



LTSS CHOICES

Coordinating Housing, Health and LTSS through Home-Based Care Management

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About this Series

This Spotlight is part of the AARP Public Policy Institute's LTSS Choices initiative. This initiative includes a series of reports, blogs, videos, podcasts, and virtual convenings that seeks to spark ideas for immediate, intermediate, and long-term options for transforming long-term services and supports (LTSS). We will explore a growing list of innovative models and evidence-based solutions—at both the national and international levels—to achieve system-wide LTSS reform.

We recognize the importance of collaborating and partnering with others across the array of sectors, disciplines, and diverse populations to truly transform and modernize the LTSS system. We invite new ideas and look forward to opportunities for collaboration.

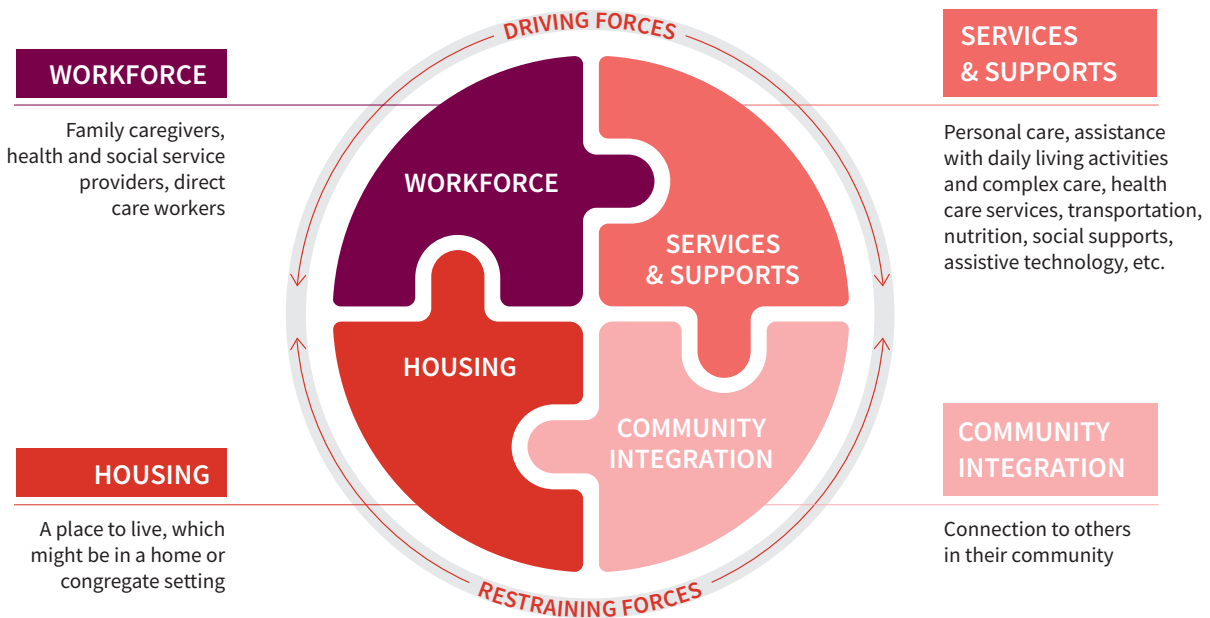
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The issues facing people who need long-term services and supports (LTSS) cannot be solved without considering new approaches to the issue of housing. Housing forms one of the four pillars in the LTSS Choices framework (see figure 1). It is a basic need that all people have—that is, a place to live. Yet despite all the other challenges that people with LTSS needs face, housing is often one of the biggest. Beyond merely having a place to live, it is intimately connected to the LTSS choices that are available to them. People who need LTSS must have choice when it comes to where they live. The availability, accessibility, and affordability of housing therefore becomes a driving force that shapes the LTSS landscape. It is connected to every other pillar (and challenge) in the long-term services and supports system: workforce, community integration, and services and supports.¹

Housing is also one of the most important social determinants of health. Some of the most influential studies of inequality in health have revealed life-expectancy differences of more than a decade between different neighborhoods in the same city; these differences are almost always an extension of

¹ For more detail on the LTSS Choices Framework, see Reinhard, Susan, "A Series on Transforming Long-Term Services & Supports," AARP Public Policy Institute, Washington DC, 2020. Accessed May 2021: <https://www.aarp.org/content/dam/aarp/ppi/2020/12/ltss-choices-framework.pdf>

FIGURE 1: THE FOUR BASIC REQUIREMENTS OF PEOPLE WHO NEED LTSS



the quality of the built environment.² The design of a neighborhood can affect so many aspects of residents’ everyday life, such as mobility for people with disabilities, the availability of clean drinking water, opportunities to buy healthy food, the ability to exercise, and more. All these factors can lead to life-long disparities in health and greater need for health care and long-term services and supports. Further, there is a national shortage of housing that is affordable to those with lower incomes, including many with LTSS needs.³ As a result, the combined costs of housing and services can become a major challenge. Lack of safe, affordable, and accessible housing is a major problem, but there is another, more positive way to think about housing and health: Housing infrastructure can be used to *address* some of the most intractable challenges in our services system. Housing can be part of the solution, not just a part of the problem.

In fact, many health care providers and LTSS programs and providers alike are working to strengthen their relationships with housing programs and systems. There are many ways stakeholders working together across these arenas might help address inequality in housing.⁴ This paper describes one model called Support and Services at Home (SASH), which is a housing-based care management (HBCM)

² For an overview of social determinants related to housing and the built environment, see Office of Disease Prevention and Health Promotion, “Social Determinants of Health” Office of Disease Prevention and Health Promotion, Washington DC, accessed May 2021. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources>.

³ See National Low-Income Housing Coalition, “Out of Reach The High Cost of Housing,” 2021, accessed September 2021: https://nlihc.org/sites/default/files/oor/2021/Out-of-Reach_2021.pdf

⁴ One excellent overview is Peggy Bailey, “Housing and Health Partners Can Work Together to Close the Affordability Gap,” Center on Budget and Policy Priorities, January 2020, <https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability>

program. HBCM programs activate housing providers as new nodes for prevention, primary care, long-term supports and services, and community outreach. By focusing on housing as a platform for LTSS system transformation, HBCM models work to address some of the most persistent problems and inequalities older adults and people with disabilities face. Furthermore, this approach to empowering residents and communities helps individuals take charge of their own health and realize their goals for independent, community living. It is part of a larger movement toward reforming the health care system to make it less episodic, more person-centered and more accountable.

A key principle of the independent living movement and person-centered planning is that the participant is that participants are “in the driver’s seat.” This is also a critical element of the housing-based care management model. The model is firmly aligned with basic principles of person-centered planning, which include focus on the person, choice and self-determination, community inclusion, services and supports availability, information, coordinated supports, and positive expectations.⁵ It helps participants to focus on what is important *to* them, in addition to what is important *for* them.

In the pages that follow, we take an in-depth look at SASH™ in Vermont, where it originated and has now expanded across the state based on documented evidence of its effectiveness.⁶ The program’s leaders are now pursuing replication opportunities in across the United States, offering both opportunities and new challenges from which to learn even more. This exciting story of growth and innovation offers lessons for all leaders looking for new ways to connect housing, health, and LTSS.

Introducing the Support and Services at Home (SASH) Model in Vermont

More than a decade ago, Nancy Eldridge, then the CEO of housing nonprofit Cathedral Square in Burlington, Vermont, developed a vision for what became the home-based care management model now known as Support and Services at Home (SASH). First prototyped at Cathedral Square in 2009, SASH has since expanded across the entire state, and today serves approximately 5,000 participants.⁷ The key idea is to use the existing housing system to extend primary care and human services practices into the home, creating a more robust network of care and services. This is accomplished through agreements with 70 partners organizations, including hospitals, community-based organizations, and academic institutions.

The original idea was to take advantage of common features of the affordable housing system to promote population health. SASH builds on the recognition that there are often large concentrations of people with the high levels of health needs living in low-income congregate housing for older individuals. The residents’ proximity to one another and the similarities many share in terms of challenges and health care needs creates an opportunity for efficiencies of scale. The model builds on public investments that have already been made in housing infrastructure.⁸

⁵ Human Services Research Institute. (2019). *Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Definitions and Principles*. Cambridge, MA: National Center on Advancing Person-Centered Practices and Systems.

⁶ Robyn Lunge, *An Early Look at Vermont’s Rollout of Its Value-Based, Multi-Payer “Next Gen” Model to Lower Costs and Improve Population Health*, National Academy of State Health Policy, June 2018.

⁷ Support and Services at Home, “Learn About SASH,” Support and Services at Home, accessed May 2021, <https://sashvt.org/learn/>.

⁸ Ibid.

At the core of the SASH experience are participant panels made up of approximately 100 people each. Most of the participants are Medicare enrollees living in one of the more than 140 affordable housing sites in Vermont that have formed partnerships to create SASH. However, they can come from many other backgrounds and residential setups, including older adults living independently in single-family homes and adults with disabilities.

When a SASH participant joins a panel, he or she works with a care coordinator and wellness nurse to design an individually tailored wellness plan. This adds value to typical primary care visits or services coordinated by a case worker. Eldridge has observed that the success of the program stems from its focus on what motivates people – that is, what means something to them, what they see as their purpose.⁹

Because the wellness nurses interact regularly with participants where they live and know the overall needs of the people they serve, they can offer evidence-based interventions and track outcomes that fit the goals of their population. The care team doesn't just monitor typical biometrics like blood pressure or blood sugar levels but proactively selects programs like cooking classes and tai chi lessons to meet their group's needs based on knowledge gained from assessments. SASH's preventative approach to care seeks to address participants' issues before they end up in the emergency room.

The ongoing relationships and emphasis on promoting independence also helps SASH address the difficult issues of care transitions. The scale of the participant panels and its integration into the housing network makes it easier for the care team to coordinate transitions with local hospitals, nursing homes, and other organizations in the health care system. SASH can disrupt the all-too-common pathway that people take as they age or develop the need for more LTSS – historically going from living where they want to live, in their homes and communities, to living in institutions,¹⁰

As an alternative to institutions and residential care communities, HBCM models could provide a more affordable way for our society to help older people and people with disabilities live and maintain their health and independence at home. Many questions must be answered along the way, however. These include identifying the best way to measure HBCMs' impact and the best approaches to replicating the model across very different locations.

Essential Components of SASH's HBCM Model

The housing-based care management model as realized by SASH has several key components:

The participant panel. As previously referenced, every SASH participant is a member of a group of approximately 100 people who are all focused on staying healthy and living independently in their own homes. When individuals join the panel, they work with staff to develop a “Healthy Living Plan.” This is a person-centered plan developed through shared decision making based on data gathered in a health and social needs assessment. The interdisciplinary care team uses motivational interviewing techniques to work with participants on goal setting. The members of the panel also work together as a community to develop goals and request programming for their buildings or neighborhood. These goals

⁹ Gaby Galbin, “Aging Into a Better Life,” U.S. News and World Report August 2018, <https://www.usnews.com/news/healthiest-communities/articles/2018-08-30/vermont-elderly-care-program-aims-for-better-lives-health-savings>

¹⁰ National Well Home Network, “Housing-Based Service Models,” National Well Home Network, July 2018, https://www.wellhome.org/wp-content/uploads/2018/07/Attachment_2_HBSMs_Definition_and_Key_Components-1.pdf

are met through a menu of evidence-based practices that can be implemented or coordinated by SASH personnel. Unlike typical on-site offerings, the outcomes of these interventions are tracked over time.

Housing partners. SASH works with existing housing organizations and creates infrastructure. These organizations and stakeholders have the tools and incentives to stay in touch with participants in a way that other organizations cannot. A network of community partners centered on one's home help enable consistent relationships and reliable, timely services.

Formalized partnerships with community agencies. SASH is at the center of a network of agencies that serve its participants in various ways. Agencies on Aging, community mental health agencies, home health agencies or other critical community-based assets agree to send one, consistent staff person to monthly SASH meetings at the housing site to coordinate on action plans for high-need participants. SASH participants are strongly encouraged to attend and bring a family member if they wish. Consistency among agency attendees increases cross-agency trust, deep knowledge of participants, efficient use of resources, and true person-centered care.

Care coordinators. These members of the care team work one-on-one with participants to develop their wellness plans and to connect with essential services. As the most frequent contact between the participants and the rest of the SASH team, care coordinators must maintain trusting relationships and adopt a holistic view of participants' health and personal goals. With the approach following the community health worker model, coordinators are meant to be representative of the community they serve, which is essential for building understanding and trust.

Wellness nurses. Serving each SASH panel is a part-time registered nurse who regularly checks in with participants. These nurses use validated health-care and social-care assessment tools to understand participants' health. This assessment is coordinated with primary care providers to minimize duplication and effort within the health care system. Nurses also provide health education and coaching as well as work with participants to design wellness programming for their group. When more serious health problems are present, nurses help manage chronic conditions, oversee self-management of medications, and facilitate transitions with health care facilities.

Evidence-Based Practices Offered Through SASH

A critical component of the HBCM model is addressing participants' chronic health problems and other life challenges through evidence-based interventions. In the case of SASH, the care coordinator and wellness nurse work with SASH partner organizations and the participant panel to select interventions that will work best for their group. Here are a few of the interventions being pursued, organized by chronic condition:

Hypertension Management	Diabetes and COPD Management	Falls Prevention and Chronic Pain	Social Isolation and Behavioral Health
<p>Blood Pressure Clinics and Self-Management A regular monitoring and education program based on the American Heart Association’s Million Hearts Initiative.</p> <p>“The Beat Goes On” Heart Health Series A series of short classes on heart health and hypertension management based on the “Your Heart, Your Life” manual created by the National Heart, Lung, and Blood Institute.</p> <p>Destination Walking Group A walking club where participants track steps and virtually travel together to far-off destinations like Las Vegas or Jamaica, after which the group celebrates together.</p>	<p>Diabetes Self-Management Program Participants learn together about disease management topics like exercise, healthy eating, and medication. Coordinators help participants create weekly action plans and solve common challenges together.</p> <p>Living Well with COPD A series of seven education sessions designed to help the community deal with the most common issues from the disease.</p> <p>Cooking Matters A basic culinary course designed to help participants prepare healthy food on a budget, with an emphasis on diabetes-friendly meals and cooking for one. In some cases, SASH personnel cooperate with local organizations like food banks for this program.</p>	<p>Bone Builders A popular, simple exercise program designed to prevent (and even reverse) the effects of osteoporosis.</p> <p>Tai Chi from the Arthritis Foundation An adaptation of the ancient Chinese practice to help people suffering from arthritis improve strength and balance, relieve pain, and improve quality of life.</p> <p>Stepping On Working in small groups, participants use practices from cognitive behavioral therapy to change habits that make falls less likely.</p>	<p>WRAP (Wellness Recovery Action Plan) Using action planning and peer coaching techniques, participants work with clinical coordinators to develop their own personalized plan for emotional well-being and social support.</p> <p>Aging Well An eight-week program designed to foster a positive view of aging and give participants tools to adapt to changes in lifestyle, mobility, mental acuity, etc. Includes modules on mindfulness, meditation, and other practices for mental and emotional well-being.</p> <p>30-Day Gratitude Challenge This program draws on research showing the positive effects of gratitude journaling and other practices. This intervention focuses in particular on chronic disease patients in care transitions.</p>

Value-Based Care and HBCM Models

In 2017, the state of Vermont launched an “all-payer” accountable care organization model that coordinates payments among Medicare, Medicaid, and commercial health care payers. The goals of the system are to incentivize improved care at lower cost for the patients served by these systems. The all-payer model builds upon efforts toward value-based care in Vermont that began in 2011.¹¹

SASH provides an excellent example of how such value-based care systems function. Initial funding in 2011 through a CMS Medicare Demonstration provided \$70,000 per panel to support the care

¹¹ For the history of the Vermont all-payer model and ongoing evaluation of its effectiveness, see Centers for Medicare & Medicaid Services, “Vermont All-Payer ACO Model,” Centers for Medicare & Medicaid Services, accessed May 2021, <https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model>

coordinator and wellness nurse.¹² The idea is that this investment will save the state and federal governments money through preventing more serious health care expenses down the road. Some of these savings have already been demonstrated (see next section). It is anticipated that a comprehensive review of Vermont's all-payer model will occur in 2022.

How to Evaluate HBCM Models

Since SASH was launched in 2009, its advocates have explored many ways to capture its impact. These evaluations have involved an array of outside partners. A look at this experience collectively provides an opportunity to understand the evidence supporting the HBCM concept and to evaluate future implementations.

Systemic impact. A key rationale for SASH in Vermont is the intended reduced rate of growth in Medicare and Medicaid expenditures that the model conceivably would bring. A 2019 external evaluation by RTI International and LeadingAge found participants in urban panels saw slower growth in Medicare expenditures, reducing growth by over \$1,450 per beneficiary per year. Study authors also found among dually eligible SASH participants, growth in Medicaid expenditures for institutional long-term care was significantly slower for participants in the site-based and rural panels: the average impact was \$400 per participant per year. While the authors of the RTI study did not find evidence that SASH reduces Medicare expenditures in all populations in which it is implemented, they argued that it would be worthwhile to explore the impact of models like SASH on both Medicare and Medicaid spending in other contexts. This will be a key area to watch as the HBCM model reaches other parts of the country with different demographic traits, population densities, health care spending patterns, and reimbursement models.¹³

Clinical indicators. In cooperation with participants, the care team serving each SASH panel defines clinical goals for their panel of approximately 100 people and measures progress against them. Efforts have also been made to demonstrate the model's clinical effects on larger populations. Using a grant from the Vermont Department of Health with funding from the Centers for Disease Control and Prevention, SASH leaders studied the program's impact on high blood pressure. They found that 70 percent of participants in the study reduced their blood pressure and 50 percent even moved into a lower risk category for serious illness.¹⁴ A study funded by the Vermont Department of Health also recently demonstrated that a SASH diabetes self-management program led to lower A1C levels in 48 percent of participants in the study, reducing their risk for serious health consequences.¹⁵

System utilization. Early data suggests that SASH reduces health care utilization among participants. Studies from the Vermont Department of Health showed decreases in hospitalizations from falls at several SASH sites in the state. Improvements are particularly pronounced among participants who

¹² National Well Home Network, "Housing-Based Service Models," National Well Home Network, July 2018, https://www.wellhome.org/wp-content/uploads/2018/07/Attachment_2_HBSMs_Definition_and_Key_Components-1.pdf

¹³ Kandilov, Keyes, van Hasselt, Sanders, Siegfried, Stone, Edwards, Collins, and Brophy, "The Impact of the Vermont Support and Services at Home Program on Healthcare Expenditures," U.S. Department of Housing and Urban Development, *Cityscape: A Journal of Policy Development and Research* Vol. 20 No. 2, 2018, <https://www.huduser.gov/portal/periodicals/cityscpe/vol20num2/ch1.pdf>

¹⁴ Department of Health and Human Services, "Support and Services at Home (SASH) Evaluation: The First Four Years," Department of Health and Human Services, Washington DC, March 2017, <https://aspe.hhs.gov/system/files/pdf/257926/SASH4hl-rs.pdf>

¹⁵ Support and Services at Home, "Succeeding with Diabetes Management and Prevention," Support and Services at Home, January 2019

frequently visit the emergency room. An in-house analysis of longitudinal participant data found a 40 percent reduction in Emergency Room visits among high utilizers between 2018 and 2019.¹⁶

Empowerment and subjective well-being—and resulting potential savings. For SASH leaders, helping participants feel empowered and self-sufficient is at the beginning and end of everything they do. So, checking in with participants' own view of their experience is also essential. In several different surveys, SASH participants said that they felt that they had easier access to mental health services and reduced social isolation. Another important measure of patient empowerment is the way in which SASH has increased the number of participants using advanced directives for end-of-life care. SASH leaders say that as of 2019, 67 percent of participants have completed advance directives stating their end-of-life wishes, well above the national average of 46 percent.

Questions to be Addressed as the HBCM Model Spreads

In 2017, Eldridge founded the National Well Home Network. The organization's mission is to replicate the HBCM model nationwide, creating more effective health solutions for seniors and other residents of affordable housing. The organization has pursued expansion on several fronts, each of which raise questions about the future of HBCMs.

How can HBCMs be adapted to states and localities with a variety of payment systems and policy priorities?

The first projects along these lines, implemented in Minnesota and Rhode Island, were direct replications of the SASH model. The Saint Elizabeth Community, SASH's expansion partner in Rhode Island, eventually plans to scale up the model to serve the entire state. This expansion is anticipated to follow a similar trajectory as Vermont's, by incorporating a wide variety of partners across sectors. But the expansion of HBCM models could look very different in a large state like California. That state recently highlighted "Housing for All Stages and Ages" as a key component of its Master Plan for Aging.¹⁷ In response, LeadingAge California is working on a demonstration project focused on residents of publicly assisted housing plus the "forgotten middle" population that qualifies for Medicare and Medi-Cal, California's Medicaid program.¹⁸ Many such nuances will need to be addressed in order to build HBCM models in diverse policy environments.

How might the administration and impact of HBCMs look different in a more urban environment?

The most persuasive evidence for SASH's effectiveness comes from Chittenden County, Vermont. Chittenden is home to Vermont's largest city (Burlington) and about 150,000 people. A new project is underway in Baltimore, allowing for a test of the HBCM concept in one of the nation's most urban environments. For the project—called Baltimore Integrated Complex Care at Home, powered by SASH,TM—National Well Home Network has partnered with dozens of stakeholders in the city, including the Maryland Primary Care Program, LifeBridge Health, Enterprise Community Partners, and an array of affordable housing nonprofits. The partners are seeking funding to serve between 500 and 1,000

¹⁶ Support and Services at Home, "ER Visits by High-Use Participants Drop 40% from 2018 to 2019," Support and Services at Home, 2021

¹⁷ California Department of Aging, "Master Plan for Aging," California Department of Aging, January 2021, <https://mpa.aging.ca.gov>

¹⁸ Rose, Green, Eldridge, Utsumi, "Beyond IWISH — Applying a Systems Change Approach to Integrating Care at Home," Engage Magazine, November 2020, <http://engageheadlines.com/beyond-iwish-applying-a-systems-change-approach-to-integrating-care-at-home/>

participants. Results from the program will also advance Maryland's Total Cost of Care goals, which is designed to limit overall Medicare spending across the state.¹⁹

How can a national body of knowledge and evidence be developed for HBCM models?

The Department of Housing and Urban Development is currently running a national study comparing outcomes in housing units deploying an HBCM model with a control group. Though largely inspired by SASH, HUD's model is known as Integrated Wellness in Supportive Housing (IWISH). The study is looking at outcomes at 40 different HUD-assisted multifamily properties in seven states: California, Illinois, Maryland, Massachusetts, Michigan, New Jersey, and South Carolina. This expanded test of the model provides evidence in urban properties made up of racially and ethnically diverse residents, all with very low incomes, compared to the majority White population in SASH Vermont. Data from these sites will be used to analyze whether the IWISH model affects "the healthcare utilization and housing stability of low-income adults aged 62 and older living in HUD-assisted multifamily properties."²⁰

Can the HBCM model help to address health equity?

The past few years have seen significantly increased interest in health equity. The stark racial inequality in the COVID-19 death tolls in the United States as well as new movements against racism have made the problems to be solved clearer than ever before.²¹ At the same time, governments and philanthropic foundations are showing a new willingness to invest in solutions that will reduce the gaps between the Americans with the longest life expectancies and those whose lives are unfairly cut short. There are many housing-related issues that disproportionately and negatively impact the health of minority populations in the U.S.: accessibility of healthcare, overcrowding, pollution, lead, food deserts, social isolation, and so forth. HCBM models are not able to address all of these, but further research may demonstrate if they can mitigate some of the affects.

Could similar partnerships between LTSS and housing impact other vulnerable populations?

Housing-based care management has been shown to be effective at supporting older adults. Different models could emerge that involve LTSS providers, health care providers, and housing organizations working together to serve other populations such as veterans, domestic abuse victims, human trafficking victims, and the chronically homeless.

Conclusion

As evidence coming out of SASH and other HCBM models indicates, housing organizations can offer a relationship with residents that does not begin or end with a clinical encounter. The people with the highest levels of LTSS needs, who are at the highest risk of nursing home admission, are also those most likely to "fall through the cracks" found between different providers, insurers, networks, and so forth. A significant segment of those people who would otherwise become disconnected from services can retain that connection if a housing organization is part of the team.

¹⁹ Centers for Medicare & Medicaid Services, "Maryland Total Cost of Care Model," Centers for Medicare & Medicaid Services, accessed May 2021, <https://innovation.cms.gov/innovation-models/md-tccm>

²⁰ For an overview and several reports on the IWISH study, see Department of Housing and Urban Development, "Support Services Demonstration and Evaluation: Testing the Integrated Wellness in Supportive Housing (IWISH) Model," Department of Housing and Urban Development, accessed May 2021, https://www.huduser.gov/portal/IWISH_Evaluation.html

²¹ APM Research Lab, "The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S." APM Research Lab, March 5, 2021, <https://www.apmresearchlab.org/covid/deaths-by-race>

As health care organizations and LTSS providers create new relationships with housing entities, the principle of complementary strengths can help determine the agenda. The experience of SASH and other programs reveals that housing and health care experts can work as effective partners to help fill gaps while preserving individuals' choice in where they live, what types of services they get, and who provides them. The data demonstrating HBCM models' impact is still emerging. As they spread into new areas, different factors such as funding and community priorities will shape their goals and outcomes. However, the evidence of its effectiveness and efficiency in terms of cost is promising. Policymakers working to strengthen their LTSS and housing systems should consider how the HCBS model might help improve the health and independence of older adults in their communities.

About the Authors

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Appendix I: HBCM Sites Around the Nation

The original SASH model now operates across the state of Vermont. Here are some of the other HBCM models it has inspired.

Licensed SASH models in other states. These partners pay a licensing fee to the nonprofit Cathedral Square for use of SASH intellectual property, providing them access to documents, tools, training and other resources. These organizations may decide to act as “SASH Statewide Administrators” to convene partners and build capacity throughout the state. Partners include:

- Rhode Island - Saint Elizabeth Community
- Minnesota - Presbyterian Homes and Services

National Well Home Network (*projects in development*). The National Well Home Network creates integrated systems that empower older adults and adults with disabilities to live and age well in their communities and homes. Current projects include:

- Baltimore Integrated Complex Care at Home, powered by SASH™
- California Integrated Care at Home

HUD IWISH sites. Inspired by SASH, the Department of Housing and Urban Development developed a pilot program in 2017 called Integrated Wellness in Supportive Housing (IWISH). The program was tested at 40 locations across the country; nearby control sites have also been selected in order for HUD to learn more about the specific effects of implementing this model. As described in a HUD report, the aim of the research is “to test the impact of housing-based supportive services on the healthcare utilization and housing stability of low-income adults aged 62 and older living in HUD-assisted multifamily properties.”

State	City	Site
California	Los Angeles	Castle Argyle Apartments Vista Tower Good Shepherd Manor
	Redondo Beach	Casa De Los Amigos
	Fountain Valley	Our Lady of Guadalupe
	Ontario	Palm Terrace I Co op
	San Bernardino	TELACU Hacienda TELACU Buena Vista
	Chula Vista	The Salvation Army Chula Vista Residences
	Oakland	Allen Temple Arms I Allen Temple Arms II
	San Francisco	Dorothy Day Community
	San Rafael	Maria B. Freitas Senior Housing
	Santa Cruz	East Cliff Village Apartments
	Rocklin	Rolling Oaks Apartments
	Glenview	Patten House of Glenview

State	City	Site
Illinois	Chicago	Greencastle of Kenwood Greencastle of Morgan Park Charles A. Beckett Apartments
	Rockford	Luther Center
Maryland	Owings Mill	Weinberg Village I
	Baltimore	Wabash Estates Co-op
Massachusetts	Jamaica Plain	Franklin Park Villa Co-op
	Roslindale	Blue Ledge Co-Op
	South Boston	Castle Cove Co-op
	Worcester	Colony Retirement Homes I & II Colony Retirement Homes IV
	Springfield	Seniority House
	Belleville	Belleville Co-op Apartments
Michigan	Pontiac	Pontiac Village Estates Co-op
	Hazel Park	Hazel Park Manor Co-op
	Royal Oak	Barton Towers Co-op
	Riverview	Riverview Towers Co-op
	Detroit	Rio Vista Detroit Co-op
	Canton	Canton Place
New Jersey	Ocean City	Wesley by the Bay
	Union City	Holy Rosary Housing
	Pennsauken	Stonegate at St. Stephen's
South Carolina	Columbia	New Lakeside Apartments
		Finlay House