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R3: *Right Care, Right Place, Right Time*

Analysis of Interviews with Housing and Community Partners

Prepared for
Hebrew Senior Life

Edward Alan Miller, PhD, MPA
Elizabeth Simpson, MPH
Pamela Nadash, PhD, BPhil
Natalie Shellito, MA
Taylor Jansen, BS
Yan Lin, PhD
Marc Cohen, PhD

February 28, 2020

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EXECUTIVE SUMMARY

This report presents findings from interviews conducted with housing and community partners participating in the Right Care, Right Place, Right Time (R3) program. The R3 program consists of two on-site wellness teams that provide services in four affordable housing communities. Each R3 wellness team, which includes a wellness nurse and a wellness coordinator (social worker by training), serves two sites, respectively, in the Boston and South Shore regions: one Hebrew SeniorLife (HSL) and one non-HSL affiliated. The evaluation team conducted in-depth interviews with 24 housing and community partners from November 2 to December 19 2018. Interviewees were asked to share perspectives about their organization's reasons for participating with the R3 program, as well as its role, as applicable, in program design, development, launch, implementation, and ongoing operations. They were asked about what they liked and did not like about R3 and how it could be improved. Participants were additionally asked about their experiences working with the wellness teams and the extent to which R3 met expectations for desired outcomes, as well as the ongoing sustainability and replicability of the program.

REASONS FOR PARTICIPATING IN THE R3 PROGRAM

Housing and community partners described a range of resident and housing/system-related reasons underlying their organization's decision to participate in the R3 program. Resident-related reasons include: serving residents better, supporting aging in place, and meeting the needs of an increasingly complex resident population. Housing/system-related reasons include: enhancing available resources, having a national impact on senior care, focusing on the social determinants of health, and reducing non-emergency/unnecessary EMS utilization.

OVERALL ASSESSMENT OF THE R3 PROGRAM

Housing partners overwhelmingly reported positive overall assessments of the R3 program. Community partners also reported positive overall assessments of R3, including individuals representing the first responder agencies, Aging Services Access Points (ASAPs), and Health Policy Commission, R3's primary funder. Some partners, however, expressed uncertainty about overall program performance despite otherwise positive feelings about R3. This uncertainty largely derived from the perceived newness of the program—though it had been implemented for a year and a half or more when the interviewees took place—as well as limited evaluation findings generated to date. Some interviewees expressed concern about the negative fallout that would follow the cessation of program activities, no matter when R3 ended, in light of perceived program benefits. A few interviewees suggested the need to ease residents out of the program should it eventually be withdrawn from the housing sites.

BENEFITS OF R3 FOR RESIDENTS

Housing and community partners described a range of concrete and psychosocial benefits housing residents derived from participating in the R3 program. Concrete benefits included: receiving additional attention and support; connecting with family, physicians, and other resources; enhancing available wellness programming; preventing ambulance transports; helping with transitions; improving health; and increasing quality of life. Psychosocial benefits included:

empowering program participants; providing socio-emotional support; and alleviating psychosocial distress. Additionally, several partners reported benefits accrued, in part, to non-participating housing residents through wellness programming and referrals.

BENEFITS OF R3 FOR HOUSING PARTNERS

Housing and community partners described a range of staffing, resident, and housing-related benefits to the housing sites from participating in the R3 program. Staffing-related benefits included: augmenting staffing levels and skills and enhancing existing staff capabilities. Resident-related benefits included: proactively tracking and responding to resident needs and lowering resident turnover. Housing-related benefits included: extending and supplementing wellness programming and learning from and adopting procedures and processes underlying the R3 philosophy.

IMPLEMENTING R3 AT THE HOUSING SITES

Housing partners described how relationships with HSL informed the housing partner role in the R3 program. They also highlighted the key role played by senior management support in facilitating implementation of the program. At program launch, housing partners stressed the importance of educating housing staff about R3, on the one hand, and onboarding wellness team members at the housing sites, on the other hand. Several housing partners noted the time consuming and resource intensive nature of implementing R3, at least initially. It was reported, however, that HSL and housing partner staff have worked well together in implementing R3; the non-HSL housing partners, in particular, reported feeling valued/satisfied with their role.

WELLNESS TEAM STAFFING

Housing partners found wellness team members highly likeable, noting several positive personality attributes. Most concluded that wellness team members fit well with other housing staff and were generally a visible presence within their housing communities. This visibility, in turn, had positive implications for establishing relationships with residents, which, in turn, enhanced program effectiveness. Still, housing partners reported challenges posed by wellness team availability. These challenges stemmed from the limited number of hours spent at specific sites and buildings and the diverse array of tasks and responsibilities undertaken. They also stemmed from the need for other housing staff to fill in and cover when wellness team members are off site. Strategies suggested for improving wellness team availability generally revolved around the provision of additional hours, but also included additional or different types of staff.

PROGRAM RECRUITMENT AND ENGAGEMENT

Housing and community partners indicated that recruitment and engagement have been impeded by privacy and confidentiality concerns, a lack of clarity and understanding, and language and mental health challenges. On the other hand, they reported that recruitment and engagement has been facilitated by the involvement of existing housing staff, as well as resident and participant exposure to the wellness teams and R3-sponsored programming. The development of trust between wellness team members and residents/participants has played a particularly important

role in this regard. Housing partners explained that initial recruitment into R3 went well, but that ongoing recruitment has been harder. Thus, in order to maintain momentum, partners suggested the need to continue promoting recruitment and engagement. Strategies proposed included: focusing on higher need, harder to reach residents, marketing to non-participants (e.g., holding meet-and-greets, employing rewards/other incentives), developing a clearer and simpler description of the R3 program, using concrete examples of R3's successes, adding more wellness programming, promoting the program through family, and serving entire buildings.

WELLNESS TEAMS AND HOUSING STAFF COMMUNICATION

Housing partners were largely satisfied with the degree of communication and collaboration that has taken place with wellness team members, though a few partners highlighted communication challenges. Housing partners reported interacting with wellness team members both formally and informally through regularly scheduled meetings, email, phone calls, and ad hoc in-person contact. Most housing partners reported that wellness team members collaborate with other housing staff to meet participants' needs. Key dimensions of this collaboration include: exchanging information about particular program participants, deliberating about how best to address those issues, and determining who will take the lead in doing so. Housing partners reported the steps required to coordinate and schedule R3-sponsored wellness programming organized by wellness team members, including balancing the amount of programming available at the housing site with the need to promote participation.

COMMUNITY PARTNERS

General strategies noted for forming effective community partnerships include: building on existing relationships and identifying a common theme or purpose on which to ground the collaboration. Initial funding may have attracted participation among some community partners, but natural reasons and incentives are required to engender long run involvement. Ultimately, each community partner rated their experience with HSL and the R3 program positively.

FIRST RESPONDERS

The emergency medical services (EMS) partners representing Randolph Fire Department and Fallon Ambulance Service reported that strong partnerships with the R3 program were facilitated by familiarity with the housing sites. Specific activities include: continuing to conduct onsite activities performed prior to participation in R3, in addition to sharing data on calls and transports with wellness team members. Beyond serving residents better by reducing unnecessary or preventable calls and transports, the perceived benefits to participating in R3 differed somewhat between the two EMS agencies, largely due to the different financial models under which both organizations operate. Going forward it was suggested that R3 staff connect more with direct service personnel at the EMS providers. Varying views were shared about the potential appeal of the R3 program for other EMS agencies. Brookline Police Department, in the Boston region, has partnered with R3 as well, with wellness team members attending meetings and serving as a source of contact and referral for the Department's Crisis Intervention Team.

AGING SERVICES ACCESS POINTS (ASAPS)

The ASAP personnel from Springwell and South Shore Elder Services reported challenges pertaining to the lack of funding to pay for enhanced contact with the housing sites, potential duplication in the R3 and ASAP roles, and the capability and inclination of other ASAPs to participate in the program. Still, they felt that collaboration was a natural fit due to consistency between R3 and the ASAP model and philosophy, both generally, in relation to improving information sharing and linkages to community resources, and specifically, with respect to each ASAP's particular approach to supporting housing providers and residents. The ASAPs' day-to-day experience with the R3 program largely involved interaction between wellness team members and ASAP case managers and subcontracting providers. Housing and ASAP partners described different processes of communication with the Boston- and South Shore-based wellness teams, with communication largely occurring on an as-needed basis with respect to the former, and more formally through regularly scheduled meetings in the case of the latter.

HOSPITALS

Housing and community partners observed little headway in forging productive connections with hospitals. Thus, R3 has been unable to acquire utilization data to inform care planning and evaluation, nor engaged in meaningful day-to-day communication with discharge planning and other hospital staff. Challenges reported by partners included: the large number of admitting hospitals; staff turnover; and, in the case of some South Shore hospitals, limited decision-making authority. Strategies suggested by partners for promoting hospital engagement included: demonstrating positive impact for the bottom line, bringing staff from the local housing site to meetings at the hospital, connecting with hospitals through the HSL liaison, and contacting middle management rather than senior executive or front-line staff. One community partner, a representative from Tufts Health Plan, commented on the initial and ongoing role of Tufts in the R3 program. Impediments to insurer participation in the R3 program were discussed, in addition to suggestions for improving the insurer role.

INSURERS

Only Tufts Health Plan, in its limited advisory role, has participated in the R3 program, though it subsequently agreed to pilot a sustainable funding model during the program's second phase, $R3^2$. One impediment to insurer involvement pertains to the limited proportion of residents covered by each health plan at the housing sites. The other impediment pertains to the arm's length relationship insurance case managers often have with beneficiaries. A partner from Tufts Health Plan made two suggestions for improving the insurer role: incenting collaboration among care managers, and having insurers contract directly with the R3 program to provide some services (e.g., care coordination/management).

HEALTH POLICY COMMISSION

The R3 program was funded by the Health Policy Commission (HPC) and other supplemental funders. Staff from the HPC reported that the R3 program's innovative approach to addressing cost drivers in health care at the intersection of acute care, long-term care, and the social

determinants of health proved an excellent fit for the HPC. It was reported that the HSL has been a model awardee—proactive, responsive, collaborative, innovative, adaptive, and focused on replication. Beyond funding, the HPC played a range of roles in the R3 program, particularly in informing the design and evaluation and providing advice on ongoing operations.

SUSTAINABILITY

During the interviews, housing and community partners identified funding as the largest obstacle to the sustainability of the R3 program. The partners thus shared the belief that creating an evidence-base documenting the successes of the R3 program will prove essential for garnering support for the program. Partners described potential costs and benefits that should be measured in proving the R3 program out, in addition to the role that the data could play in engendering buy-in from potential funders, specifically. They pointed to staffing as the primary additional cost deriving from the R3 program. In contrast, they highlighted a range of potential benefits that could be tracked, including reductions in long-term care and health system costs, particularly related to hospitalizations and emergency department visits. They also included improvements in resident health and quality of life in relation to such areas as exercise, socialization, nutrition, falls, and the ability to access services through program staff. Potential long-term sources of funding included: insurance companies, Medicare, MassHealth, public housing programs, health care providers, housing providers, and resident fees and family contributions.

REPLICABILITY

Housing and community partners agreed that a primary goal of the R3 demonstration is to further the diffusion of the program to other housing sites around the country. Partners expected the demonstration to promote this diffusion, in part, by serving as an example of what is possible when affordable senior housing communities adopt additional services and supports, and by leading to the production of a manual or guide that could be useful to replicating sites during implementation of the R3 program elsewhere. It was stressed that funding is a precondition for housing site adoption of the R3 program; so too is demonstrating the expected benefits to housing communities from doing so. Partners touted the importance of industry-level communication mechanisms in promoting the diffusion of the R3 program. Even with potential benefits, executive leadership at the housing sites need to be willing to do something different, perhaps even taking the “long view” on the potential return on investment or accepting a certain amount of upfront financial risk. Housing and community partners noted several “lessons learned” that may be helpful to other sites replicating the R3 program, including: ensuring strong support among housing site executives, becoming more engaged when interacting with residents, catering to the local housing community/context, forming relationships with local EMS and other community partners, and hiring the “right staff.”

INTRODUCTION

This report presents findings from interviews conducted with housing and community partners participating in the Right Care, Right Place, Right Time (R3) program. The R3 program consists of two on-site wellness teams that provide services in four affordable housing communities. Each R3 wellness team includes a wellness coordinator and a wellness nurse. The wellness coordinator is charged with directing relationships with health care providers, educating and promoting self-directed care, and enhancing connections with services. The wellness nurse is charged with facilitating transitions, monitoring at-risk residents, and communicating with payers and care managers. Two senior staff also take primary roles in administering the R3 program, one project leader and one program director.

All residents aged 62 years or older are eligible to participate. The implementation period ran from July 1, 2017 to December 31, 2018, preceded by a sixth month preparation period (January 1, 2018 to June 30, 2018). The program has since been extended for two years as $R3^2$ (January 1, 2019-December 31, 2020). The underlying notion is that by offering greater coordination of providers and services, empowering residents with education and knowledge about how to access needed assistance, training other staff members who are on site, and enabling more timely responses to the needs of residents, there will be fewer transfers from home to either the hospital and/or emergency departments or long-term care facilities. In other words, the wellness teams are intended to act as a bridge between the housing infrastructure and health and supportive care system.

Each participating affordable housing site offers a range of services. All four sites provide residents with core supports: a resident service coordinator, fitness, and programming. Two service-enriched sites offer residents additional supports: dining, Vitalize 360 (a person-centered wellness coaching system, see www.vitalize360.org), facilitated access to HSL-sponsored home care services, and, in the case of one site, a medical practice. The two service-enriched settings are operated by Hebrew SeniorLife (HSL) (Sites 1.a and 2.a); the other two sites consist of a for-profit housing provider and a non-profit housing provider (Sites 1.b and 2.b, respectively).

Each wellness team is responsible for about 200 participants across two intervention sites, including one of the service-enriched sites. The wellness team in the Boston region serves R3 program participants at Sites 1.a and 1.b located in Brookline, Massachusetts; the wellness team in the South Shore region serves R3 participants at Sites 2.a and 2.b just South of Boston. Overall, the R3 program was implemented in seven affordable housing buildings, including two single building sites (1.b and 2.a), one two building site (2.b) (with one "building" consisting of five smaller dwellings), and one three building site (1.a).

The evaluation team conducted in-depth interviews with 24 housing and community partners from November 2, 2018 to December 19, 2018; 10 interviews took place in person and 14 interviews took place over the telephone. In all, 16 housing partner staff and 8 community partner staff participated in the interviews. The housing partner staff interviewed include 9 individuals from the HSL sites (5 from Site 1.a and 4 from Site 2.a) and 7 individuals from the non-HSL sites (3 from Site 1.b and 4 from Site 2.b). The objective was to interview housing staff with the greatest knowledge and involvement with the R3 program. The specific positions

represented depended, in part, on how staffing at the sites were configured, but included executive directors (2), resident services coordinators (3), and directors of community life (2), as well as social services (1), activities (1), fitness (1), and facilities (2) staff. Other staff embedded at the sites—a nurse practitioner (1), clinical liaison (1), program coordinator (1), and executive vice president (1) at one of the parent companies—were interviewed as well. The community partner staff interviewed included administrative staff at the participating first responder agencies (4) and chief executive officers at the participating Aging Services Access Points (ASAPs) (2). They also included senior management at the Health Policy Commission (1), which provided key funding for the R3 Program, and Tufts Health Plan (1), which had long been in discussions with HSL about the insurer role in housing plus services.

Interviewees were asked to share perspectives about their organization's reasons for participating in the R3 program, as well as its role, as applicable, in program design, development, launch, implementation, and ongoing operations. They were asked about what they liked and did not like about the way the R3 program operates and how the program could be improved. Participants were additionally asked to reflect on their organization's experiences working with R3 staff and to what extent the R3 program met expectations for desired outcomes. They were asked about the ongoing sustainability of the R3 program and its replicability in other settings as well.

The interviews were audio-recorded and transcribed by an independent transcription company. The research team worked together to identify and verify themes and subthemes across the seven interviews. The analysis used NVivo 12, a software program that supports qualitative and mixed methods research. It is designed to help organize, analyze, and find insights in unstructured or qualitative data. Institutional Review Board approval for the evaluation was obtained.

We begin by describing our findings regarding housing and community partner reasons for participating in the R3 program. Next, we report interviewees' overall assessment of the program before discussing program benefits for residents and housing sites. Then, we report on key implementation issues, wellness team staffing, resident recruitment and engagement, and wellness team/housing staff communication. This is followed by a review of the community partner role, focusing mainly on first responders and Aging Services Access Points, but also discussing hospitals, insurers, and the Health Policy Commission. We conclude by reviewing partners' reflections on R3 program sustainability and replicability.

REASONS FOR PARTICIPATING IN THE R3 PROGRAM

Housing and community partners described a range of resident and housing/system-related reasons underlying their organization's decision to participate in the R3 program.

RESIDENT-RELATED GOALS

Resident-related reasons for participating in the R3 program include: serving residents better, supporting aging in place, and meeting the needs of an increasingly complex resident population.

Serving Residents Better

Interviewees indicated that their organizations elected to participate in the R3 program, in part, due to the potential to improve the health and quality of life of seniors residing in affordable housing communities. Interviewees also indicated that their organizations elected to participate in the R3 program to increase access to available services and supports.

Supporting Aging in Place

Most partners reported the desire to promote aging in place as a reason for participating in the R3 program. This emphasis on aging in place is reflected, in part, in the objective of enabling seniors to live on their own longer. It is also reflected, in part, in the objective, particularly among the non-HSL housing sites, to reduce turnover and increase the attractiveness of the housing community among the resident population.

Living Independently as Long as Possible. Most housing partners indicated that their organizations chose to participate in the R3 program, in part, because of its potential for helping residents to live independently as long as is safely possible.

Lower Turnover among the Resident Population. Relatedly, several housing partners identified lowering resident turnover as one reason that their organizations decided to participate in the R3 program given the lost rent, refurbishing, and other costs associated with turning over a unit.

Increase Attractiveness of the Housing Community. A few housing partners pointed to the opportunity to "stand out" that the R3 program provides, thereby increasing the attractiveness of the housing property to current or prospective residents. This appeal may, then, help to reduce turnover while facilitating recruitment of residents when vacancies do arise.

Meeting the Needs of Increasingly Complex Residents

A few of the HSL housing partners and ASAP staff reported the imperative to serve and meet the needs of an increasingly complex and frail resident population—some of whom might have previously stepped-up to nursing home level care—as a factor spurring participation in the R3 program.

HOUSING/SYSTEM-RELATED GOALS

In addition to resident-related reasons for participating in the R3 program, housing and community partners identified several housing/system-related reasons for doing so. These include: enhancing available resources, having a national impact on senior care, focusing on the social determinants of health, and reducing non-emergency/unnecessary EMS utilization.

Enhancing Available Resources

Some housing partners highlighted the prospect of enhancing available resources within the housing community and the ability to offer more services to residents as an attractive reason for

participating in the R3 program. Specific resources indicated include expected increases in staffing and programming that involvement in the R3 program would provide.

Increases in Staffing. Staffing was the most frequently expected enhancement identified by interviewees, both with respect to the increase in staffing generally and with respect to the addition of staff with particular expertise (e.g., a nurse and social worker).

Increases in Programming. One interviewee identified several additional programming options expected to benefit residents under R3.

Having a National Impact on Senior Care

Most housing and community partners reported that their organizations chose to participate in the R3 program, in part, as a means of impacting senior care nationally. This objective was reflected in the desire to influence the provision of services and supports within the independent living industry generally. It was also reflected in the desire to demonstrate the cost effectiveness of the R3 program specifically, thereby bolstering its sustainability and replicability in other housing settings.

Broadly Impacting the Independent Living Industry. Many housing partners indicated that the appeal of the R3 program stemmed, in part, from the opportunity to demonstrate an innovative and potentially industry transforming approach to integrating health care into senior living.

Demonstrating the Cost Effectiveness of the R3 Model. Some housing and community partners indicated that the appeal of the R3 program stemmed, in part, from the evaluation component of the initiative whereby cost effectiveness and/or cost savings of the R3 model could be demonstrated.

Demonstration Results Leading to a Sustainable and Replicable Model. A few housing partners took the appeal of the research component a step further, proposing that it could serve as a means to justifying the funding needed to sustain and expand the model once the demonstration concluded.

Focusing on the Social Determinants of Health

Several community partners pointed to a desire to target the social determinants of health as a factor spurring their organizations to participate in the R3 program. Here, the objective is to overcome the disconnect between health care and housing given recognition that housing plays a critical role in influencing health, and that further integration of health care into housing could generate significant dividends in this regard.

Reducing Unnecessary Ambulance Transports to the Emergency Department

Both the housing partners and first responders identified the need to reduce unnecessary and non-emergent ambulance transports to the emergency department as a reason for participating in the

R3 program. This desire to reduce ambulance service calls and transports stemmed, in part, from the recognition that unnecessary transports were not a good use of available resources and potentially harmful to older adults themselves. It also stemmed, in part, from the recognition that a good proportion of transports might be avoided through the provision of additional services and supports at the housing sites (e.g., resident education, care planning, falls prevention programming).

OVERALL ASSESSMENT OF THE R3 PROGRAM

Housing and community overwhelmingly reported positive overall assessments of the R3 program. Still, there were some uncertainties reported, as well as concerns about the future, in light of the positive overall perceived impact of the program.

POSITIVE ASSESSMENT

Housing partners at both the HSL and non-HSL housing sites reported positive overall views of the R3 program. Community partners also reported positive overall assessments of R3, including individuals representing the first responder agencies, Aging Services Access Points (ASAPs), and Health Policy Commission, the R3 program's primary funder.

UNCERTAINTIES

Some partners expressed uncertainty about the overall performance of the R3 program despite otherwise positive feelings about the program overall. This uncertainty largely derived from the perceived newness of the program—though it had been implemented for a year and a half or more when the interviewees took place—as well as the limited evaluation findings generated by that time.

CONCERNS ABOUT THE FUTURE

The R3 program initially ran for two years (July 1, 2017 to December 21, 2018), preceded by a six-month preparation period. It was subsequently extended for two years as $R3^2$ (January 1, 2019 to December 31, 2020). Some interviewees expressed concern about the negative fallout that would follow the cessation of program activities, no matter when the R3 program ended, in light of perceived program benefits. A few interviewees suggested the need to ease residents out of the program should it eventually be withdrawn from the housing sites.

Negative Fallout for Residents If R3 Ends

It was pointed out that over time residents have come to rely on the R3 program and its services, programming, and staff. Thus, some housing and community partners feared the negative ramifications that would befall participating residents and housing sites should the program end.

Need to Ease Residents Out of the Program If It Ends

Rather than ending the program "cold turkey," a few housing partners stressed the need to transition residents out of the R3 program in an effort to mitigate the negative impact of withdrawing the program from the housing sites.

BENEFITS OF R3 FOR RESIDENTS

Housing and community partners described a range of concrete and psychosocial benefits from the R3 program.

CONCRETE BENEFITS

Concrete benefits identified by housing partners included: receiving additional attention and support; connecting with family, physicians, and other resources; enhancing available wellness programming; preventing ambulance transports; helping with transitions; improving health; and increasing quality of life.

Receiving Additional Attention and Support

A number of housing partners pointed to additional attention and support provided through the R3 program, a benefit deemed particularly important for program participants with limited or absent family care.

Increased Staffing and Services. Housing partners pointed to increased staffing and services provided under the R3 program as a concrete benefit experienced by program participants.

Complementing or Substituting for Family Members. Some housing partners reported that wellness team members serve, in part, as substitutes or complements for family members who may be unavailable or unable to help out.

Connecting with Family, Physicians, and Other Resources

Housing partners reported that wellness team members help program participants connect with available resources. Thus, in addition to communicating with family members and physicians, as needed, wellness team members connect participants to a range of other needed services and supports.

Communicating with Family Members and Physicians. Some housing partners indicated that wellness team members connect with participants' family members and physicians when needed.

Connecting with a Range of Services and Supports. Specific services and supports noted by housing partners include, for example, physician services, visiting nurse/other home care services, the Program for All-Inclusive Care for the Elderly (PACE), and, at the HSL sites, HSL affiliated providers.

Enhancing Available Wellness Programming

Housing partners pointed to wellness programming as a concrete benefit of the R3 program. In doing so, they highlighted the opportunity programming provides to increase resident socialization.

Increased Growth and Participation in Wellness Programming. Some housing partners, but especially those from the non-HSL sites, identified wellness programming as a concrete benefit of the R3 program, pointing to growth in the number and participation in available programs, as well as their health-related focus.

The Social Component of Programming. Housing partners from both the HSL and non-HSL sites recognized that programming provides opportunities for residents to socialize and develop an esprit de corps, while reducing isolation among residents who might otherwise stay within their apartments.

Preventing Ambulance Transports

The housing partners felt that the R3 program has been successful in reducing ambulance calls and transports from the housing sites. Partners attributed this perceived decline in calls and transports, in part, to resident education about 9-1-1. They also attributed the perceived decline to wellness team consultation and assistance in particular cases.

Educating Residents about Options to 9-1-1. It was reported the wellness teams had conducted programs to educate residents about the appropriate use of and alternative options to calling 9-1-1.

Providing Residents with Consultation and Assistance. It was reported wellness team members also prevent potential ambulance calls and transports by providing direct consultation and assistance to residents with medical concerns who might otherwise call 9-1-1 and go to the emergency room.

Helping with Transitions

Housing partners reported that post-hospitalization discharge assistance is a concrete benefit of the R3 program. They pointed out that lack of sufficient services and supports post-discharge is a contributing factor to rehospitalization.

Assisting Residents Post-Hospital Discharge. Older adults are sometimes discharged home without sufficient services and supports following a hospitalization or post-acute care or rehabilitation stay in a skilled nursing facility. Thus, an important program benefit, according to several partners, is assistance wellness team members provide in facilitating such transitions. This assistance involves providing some direct supports but primarily determining and arranging the services needed, including, for example, visiting nurse, home health, physical and occupational therapy, and personal attendant services.

Appropriate Transitions Reduce the Likelihood of Rehospitalization. A few housing partners stressed the importance of arranging appropriate transitions for preventing rehospitalization.

Improving Health and Quality of Life

The partners believed that the R3 program has played an important role in improving the health and quality of life of program participants. The role of medication management and fall prevention were highlighted in this regard, in addition to the increase in services and supports noted more generally. Also discussed were the residency extending implications of the health and quality of life improvements observed.

Improving Health. Some partners pointed to health improvements as a concrete benefit experienced by program participants.

Improving Quality of Life. Other partners pointed to improvement in resident quality of life as a concrete benefit deriving from participation in the R3 program.

Improving Medication Management and Fall Prevention. Medication management involves a range of activities, including holding medication clinics, setting up medication plans, helping residents organize medications, and connecting with primary care physicians, pharmacies, and other providers. Fall prevention activities include onsite fitness, balance clinics, PT/OT referrals, printed materials, housing staff education, and teaching residents how to safely get up from a fall in addition to preventing falls in the first place. A few housing partners attribute health and quality of life improvements, in part, to the medication management and falls preventions activities undertaken by wellness team members.

Extending Residency at the Housing Sites. A couple of housing partners felt that health and quality of life improvements stemming from the R3 program may have helped keep some residents in their apartments longer than otherwise would have been the case.

PSYCHOSOCIAL BENEFITS

In addition to concrete benefits, housing and community partners noted several psychosocial benefits deriving from participation in the R3 program. These psychosocial benefits include: empowering program participants, providing socio-emotional support, and alleviating psychosocial distress.

Empowering Program Participants

Several housing partners indicated that the R3 program has empowered program participants with the education, knowledge, and interest needed to make better decisions and to take the lead and responsibility for their own health and well-being.

Providing Socio-Emotional Support

Housing partners identified the provision of socio-emotional support as another psychosocial benefit deriving from the R3 program. This support includes feeling valued and cared for, having someone to talk to and problem solve with, and experiencing a greater sense of safety and security.

Directly Addressing Psychosocial Issues

Housing partners felt that the R3 program also benefits program participants by directly impacting residents psychosocially. This effect was described both in terms of alleviating psychosocial and emotional concerns generally and anxiety, depression, and isolation specifically.

BENEFITING NON-R3 PARTICIPATING RESIDENTS

Several housing partners reported that benefits from the R3 program accrue, in part, to non-participating housing residents through wellness programming and referrals.

Openness of R3-Sponsored Wellness Programming. It was pointed out that R3-sponsored wellness programming is open to everyone, regardless of participation status.

Referral of Non-Participating Residents to R3. Housing partners, particularly at the non-HSL sites, reported referring residents to wellness team members even though they are not formally R3 program participants.

BENEFITS OF R3 FOR HOUSING PARTNERS

Housing and community partners described a range of staffing, resident, and housing-related benefits to the housing sites from participating in the R3 program.

STAFFING-RELATED BENEFITS

Staffing-related benefits identified by housing and community partners included augmenting staffing levels and skills, and enhancing existing staff capabilities.

Augmenting Staffing Level and Skills

Most housing partners reported that the provision of higher staffing levels and skills as an important benefit to housing partners through participation in the R3 program. Specific benefits experienced from having additional staffing noted by the housing partners include: having someone to share the workload with; relieving burdens on existing staff; providing previously unavailable capabilities, knowledge, and skills; and adding a nurse to the housing staff, specifically.

Sharing the Workload. Housing partners appreciated having additional personnel on staff with whom to share the existing workload. Several valued being able to share their community's overwhelming social work demands with someone else, for example.

Relieving Burdens on Existing Staff. The non-HSL partners, in particular, felt that the R3 program had relieved burdens on existing staff to the extent that it has proven successful in addressing previously unaddressed issues and improving resident health and well-being.

Providing Additional Capabilities, Knowledge, and Skills. According to the housing partners, the provision of additional staff also proved beneficial to the extent that they brought previously unavailable capabilities, knowledge and skills, particularly about community resources and health and medical issues, to the housing sites.

Adding a Nurse to the Housing Site. Particularly notable to the housing partners was the addition of a nurse to the housing sites. They were appreciative of the health-related programming and interventions conducted by the two wellness nurses, including, for example, blood pressure clinics, chronic disease management, and medication management. They were also appreciative of having the wellness nurses available to check in on residents with health or medical needs and to talk to and observe residents who may be contemplating calling an ambulance and going to the emergency department.

Enhancing Existing Staff Capabilities

Most housing partners reported that the provision of additional staff enhanced housing sites' abilities to perform certain preexisting tasks, procedures, and routines. This enhancement of previously performed activities and functions was, perhaps, most true of the Boston-based HSL site which is comparatively better resourced than the South Shore-based HSL site and especially the two non-HSL sites.

Despite cross-site variation in service and staffing levels, specific examples of wellness team members enhancing previously performed activities and functions were provided by housing partners from all sites. Thus, to varying degrees, the housing partners described the enhancement of the R3 program to existing departments and to the ability to conduct case management, provide resident support, and connect with community resources.

Extending the Abilities of Existing Departments. Some housing partners viewed R3 staff as extensions of existing departments, whether it be, for example, social work, resident services, or programming.

Providing Additional Case Management Capabilities. Some housing partners reported that wellness team members contributed to the housing sites, in part, by providing additional staff to case manage and coordinate resident care and services.

Providing More In-Depth Resident Support. A few housing partners reported that wellness team members enable their communities to provide more in-depth support, particularly to high needs residents, than previously has been possible without R3 staff.

Connecting More with Community Resources. Housing staff routinely connect with and bring community resources to housing communities. A few housing partners felt that wellness team members enhanced their housing community's ability to do so.

RESIDENT-RELATED BENEFITS

In addition to staffing-related benefits supports, housing and community partners noted several resident-related benefits deriving from participation in the R3 program. These resident-related benefits include proactively tracking and responding to resident needs, and lowering resident turnover.

Proactively Tracking and Responding to Resident Needs

Housing partners and some first responders reported that the R3 program has better enabled the housing sites to proactively respond to resident needs. This improvement is reflected in the development and implementation of data tracking tools. It is also reflected in the generation of more actionable data through monthly resident contacts and other interactions with R3 staff as well as ambulance data provided by the first responders.

Developing Data Tracking Tools. One contribution, according to a handful of housing partners at the Boston-based HSL site, is the adoption of tools to document and measure resident data, including outcomes.

Generating More Actionable Data. A number of housing partners pointed to the generation of more actionable data on residents through monthly contacts and other interactions with wellness team members (e.g., one-on-one meetings, hallway interactions, apartment visits) as a benefit of the R3 program.

Receiving First Responder Data. The wellness teams receive data on a monthly and daily basis from the EMS agencies serving the housing sites—Randolph Fire Department and Fallon Ambulance Service. The housing partners and first responders identified the receipt and use of this data as an important benefit to housing sites participating in the R3 program.

Lowering Resident Turnover

Some housing partners felt that the R3 program had contributed to lower resident turnover within their communities; others pointed out that not all turnover is necessarily inappropriate.

Slight Reduction in Resident Turnover. The housing partners generally reported low resident turnover within their communities. Still, a few partners from the non-HSL sites felt that the R3 program may have contributed to a small reduction in resident turnover, although acknowledging a lack of data or evidence to back up this perception and the potential cost savings resulting thereof definitively.

Not All Turnover Is a Bad Thing. A few housing partners recognized that while the R3 program may help prevent some residents from leaving the building, other residents who need to

step up to a higher level of care in an assisted living facility or nursing home because they are not able to receive the services and supports necessary in their current situation may be identified by wellness team members.

HOUSING-RELATED BENEFITS

In addition to staffing and resident-related benefits, participants noted benefits to the housing sites more generally. These housing-related benefits include extending and supplementing wellness programming and learning from and adopting procedures and processes underlying the R3 philosophy.

Extending Wellness Programming

Most housing partners reported that the R3 program extended wellness programming available to residents at the housing sites. This extension involved supplementing existing programming, while bolstering its health-related focus.

Providing Supplemental Programming. All housing sites offered programming prior to the implementation of the R3 program. Housing partners nevertheless expressed appreciation for the additional programming organized and/or provided by wellness team members, believing that it further enriched the offerings available to residents in their communities.

Bolstering the Health-Related Focus of Wellness Programming. Housing partners emphasized the increased provision of health-related programming at the housing sites under the R3 program. Specific examples include presentations on chronic disease management and healthy eating, blood pressure and diabetes clinics, relaxation groups, and "brain games."

Integrating the R3 Program Philosophy into the Housing Site

Housing partners reported learning from and, in some cases, adopting procedures and processes underlying the R3 program philosophy. They spoke about this adoption both in a general sense and more specifically in relation to looking out for issues with residents—that is, adopting a more "eyes-on" culture.

Incorporating the R3 Philosophy. Housing partners indicated that their housing communities benefited from incorporation of the R3 philosophy into site practices and operations.

Becoming More "Eyes-On." A few housing partners reported that the eyes-on culture was already embedded within their housing communities, at least to a certain extent. Several non-HSL staff, however, reported their housing communities becoming even more eyes-on after the R3 program had been implemented, due to the presence of wellness team members on site and the provision of trainings in this area.

IMPLEMENTING R3 AT THE HOUSING SITES

Housing and community partners commented on the implementation of the R3 program at the housing sites, including with respect to the initiation, development and launch of the program. They also assessed the nature and extent of HSL's collaboration with the housing partners at this time.

INITIATION AND DEVELOMPENT OF THE R3 PROGRAM

Housing partners described how relationships with HSL informed the housing partner role in the R3 program. They also highlighted the key role played by senior management support in facilitating implementation of the program.

Relationships with Hebrew SeniorLife Informed Housing Partner Role

The R3 program was implemented at four sites: two HSL and two non-HSL. Housing partners commented on how relationships between the four sites and the R3 program's sponsoring entity, HSL, impacted the housing partner role in the program. The role of the two HSL sites was informed by their inclusion within the sponsoring system (HSL). The role of the two non-HSL sites was informed by executive-level discussions between HSL and the two sites.

HSL Housing Sites' Inclusion within the Sponsoring System. The project leader, Kim Brooks, Chief Operating Officer for Senior at HSL, led the initiation and development of the R3 program, with assistance from the program director, Stephanie Small, also Executive Director at the South Shore-based HSL site. It was relatively straightforward recruiting the HSL sites—1.a and 2.a—to participate in the R3 program since they are both within the broader system sponsoring the program. The lines of authority established by the dual roles of the project leader and program director helped to facilitate integration of the R3 program at the HSL sites as well.

Executive-Level Discussions at the Non-HSL Housing Sites . Discussions with executive leadership at HSL informed the role of the two non-HSL sites (1.b, 2.b) in the R3 program. Even before R3 began, the executive leadership in Site 1.b's corporate office had approached HSL to work together to enhance the services provided at their housing sites; consequently, Site 1.b was on board when presented with the opportunity to participate in the R3 program. By contrast, serious discussions about collaborating with HSL only took place with the executive leadership at Site 2.b after senior HSL staff decided to implement the R3 program at a second site in the South Shore region.

Senior Management Support

A few interviewees stressed the important role of senior management in the implementation of the R3 program, both on the part of HSL—the project leader, program manager, and Chief Executive Officer (CEO)—and, on the part of one organization that operates one of the two non-HSL participating housing communities.

LAUNCH OF THE R3 PROGRAM

Housing partners discussed the launch of the R3 program at the housing sites. They highlighted the importance of educating housing staff about the program, on the one hand, as well as the importance of onboarding wellness team members at the housing sites, on the other hand. Several housing partners noted the time consuming and resource intensive nature of implementing the program, at least initially.

Educating Housing Staff about R3

Housing partners highlighted the importance of educating housing staff about the R3 program. A few partners reported knowing little about R3 before implementation took place. Other partners reported good education and communication about the program once it had been launched. Suggestions for improvement included adopting an earlier, more formal educational process initially, followed by more frequent and comprehensive updates on an ongoing basis.

Limited Knowledge about the R3 Program Going In. A few housing partners reported knowing little about R3 before the program launched. They placed this limited understanding in the context of the speed with which they felt that program was implemented once it arrived onsite.

Good Education and Communication about the R3 Program. Still, at launch, a number of housing partners reported good education and communication about the R3 program, including, in some cases, having the opportunity to offer input into how the program could be implemented successfully within their housing community.

Going Forward: Adopt an Earlier, More Formal Education Process. Several housing partners suggested that housing staff would benefit from an earlier and more formal educational process before implementation of the R3 program occurs within housing communities. Specific recommendations include distributing additional background materials and holding more meetings to inform housing staff about the program, and providing housing staff with a longer lead-up time for further planning around program specifics.

Going Forward: Institute More Frequent and Comprehensive Updates on Program Status. Some housing partners wished to be kept informed about bigger picture issues, including activities taking place beyond specific housing sites and data on program performance and outcomes. It was reported that some of this was happening, but not necessarily with on the ground staff nor as frequently as desired.

Onboarding Wellness Teams into the Housing Sites

Housing partners reported integrating wellness team members into the housing sites. It was reported that at the HSL sites this process began by assisting R3 program management in identifying and hiring members of the wellness teams. Once hired, housing sites needed to create the physical infrastructure necessary to accommodate them, and to educate them about the housing site.

Hiring Wellness Team Members with HSL Housing Staff Involvement. A few housing partners at the HSL sites reported housing staff involvement in the hiring process, namely interviewing and informing the selection of wellness team members.

Creating Physical Space for Wellness Team Members. A number of housing partners reported the need to identify and, in some cases, build office space to accommodate wellness team members. Phone lines, laptops, copiers, printers, and other supplies were provided as well.

Educating Wellness Teams about the Housing Site. Most housing partners described spending time with wellness team members by taking them "under their wing" and showing them the "lay of the land." Some spoke to the orientation process generally, others to specific aspects, including learning about the site and its residents, operations, and culture.

Time Consuming and Resource Intensive Initially

Several housing partners reported that, in the beginning, implementing the R3 program proved time consuming and resource intensive, but that these initial challenges have largely been worked out over time. Specific challenges noted by housing partners included the need to develop the specifics of the R3 program as it was being implemented; to collect information, including helping with baseline assessments; and to figure out the relative roles of R3 and other housing staff.

Developing Program Specifics as It is Being Implemented. Some housing partners felt that senior program management were still developing the R3 program during the early stages of the implementation process. The resulting lack of program specifics contributed to a lack of understanding and confusion on the part of housing staff, which made the initial implementation period more burdensome than otherwise might have been the case.

Assisting in Resident Recruitment into the Program. The housing site role in recruiting residents into the R3 program will be discussed in greater depth below. At this point, it is sufficient to note that the housing partners reported investing considerable time and energy to this task at program launch, before subsiding once initial recruitment goals had been reached.

Producing Baseline Information and Assessments. Some housing partners reported devoting time and effort to initial data collection tasks, which would subside after the early implementation stage. These tasks included gathering certain resident and programming information available in existing databases, but largely pertained to assisting wellness team members in completing baseline assessments with R3 program participants. The assessments used a modified version of the Vitalize 360 health assessment instrument, which is part of Vitalize 360, a person-centered wellness coaching system adopted organization-wide by HSL (see www.vitalize360.org).

Figuring out the Relative Roles of R3 and Other Housing Staff. Some housing partners pointed out that, like with the introduction of any new position, the relative roles of R3 and existing housing staff needed to be figured out when the R3 program was first implemented

at the housing sites. This negotiation of roles no longer proved an obstacle to program operations once this initial adjustment period concluded.

HOUSING PARTNER COLLABORATION AT START-UP

Housing partners assessed the nature of the HSL-housing partner relationship, particularly at start-up. They reported that HSL and the housing partners have worked well together in implementing the R3 program; the non-HSL housing partners, in particular, reported feeling valued/satisfied with their role.

HSL and Housing Partners Worked Well Together

Some housing partners indicated that HSL and their housing sites collaborated effectively when implementing the R3 program, and that trust between HSL and the housing sites promoted this effective working relationship.

Effective Collaboration between HSL and the Housing Partners. Housing partners at both the HSL and non-HSL sites spoke positively about the nature of their collaboration with R3 program management and staff in effectively implementing the R3 program.

Trust Promoted an Effective Working Relationship. Some housing partners felt that trust and respect between HSL and the housing sites served as the foundation for the favorable working relationship that developed between the two parties in implementing the R3 program.

Non-HSL Housing Sites Feel Valued/Satisfied with Role

HSL ownership and management of the R3 program clearly facilitated development of an effective working relationship between the R3 program and management and staff at the two HSL sites. Notably, though, housing partners from the two non-HSL sites felt valued and satisfied with their role in the R3 program, even though it was led by HSL, an outside organization. They especially appreciated HSL openness to their input, as well as the level and type of involvement afforded them in implementing the program.

Non-HSL Sites Appreciate HSL's Openness to Input and Ideas. Several non-HSL housing partners pointed to HSL's willingness and openness to listen and incorporate ideas and insights generated by their counterparts at the non-HSL housing sites.

Non-HSL Sites Appreciate Their Level and Type of Involvement. Several non-HSL housing partners reported general satisfaction with the nature and degree of their organizations' involvement in the R3 program, given prevailing structural, philosophical, and financial realities.

WELLNESS TEAM STAFFING

Housing partners commented on several aspects of wellness team staffing. They noted positive attributes of wellness team members. Overall, they felt that the wellness teams were generally present and visible at the housing sites, though challenges posed by wellness team hours and

schedules were reported. Strategies for improving wellness team availability were noted as well.

POSITIVE ATTRIBUTES OF WELLNESS TEAM MEMBERS

Housing partners found wellness team members highly likeable, noting several positive personality attributes. Most concluded that wellness team members fit well with other staff at their housing communities.

Likeability of Wellness Team Members

A number of partners assessed the overall performance of wellness team members positively, noting how "likeable" and "wonderful" they were to work with.

Personality Attributes of Wellness Team Members

Several partners identified specific attributes that make wellness team members such good colleagues, including that they were good listeners, enthusiastic, skilled, resourceful, warm, approachable, and collaborative.

Fit of Wellness Team Members within the Housing Communities

Both HSL and non-HSL affiliated housing partners concluded that the wellness team members were excellent fits, integrating well and almost seamlessly into the housing teams and communities.

VISIBILITY OF WELLNESS TEAM MEMBERS

Housing partners reported that wellness team members were generally a visible presence withn their housing communities. This visibility, in turn, had positive implications for establishing relationships with residents, which, in turn, enhanced program effectiveness.

Establishing a Presence at the Housing Sites

A number of housing partners indicated that the wellness teams had established a noticeable presence, whether through their office hours, programming, or other activities and functions at the housing sites.

Face Time Enhances Program Effectiveness

Some housing partners pointed to the positive implications of wellness team visibility for forming relationships and helping residents in need of assistance and support. Greater and more consistent face time allows wellness team members to get to know residents better, contributes to resident comfort and trust, and promotes contact and information sharing.

CHALLENGES POSED BY WELLNESS TEAM AVAILABILITY

Despite being a visible presence at the housing sites, housing partners reported challenges posed by wellness team availability. These challenges stem from the limited number of hours spent at specific sites and buildings and the diverse array of tasks and responsibilities undertaken. They also stem from the need for other housing staff to fill in and cover when wellness team members are off site.

Limited Scheduled Hours at the Housing Sites and Buildings

It was pointed out that wellness team members must divide their time across several sites and buildings (within Sites 1.a and 2.b), thereby limiting wellness team hours at specific locations with potentially negative consequences for the breadth and depth of resident engagement.

Diverse Array of Tasks and Responsibilities

The R3 program assigns a wide range of tasks to wellness team members related to research and evaluation (e.g., data gathering, ongoing recruitment) and supporting participants' health/wellbeing. The latter responsibilities include: undertaking case management/coordination, assessment, and referral; communicating with family and providers; connecting with community resources; facilitating care transitions; conducting/organizing wellness programming; making monthly contacts with program participants; engaging in one-on-one education/counseling; and collaborating with other housing staff. Some housing partners spoke to this diverse array of tasks and responsibilities, observing that it serves to limit wellness team availability, both generally and especially during those periods when wellness team members must, in addition to their regular duties, devote time to completing assessments for all enrolled program participants.

Filling in for Wellness Team Members

A few housing partners reported filling in when wellness team members are off site, say, at another housing community, or onsite but focusing on other responsibilities. This means undertaking certain tasks themselves (e.g., conducting monthly phone calls, addressing resident issues), and, in some cases, ensuring that other housing staff are scheduled when R3 staff are not.

STRATEGIES FOR IMPROVING WELLNESS TEAM AVAILABILITY

Housing partners suggested several strategies for improving wellness team availability. These generally revolved around the provision of additional hours, but also included additional or different types of staff.

Adding Wellness Team Hours to the Schedule

Several housing partners suggested adding more wellness team hours to the schedule, sometimes generally, other times with respect to certain uncovered periods (weekends, evenings), and other times with respect to specific personnel (typically. the wellness nurses).

Incorporating Additional or Different Types of Staff

A couple of partners suggested adding more staff, perhaps with skillsets different from those currently covered by wellness team members. Examples include a mental health specialist, physician, nurse practitioner (NP) or physician assistant (PA), and licensed practical nurse (LPN) or certified nurse assistant (CNA) with expanded roles.

PROGRAM RECRUITMENT AND ENGAGEMENT

Housing and community partners identified several barriers and facilitators to resident recruitment and, once recruited, to engagement with the R3 program. They also suggested strategies for improving recruitment and engagement.

BARRIERS TO RECRUITMENT AND ENGAGEMENT

Housing and community partners indicated that recruitment and engagement are impeded by privacy and confidentiality concerns, a lack of clarity and understanding, and language and mental health challenges.

Impeded by Privacy and Confidentiality Concerns

Housing partners believed that concerns about the privacy and confidentiality of personal information posed an impediment to resident recruitment and engagement in the R3 program. A few housing partners pointed to variation in concern about this issue across housing sites.

Concerns about Information Sharing. It was pointed out that some people are reluctant to share certain information, both generally and because of fear that the housing site's management might find out about their personal issues.

Variation in Privacy and Confidentiality Concern across Housing Sites. A couple of housing partners felt that concerns about privacy and confidentiality might be greater at the non-HSL than HSL sites because residents at the less resource enhanced non-HSL sites were not as accustomed to comparatively high degrees of staff involvement, nor to programs such as R3.

Impeded by a Lack of Understanding

Housing partners reported that recruitment and participation has been impeded, in part, by a lack of understanding of the R3 program on the part of residents and program participants. This issue was raised in several respects, including with regard to what the R3 program is and how it could affect them, uncertainty about the relative roles of wellness team members and other housing staff, and confusion about the openness of R3 sponsored wellness programming to non-R3 participating residents.

What Is the R3 Program? Some housing partners pointed to a lack of resident understanding of the R3 program, both initially and on an ongoing basis.

How Does the R3 Program Affect Me? Some housing partners reported uncertainty among certain residents regarding both the demands that would be placed on them due to

participation in the R3 program and how the R3 program could assist them, particular if they were healthy.

Why Should I Contact the Wellness Teams? Some housing partners reported that, once enrolled, some program participants were unsure about when to contact wellness team members versus other housing staff. They also reported some confusion about the roles of the two wellness team members, both generally and with respect to the wellness nurse specifically, who they thought was going to be available as needed to provide direct health care assistance. Each of these challenges improved after the initial implementation period with resident experience and education.

Can I Attend R3-Sponsored Programming? It was intended that R3-sponsored wellness programming would be available to all residents at the housing sites, regardless of their R3 participation status. However, housing partners at one of the non-HSL sites pointed to confusion about the ability of non-R3 residents to attend these events; as a consequence, the site stopped branding these programs as R3.

Impeded by Language and Mental Health Challenges

Housing partners at the HSL sites highlighted language and mental health challenges that impeded program participation and engagement on the part of certain residents.

Language Barriers. HSL-affiliated housing partners reported that language barriers impeded recruitment of Cantonese, Mandarin, and Haitian Creole speaking residents in the South Shore region and Russian speaking residents in the Boston region. The importance of translation services in promoting recruitment and engagement among non-English speaking residents was noted as well.

Mental Health Barriers. HSL-affiliated housing partners reported that it was harder to recruit and engage residents with mental health and behavioral issues.

FACILITATORS TO RECRUITMENT AND ENGAGEMENT

Housing and community partners identified several factors that have promoted recruitment and engagement. They indicated that recruitment and engagement has been facilitated by the involvement of existing housing staff, as well as resident and participant exposure to the wellness teams and R3-sponsored programming. The development of trust between wellness team members and residents/participants played a particularly important role in this regard.

Facilitated by Housing Staff Involvement

Housing partners identified a multitude of ways in which they helped promote recruitment and engagement in the R3 program. Community meetings and education sessions were held where residents were introduced to the program. Fliers and posters were distributed and residents were informed about the program in newsletters. Housing partners talked up R3, promoting it during group activities and one-on-one interactions. Sometimes housing staff would identify and contact

potential participants directly; other times they would identify potential participants so that wellness team members could do the contacting; still other times they would talk to and suggest that specific residents reach out and contact the wellness teams. Housing staff reported focusing on recruiting new residents after the initial recruitment period.

Holding Group Meetings. Housing partners variously described coffee hours, meet-and-greets, ice cream socials, and other get-to-know-you events to introduce residents to the R3 program and wellness team members.

Distributing Fliers, Posters, Newsletters. Housing partners reported hanging posters and distributing fliers to get the word out about the R3 program. They also described the R3 program and posted information about wellness team members and how to contact them in the site calendar and newsletter, including their pictures, hours, and phone numbers.

Talking Up the R3 Program. Housing partners promoted and spoke positively about the R3 program and wellness team members when interacting with residents. They reported doing so both generally and specifically, when engaging residents, say, at the fitness center or resident services and property management offices, during medical appointments and Vitalize 360 coaching sessions, and at group programs. Some housing staff focused this individual outreach on residents they knew well or with whom they had a pre-existing relationship.

Identifying and Contacting Potential Participants Directly. Housing partners reported identifying and contacting specific residents to recommend that they participate in the R3 program. These contacts included residents that had not attended community-wide recruitment events, or, again, those with whom housing staff had good preexisting relationships. They also included non-participating residents in crisis or as at risk for undesirable health outcomes (e.g., falls, hospitalization).

Identifying and Referring Potential Participants to the Wellness Teams. Housing partners reported identifying and referring prospective participants to wellness team members so that they could make the contact. In part, this approach involved reviewing lists of residents who frequented the medical practice or participated in Vitalize 360 to identify those individuals who might be interested in or likely to benefit most from the program.

Suggest that Specific Residents Contact Wellness Teams. Housing partners reported talking to specific residents and suggesting that they contact wellness team members to talk about the R3 program.

Focusing on New Residents. Some housing partners reported focusing their efforts on recruiting new residents to the housing site after the initial recruitment period. It was felt that newly moved in residents would be particularly appreciative of the additional services provided by R3.

Facilitated by Exposure to Wellness Teams/Programming

Housing partners reported that the accumulation of participant experiences with the R3 program, both directly and word-of-mouth, has promoted increased participation.

Direct Exposure to the R3 Program. Housing partners observed that resident engagement with the R3 program has been facilitated by exposure to wellness team members and programming, after directly witnessing, experiencing, and learning more about what the R3 program could do for them.

Indirect Exposure via Word-of-Worth. Housing partners observed that exposure to the wellness teams and programming has contributed indirectly to furthering engagement as residents learn word-of-mouth about their neighbors' experiences with the R3 program.

Facilitated by Building Trust with Wellness Teams

Some housing partners felt that recruitment and participation has been facilitated by the development of trust, in some cases engendered by other housing staff.

Trust Promotes Engagement. Building trust was a key factor promoting program engagement noted by housing partners. Trust-building involved developing trust in individual wellness team members. It also involved developing trust in the R3 program as a whole – that is, that participants could count on the program going forward. Once established, trust promotes information sharing, helping to overcome privacy and confidentiality concerns otherwise impeding recruitment/engagement.

The Transfer of Trust. A few housing partners reported that "a transfer of trust" took place when housing staff vouched for the R3 program and wellness team members in the individual and group settings noted above.

STRATEGIES FOR IMPROVING RECRUITMENT AND ENGAGEMENT

Housing partners reported that recruitment into the R3 program went well, but that ongoing recruitment has been harder. Thus, in order to maintain momentum, partners suggested the need to continue promoting recruitment and engagement into the program. Several strategies to further recruitment and engagement were thus proposed.

Difficulties with Ongoing Recruitment

Housing partners were largely satisfied with program recruitment, but reported that ongoing recruitment has been more challenging, after the easiest to reach and most "approachable" and "accommodating" residents have been brought into the program. They felt that efforts targeted at recruiting additional residents were needed to maintain momentum and to continue to grow the program.

Proposed Recruitment and Engagement Strategies

Recruitment and engagement strategies suggested by the housing partners and some community partners included: focusing on higher need, harder to reach residents; marketing to non-participants, including holding additional meet-and-greets and employing contests, rewards, and other incentives; developing a clearer and simpler description of the R3 program; demonstrating what the program can do through concrete examples of its successes; adding more wellness programming; promoting the program through family; and serving entire buildings.

WELLNESS TEAMS AND HOUSING STAFF COMMUNICATION

Housing partners commented on the quality, nature, and extent of communication between wellness team members and other housing staff. They assessed the overall quality of communication positively. They reported relying on both formal and informal/ad hoc communication mechanisms, while highlighting the extensive collaboration that takes place when addressing resident needs. A substantial amount of communication occurred around scheduling wellness program as well.

OVERALL ASSESSMENT OF COMMUNICATION

Housing partners were largely satisfied with the degree of communication and collaboration that has taken place with wellness team members. A few partners, however, highlighted communication challenges.

Communication Has Proceeded Positively

Most housing partners concluded that communication has proceeded smoothly between wellness team members and other housing staff.

Initial and Ongoing Communication Challenges

A few housing partners noted initial communication challenges that had been overcome as the program matured; by contrast, one partner felt that communication became less reliable over time as wellness team members began to operate more independently at the housing site.

COMMUNICATION MECHANISMS

Housing partners reported interacting with wellness team members both formally and informally through meetings, email, phone calls, and ad hoc in-person contact

Formal Communication

Housing partners identified regularly scheduled meetings and routine email contact as the main forms of communication between wellness team members and other housing staff.

Regularly Scheduled Meetings. Most housing partners reported that wellness team members, as members of the housing team, participate in staff meetings at the housing sites, including regular resident services meetings and R3-specific collaboration meetings. Resident

services meetings are held weekly at the two HSL locations (1.a, 2.a); additional R3 collaboration meetings are held as well. Weekly staff meetings are also held at the multi-building location of the non-HSL South Shore site (2.b), but not the single-building location (where they try to meet bi-weekly). The wellness teams meet monthly with the resident services staff at Boston-based Site 1.b, though they did not do so initially. Housing partners observed that meeting regularly has facilitated information sharing, collaboration, problem solving, and action-plan development between R3 and other housing staff, both in addressing resident needs and R3 program implementation more generally.

Routine Email Contact. Most housing partners highlighted the significant role email plays in communicating with wellness team members, particularly regarding short, specific questions around meeting resident needs. Indeed, at Site 1.a, complexity deriving from the large number of potential staff contacts led to the creation of an email protocol and group, "R3 Collaboration," to ensure that all housing staff, including wellness team members, were aware of and had the opportunity to provide input on issues that had arisen with specific residents enrolled in the R3 program. A couple of housing partners commented on the volume of emails. One observed that email increasingly substituted for in-person contact as wellness team members got busier. The other felt overwhelmed by the large number of emails received given time constraints imposed by their broader job responsibilities.

Informal Communication

In addition to regularly scheduled meetings and routine email contact, housing partners reported that a substantial amount of informal/ad hoc interaction occurs with wellness team members. This interaction typically takes place in person, in a shared space or hallway, but also virtually, extemporaneously over the telephone and email should, say, an immediate need for contact arise due to emergent circumstances.

COLLABORATING TO SERVE PROGRAM PARTICIPANTS

Most housing partners reported that wellness team members collaborate with other housing staff to meet participants' needs. Key dimensions of this collaboration include exchanging information about particular program participants, deliberating about how best to address those issues, and determining who will take the lead in doing so.

Exchanging Information

A number of housing partners reported that wellness team members and other housing staff share information about residents and their issues. This dynamic goes both ways, with R3 staff learning about issues from other housing staff and vice versa. Both parties benefit from this relationship in that it enables them to serve their clients better and more effectively.

Determining Action

Most housing partners reported that wellness team members consult closely with other housing staff when deliberating about program participants. This deliberation involves seeking and

providing advice and brain storming about how best to approach the issues being addressed. It also involves informing and/or connecting the other party to the requisite resources and supports required to tackle those issues.

Assigning Responsibility

Some housing partners touched on the issue of how responsibility is determined with respect to whether it is an R3 or other housing staff member who takes the lead in addressing issues with particular program participants. This issue was raised more frequently in the context of the HSL sites, which had larger, more engaged housing staffs assisting residents. It was reported that, even in the case of R3 program participants, it is often the best situated staff member, because of their familiarity to the resident or because they have the requisite knowledge/skills, that generally takes the lead in helping them solve their problems. It was also reported that residents were informed that there is no wrong doorway, that they can contact any staff member who, in turn, will communicate with the wellness team (or vice versa) if need be.

SCHEDULING PROGRAMMING

Housing partners reported the steps required to coordinate and schedule the R3-sponsored wellness programming organized by wellness team members, including balancing the amount of programming available at the housing site with the need to promote participation.

Steps to Scheduling Wellness Programming

The process of scheduling wellness programming involves meeting with wellness team members, determining what programming they have planned, integrating that programming into the housing site's schedule/calendar, and getting the word out to residents. The aim is to promote participation, which means, in part, avoiding conflicts and cancelations.

Balancing the Breadth of Programs with Participation

Housing partners appreciated the additional programming provided by the R3 program. A few, however, raised concerns about the effect that offering too many programs might have on participation.

COMMUNITY PARTNERS

The R3 program has formed several effective community partnerships. Especially strong relationships have been established with the major first responder agencies in each region; productive connections have been established with the local Aging Services Access Points (ASAPs) as well. Comparatively limited progress had been made forming relationships with hospitals and insurers, though Tufts Health Plan has had a limited formal role in the program. The Health Policy Commission has served as the primary funder of the project.

FORMING EFFECTIVE COMMUNITY PARTNERSHIPS

Some housing and community partners commented on how to form effective community partnerships. General strategies noted include building on existing relationships and identifying a common theme or purpose on which to ground the collaboration. Initial funding may have attracted initial involvement among some community partners, but natural reasons and incentives are required to engender long run involvement. Ultimately, each community partner interviewed rated their experience with HSL and the R3 program positively.

Building on Existing Relationships

Several partners reported forming partnership based, in part, on existing relationships. This occurred primarily in relation to HSL's relationships with community organizations such as the major local first responder and mental health agencies.

Grounding Partnerships in a Common Theme or Purpose

Several partners highlighted the importance of basing community partnerships on a common theme or purpose. Here, it is critical that potential partners understand the R3 program and how it could help them accomplish their missions in relation to the common population served.

Initial Funding Can Open Doors but Concrete Benefits Keep Partnerships Going

A representative from the Health Policy Commission reported that some community partners received modest funding to engage with the R3 program formally through attendance at quarterly partnership meetings. This individual stressed, however, that there needs to be natural reasons and incentives for community partners to remain engaged with the R3 program if such partnerships are going to be self-sustaining over the long run.

Overall Positive Assessment of Community Partnerships

Each first responder and ASAP representative interviewed rated their overall interaction and partnership with HSL and the R3 program positively

FIRST RESPONDERS

The first responders include Randolph Fire Department, which responds to emergency calls from Site 2.a (South Shore), and Fallon Ambulance Service, which responds to emergency calls at Site 2.b (South Shore), as well as at Sites 1.a and 1.b (Boston). Among first responders, Randolph Fire and Fallon Ambulance play the largest role in the R3 program, but Brookline Police Department, in the Boston region, has partnered with the program as well. All three organizations regularly attend and contribute to the quarterly partner meetings.

The EMS providers reported that partnerships with the R3 program were facilitated by familiarity with the housing sites. These partnerships include continuing to conduct onsite activities performed prior to participation in R3, in addition to sharing data on calls and transports with wellness team members. Perceived benefits to participating in the R3 program differed somewhat between staff from Randolph Fire Department and Fallon Ambulance

Services largely due to the different financial models under which both organizations operate. Several suggestions were made for further enhancing the EMS role in housing with services.

EMS Partnerships Facilitated by Familiarity with the Housing Sites

The EMS providers reported that partnerships with the R3 program were facilitated by familiarity with the housing sites, having responded to calls, made transports, provided lift assists, and engaged in some prevention work on site.

EMS Providers Conduct Group Programming

Onsite activities by the EMS providers have continued under the R3 program, including providing group presentations and ambulance tours aimed at educating residents about general fire and living safety (e.g., decluttering) and the appropriate use of and alternatives to calling 9-1-1. One EMS official felt that residents pay more attention to certain information when it is conveyed by someone in uniform.

EMS Providers Share Data on Calls and Transports

The EMS providers were pleased with their primary role to share data on EMS calls and transports, a major innovation, according to the representative from the Health Policy Commission. This data, which is not available elsewhere, required the EMS providers to enter into business agreements with HSL to overcome HIPPA concerns related to data sharing. It was reported that the data is relatively straightforward for the EMS providers to produce, beginning with the provision of monthly aggregate data at the start of R3, then volunteering to provide increasingly detailed individually identifiable and actionable data daily. Data on calls and transports is used to fill in gaps in knowledge, including identifying transports that housing sites do not know about and frequent users and causes of EMS calls.

Perceived Benefits to Participating EMS Providers Given Financial Model

Partners from the two major EMS agencies reported participating in the R3 program because it provided an opportunity to serve clients better by reducing unnecessary or preventable calls and transports to the emergency department from the housing sites. Randolph Fire Department, however, operates on a fixed budget, which further encouraged data sharing to reduce unnecessary/preventable calls and transports. This is in contrast to Fallon Ambulance Service, which in operating in a fee-for-service context, experiences adverse financial implications should reductions in calls and transports occur. Instead, it was reported that Fallon Ambulance is taking the long view with respect to where it hopes the EMS role is headed, treating clients at home rather than in the emergency department or hospital.

Randolph Fire Department: Operating on a Fixed Budget. The Randolph Fire Department operates on a fixed budget provided by the City of Randolph. Though it bills the insurance companies for services rendered, any payment received goes back to the town's general fund. Because its operating budget is fixed, the incentive for Randolph Fire is clear: Stretching resources further by lowering the number of lower priority and preventable calls from

"hot spots" such as affordable senior housing. It was pointed out that reducing the number of transports to the hospital does not adversely impact the bottom line because there are more than enough high priority calls to respond to given prevailing resource constraints.

Fallon Ambulance Service: Operating in a Fee-for-Service Context. Fallon Ambulance Service, which is operating in a fee-for-service context, only gets reimbursed for actual transports, not simply for responding to calls and showing up at the scene. Consequently, a reduction in transports means a reduction in revenue for the organization. It was explained that, in the case of the R3 program, Fallon Ambulance Service was looking to its vision of the future where the primary goal is to treat people at home rather than transporting them to the emergency department or hospital, should the requisite licensing and reimbursement changes take place. Fallon thus views the R3 program, in part, as a jumping off point to mobile integrated health whereby EMS staff treat people at home, including, perhaps, lift assists, post-hospital transitional care, and non-emergent transport to medical appointments and urgent care It was reported that regulations were being considered in Massachusetts as a step towards making mobile integrated health a reality. Fallon Ambulance Service intends to be at the vanguard of this change, which, if in effect, would allow them to receive reimbursement for the onsite provision of care.

Going Forward with EMS in the R3 Program

It was suggested that R3 staff connect more with direct service personnel at the EMS agencies. The potential appeal of the R3 program for other EMS providers was touched on as well.

Connecting More with Direct Service EMS Personnel. A few partners reported that the R3 program has primarily connected with supervisory and administrative staff at the first responder agencies to the exclusion of the direct care personnel who respond to most of the calls at the housing sites. It was suggested that further education of the EMTs, paramedics, and firefighters who directly respond to calls would prove helpful, particularly in understanding the role and importance of the information collected during transports which, in turn, would be sent back to the housing sites as part of the daily ambulance reports. This, according to one first responder, might involve R3 staff coming to talk directly with direct service personnel.

Appeal of the R3 Program to Other EMS Agencies. A few EMS partners commented on the potential appeal of the R3 program to other EMS providers. A few thought other EMS agencies would be willing to participate in the program because they are already immersed in their local senior housing communities, responding to calls and offering programming, and because any concerns about data sharing, which has not proven burdensome, can be overcome through the execution of a business agreement. One felt that other EMS providers may not be as ready to take on the data sharing aspects of the partnership, nor as motivated to take on new projects such as R3, due to prevailing funding constraints.

Brookline Police Department and the R3 Program

All officers with the Brookline Police Department receive eight hours of mental health training. Moreover, a large proportion officers have volunteered and received an additional 40 hours of training as part of the Department's Crisis Intervention Team, "an integrated unit specially

trained to respond to individuals with acute mental health needs." The main objective of the CIT is to facilitate communication and improve the response of public and private agencies when intervening with individuals with mental illness, substance abuse challenges, and other mental health difficulties. The CIT has forged relationships with a range of agencies within the community in pursuit of this aim. Officers report people with clear mental health issues to the CIT; the CIT also keeps track of high utilizers of police and emergency services. The CIT coordinator or social worker then reaches out to engage that person to see if they can help them, say, by connecting them to appropriate community resources such as the Brookline Community Mental Health Center.

The coordinator of the CIT has been actively involved with the R3 program, attending the quarterly partnership meetings and interacting with members of the Boston-based wellness team. The Boston-based team serves as source of contact and referral when the CIT identifies individuals in need of support residing in the buildings served by R3. The Boston-based team or other housing staff also attend monthly CIT meetings.

Serving as a Source of Contact and Referral for the CIT. It was reported that the CIT shares the names of people that come up frequently from the Boston-based housing sites with the wellness team. In this respect, the wellness team serves as a useful source of contact and referral. The CIT does not necessarily know if someone is enrolled in the R3 program beforehand. If enrolled, then wellness team members are available to help that person, which may involve collaboration with the CIT. If not enrolled, then wellness team members may still look in on them, or connect with other housing staff who might be able to help, or refer back out to the CIT.

Attending Monthly CIT Meetings. It was reported that the Boston-based wellness coordinator attends monthly CIT meetings held between Brookline Police Department, Brookline Mental Health Services, and the senior center to discuss specific complex cases and opportunities to collaborate in serving them better.

AGING SERVICES ACCESS POINTS (ASAPS)

Aging Services Access Points are 26 state designated, private, non-profit agencies that serve as the single point-of-entry for older adults aged 60 years and older to access a range of state and federally funded programs and services. In this capacity, most ASAPs also serve as federally designated Area Agencies on Aging (AAA) charged with the responsibility to plan and support social services under the Older Americans Act. ASAPs contract with non-governmental actors as well (e.g., hospitals, insurers, accountable care organizations (ACOs), housing providers). Broad functions include information and referral; interdisciplinary case management; intake and assessment; development, implementation, and monitoring of service plans; needs assessment; and investigation of elder abuse and neglect. ASAPs subcontract with certified medical service providers (e.g., home health care). They also subcontract with non-certified providers (e.g., personal care, homemaker services). The R3 program has developed relationships with two ASAPs, Springwell and South Shore Elder Services, serving the Boston and South Shore regions, respectively. ASAP personnel spoke to big picture issues around ASAP involvement in the R3 program, as well as ASAPs' day-to-day experiences interacting and collaborating with wellness team members at the housing sites.

Big Picture Aspects of ASAP Involvement in the R3 Program

The ASAP partners reported being involved in conversations with senior program management about the R3 program. They also reported fundamental challenges, as well as consistencies between the R3 and ASAP models and philosophies.

Connecting with Senior Program Management. ASAP personnel reported having big picture conversations about the R3 program, communicating with senior program management to learn about R3 and to determine where it fits within the ASAPs' line of business. The major objective has to been find common ground and opportunities to further collaboration between the two programs.

Entering into Business Agreements with HSL. Formally, one ASAP partner reported entering into business agreements with HSL and subcontracted providers to overcome HIPPA concerns related to the information sharing required when collaborating to support individual program participants enrolled in the R3 program.

Fundamental Challenges to Partnering with R3. The ASAP partners identified three broad challenges with current and potential future ASAP involvement in the R3 program: funding, duplication, and capability/inclination.

- **Lack of Funding to Promote Robust Communication between ASAP and R3**

The first challenge pertained to the lack of funding provided for ASAPs under R3, given that onsite ASAP staff now need to devote time to interacting and communicating with wellness team members. The state, it was pointed out, pays for case managers to do home visits and to conduct assessments and coordinate care; it does not pay for them to devote 15 to 20 minutes (times X number of participants) to speaking with R3 staff about each client served by both programs. High caseloads combined with the absence of additional funds provided by R3 for this purpose limits the robustness with which that communication can take place.

- **Inefficiencies and Friction Stemming from Duplication in R3 and ASAP Roles**

The second challenge pertained to potential duplication in the R3 and ASAP roles. It was pointed out that no single entity is responsible for coordinating service and supports for specific residents, resulting in potential inefficiencies and friction among the entities serving them.

- **Issues When Partnering with Other ASAPs (Staffing, Funding, Approach)**

The third challenge pertained to the potential role of other ASAPs in the R3 program. Springwell and South Shore Elder Services have been enthusiastic partners. It may be harder to recruit other ASAPs, in part, because of staffing and funding concerns and because R3 does not necessarily fit with their approach to providing senior care. And even if other ASAPs were willing to partner, the form of that partnership may vary because, as one partner, explained, no two ASAPs are alike.

Consistency between the R3 and ASAP Models. Despite potential challenges, ASAP personnel felt that collaboration with the R3 program was a natural fit due to consistency between R3 and the ASAP model and philosophy, both generally, in relation to improving information sharing and linkages to community resources, and specifically, with respect to each ASAP's particular approach to supporting housing providers and residents.

- **General Consistency between R3 and ASAP Goals and Philosophy**

It was explained that the ASAPs are natural community partners, in part, because of the R3 programs' goal of promoting information exchange and stronger links to community resources in connecting residents to needed services and supports.

- **R3 Is Consistent with the Cluster Model Used by South Shore Elder Services**

The partner from South Shore Elder Services further explained that the R3 program is consistent with the "cluster model" used by the agency, which involves entering into multiple agreements with subcontracted providers to serve defined areas such as geographically set neighborhoods and, notably, senior housing communities.

- **R3 Is Consistent with the Springwell's Approach to Supporting Housing Providers**

The partner from Springwell further explained that although the specifics are different, the R3 program is consistent with the approach the agency developed in contracting with housing providers to improve quality of life and health while reducing cost. It was reported that Springwell's Care Connections Program, in particular, became the prototype for the State Supportive Housing Program in Massachusetts.

On the Ground Aspects of the ASAP Experience with the R3 Program

Wellness team members primarily interact with ASAP case managers and subcontracting providers at the housing sites. It was reported that ASAP staff met with R3 program staff, both initially to familiar themselves with their respective programs and processes, and on an ongoing basis to support resident needs. The housing and ASAP partners described very different processes of communication with the Boston- and South Shore-based wellness teams, with communication largely occurring on an as-needed basis with respect to the former, and more formally through regularly scheduled meetings in the case of the latter. They also reported that the foundation underlying the ASAP role, at least on the South Shore, varied across the HSL and non-HSL sites, thereby contributing to differences in the nature of the ASAP-R3 relationship at the two communities. The sheer number of care managers operating in a single building poses a challenge to effective communication between ASAP, R3, insurer, provider, and other personnel supporting individual residents, no matter the location.

Initial Discussions between R3 and ASAP Staff. Early on, the wellness teams met with ASAP staff to introduce themselves and the R3 program. In turn, ASAP staff informed the

wellness teams about available services and supports and the referral process, in addition to the staff serving specific buildings.

No Dedicated Communications Process between R3 and Springwell. It was reported that Springwell did not develop a formal communication process with wellness team members at the Boston-based housing sites. Thus, rather than meeting regularly on an ongoing basis to talk about specific residents, Springwell and R3 staff connect on an as-needed basis as issues arise using mechanisms available to all providers to connect with the ASAP to bring supports to seniors.

Bringing R3 into Cluster Meetings Held by South Shore Elder Services. South Shore Elder Services did not develop a dedicated communication process with the R3 program either. However, wellness team members do attend monthly cluster meetings at which the ASAP, subcontracted providers, and other building staff talk about individual clients.

ASAP Experience on the South Shore Varied Across the HSL and Non-HSL Sites. South Shore Elder Services found it somewhat easier to engage the R3 program at the HSL site (2.a) than the non-HSL site (2.b). Three main reasons were highlighted. First, it was reported that the ASAP's mission more closely aligned with the mission and approach taken by Site 2.a to supporting residents. Second, it was reported that the ASAP had already been fully immersed serving residents at Site 2.a, which was thus granted cluster status, whereas the ASAP served relatively few residents at Site 2.b, which was thus incorporated into the regional cluster rather than being designated as a cluster itself. Third, it was reported that ASAP staff had already established productive relationships with housing staff at Site 2.a, given the large volume of residents served; this had yet to be the case with Site 2.b, given the comparatively small volume of resident contacts. It was reported, however, that the R3 program represented an opportunity to expand the ASAP's role at Site 2.b, which it began to do after the R3 program launched.

Large Number of Case Managers and Their Willingness to Accommodate R3 Impede Effective Communication. The ASAP partners noted that communication around meeting the needs of individual residents is difficult, in part, due to the large numbers of case managers operating with the buildings, whether from the ASAP or other entities, and variation in case manager willingness to accommodate R3. The large number of potential contacts derives, in part, from each ASAP having multiple case managers engaged with each housing site, including different ones for each enrolled program and language spoken at the site. The large number of potential contacts also derives from the additional case management provide by insurers, hospitals, large physician practices, ACOs, and other entities. Alternatively, there may be communication challenges deriving from the willingness of some case managers to accommodate and engage R3 staff.

HOSPITALS

Housing and community partners observed little headway in forging productive connections between the R3 program and hospitals serving residents at the participating housing sites. Thus, R3 has been unable to acquire the utilization data to inform care planning and evaluation, nor engaged in meaningful day-to-day communication with discharge planning and other staff

following an emergency department or inpatient hospital admission. Several challenges were noted inhibiting these connections; strategies to promote those connections were proposed as well.

Lack of Connections Made to Further Large-Scale Data Sharing

One community partner reported that senior program management in the R3 program had yet to develop the relationships needed to promote large scale data sharing with hospitals, thereby inhibiting assessment of certain program aims related to hospitalizations. This individual recognized effort made by R3 staff to promote connections with pertinent hospital staff. They hoped that the hospitals would be more amenable to sharing utilization information in the future.

Lack of Connections Made to Further Day-to-Day Communication

Housing and community highlighted the importance of day-to-day contact between hospital and R3 staff about specific program participants; connections have been made with discharge planning and case management staff at some hospitals but not others.

The Importance of Routine Contact with Hospital Staff. Housing and community partners felt that contact between hospital and R3 staff is important, both at the initiation and conclusion of a hospitalization. On the front end, hospital and community partners felt that connections with hospitals staff are important so that R3 and other housing staff know when a hospital admission has taken place, and what happens to program participants once they enter the hospital. On the back end, housing and community partners felt that it was important that these connections be made so that R3 and other housing staff know when program participants are going to be released from hospital and hospital staff know what is available to support patients once they are discharged back to the housing site.

Extent of Connection with Hospital Staff Varies. Housing partners reported being able to connect with hospital staff at some hospitals, but not others.

Challenges and Strategies to Connecting with Hospitals

Challenges to Connecting with Hospitals. Housing and community partners pointed to several challenges with connecting with hospital case management and discharge planning staff. First, it is difficult to develop productive connections with hospitals due to staff turnover. Second, it is difficult to develop productive connections with hospitals due to the large number of different hospitals to which housing residents get admitted. Third, it is difficult to develop productive connections with certain hospitals on the South Shore, in particular, because they are not governed locally, but instead by larger parent hospitals in Boston.

Strategies for Connecting Better with Hospitals. Housing and community partners suggested some strategies for better connecting with hospitals. One housing partner highlighted the importance of identifying the right people and demonstrating how greater engagement with R3 and the housing sites would be beneficial to the hospital's bottom line. A second housing partner suggested bringing housing staff to meetings between R3 and hospital staff to better

underline the local relevance and impact of the relationship. A third housing partner suggested connecting to hospitals through the HSL liaison to those facilities. A fourth partner suggested focusing on middle management rather than, say, the CEO or line nurse, when targeting hospital staff.

INSURERS

One of the community partners, a representative from Tufts Health Plan, commented on the initial and ongoing role of Tufts in the R3 program. Impediments to insurer participation in the R3 program was discussed, in addition to suggestions for improving the insurer role.

The Limited Role of Tufts Health Plan in the R3 Program

Prior to the R3 program, Hebrew SeniorLife had been in ongoing conversations with Tufts Health Plan about how the two organizations could partner better in supporting housing with services. Subsequently, Tufts role in the implementation of the R3 program has been limited largely to participation in quarterly advisory group meetings. No other participating health insurance plan was mentioned during the course of the housing and community partner interviews. It should be noted, however, that Tufts agreed to pilot a sustainable funding model on a per-member per-month basis as part of the second phase of the R3 program, $R3^2$, which began after the initial R3 demonstration period which is covered by this report concluded.

Impediments to the Insurer Role in the R3 Program

Two impediments to insurer participation in the R3 program were discussed. One impediment, identified by the partner at Tufts, pertained to the limited proportion of residents covered by each health plan at the housing sites. The other impediment, identified by one of the housing partners, pertained to the arm's length relationship insurance case managers often have with beneficiaries

Limited Proportion of Covered Residents at the Housing Sites. Most affordable senior housing residents are enrolled in Medicare fee-for-service, rather than a Senior Care Organization (SCO) or Medicare Advantage plan. It was thus reported that a major factor limiting insurer participation in the R3 program, or otherwise to investing more directly in the housing sites on their own accord, is the low proportion of residents covered by each plan.

The Arm's Length Relationship of Case Managers with Beneficiaries Limits the Utility of the Information Provided. One housing partner agreed that information should flow back and forth between the health plans and housing sites. But this exchange, it was noted, is hampered by the limited utility of the information provided due to a comparatively superficial relationship of insurer case managers with beneficiaries.

Suggestions for Improving the Insurer Role in the R3 Program

The partner from Tufts Health Plan made two suggestions for improving the insurer role: incenting collaboration among care managers, and having insurers contract directly with the R3 program to provide some services (e.g., care coordination/management).

Incenting Collaboration among Care Managers. One suggestion for improving the insurer role involved incenting collaboration among care managers from the different players, including the ASAPs, R3, insurers, and providers. It was pointed out that incentives are needed, in part, because care managers can sometimes get territorial about particular clients, rather than collaborating with the broader group. On the other hand, it was noted that incentives may be needed to influence the behavior of care managers hired and paid for by other entities, even though they assume responsibility for managing the care of your clients or beneficiaries.

Insurers Contracting with R3 to Provide Services. It was pointed out that insurers contract with ASAPs to provide services and manage care under the SCO program. It was suggested that insurers could similarly contract with the R3 program to perform comparable functions at the housing sites, perhaps on a more delineated and integrated basis than would be the case when bringing in entities from the outside.

HEALTH POLICY COMMISSION

The R3 program was funded by the Massachusetts Health Policy Commission (HPC) and other supplemental funders. The primary funder was the HPC through its Health Care Innovation Investment (HCII) Program. The purpose of the HCII was to test promising care delivery and payment innovations that target complex health care cost challenges with the aim of reducing growth in health care cost within the Commonwealth while maintaining or improving quality, access, and provider experience. One of the community partners, a representative from the HPC, reported that R3 fit well with the goals of the HCII Program and that Hebrew SeniorLife has been a model awardee. This individual also spoke to the HPC's role in R3 beyond serving as the primary funding.

The R3 Program's Innovative Approach to Addressing Cost Drivers

It was reported that the R3 program's innovative approach to addressing cost drivers in health care proved an excellent fit for the HPC's HCII funding initiative. That it did so at the intersection of acute care, long-term services, and supports, housing, and the social determinants of health proved especially appealing to the HPC as well.

HSL Has Been a Model Awardee to the HPC

It was reported that the HSL has been a model awardee – proactive, responsive, collaborative, innovative, adaptive, and focused on replication.

The Role of the HPC Beyond Funding

The HPC played a range of roles in the R3 program beyond serving as the primary funding, particularly in informing the design and evaluation and providing advice on ongoing operations.

Focusing on Partnering and Collaborating with Non-Affiliated Entities. It was reported that the HPC informed the design of the R3 program. This is reflected, in part, in the

HPC's focus on having HSL partner and collaborate with non-corporate affiliated entities, including the first responders but especially Site 1.b, an ostensible competitor, where the model was transferred to a new site.

Requiring Identification and Measurement of Key Performance Indicators. The HPC's role in the evaluation is reflected in the requirement that senior program management identify and measure key performance indicators (KPIs) used for assessing program impact.

Providing a Sounding Board and Connector to Other Funding and Data Sources. Finally, the HPC played a role as sounding board, helping senior program management to brain storm ideas and to identify and connect with additional funding and data sources.

SUSTAINABILITY

During the interviews, housing and community partners identified funding as the largest obstacle to the sustainability of the R3 program. Thus, interviewees stressed the importance of generating the empirical data necessary to prove out the R3 model and to gain buy-in from potential funders/sponsors. Several potential long-term funding sources were also identified.

FUNDING AS THE LARGEST OBSTACLE TO SUSTAINABILITY

Housing and community partners highlighted the importance of funding for the R3 program's long-term viability.

GENERATING EMPIRICAL DATA TO PROVE THE R3 PROGRAM OUT

Housing partners shared the belief that creating an evidence-base documenting the successes of the R3 program will prove essential for garnering support for the program. Partners described potential costs and benefits that should be measured in proving the R3 program out, in addition to the role that the data could play in engendering buy-in from potential funders, specifically.

Measuring Costs and Benefits of the R3 Program

Housing partners pointed to staffing as the primary additional cost deriving from the R3 program. *"To put a price on things,"* as one housing partner reported, *"I look at it as strictly staff time."* (HSL/FIRE, 9). In contrast, housing and community partners highlighted a range of potential benefits that could be tracked to help prove the R3 program out. These benefits included reductions in long-term care and health system costs, particularly related to hospitalizations and emergency department visits. They also included improvements in resident health and quality of life in relation to such areas as exercise, socialization, nutrition, falls, and the ability to access services through program staff.

Gaining Buy-In from Potential Funders/Sponsors

Housing and community partners specifically connected the importance of demonstrating the efficacy of the R3 program through research and evaluation to the ultimate goal of securing

funding, both for purposes of supporting R3 at current sites and for extending the program's reach to other locations.

POTENTIAL LONG-TERM FUNDING SOURCES

Housing and community partners suggested several potential sources of long-term funding for the R3 program, including insurance companies, government health programs (Medicare, MassHealth), public housing programs, health care providers (e.g., health systems, ACOs), housing providers, including cross-site funding mechanisms, and resident fees and family contributions. Still other suggested funding mechanisms included lotteries and businesses such as CVS.

REPLICABILITY

Housing and community partners agreed that a primary goal of the R3 demonstration is to further the diffusion of the program to other housing sites around the country. Essential conditions and consideration for replicating the R3 program were discussed.

REPLICABILITY AS A GOAL FOR THE R3 PROGRAM DEMONSTRATION

Several housing and community partners identified replicability of the R3 program in other affordable housing communities as a major objective of the demonstration. Partners expected the demonstration to promote diffusion of the R3 program, in part, by serving as an example of what is possible when affordable senior housing communities adopt additional services and supports and by leading to the production of a manual or guide that could be useful to replicating sites during implementation of the R3 program elsewhere.

Serving as an Example to Other Housing Communities

Interviewees at both the HSL and non-HSL sites expressed pride in being part of a project that could lead to a pattern of wide-spread integration of health-related services and supports in senior housing communities through adoption of programs such as R3.

Producing a Roadmap to Facilitate Replication

Some housing and community partners highlighted the importance of documenting successes and challenges implementing the R3 program with the aim of producing a manual or guide for other affordable housing providers to follow, thereby facilitating adoption of the R3 program elsewhere. This means figuring out basic structures and processes of the program so that it can be scaled up similarly at other housing communities with, hopefully, engagement from funders and other community partners who are willing to participate because the local housing site is closely following a model that had been previously proven out with the evaluation.

ESSENTIAL CONDITIONS FOR REPLICATING R3 AT OTHER HOUSING SITES

Housing and community partners pointed out that funding is a precondition for housing site adoption of the R3 program; so too is demonstrating the expected benefits to housing communities from doing so. Getting the word out about the R3 program to other housing providers is a necessary prerequisite for diffusing the model elsewhere. But, so too is a willingness on the part of other housing communities to take the leap in adopting R3.

Funding as a Precondition for Housing Site Adoption

Funding was a commonly stated prerequisite for replication of the R3 program.

Demonstrating Benefits as a Key to Gaining Buy-In

Housing and community partners observed that affordable senior housing communities have an interest in serving their residents better while improving the bottom line, both generally and with respect to reducing turnover specifically.

Demonstrating the Overall Benefits of the R3 Program. Partners noted that demonstrating the overall benefits of the R3 program would be a compelling reason for promoting buy-in and adoption by other housing communities. Partners from the non-HSL sites, in particular, emphasized that other housing communities would be particularly responsive to financial incentives or rewards.

Demonstrating Reductions in Resident Turnover with the R3 Program. Partners felt that, as a key benefit for housing providers, it was important to demonstrate that the R3 program helped to lower resident turnover while, potentially, attracting new residents.

Getting the Word Out to Other Housing Providers

Partners touted the importance of industry-level communication mechanisms in promoting the diffusion of the R3 program. They indicated that word-of-mouth from other industry players carries weight with communities considering adding programs such as R3 to their housing environments.

Taking the "Long View" or Openness to Risk

Even with potential benefits, executive leadership at the housing sites need to be willing to do something different, perhaps even taking the "long view" on the potential return on investment or accepting a certain amount of upfront financial risk before committing to implement enhanced housing with services models such as R3.

IMPLEMENTATION CONSIDERATIONS AT REPLICATING SITES

Housing and community partners noted several "lessons learned" that may be helpful to other sites replicating the R3 program. These lessons include: ensuring strong support among housing

site executives; becoming more engaged when interacting with residents; catering to the local housing community/context; forming relationships with local EMS and other community partners; and hiring the "right staff."

Executive Support Is Essential at Implementing Sites

Partners pointed out that strong leadership on the part of top-level executives will be essential to successful replication of the R3 program at other housing site. This extends not only to the provision of concrete resources, but also to less tangible support such as empowering front line staff and promoting open communication processes during program implementation.

Becoming More Engaged When Interacting with Residents

Partners noted that there would be a need, in part, to shift the approach at replicating housing sites—to become more "eyes-on" and less "hands off" when interacting with residents under the R3 Program.

Catering to the Local Housing Community/Context

Housing and community partners felt that replicating housing sites would need to cater the R3 program to the unique attributes of those communities and the contexts within which they are situated. It was pointed out that significant variation across communities suggests that what works in one community may not necessarily work in another community unless specific accommodations are made with those differences in mind.

Establishing Relationship with Local EMS and Other Community Partners

Housing and community partners observed that replicating housing sites would need to put in the hard work to establish partnerships with the pertinent EMS agencies, ASAPs, and other community providers and resources.

Hiring and Investing in the "Right Staff"

Housing and community partners highlighted the importance of hiring the "right staff" when replicating the R3 program. They articulated this imperative in relation to both general staff attributes, such as dependability and stability, and program-specific attributes such as experience working with older adults and qualifications for serving in the wellness nurse and wellness coordinator positions.