



RESEARCH SUMMARY

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY

SUPPORT AND SERVICES AT HOME (SASH) EVALUATION: HIGHLIGHTS FROM THE FIRST FOUR YEARS

Evaluation Overview

The Support and Services at Home (SASH) program, launched in July 2011, is designed to connect older adults living in affordable senior housing properties in Vermont with community-based health care and support services, in order to promote greater care coordination, improve health status, and slow the growth of health care expenditures. Under contract from the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Housing and Urban Development (HUD), RTI International and the LeadingAge Center for Applied Research conducted an evaluation of the SASH program using data collected from interviews with SASH staff and key stakeholders, a SASH panel cost survey, a Medicare beneficiary mail survey, and Medicare claims. The evaluation examines the implementation of the SASH program and compares health outcomes and service utilization of SASH participants with those of Medicare beneficiaries living in HUD-assisted properties not participating in SASH. We describe the primary features of the SASH program and summarize the main findings of the evaluation.

What is SASH?

The SASH program was created to meet the complex health care needs of older adults and individuals with disabilities living in affordable housing properties. In conjunction with the Community Health Teams (CHTs) that were part of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration in Vermont, the SASH program facilitates a range of support and in-home services for its participants. Each SASH “panel” consists of up to 100 participants served by a full-time SASH coordinator and a quarter-time wellness nurse; almost all of the 54 SASH panels are hosted by non-profit housing organizations and located in HUD-assisted or other non-profit affordable housing properties. Using evidence-based practices, key services provided by core SASH staff include comprehensive health and wellness assessments, creation of individualized care plans, on-site one-on-one nurse coaching, care coordination, and health and wellness group programs. Formal community partners collaborate with the core SASH staff to coordinate care and services for participants and offer on-site health and wellness programming.

Who are the “Community Participants”?

Although SASH was originally created to help meet the needs of older adults and individuals with disabilities living in affordable housing sites (“site-based participants”), the program is available to any Medicare beneficiary living in surrounding communities (“community participants”). SASH panels established before April 2012 (“early panels”) primarily serve residents in affordable housing sites; these are “site-based panels.” As the SASH program expanded statewide, some panels based in affordable housing sites were created to serve a mixture of site-based and community participants (“mixed-panels”), and a few panels were created solely for community participants (“community panels”). “Late panels,” established after April 2012, include site-based panels, mixed-panels, and community panels.

Community participants receive the same services as site-based participants. From the claims data analysis, community participants were found to have more health care needs and higher health care expenditures compared to site-based participants. SASH staff also reported that community participants have more environmental issues with their homes compared to site-based participants, ranging from inaccessibility to severe dilapidation.

How are SASH Participants Recruited?

To reach potential participants, SASH Team members use word of mouth, host informational events, and produce local advertisements (newspaper articles and television programs). Additionally, health care providers, community partners, hospitals, and CHT members make referrals to the program. As of June 2015 there were 54 SASH panels, and 4,741 individuals had participated in the SASH program for at least 3 months. Of those participants, approximately one-quarter were living in the community.

How is SASH Funded?

Funding sources for the SASH program during the evaluation period included the HHS Centers for Medicare & Medicaid Services (CMS); Vermont Medicaid; the Department of Disabilities, Aging and Independent Living; the Department of Vermont Health Access; the Department of Health; and various foundations. The CMS funding, which was provided through the MAPCP Demonstration and was the largest source of funding for the SASH program, ended in December 2016. Beginning in January 2017, Vermont moved to an All-Payer Accountable Care Organization Model, and SASH funding continues under that model.

From July 2011 through December 2016, each SASH panel received \$68,600 per year to cover the salaries of a full-time SASH coordinator and a quarter-time (10 hours per week) wellness nurse. The survey of SASH panels revealed that the annual cost of operating a SASH panel was between \$76,100 and \$83,300 per year, meaning that the panels surveyed had an annual operating cost gap of \$7,500 to \$14,700.

What did the Evaluation Find?

- SASH staff work with participants to improve their self-management of health care issues and work with both participants and property managers to address environmental issues that could contribute to falls; these efforts have the potential to positively impact the health and functional status of participants. From the survey of Medicare beneficiaries, SASH participants reported higher overall functional status compared to survey respondents who were not participating in SASH. SASH participants and comparison group beneficiaries reported similar ability to perform basic daily activities and similar overall health status. SASH staff interviewed during the evaluation believed participants were well-educated about their health issues and that SASH helped participants learn self-care and disease self-management skills. SASH participants and wellness nurses were able to identify health issues early before those issues progressed to more serious incidents.
- Analysis of Medicare claims data indicated that SASH participants in the early panels--which included 40% of the site-based participants with Medicare coverage--had lower rates of all-cause hospital admissions compared to non-participants. However, there was no evidence that the SASH program reduced the rates of emergency room visits.
- Medicare claims data also showed that, among the site-based SASH participants in early panels, growth in annual Medicare expenditures was slower by an estimated \$1,227 per-beneficiary per year. These same beneficiaries in the early panels also had slower rates of growth for hospital and specialty physician costs. However, there was no evidence that the SASH program decreased Medicare expenditures for the participants in the late panels.
- SASH participants reported having significantly less difficulty with common medication management tasks compared to Medicare beneficiaries who were not in the SASH program, according to survey results. Site visit interviewees described how SASH staff help identify participants' potential medication problems early and prevent medication mismanagement.
- To achieve its goal of improving participant health, the SASH program seeks to empower participants with knowledge and skills to improve their nutrition and dietary habits. Our interviews highlighted that program staff encourage participants to eat healthier foods, educate participants on nutrition and food labels, and connect participants to nutrition-related resources in the community. These efforts are designed to help participants access healthy food and improve their diets. However, there was no evidence from the beneficiary survey that the SASH program improved participant nutrition, compared to similar Medicare beneficiaries who were not participating in the SASH program.
- Property managers and SASH staff interviewed by the evaluation team reported that the SASH program has been successful in helping participants remain in

their homes, both in terms of aging in place as their health and functional needs increase and in helping participants avoid eviction. SASH staff help ensure that participants have the services and resources needed to be safe in their apartments and uphold their tenancy obligations.

- From our interviews with stakeholders, one of the most commonly described successes of the SASH program was the creation of linkages between participants and vital resources in the community. Having connections with a diverse team of service, health care, and housing providers enables better coordination of care for SASH program participants.

What are the Lessons for Replication?

- Across both site-based and community-based panels, site visit interviewees emphasized the limited number of wellness nurse hours as one of the challenges in the SASH program. Increasing the wellness nurse hours could result in larger impacts on participants, especially those participants living in the community. In discussing the greater needs of community participants during site visits, SASH staff felt that a manageable panel would include no more than one-third to one-half community participants.
- While we see slower growth in Medicare spending in the “early panels” (which are predominantly site-based and in more urban areas), we do not see the same trend for the “later panels” (which are more rural and have more community participants). This may be because of the greater needs of community participants or the greater travel time required for staff to meet with community participants. Site-based participants may benefit more from the program than the community participants because the SASH staff offices and the group programming are in closer proximity, located in their housing properties. We do not have enough information from our evaluation to know for certain which, if any, of these hypotheses explain the difference between the outcomes for the early and late panels.
- Implementation of a comprehensive training program was identified as an operational success by interviewees. A training program for new staff, as well as ongoing training for existing SASH staff, ensures that staff maintain the necessary knowledge and skills to best serve SASH participants.
- A focus of the SASH program is building relationships and fostering greater collaboration across community organizations, which in turn can help connect SASH participants to a variety of needed services and resources. While some partner agencies perceived that SASH activities are a duplication of services already being provided, others felt that the relationship with the SASH Team was collaborative and that the SASH program complemented their own services. Other communities seeking to implement SASH-like programs should plan to spend time educating partner agencies and clearly delineating roles and

responsibilities across organizations and programs, to avoid any real or perceived duplication of services.

Conclusion

The SASH program is designed to promote greater care coordination for a population of older adults and individuals with disabilities who have high-cost health care needs and who are living in affordable housing properties and the surrounding communities. The program's unique contribution is its use of teams embedded in affordable housing properties as a platform to connect residents to health services and social supports. The evaluation identified many successes attributable to the SASH program as well as challenges to consider when implementing any similar housing with services program.

This Research Summary describes the primary features of the SASH program and summarizes the main findings of the evaluation to date. The Summary was authored by Amy Kandilov, Vincent Keyes, Noelle Siegfried, Kevin Smith, Patrick Edwards, Jenna Brophy, Aubrey Collins, Ann Larsen and Martijn Van Hasselt from RTI International, and Alisha Sanders and Robyn Stone from LeadingAge Center for Applied Research.

This Summary was prepared under contract #HHSP23337006T between HHS's ASPE/DALTCP and RTI International. For additional information about this subject, you can visit the DALTCP home page at <https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltp> or contact the ASPE Project Officer, Emily Rosenoff, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Emily.Rosenoff@hhs.gov.

The opinions and views expressed in this Summary are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

SUPPORT AND SERVICES AT HOME (SASH) EVALUATION

Reports Available for This Project

SUPPORT AND SERVICES AT HOME (SASH) EVALUATION: FIRST ANNUAL REPORT

- HTML <https://aspe.hhs.gov/report/support-and-services-home-sash-evaluation-first-annual-report>
- PDF <https://aspe.hhs.gov/pdf-report/support-and-services-home-sash-evaluation-first-annual-report>

SUPPORT AND SERVICES AT HOME (SASH) EVALUATION: SECOND ANNUAL REPORT

- HTML <https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-second-annual-report>
- PDF <https://aspe.hhs.gov/pdf-report/support-and-services-home-sash-evaluation-second-annual-report>

SUPPORT AND SERVICES AT HOME (SASH) EVALUATION: HIGHLIGHTS FROM THE FIRST FOUR YEARS

- HTML <https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-highlights-first-four-years-research-summary>
- PDF <https://aspe.hhs.gov/pdf-report/support-and-services-home-sash-evaluation-highlights-first-four-years-research-summary>

SUPPORT AND SERVICES AT HOME (SASH) EVALUATION: EVALUATION OF THE FIRST FOUR YEARS

- HTML <https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-evaluation-first-four-years>
- PDF <https://aspe.hhs.gov/pdf-report/support-and-services-home-sash-evaluation-evaluation-first-four-years>

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U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
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Washington, D.C. 20201
FAX: 202-401-7733

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