grantees vary in a number of program design and implementation areas, the most important of which are briefly described below:

- **Instruments used to assess frailty**: All but one grantee uses an established frailty assessment tool and crosswalks its ADL categories with HUD's ADL definitions.
- **Types of Services**: Grantees delivered a common cluster of services that included case management, linkage services such as transportation, personal care, and homemaker and chore services. Other services (advocacy, social and behavioral support, and recreation and socialization), although recognized as needed by some grantees, were much less commonly offered.
- **Organization of Service Delivery**: Only one grantee directly delivered supportive services to HOPE IV participants. The others contracted out the actual delivery of services. Several also contracted for service coordination, and a few for PAC functions, as well.
- **Record keeping and cost accounting plans and procedures**: Grantees maintained various types of records, but used different service classifications and forms. This necessitated the design and use of standard data collection instruments by the evaluation project.

8.7 Factors Affecting Program Implementation

HOPE IV implementation faced several challenges, and in all but one site proceeded more slowly than originally projected. As late as December 1995, nearly three years after receiving awards, only about half the participants authorized were placed. The pattern was mixed, however, since one site leased up and began services for all authorized participants within one year of the award. Nevertheless, most grantees believed that, under the circumstances, there is little they could have done differently. Grantees agreed they had been learning as they went along, addressing issues "in real time." Recognizing and responding to the combination of mostly unanticipated pressures affecting HOPE IV program implementation has been and remains an ongoing process. Grantee PHAs had to respond to organizational pressures to adapt their Section 8 programs to the special needs of the frail elderly. They had to define and regularize their relationship to their partner service delivery agencies. HOPE IV participants' needs have also been more intense and far-reaching than expected. While the demands of HOPE IV have exceeded

PHA expectations, the grantees regard this as an indication of the program's importance for the frail elderly in their communities.

Seen in this light, enrolling approximately 40 percent of all HOPE IV participants by mid-December 1994 and 50 percent by December 1995 is a respectable accomplishment, especially given extensive attrition. The major factors affecting HOPE IV program implementation are summarized below.

- Many grantee PHAs were initially unprepared to run a program like HOPE IV. Typical Section 8 waiting list and recruitment procedures yielded very few participants for the program. Existing Section 8 staff and new supportive services personnel came under pressure to adapt their activities to the needs of a frail elderly tenant population. Responding to these pressures sometimes required organizational adaptations in the PHA or rearrangements in the relationship between the PHA and service agencies.

- A greater-than-expected number of HOPE IV participants were very poor and had access to fewer resources than program staff had expected. More participants than anticipated also had to move to qualify for the HOPE IV program. Responding to these needs required ingenuity, time, and patience from program staff. It also added a number of unanticipated and often time-consuming tasks to their recruitment and enrollment activities. Attrition from the program just prior to or soon after lease-up also absorbed staff resources.

- The frail elderly were physically and emotionally vulnerable to the traumatic effects of moving. Even those who could lease in place often found it difficult to learn to accept formal supportive services. Program staff had to adapt the pace of enrollment to minimize stress to the frail participants and lower the risk of post-enrollment hospitalization. Pre-screening applicants for frailty and income eligibility, as well as conducting frailty assessments and accompanying Professional Assessment Committee (PAC) reviews, is also extremely labor-intensive and unexpectedly lengthy.

- Grantees dealt with intensified demands on staff time and creativity by expanding the Service Coordinator role well beyond its original job description. Service Coordinators took on a variety of unanticipated tasks like marketing; helping participants locate, lease up, and move into their housing units; and handling growing paperwork and administrative responsibilities. To this was added the responsibility for overseeing and monitoring service provision to participants with a shifting and large array of needs for personal care, home management, and linkage with other community services such as medical care.

- Grantees adapted in various, ad hoc ways to the overloading of the Service Coordinator role by hiring additional personnel, slowing the pace of enrollment, or emphasizing certain functions (administration) over others (personalized case management). Ten of the 16 grantees took advantage of the HUD July 1994 NOFA to obtain additional funds they will use to enhance and supplement Service Coordinator

activities. Several grantees divided the Service Coordinator role into two distinct functions performed by two people: one handled administrative, management, and agency linkage activities; the other concentrated on providing ongoing case management to HOPE IV participants.

8.8 Grantee Recommendations for the HOPE IV Program

The 16 grantees offered several recommendations to HUD for improving the HOPE IV Program based on their experiences.

- *HUD Should Supply Technical Assistance* -- While recognizing that HOPE IV is a demonstration program, given its newness and the special challenges it presents, eight grantees expressed a desire for guidance or technical assistance from HUD in program design and implementation. Several mentioned a particular need for help with start-up issues and the mechanics of handling the matching fund requirement. Various suggestions were offered, including: building time into the grant for program start-up; allowing grantees to send questions to HUD and distributing the answers to all grantees; convening a conference at which grantees can share experiences and solutions to common problems.

  Based on the efforts of one grantee, several HOPE IV Service Coordinators met in March and April 1998 at the National Council on the Aging conference to exchange ideas on the program. This was the first time these persons had come together for this purpose.

  Five grantees also indicated that delays in signing the grant agreement with HUD had contributed to delays in program start-up, and in some cases, had complicated their relationships with their partner agencies.

- *HUD Should Change the Participant Fee Structure* -- Five grantees suggested that the 10 percent participant fee either be charged on a sliding scale or eliminated altogether. They felt that most HOPE IV participants are too poor to have to pay for their services, and the requirement causes more problems than it is worth.

- *HUD Should Allow Qualified Existing Section 8 Tenants to Participate in HOPE IV* -- Four grantees recommended that frail elderly, existing Section 8 tenants who qualify be allowed to participate in the HOPE IV Program. They believe these persons should not be deprived of the program's benefits; also, since they are already leased up, allowing them to participate would help speed enrollment.

- *HUD Should Fund Additional Unexpected Costs* -- Three grantees suggested that HUD should provide funds to pay for time Service Coordinators and others have spent recruiting, marketing, and helping participants locate and move into housing.

- *Other Recommendations*: The remaining grantee recommendations fall into several different categories.

  - *Find Better Ways of Accommodating Nursing Home Short Stays and Other "Chronic Flareups"* -- HOPE IV participants experienced short-term, chronic flareups which temporarily require them to receive more assistance than HOPE IV can provide. Afterwards, participants were again "eligible" for HOPE IV. Handling these situations, which were relatively common in the lives of frail elderly, created problems for the grantees. Three grantees specifically cited difficulties with Section 8 rules that do not permit tenants to be out of their units for more than 60 days. HOPE IV participants admitted to nursing homes after hospitalization rarely return home within the 60-day limit.

  - *PACS*: Two grantees recommended restricting the PAC's responsibilities and reducing the number of full PAC meetings.

  - *Frailty Requirements*: Two grantees said that requiring three ADLs "was too many." They believe many participants are already too far into a pattern of decline to benefit from the program. In addition, remarked one Service Coordinator: "I find myself having to ask people who could clearly benefit from the (HOPE IV) program to give me a call when they get worse."

8.9 Characteristics of the HOPE IV Participants

Consistent with the HOPE IV regulations, the majority of program participants are quite frail. For example, HOPE IV participants reported a basic level of frailty that was about seven times greater than the elderly household population as a whole. According to the five-item Activity of Daily Living scale (used in Table 5-1), 74 percent for HOPE IV participants at baseline reported difficulty performing at least one activity, compared to only 11 percent for all elderly in the community.

Compared to the nursing home population and participants in various home care programs for nursing home eligibles, the HOPE IV participants were much less frail. For example, when measuring frailty based on receiving assistance from another person to perform an activity, as opposed to just having difficulty with it, approximately 30 percent of the HOPE IV participants reported getting such help; the corresponding figure for all elderly (65+) in the community is about 8 percent. This compares to 92 percent for nursing home residents, 84 percent for the Long Term Care Channeling Demonstration program, and between 79 percent and 95 percent for the PACE programs that provided home care to the frail elderly eligible for nursing home placement. This shows that HOPE IV participants have a level of

ADL dependency roughly one-third that of those receiving or in need of nursing home care and nearly four times greater than all elderly persons living outside of institutions.

Between baseline and follow-up, participant levels of frailty increased, relative to the comparison group. While comparison group levels of frailty remained quite constant over the two years, participant rates rose.

Beyond frailty, participants also reported many other factors that place them at risk for loss of independence. For example, almost 60 percent said their overall health was either fair or poor, and they had many diagnosed chronic medical conditions, including arthritis, high blood pressure, and heart disease. Over 40 percent had experienced a fall during the past year, and an equal number found it necessary to use a hospital emergency room at least once during that same period. These rates changed little between baseline and follow-up and were very similar for the participant and comparison group.

Further intensifying the risk for institutionalization posed by these health and disability factors, virtually all participants lived completely alone, half were over the age of 75, and nearly 50 percent had less than a high school education and annual incomes at or below $8,000.

Despite a substantial level of poor health and frailty, the participants reported a relatively high level of satisfaction with many aspects of their lives. For example, 70 percent were very satisfied with their living arrangements, and about 60 percent reported feeling calm, peaceful, and being a happy person most or all of the time during the past month. Nearly 60 percent felt they had a great deal of choice in what they do and when, and only a small percent said they were very unhappy with the frequency of their social contacts. Overall levels of participant satisfaction with social contact rose from 42 percent at baseline to 56 percent at follow-up, and these rates were nearly identical for the comparison group.

However, some participants did report a number of negative aspects in the quality of their lives and identify additional services they need. This is not surprising given that, by design, the HOPE IV program targets persons with limitations in activities essential for independent living. For example, nearly one-fifth are not satisfied with life, and almost half report having a fair to poor appetite. About one quarter said they rarely if ever felt full of life and an equal number reported they were a very nervous person most or all of the time during the past month. About half of the participants said they would like to be doing more socially, and about 20 percent expressed a need for additional services, most notably

housekeeping and transportation. These patterns remained very constant between baseline and follow-up and between participants and comparison group members, however.

These data show that while certain characteristics dominate the participant profile, such as gender (80 percent are women) and specific measures of life satisfaction (almost half are very confident), there is considerable variation among participants in many factors such as multiple ADL limitations. For example, 26 percent of participants reported no ADL limitations, while 37 percent reported at least three, the latter an indication of considerable frailty. As discussed in Chapter 5, there are several ADL limitation scales. The one referenced here is based on the scale developed by Sidney Katz, as referenced in Section 5.1, above, and constitutes a more restrictive activity list than appears in the HOPE IV regulations. This variation in levels of frailty suggests a participant group that is far from homogeneous, confirming the need for individual case management, tailoring an appropriate mix and level of supportive services in response to each participant's needs. At the same time, this heterogeneity had significant implications for the impact analysis, for we had to control for the degree of frailty, in conjunction with age, education, and other factors. For this reason, the impact analysis could not treat the participants as a single group, and these data helped identify logical sub-groups for analytical purposes.

In spite of their high level of disability, a number of participants do not appear to meet the HOPE IV definition of frailty. For example, when analyzing all activities referenced in the HOPE IV regulations, about 20 percent of participants did not report a limitation in performing at least three. However, this may be a function of the frail elderly tending to underreport their ADL limitations, relative to professional assessments. It also may be due to differences among the grantees in measurement of ADL limitations and interpretation of the HOPE IV regulations.

8.10 Social Support and Satisfaction with the HOPE IV Program

The striking similarity between the HOPE IV participants and comparison group in both the frequency and patterns of their informal social contacts with children, other relatives, and friends and neighbors is quite interesting, and between baseline and follow-up, the two groups became more similar in their patterns of social support. Both groups have regular telephone and in-person contact with at least one other person outside their household, on average, nearly every day in the month. However, the distribution of contact is such that about one-fifth of both HOPE IV participants and comparison group members do not see anyone in the course of a month, while about one-third of both groups do not speak

with anyone on the telephone during the month. At baseline, 11 percent of participants and seven percent of the comparison group reported no telephone or in-person contacts during the month. At follow-up, the rates were nine percent and eight percent, respectively.

Thirty-seven percent of participants reported daily in-person contact, versus 45 percent for the comparison group. These figures remained virtually unchanged between baseline and follow-up.

For telephone contact, 37 percent of participants and 39 percent of the comparison group reported daily telephone contact. At follow-up the rates had changed very little to 30 percent versus 36 percent, respectively.

Most HOPE IV participants report extremely high levels of satisfaction with their Service Coordinators, the services they get, and the HOPE IV program overall. Virtually all the participants view the Program as essential in enabling them to remain independent in their own homes. The relatively few expressing any dissatisfaction basically want additional housekeeping or transportation services, or more contact with their Service Coordinators. The extent of participant satisfaction with HOPE IV is all the more impressive in light of peculiar circumstances at one of the 16 grantee sites, where participants had to wait for many months, even up to one year after moving into Section 8 housing, before actually beginning to receive their supportive service packages.

Without discounting the very high level of initial satisfaction of participants with the HOPE IV Program, it is nevertheless interesting that comparison group members are also highly satisfied with their housing and supportive services. This, no doubt, partly reflects that comparison group respondents also receive Section 8 rental assistance, while a reasonably large segment get many of the same supportive services as the HOPE IV participants. However, from a "consumer satisfaction" perspective, these findings may also suggest that low-income, frail elderly persons are so extraordinarily grateful for any help that keeps them from having to enter nursing homes, they may not be the most critical or discerning consumers. Even if it were true, this would in no way minimize the very real importance of HOPE IV to its participants.

8.11 Policy Implications of the Evaluation

This section of the report suggests how HUD and PHAs might use the results of the HOPE IV evaluation to inform and support their decision-making on housing assistance policies and programs

for low-income, frail elderly persons. The HOPE IV demonstrations comprise a rich body of experience that can provide both conceptual guidance and specific examples for enhancing the level and scope of services for an aging tenant population.

The policy implications of the evaluation are influenced by two very important and complementary findings. First, the study showed that the HOPE IV demonstrations were successful in improving the quality of life and care for low-income, frail elderly tenants by providing a unique combination of housing assistance, case management, and supportive services that was often unavailable elsewhere in the community. A second finding, however, was that even with the benefit of separate funding and a PHA commitment for the program, these demonstrations had to first overcome substantial structural and functional barriers to implementation within their own host agencies and among other community partners, in addition to the extensive effort required to serve a population with considerable needs.

Fortunately, the HOPE IV agencies demonstrated not only how to effectively combine housing and supportive services for a frail elderly constituency, but also successful approaches for altering PHA policies and procedures to removed barriers and facilitate implementation. Beyond program operations, these structural and functional changes were essential for the success of HOPE IV, and they have important policy implications for HUD and its network of PHAs.

Congressional appropriations for HOPE IV ended after the first two rounds of awards, and there are no current provisions for continuing the demonstrations. In the absence of additional funding, however, there are several HUD policy and program initiatives that could accomplish many of the purposes of HOPE IV using existing resources. Each of these policy initiatives appears below in Italics followed by a brief explanation and recommendations for action, based on the evaluation's findings.

> *The role of the HOPE IV Service Coordinator was essential for creating an internal PHA climate conducive for successful design and implementation of the demonstrations. In the absence of new funding, HUD could expand the existing Section 202 Service Coordinator program to help support these functions for frail elderly Section 8 tenants.*

Systemic change often requires the presence of a key individual to increase awareness among staff and promote policy and program initiatives, in this case to respond to the complex needs of a frail elderly tenant population. The evaluation showed that prior to HOPE IV, existing Section 8 policies

and procedures often discouraged application and participation by eligible frail elderly persons. In-person application requirements, the need for assistance in locating accessible rental housing for persons with disabilities, the absence of linkages with care providers, and the steering of aging tenants to congregate options, often excluded frail elderly persons from Section 8 altogether. These barriers affected not only new frail elderly applicants, but also existing Section 8 tenants who had aged in place.

The HOPE IV Service Coordinators played an important role in changing this orientation by educating existing PHA Section 8 staff, building linkages with other community agencies, and providing case management services to individual HOPE IV participants. At the national level, HUD could allow the Section 202 Service Coordinator funding to be used to address the concerns of frail elderly Section 8 Voucher and Certificate holders as well. While the realities of limited funding may preclude providing extensive individual case management for Section 8 tenants, the Section 202 Service Coordinators could provide an important staff training and orientation function to help encourage frail elderly recruitment, placement, and linkage with other community service providers.

The current PHA structure is highly compartmentalized, and Section 202 Service Coordinators now have little opportunity to influence the Section 8 staff and functions. Expanding the opportunity, if not the mandate, for these Service Coordinators to support Section 8 could do much to reverse this trend. There are already models for such broad-based PHA leadership positions and functions to address the needs of frail elderly tenants. For example, with supplemental HUD funding during the HOPE IV demonstrations, grantees often hired staff and divided the responsibilities of the Service Coordinator between: 1) stewardship of the program as a staff function within the PHA and 2) case management services for individual clients, frequently through subcontracts with other community agencies.

> *To complement its housing assistance programs, HUD could encourage the provision of supportive services for frail elderly Section 8 tenants through linkages with other federal, state, and community-based programs on aging.*

The HOPE IV evaluation found that the success of the demonstration virtually always depended on effective linkages and purchase of service agreements between the PHAs and other community agencies operating programs on aging. Prior to HOPE IV, such relationships were infrequent, and during the demonstration grantees often tapped the resources of these other agencies to supplement the supportive services funding under the demonstration. This suggests that opportunities for

collaboration and potentially beneficial relationships exist beyond the purview of HOPE IV. Most of the community agencies working with the PHAs, such as Area Agencies on Aging, receive funding from the national level, and HUD may be able to facilitate local partnerships thorough collaboration with the sponsoring federal agencies. For example, HUD linkages with the HHS Administration on Aging could promote corresponding interaction at the state and local levels with State and Area Agencies on Aging. There are 57 State Agencies on Aging, over 660 Area Agencies on Aging, and literally thousands of service providers funded by them that may be able to serve frail elderly tenants in PHA programs.

Deciding how to best serve tenant needs beyond housing assistance is a continuing policy issue for HUD. In the past, HUD has funded many demonstration programs that combine housing assistance with various types of services for special populations. These include support for homeless persons and those with substance abuse problems, child care and other assistance to encourage tenant employment, and a range of other services that recognize needs beyond housing assistance. Some of these programs have moved from a demonstration phase to on-going funding for PHAs and other community agencies. Others, such as HOPE IV, have not.

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

> *The HOPE IV demonstrations and evaluation constitute a valuable information resource, and HUD can encourage dissemination and utilization of the results through existing clearinghouse and communication mechanisms.*

Each HOPE IV grantee developed a considerable body of printed material documenting and supporting the design and implementation of the demonstration. *HUD User* might acquire and abstract this documentation from the grantees and, proactively, make it available to interested PHAs and other agencies and organizations. The program descriptions, operations manuals, recruitment materials, assessment instruments, and other documents may be quite helpful to those wishing to adopt HOPE IV models and expand services to the frail elderly. Also, Internet access to these documents, or abstracts of them, could assist PHAs to identify and request material of interest to them.

As another approach to dissemination, presentations at national conferences and publication of journal articles, for example through the National Association of Housing and Redevelopment Officials (NAHRO), might encourage PHAs to develop such programs by linking them with information and assistance from their peers in the demonstration sites. There are now specific models for the design, implementation, and operation of a Section 8 Voucher program that effectively combine case management and home care with housing assistance for frail elderly tenants. In addition, there is an experienced and committed cadre of PHA staff and personnel from other partner agencies in the community who could potentially assist in the sharing of information and transfer of best-practice approaches. HUD could consider taping this experience and making it available to others by sponsoring forums, training, and technical assistance to promote replication of the results of HOPE IV. The Westat study team has conducted many workshops on HOPE IV at professional meetings, covering both housing and supportive services professionals, and we suggest that this practice continue.

An important finding from the study was that even with the benefit of a demonstration and local agreements to develop this program, grantees often took several years to actually implement HOPE IV. In the absence of new financial support and in the face of such implementation difficulties, it is reasonable to assume that concerted HUD policy and program initiatives are essential for adoption of these best practices.

For example, during the evaluation, HOPE IV Service Coordinators said they would have benefited greatly from training, technical assistance, and the sharing of information among grantees on the initial development of the demonstration. This included having access to underlying conceptual designs, such as which functions to retain within the PHA, versus those that could be reasonably, and preferably, delegated to other community agencies already serving the case management and home care needs of frail elderly. According to these HOPE IV Service Coordinators, such training and technical assistance also could have included guidance on the development of specific client assessment instruments and procedures for selecting eligible and appropriate participants for this program.

> *Long waiting lists and limited availability of rental Vouchers and Certificates severely restrict opportunities to expand the Section 8 program to a frail elderly constituency. HUD could provide incentives to PHAs to help ensure that frail elderly receive their fair share of Section 8 rental assistance.*

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

To address the waiting list problem under Section 8, HUD could permit PHAs to set aside a certain number of Vouchers and Certificates for the frail elderly; or HUD might offer additional ones as an incentive to PHAs that commit to arranging supportive services through collaborative ventures with other agencies serving the elderly.

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

Ironically, the loss of HOPE IV funding provides an opportunity to determine if the program can continue using other resources from the PHA and elsewhere in the community. Based on meetings and discussions with HOPE IV Service Coordinators in April 1998, the grantees are addressing the end of the program in several ways. At least one of the demonstrations is no longer recruiting and placing new HOPE IV participants when vacancies occur, but most are filling vacancies when someone leaves the program. This means that even as the demonstrations near their end, many of the participants are quite new to the program, and their need for a Service Coordinator and supportive services is likely to continue beyond the effective end of the demonstration and available funds. In response to this situation, most Service Coordinators reported they were exploring alternative sources of funds, but they had made no specific provisions for continuation.

The evaluation has ended and will not be able to track how well the current demonstrations are able to continue as a result of contingency planning and alternative programming currently under way. We strongly recommend that HUD monitor the progress of these continuation efforts by local grantees to identify how and to what extent these PHAs and their other community partner agencies are successfully incorporating the concepts and specific examples from the HOPE IV demonstration into their on-going housing assistance and supportive services programs. It is reasonable to assume that the greatest prospects for continuation of HOPE IV, after the demonstration funding is gone, are at the original

grantee sites. Tracking the efforts within these agencies to sustain the program will show both the viability of the demonstration for continuation on its own, and the specific steps and resources PHAs might use to do so. This monitoring also will identify any risks to the health and safety of current HOPE IV participants who may no longer have access to the care they need as grantees exhaust their demonstration funds.

Analysis of the evaluation's comparison group revealed relatively high levels of frailty and unmet need for services among current Section 8 tenants. HUD could promote adoption of the HOPE IV models for existing tenants as well as new Section 8 applicants.

The evaluation clearly showed that serving a frail elderly population involves not only reaching out to a new constituency, as occurred under HOPE IV, but also acknowledging and responding to the needs of existing Section 8 tenants. Current residents of Section 8 scattered-site housing are aging in place, and a substantial number have levels of frailty similar to HOPE IV participants. For example, during the evaluation's comparison group selection process, random screening of elderly Section 8 tenants who were not participating in HOPE IV revealed that one in five, or 20 percent, had levels of frailty similar to HOPE IV participants. At the same time, the study showed that over one-third of these persons were not receiving any services, despite similar indicators of need for care. The locations where this comparison group screening occurred were similar to the HOPE IV demonstration sites and, therefore, not necessarily representative of the nation as a whole. However, the consistency with which this comparable level of frailty occurred and the range of geographic locations involved suggest that these patterns are widespread.

HUD policies should ensure that frail elderly have a range of housing assistance options and the opportunity to choose from among them, rather than favoring congregate versus scattered-site programs.

The evaluation showed that HOPE IV was successful in terms of both positive outcomes and a high level of satisfaction among program participants. However, Chapter 7 shows that turnover of participants is substantial, and during the two-year period between the baseline and follow-up interviews, 40 percent of the participants left Section 8 and HOPE IV, many as a function of increasing levels of frailty. This shows that the presence of ADL limitations beyond certain levels may preclude participation in Section 8 even with a viable care component. This is an issue both for current tenants whose level of frailty may increase during the course of participation, as well as for those with substantial numbers of

ADL limitations at the time of application for housing assistance. This shows that one critical policy issue is having several choices for frail elderly tenants, rather than focusing on a narrow range of options.

When asked to comment on such policy options, the current HOPE IV Service Coordinators also said that the issue is ensuring choices for both congregate and scattered-site housing, rather than one or the other. They said the level of disability and the particular circumstances of individual elderly persons vary considerably, and it is important to offer a range of options to address a broad spectrum of changing needs.