Supporting Statement A for
Support and Services at Home (SASH) Evolution:
Conduct Beneficiary Survey

RTI International

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A. BACKGROUND

Older adults prefer to remain as independent as possible for as long as possible and "age in place" in their own communities. Advanced age, however, increases the likelihood of chronic illness, frailty, and disability and consequently places some older adults in greater need of health and long-term services and supports (AARP, 2009; National Center for Health Statistics, 2007; Redford & Cook, 2001). How well older adults function is affected by the demands of their housing and social environment and by its adaptive attributes (Lawton, 1976). Today, a large and rapidly expanding pool of lower-income seniors face the dual challenges of finding and maintaining affordable housing that can adapt to their changing needs should they become ill or disabled as they age. An estimated 1.9 million elderly individuals live in publicly assisted housing (Wilden & Redfoot, 2002). A potential approach to help these lower-income older adults meet their health and functional challenges involves capitalizing on independent, publicly assisted, multi-unit rental properties either designated for low-income seniors or located where large numbers of seniors live. Organizing a system of health and long-term services and supports around this type of housing may result in a number of potential benefits. Because publicly assisted housing provides a critical mass of elderly residents in one place, an economy of scale can be achieved in organizing, delivering, and purchasing services, increasing efficiency and affordability.

In 2008, Cathedral Square Corporation (CSC) in South Burlington, Vermont, began developing the Support and Services at Home (SASH) program out of concern that frail residents in its properties were not able to access or receive adequate supports to remain safely in their homes. CSC believed that affordable housing providers could offer several advantages to the health and long-term services and supports systems, including (1) a concentration of individuals whose high incidence of health care and long-term care use (and accompanying high costs) the state would like to address, (2) the economies of scale that result from easy access to this concentrated community of high cost beneficiaries, (3) a realistic and holistic view of these users' daily lives, and (4) assets in the form of staff, information, and infrastructure. With the efficiency and reach they provide, CSC believes housing providers could assist in achieving many of Vermont's health-care reform goals. The SASH program links staff based in the housing property (a SASH coordinator and wellness nurse) with a team of community-based health and supportive services providers to help older adults coordinate and manage their care needs. Using evidence-based practices, key services include assessment by a multidisciplinary team, creation of an individualized care plan, on-site nursing and care coordination with team members and other local partners, and community activities to support health and wellness. SASH is anchored in affordable senior housing properties, serving residents in the property and seniors living in the surrounding community.

In 2010, the state of Vermont applied to join the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration. The MAPCP Demonstration aims to promote the principles of the patient-centered medical home (PCMH) by helping fund participating practices and Community Health Teams (CHTs). A medical home, in broad terms, is a physician-directed

practice that provides care that is "accessible, continuous, comprehensive and coordinated and delivered in the context of family and community" (AOA 2007; Barr 2008). As the state began preparing its MAPCP Demonstration application, the state decided to incorporate the SASH program as an extender of the CHTs. In July of 2011, the SASH program was officially launched with the opening of the Heinsberg panel.

The Department of Housing and Urban Development (HUD), the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration on Aging (AoA) at the Department of Health and Human Services are conducting a comprehensive evaluation of the SASH program that builds on the CMS-funded MAPCP Demonstration evaluation. The evaluation will assess whether the SASH model of coordinated health and supportive services in affordable housing improves quality of life, health and functional status of participants. It will also examine whether the systematic linking of housing and services in an affordable housing setting has observable savings in care costs for seniors.

This OMB application seeks approval to conduct a survey to assess the impacts of the SASH program on health outcomes by comparing SASH participants to peers living in affordable housing but not participating in SASH. Information that will be collected includes general health status, functional status, quality of life, medication problems, and dietary issues. The SASH survey instrument includes standardized scales with demonstrated reliability and validity in older adults, such as the RAND-12, the Activities of Daily Living Questionnaire, and the EQ-5D.

The target population for the survey is Medicare fee-for-service (FFS) and dually eligible Medicare and Medicaid beneficiaries who reside in SASH supported housing or its local area in Vermont. As of March 2013, around 2,000 Medicare beneficiaries were participating in the SASH program.

A.1 Need and Legal Basis

The contract issued by HUD, ASPE, and AoA requires a comprehensive evaluation of the Vermont SASH program. The evaluation must focus on the quality of life, health, and functional status of participants.

A.2 Information Users

The survey results will be used by ASPE/HUD/AoA to answer research questions such as:

- Do SASH participants have better physical function and better health relative to their non-SASH peers in affordable housing?
- Do SASH participants have fewer problems managing their medications?
- Do SASH participants have better overall nutrition?
- Do outcomes differ for SASH participants residing in the community compared with SASH participants living in affordable housing properties?

A.3 Use of Information Technology

The survey will make minimal use of information technology. The survey is being conducted via mail. We will prepare the questionnaire as a scannable form, allowing for easy data capture of returned surveys.

A.4 Efforts to Identify Duplication

The evaluation has been designed to comprehensively address the research questions while minimizing the burden placed on the SASH program staff, their partners (e.g., service providers), and Medicare and dually eligible Medicare and Medicaid beneficiaries.

Care has been taken to ensure that there is no overlap between other ongoing state evaluations, such as the MAPCP Demonstration evaluation. Through our ongoing discussions with SASH program staff and other state officials in Vermont, we determined that the information we seek to collect is not already being collected from our proposed sample, nor can it be measured from claims data. We will continue to monitor state survey activities to identify any surveys that may be planned for the same time period as our survey. In cases of overlap, we will collaborate with the state to avoid duplication.

As a result of these efforts, the information collected through the survey will not duplicate any other effort and is not obtainable from any other source.

A.5 Involvement of Small Entities

The collection of information associated with data submission does not unduly burden small business or small health systems, medical groups or practices. The information being requested is held to the absolute minimum required for the intended uses.

A.6 Less Frequent Collection

The survey will be conducted one time with each respondent. There are no other sources for the information to be collected.

A.7 Special Circumstances

There are no special circumstances.

A.8 Federal Register/Consultation Outside the Agency

The 60-day Federal Register Notice was published on November 14, 2013, Volume 78, Number 220 pages 68448-68449. No comments were received.

A.9 Payments/Gifts to Respondents

No remuneration will be offered to the survey participants. This practice is consistent with other mail surveys of beneficiaries, such as the Consumer Assessment of Healthcare Providers and Systems surveys.

A.10 Confidentiality

Materials sent to potential respondents will describe the purpose and the voluntary nature of the survey and will convey the extent to which respondents and their responses will be kept private to the extent allowable by law. Survey respondents will be identified only by a sequential survey identification number. The survey database will be stored on a secured server and password-protected computers. All personnel who will have access to surveys and/or individual identifiers will be trained on the significance and protection of confidentiality, particularly as it relates to controlled and protected access to survey data and summary files, Staff will be required to sign confidentiality statements accordingly.

A.11 Sensitive Questions

Information collected in the survey is not of a sensitive nature. Questions in the beneficiary survey are confined to health outcomes. The survey does not contain any open-ended questions.

A.12 Burden Estimates (Hours and Wages)

Estimates of survey burden in terms of hours and annualized costs are shown in the two tables below.

TABLE A.12 - 1 ESTIMATED BURDEN HOURS

	Estimated Annual Number of Respondents	Estimated Number of Responses for all Respondents	Average Burden Hours for all Responses	Estimated Total Annual Burden Hours Requested
Summary of Burdens	669	1	20/60	223

TABLE A.12 - 2 ANNUALIZED COST TO RESPONDENTS

	Number of Respondents	Frequency of Response	Average Time per Respondent	Hourly Wage Rate	Respondent Cost – all respondents
Summary of Costs	669	1	20/60	$12.45*	$2,776

*Taken from the median Medicare income level as provided in The Henry J. Kaiser Family Foundation, Medicare Chartbook, Fourth Edition, 2010, http://www.kff.org/medicare/upload/8103.pdf

A.13 Capital Costs

There are no capital costs.

A.14 Costs to Federal Government

Total costs are estimated to be $136,775. These costs are funded through an existing ASPE/HUD/AoA contract with RTI International.

Federal FTE costs are expected to be negligible. The Project Officer for the ASPE/HUD/AoA contract with RTI is expected to spend about 0.2% of her time on the administration of this survey.

A.15 Changes to Burden

This is a new data collection for ASPE/HUD/AoA.

A.16 Publication/Tabulation Dates

No information about individual beneficiaries will be published. Summary scores for the key beneficiary survey domains will be weighted for sample design and response propensity. These results will appear in a comprehensive evaluation report, which will be submitted to ASPE/HUD/AoA near the conclusion of the project. Summary results will also be included in the second year interim findings memorandum. The memorandum is intended to be posted on the ASPE and HUD Web sites.

A.17 Expiration Date

The OMB expiration date will be displayed on all disseminated data collection materials.

REFERENCES

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