2017

BETTER GOVERNMENT COMPETITION

Aging in America

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

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2017
BETTER GOVERNMENT COMPETITION

Winner 8

R3: Right Care, Right Place, Right Time: Effectively Integrating Senior Care and Housing

Kim Brooks
Chief Operating Officer, Senior Living
Hebrew SeniorLife

Competition Judges

Charles Baker, Sr.
Professor *Emeritus*
Northeastern University
College of Business Administration

Nick Dougherty
Program Director, PULSE@MassChallenge

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Massachusetts General Hospital

Brian Wheelan
Beacon Health Strategies

Runners Up

Special Recognition

Foreword

Good policy goes slow on ideology and accelerates big impact. If that is true, the Better Government Competition is a case study in how to use the wisdom of crowds to advance good policy. Now in its 27th year, the trajectory of the Competition has provided highly practical solutions to real-life challenges. Often the problems we were trying to solve were deeply human; certainly that is the case of previous years when we focused on issues like social services for the indigent, effective care for those with mental health issues, or ways to lower recidivism rates or reintegrate people with criminal backgrounds.

In 2017, Pioneer set a fundamentally different task for the Competition. Our focus this year is to improve the quality of life for the aging. Whereas the themes of the Competition in previous years affected limited populations, there is no "other" with aging. There is no policy solution to or escape from this universal and inevitable part of the human experience.

The "aging problem" is truly a new phenomenon; and it is, in fact, the positive outcome of a society that is working. We have more people who are living longer because we, like many other developed societies worldwide, have achieved new levels of prosperity. With prosperity comes greater attention to health and to the demand for improved medical processes and techniques to extend life—and to maintain a high quality of life. From 1930 to 2010, life expectancy in the United States rose from 60 to 79 years. Most often, the additional years have come hand in hand with the ability to lead a more fulfilling lifestyle. Given the Commonwealth's and the country's changing demographics, our burgeoning aging population presents challenges—but also ample economic and social opportunities.

In defining the playing field for 2017, Pioneer posed two questions:

> *How do we establish the care and support systems that our older populations need?*
>
> *How do we unlock the enormous social capital of our healthier aging population?*

Given those parameters, the specific goals of this year's Competition are clear: We want aging to be a meaningful and productive time of life—and that includes engaging older Americans in the workplace. We want to highlight new, successful ideas in housing, transportation, custodial care and assistance options that make an independent and fulfilling life for aging Americans possible. We want to enhance training for medical and geriatric professionals and identify policies to better coordinate care for older Americans. We want to leverage new technologies to improve the lives of seniors. And, if you have thoughts on how to ensure the future viability of retirement systems, we want those ideas, too!

In defining our objectives, Pioneer sought the counsel of an outstanding line-up of local, state and national experts. They include: John N. Morris, Director of Social and Health Policy Research and Alfred A. & Gilda Slifka Chair in Social Gerontological Research at the Institute for Aging Research; Elissa Sherman, President of LeadingAge Massachusetts; Kevin Cahill, Research Economist at Boston College's Sloan Center on Aging & Work; Mark Mather, Associate Vice President of U.S. Programs at the Population Reference Bureau; and Bronwyn Keefe, Research Assistant Professor at the Boston University School of Social Work. These are a few of the experts and policymakers who helped Pioneer refine and disseminate the 2017 Competition's problem statement.

The Institute's gratitude goes to the dozens of state legislators, executive branch officials, and media outlets whose advice and outreach expanded the number and quality of entries received.

We also thank the highly respected panel of external judges who evaluated the 2017 BGC submissions: Charles Baker, Sr., Professor *Emeritus* at Northeastern University's College of Business Administration; Nick Dougherty, Program Director at PULSE@MassChallenge; Gary P. Kearney, M.D., F.A.C.S., Pioneer Institute Board Director; Robin Lipson, Chief of Staff and Chief Strategy Officer at the Executive Office of Elder Affairs, Commonwealth of Massachusetts; James F. Seagle, Jr., President at Rogerson Communities; and Joanna Weiss, freelance journalist and former *Boston Globe* columnist.

The 2017 Competition recognized proposals in a number of areas, including ways to augment state efforts to improve the early detection of Alzheimer's disease, and two local instances of public agencies employing innovative models to give elders cheaper and more reliable transportation and keep them engaged in the workforce.

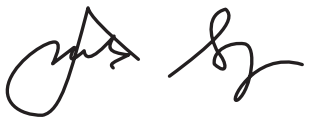
We received a number of standout submissions focusing on housing solutions for older adults. One awardee calls for a unique collaboration among existing senior service groups to create a replicable housing model specifically for seniors with lifelong developmental disabilities. Another winning idea came from graduate students that have created a digital platform to connect millions of renters to older adults with spare bedrooms, in an effort to address both affordable housing concerns and the social isolation and declining income among adults 55 and older. Other awardees focused on ensuring internal quality in assisted living communities and programming to protect poor seniors from homelessness and establish a stable channel to permanent housing.

Our 2017 first-place winner is an initiative with demonstrated success in supportive housing for older adults. "*The Right Care, Right Place, Right Time: Effectively Integrating Senior Care and Housing*" initiative from Hebrew SeniorLife makes use of wellness teams designed for specific housing sites, marrying housing with health care in a way that reduces the transfer of seniors from homes to hospitals and emergency rooms. As existing programs in Brookline and Vermont have illustrated, this model for senior housing generates significant savings in reduced medical costs while ensuring seniors are able to live independently.

This work is the product of an exceptional team. My sincere thanks go to Shawni Littlehale, who leads this Pioneer program and has built the Competition into a national reference point for innovative public policy. I'd also like to thank Matthew Blackbourn, who has demonstrated keen research, management, and social media skills, and has helped grow the Competition's reach and quality. Shawni and Matt were ably assisted by talented staff members (Mary Connaughton and Greg Sullivan), fellows (Michael Weiner and Alexander Carlin), and interns, including Benjamin Margolin and Mariella Rutigliano. All have my gratitude.

My final thank you is the most important, and it is to you. Without your support, this conversation about aging policy would be stuck in its various silos, and there would be little hope of developing a forward-looking set of solutions. The Institute and the Commonwealth of Massachusetts are greatly in your debt.

Sincerely,



James Stergios, *Executive Director*

WINNER

R3: Right Care, Right Place, Right Time: Effectively Integrating Senior Care and Housing

Kim Brooks
Chief Operating Officer, Senior Living
Hebrew SeniorLife

Problem Statement

The needs of seniors in supportive housing span a range of physical, behavioral, and social issues. Many seniors are designated as "frail" or "at risk" based on U.S. Department of Housing and Urban Development (HUD) definitions, and their physical health issues decrease mobility, impede gross and fine motor skills, and affect vision, making it difficult for seniors to shop, clean, bathe, and cook, activities needed to maintain their independence. These seniors are at increased risk of falling, a primary cause of emergency transports to hospitals, and because of the social isolation often associated with their decreased mobility, they are also at increased risk of depression.

In addition, isolation can cause seniors to fall behind on routine health care appointments, which then lead to the need for acute care services. Lack of medication adherence, in particular, is a significant factor in seniors' no longer being able to live independently.

Further complicating the situation is that many seniors in supportive housing struggle financially, which impacts the decisions they make regarding prioritization of food, prescriptions, co-pays, and other necessities.

Many seniors living in supportive housing meet the income guidelines for housing, but do not meet the income guidelines for MassHealth coverage. The lack of coordination between housing and healthcare is a missed opportunity. The result is frail, at-risk seniors trying to live independently with little discretionary income available for services and supports, and no ability to be served by the coordinated long-term services available through the Commonwealth. There is significant potential for improved outcomes and savings if care from housing staff, payers, and community based providers is better coordinated.

Many seniors living in supportive housing meet the income guidelines for housing, but do not meet the income guidelines for MassHealth coverage. The lack of coordination between housing and healthcare is a missed opportunity.

Proposed Solution

Hebrew SeniorLife (HSL) has provided health care and housing for seniors, research into aging, and education for future geriatric providers since 1903. HSL provides direct care for 3,000 seniors every day.

HSL's *Right Care, Right Place, Right Time: Effectively Integrating Senior Care and Housing* (R3) initiative provides coordinated, person-centered services to vulnerable seniors with the aim of enabling them to live independently in the community for as long as possible, receiving the right care in the right place at the right time. The long-term vision is to create a replicable, scalable, and sustainable model of housing with supportive services.

Enhanced wellness teams are embedded in specific elderly housing complexes to serve as links between housing and health care, establishing relationships with residents and collaborating on wellness and prevention efforts. These teams maximize the effectiveness of existing housing resources, and streamline communication and the exchange of information with emergency responders and payers. The teams are comprised of wellness coordinators, wellness nurses, care management staff from partner organizations and health plans, and behavioral health providers.

The primary aim of R3 is to reduce the incidence of unnecessary transfers of seniors from their homes to hospitals, emergency rooms, and long-term care facilities, as well as to reduce associated costs.

Specifically, the wellness teams' activities include:

- Assessments of participating residents to determine their needs and goals, and partnering with housing staff to tailor programming that meets those needs.
- Educating housing staff members, including office, maintenance, housekeeping, programming, and dietary staff, to identify concerning changes in residents' condition and communicate those changes in a timely and effective manner.
- Using technology (such as reverse 911) to conduct wellness checks and assist with medication adherence.
- Coordinating with primary care providers, mental health providers and hospitals.
- Partnering with emergency responders to analyze call data to identify trends, reduce unnecessary calls and transports, and facilitate communication/information flow.
- Implementing effective communication between housing and providers to relay important information (e.g., changes in condition, transitions between settings, or changes in behavior/activity levels).
- Promoting self-care among residents through individualized coaching and implementing and/or facilitating health and wellness programs, including strength and balance work to prevent falls.

The primary aim of R3 is to reduce the incidence of unnecessary transfers of seniors from their homes to hospitals, emergency rooms, and long-term care facilities, as well as to reduce associated costs. Our focus throughout will be on improving seniors' quality of life and ability to live independently.

R3 is adapted from the State of Vermont's Support and Services at Home (SASH) model.[1] SASH is a care coordination program anchored in affordable senior housing properties, serving residents on the property as well as seniors living in the surrounding communities. During the one-year testing phase, it was found that SASH interventions helped reduce hospital admissions by 19%, no SASH participant who was discharged from the hospital experienced a readmission, and falls declined by 22%. In addition, growth in annual total Medicare expenditures was lower by an estimated $1,756-$2,197 per SASH beneficiary (in well-established panels) compared to beneficiaries in two groups.

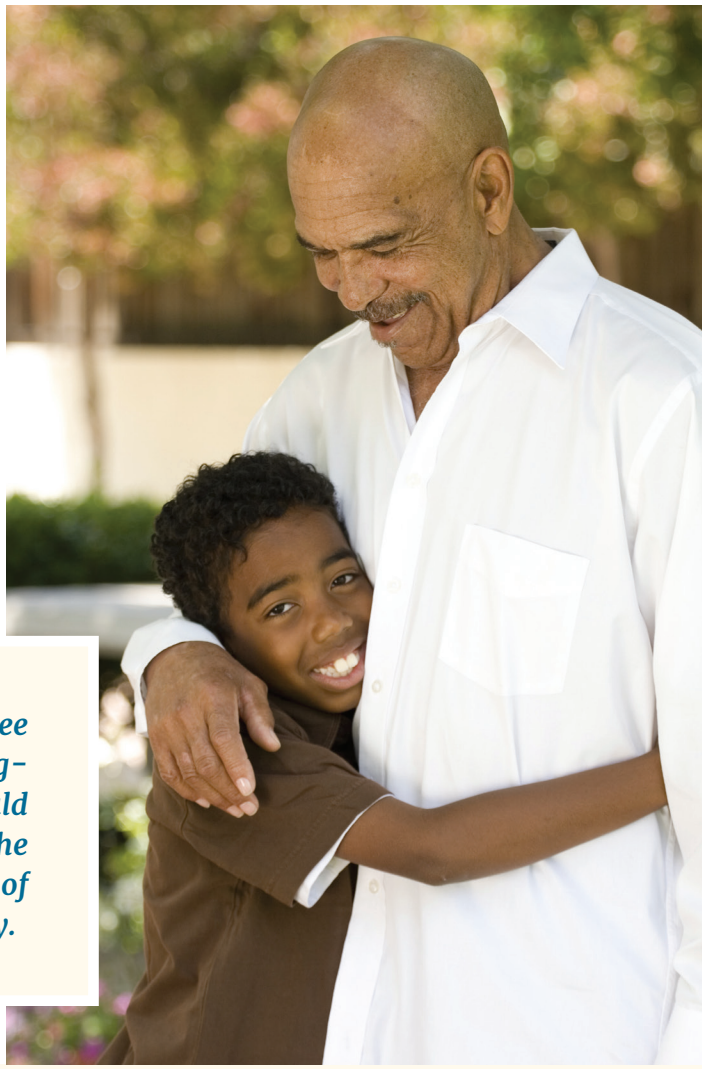
The R3 Project was also informed by the CareOregon Housing with Services model[2] which was established to coordinate the delivery of services from health, aging, and social service providers to 11 properties. Data from this model showed a 12% reduction in health care costs for residents one year after moving into an affordable housing site, as well as a 20% increase in primary care usage and an 18% reduction in emergency department usage.

R3 incorporates key lessons learned from these models, including the importance of direct engagement with hospitals that have admitted residents to ensure a smooth discharge process, the involvement of a behavioral health professional on the wellness team, and adequate time budgeted for the wellness nurse.

Projected Outcomes

R3's evaluation will track key performance indicators for residents receiving services from the wellness teams, including falls, participation in wellness programming, medication adherence, emergency room trips, transfers to hospitals and rehospitalizations, and maintained or improved quality of life.

Based on the slower rate of growth in costs from the SASH model, we anticipate a slower rate of increase for seniors' overall medical costs. As mentioned, the SASH program showed a savings due to slower growth of $1,756 - $2,197 per beneficiary per year. If we project a similar amount for 600 residents, we would show po-



[A]voiding just three placements to long-term care. . . would equate to savings to the Commonwealth of $490,000 annually.

tential savings in the form of slower growth in costs of approximately $1,053,600 annually.

If we calculate potential savings based on our projected reductions in avoidable transfers, the potential medical expense savings are consistent with the SASH savings. Using baseline emergency response information for one of HSL's locations with 560 residents over a one year period, estimated medical expense savings would be $600,000 annually. Additionally, avoiding just three placements to long-term care, assuming an average length of stay of two years and a daily rate of $225 for the long-term care facility, would equate to savings to the Commonwealth of $490,000 annually.

...related resources from the R3 experience will be made available to other senior housing sites and interested stakeholders to develop an optimal approach in innovative healthcare delivery in affordable senior housing, replicable not only in Massachusetts, but—with more than two million low-income older adults currently living in affordable senior housing across the country...

Future Goals

It is anticipated that between 2000 and 2020 there will be a 37% increase in the number of seniors 65 and older residing in Massachusetts.[3] As such, the need to ensure that housing sites can effectively serve frailer, aging seniors in a community setting is of paramount importance.

HSL is already working with a number of housing providers and health plans in the Boston area to expand the work of R3 on a broader scale. We are also involved in a collaborative effort with several local and national organizations to create a model for sustainable housing with services. Education materials, outcomes measures, communication strategies and tools, resident assessments, satisfaction surveys, and other related resources from the R3 experience will be made available to other senior housing sites and interested stakeholders to develop an optimal approach in innovative healthcare delivery in affordable senior housing, replicable not only in Massachusetts, but—with more than two million low-income older adults currently living in affordable senior housing across the country[4]—nationwide, as well.

If successful, we expect the program will serve as a model for enhanced linkages between health care and housing across the U.S.

Endnotes

1. U.S. Department of Health and Human Services, Office of Disability, Aging and Long-term Care Policy. *Support and Services at Home Evaluation: First Annual Report*, (https://aspe.hhs.gov/report/support-and-services-home-sash-evaluation-first-annual-report, viewed 3/27/17)
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Runner Up

Early Detection and Treatment of Alzheimer's Disease

Professor David L. Weimer
Edwin E. Witte Professor of Political Economy
University of Wisconsin-Madison

Dr. Mark Sager
Wisconsin Alzheimer's Institute (retired)

Problem Statement

Alzheimer's disease (AD) increases in prevalence with age, affecting up to 10% of the population aged 65 and older, but approximately 47% aged 85 and up. With an aging population—40% of persons who turned 65 in 2000 will survive to age 85—the prevalence of AD will increase from about 5 million today to 14 million by 2050.[1]

An increase in the prevalence of AD will mean higher long-term care costs. The most plausible estimates of total annual costs to the U.S. economy attributable to AD surpass $200 billion.[2] All else being equal, AD patients impose costs on Medicare about 60 percent higher than non-AD patients. For states, AD patients impose a substantial cost on Medicaid programs through nursing home use. Long-term care costs account for 34.6% of state Medicaid spending nationally.

Proposed Solution

One approach to reducing long-term care costs would be to lower demand for services by delaying the onset or slowing the progression of AD, or providing support to caregivers to enable them to keep loved ones with AD in the community longer. Although available therapies are less than ideal, evidence indicates they somewhat improve cognition, slow functional decline,[3] lower Medicare costs, and reduce the rate of nursing home institutionalization.

There is also evidence that the rate of institutionalization can be reduced through caregiver support. One study indicated that non-pharmacologic interventions directed at caregivers can delay nursing home placement by an average of 1½ years.[4]

With an aging population... the prevalence of AD will increase from about 5 million today to 14 million by 2050. An increase in the prevalence of AD will mean higher long-term care costs.

Early detection enables treatment and caregiver support when it can have the greatest impact on improving the quality of life for both those with AD and their caregivers, ultimately reducing nursing home institutionalization. Unfortunately, studies suggest that between 40% and 80% of persons with dementia go undiagnosed in primary care and, as a result, are untreated.[5]

Several inexpensive but surprisingly effective initial screens for dementia are available. The "animal naming screen," which asks respon-

Promoting early diagnosis so that treatment and counseling can be started early in the course of AD to slow its progression and enable caregivers to cope better with the burdens of the disease would delay later entry into expensive nursing homes.

dents to name as many animals as they can in one minute, has false positive and false negative rates of about 10%. The test, which can be administered with minimal training, is inexpensive. A follow-up test, such as the Cognistat exam, takes about 20 minutes to be administered by a college graduate with one-day of training. A positive Cognistat would then be followed by physician diagnosis.

Promoting early diagnosis so that treatment and counseling can be started early in the course of AD to slow its progression and enable caregivers to cope better with the burdens of the disease would delay later entry into expensive nursing homes. We propose states create incentives for early detection by reimbursing primary care physicians and county health departments for the costs of administering the animal naming and Cognistat tests.

We estimate the costs of administering these tests to be $2.30 and $17.20, respectively. To encourage participation, we propose setting reimbursement rates at 150% of actual cost, or $3.50 and $26, respectively.

Projected Outcomes

In the short-run, the AD screening program would add to state health-care costs. Based on the experience of the Wisconsin Alzheimer's Institute's use of the animal naming test and Cognistat, followed by diagnosis, and taking into account those identified as positive for AD by the first two screens who declined to proceed to the next stage in the process, AD patients can be identified at a cost of approximately $3,200 per case, of which roughly $670 would be covered by Medicare. However, long-term benefits would be substantial.

Under our proposed AD screening program, the state would have to spend approximately $2,530 for each AD diagnosis. Drug treatment alone would likely delay nursing home institutionalization by more than a year. In Wisconsin, the state Medicaid program pays on average 31 percent of the more than $46,000 annual reimbursement to nursing homes, or about $14,000. Even if this amount were realized years after diagnosis, its present value would still be significantly higher than the cost per case diagnosed.

We analyzed the present value of net social and fiscal benefits from early detection and treatment of AD.[6] We took into account several uncertainties: the mortality risks of the AD patient and his or her spouse; the risk of institutionalization at various stages of disease progression; the effect of drug treatment on the rate of disease progression; the effect of caregiver intervention on the risk of institutionalization; the probability that patients

would be diagnosed and treated at a later stage of the disease when symptoms become more apparent; and the relevant shadow prices needed to monetize all effects.

The analysis shows that benefits are larger for detection at younger ages (younger patients having more exposure to risk of nursing home care), earlier disease progressions (opportunities for slowing the progression being greater), married patients (who are more likely to have a caregiver), and women (who on average live longer). For a married 70 year-old woman at an early, but symptomatic, stage of AD, detection and treatment with currently available drugs would yield a present value of expected net social benefits of $69,000, a present value of expected net fiscal savings to Wisconsin of $4,000, and a present value of expected net fiscal savings to the federal government, which pays a larger share of Medicaid nursing home costs than the state, of $6,000. Combining drug treatment with caregiver intervention would increase net social benefits to $93,000, state savings to $15,000, and federal savings to $29,000. Drug treatment alone provides fiscal benefits to Wisconsin in excess of the expected costs per diagnosed case of $2,530. It should also be noted that, because screening offers potential savings to the federal government, one would expect states to be able to get Medicaid waivers to help pay for the program.

Future Goals

In response to our cost-benefit analysis and the involvement of the Wisconsin Alzheimer's Institute, the state of Wisconsin has developed a state-wide cognitive screening program (http://www.wai.wisc.edu/pdf/pubs/sager_ICAD2010_hawaii.pdf). As Baby Boomers age, states face the prospect of increasing Medicaid expenditures for long-term care. Analysis showing positive net social and fiscal benefits for Wisconsin from AD screening would likely show even larger benefits for Massachusetts. In FY 2015 Wisconsin's Medicaid program spent $1.85 billion on long term care while Massachusetts spent $4.63 billion, reflecting a larger population and higher nursing home costs.

Endnotes

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Runner Up

Jewish Community Housing for The Elderly and Jewish Family & Children's Service

Amy Schectman
President and *CEO*
Jewish Community Housing for the Elderly

Rimma Zelfand
CEO of Jewish Family & Children's Service of Greater Boston

Problem Statement

The challenges of growing old can humble even the hardiest among us. Many older adults face cognitive and physical changes, along with decreased income and increased social isolation. At the same time, the United States is experiencing a dramatic and unprecedented demographic shift. Americans over 65 will make up 20% of the U.S. population by 2029.

Individuals aging with intellectual and developmental disabilities (ID/DD) face even greater challenges, and they too are living longer. The number of adults with ID/DD aged 60 and older is projected to nearly double from 641,860 in 2000 to 1.2 million by 2030. Further, individuals with developmental disabilities demonstrate signs of aging in their 40s and 50s that the general population traditionally may not experience until 20 to 30 years later. These individuals are at a much higher, much earlier risk for age-related health conditions.

In Massachusetts, the majority (71%) of adults with intellectual disabilities are living with family caregivers, not in supported or even handicapped-accessible settings, and 25% of these individuals are living with caregivers over age 60 (University of Missouri-Institute for Human Development). As family caregivers age, they are unable to adequately (and indefinitely) care for their loved ones. There is an urgent and growing need for affordable, supportive housing that meets the needs of this population.

[T]here is currently little collaboration between providers of services for older adults and services for people with disabilities.

However, there are few such options for individuals with ID/DD. Their needs are rarely met by traditional housing developments for older adults. As a result, aging individuals with ID/DD often live with family members or in small group homes, and experience increased isolation as they age due to a lack of access to transportation, community programs, and their peers. As they experience declining mobility and health due to age-related issues, they also find it difficult to participate in traditional day and social programming for younger adults with ID/DD, further exacerbating their isolation.

Address
132 Chestnut Hill Avenue

Neighborhood
Brighton

Land Sq. Feet
13,847 sq ft

Building Size
56,172 sq ft

Residential Units
61

Compounding the challenges experienced by older adults with ID/DD is the fact that there has been little collaboration between providers serving older adults and those serving individuals with ID/DD. If older adults with ID/DD are to have access to housing and services that support positive aging in community, providers serving each of these populations will need to combine their resources and expertise to develop creative solutions.

Proposed Solution

Jewish Family & Children's Service (JF&CS) and *Jewish Community Housing for the Elderly (JCHE)* are embarking on a collaboration designed to better serve individuals with disabilities who are aging. Working together, they are creating a replicable housing model that will enable individuals with lifelong developmental disabilities to age in communities where they are respected, supported, and positively engaged.

The home of this collaborative project will be at JCHE's all-new, all-affordable 57,400 square foot supportive senior housing building at 132 Chestnut Hill Avenue in Brighton (scheduled to open fall 2018). The 61-unit, fully-accessible building will showcase a five-unit suite (5 bedrooms with private bathrooms and common living and kitchen area, plus space for overnight staff) designed specifically for older adults with ID/DD. The new structure will also have 3,000 square feet of ground floor commercial space for tenants and neighbors, and a connecter bridge that will provide seamless indoor passage between the new building and JCHE's existing 700-unit Brighton Campus. All residents will benefit from full access to JCHE's on-site services, amenities, and programs, including a fitness center, computer center, art studio, library, performances, classes, and clubs.

From JF&CS, the residents with ID/DD will receive intensive individual 24/7 live-in support, plus case management and personal care from JF&CS's highly trained team.

Positive or Projected Outcomes

By allowing residents with ID/DD to engage in their community, we expect this model to prevent or decrease social isolation. Plus, aging caregivers will hopefully experience significant relief knowing that their loved ones are housed, cared for, and socially and intellectually engaged.

A broad body of research shows that supportive housing effectively helps people with disabilities maintain stable housing. People living in supportive housing less frequently use

JF&CS and JCHE are working together to create a replicable housing model that will enable individuals with lifelong developmental disabilities to age in communities where they are respected, supported, and positively engaged.

costly systems like emergency health services. Supportive housing can also aid people with disabilities in receiving better health care – especially preventative care – which ultimately reduces Medicare/Medicaid expenditures.

Future Goals

JCHE and JF&CS anticipate that this pioneering model to house older adults with ID/DD within a supportive senior housing framework will be replicated in Massachusetts and beyond by those who are interested in better meeting the needs of this growing population. By integrating aging individuals with ID/DD into a senior housing facility that includes robust support services designed to meet the needs of older adults, while also providing targeted supports that will allow them to thrive in this setting, JF&CS and JCHE hope to serve as a model for similar projects. The model could be adapted for housing facilities that are being developed in the future, or with slight modifications to existing facilities.

JCHE and JF&CS's goals for the future are to: 1) identify future implementation opportunities at other JCHE buildings; 2) promote adoption of the collaborative model by creating and disseminating a best practices handbook; and 3) provide technical assistance to other organizations looking to replicate our model. Ultimately, it is the shared goal of JCHE and JF&CS to develop permanent, inclusive, and supportive housing where individuals aging with disabilities can do so successfully and live out the remainder of their lives.

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Runner Up

Mobilizing the Talent of Older Adults to Support Critical Government Services

Doug Dickson
Board Chair
Encore Boston Network

Problem Statement

Older adults watch more TV than any other age group, almost as much as they once spent working each day. And they enjoy it less (Deppe, et al.). The results are boredom, less social interaction, lower life satisfaction, and higher risks of obesity, depression, dementia, and heart, bone and diabetic disease. Too many older adults have lost purpose, which research shows can shorten life by 7.5 years (Levy, et al.).

As older adults leave the workforce in Massachusetts, we face two challenges: a) how to keep individuals active, healthy and engaged, and b) how to retain the benefit of their skills and experience.

At the same time, following the high profile deaths of children involved with the Massachusetts Department of Children and Families, DCF, the Executive Office of Health and Human Services, and the Governor's office sought ways to strengthen department operations. One step was to identify duties being handled by social workers that could be handled by clerical staff instead, to free up social workers to spend more time with children and families in need of protective services. Duties identified include transcription, data entry, filing, printing, record management, and redaction of files.

Proposed Solution

Encore Boston Network (encorebostonnetwork.org), in conjunction with DCF and the Executive Office of Elder Affairs, will develop, test and then expand effective strategies for engaging older adults as volunteers for DCF, and create a model that can be replicated by other government agencies.

Encore Boston Network will develop, test and then expand effective strategies for engaging older adults as volunteers for DCF.

Drawing on relationships developed through its Generation to Generation Boston campaign (generationtogeneration.org), which engages the talents of adults 50 and over as a human capital resource for the benefit of youth, Encore Boston Network will, as a pilot, refer older adults to fill 25 volunteer positions in 4 DCF offices (Dorchester, Roxbury, Hyde

Older adults bring knowledge, skill and experience that add capacity to government agencies. Adding capacity at DCF will benefit vulnerable children and youth.

Park, and Chelsea). As they learn from this experience, they will expand the initiative to the other 25 DCF Area Offices across the state.

Studies show that engaging older adults in purposeful paid and volunteer work creates multiple benefits (Hoffman and Andrew). Older adults bring knowledge, skill and experience that add capacity to government agencies. Adding capacity at DCF will benefit vulnerable children and youth. Additionally, volunteers gain measurable improvements in health, life satisfaction, and longevity.

One current program that connects older adults to government service is ReServe, which has filled a range of local government roles in New York City over the last decade. It pays a stipend to volunteers and charges an administrative fee to agencies. Relevant models from the nonprofit sector include Generations Incorporated, Executive Service Corps, Jumpstart Community Corps, and Boomers Leading Change.

Findings from these initiatives point to possible approaches to challenges DCF may face in recruiting, managing and retaining older volunteers, which include: a) alerting them to opportunities, b) making the experience desirable and fulfilling, and c) overcoming logistical obstacles such as lack of transportation. First, older adults respond best to volunteer opportunities when introduced to them by friends or people they respect. Second, many prefer a setting in which they feel their skills and talents are being used effectively and which connects them to likeminded individuals. Third, they prefer to work near their homes.

Specifically, Encore Boston Network will pilot the following activities:

1. Developing a targeted recruitment campaign to identify sources of and methods for

engaging older adults who have the necessary skills and experience, and developing ways to connect them to DCF staff.

2. Insuring a quality work experience by designing opportunities that can be done by teams of volunteers; by recognizing volunteer contributions in ways that include a social component; and by designing activities that extend relationships beyond the workplace.
3. Testing transportation options for volunteers that include stipends to cover costs, carpools, or directly provided group transportation. Virtual opportunities that eliminate the need for transportation altogether will also be explored.

Projected Outcomes

The lessons learned in the DCF pilot will be migrated to other agencies at the state and municipal levels. In that sense, Encore Boston Network's primary measure of success will be whether every older adult who wants to remain actively engaged will have an opportunity to do so. More specifically, Encore Boston Network's projected outcomes are:

1. The identification and placement of 25 volunteers in the initial year, learning from their experience how to shape the volunteer positions in the future so as to expand the program to additional offices.
2. The efficiency gained by having administrative duties performed by volunteers to enable social workers to be in the field more of the time. Having field professionals spend more time working cases and responding to reports will lead to better outcomes for vulnerable children and families across the state.
3. 80 percent of participating volunteers will report satisfaction with their work experience. They will feel connected to the DCF mission, their co-workers, and the communities in which they serve. At least 75 percent of older volunteers will recommit to work beyond the initial year because their needs are being met and they understand the critical nature of their contribution to DCF's mission.
4. Creation of a guide, to be shared with other DCF offices and government agencies, of best practices based on lessons gleaned from the pilot.

Future Goals

1. Based on the success Encore Boston Network achieves in filling volunteer positions in 4 Boston offices, they will look to expand the program to the other 25 DCF offices in the state.
2. Leverage the DCF prototype to encourage other government agencies and municipalities to adopt similar approaches.

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Runner Up

Return to Community Initiative

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Problem Statement

From 2017 to 2025, the costs of nursing home and continuing care retirement facilities are projected to rise in the United States from $170 billion to $260 billion.[1] Although nursing facilities are increasingly a source of post-acute care in the US, it is the long-stay resident who accounts for the largest number of nursing home (NH) days and the lion's share of Medicaid and out-of-pocket costs.

From 2017 to 2025, the cost of nursing home and continuing care retirement facilities is projected to rise in the United States from $170 billion to $260 billion.

The first 90 days after admission is critical for decisions about returning to the community or becoming a long-stay resident.[2] The decision to become a permanent resident is of considerable importance. Private paying residents face large future out of pocket costs; for the government, these individuals are at risk of exhausting their assets and converting to Medicaid.

Proposed Solution

Minnesota's Return to Community Initiative (RTCI) helps private pay nursing home residents return to the community early in their stays. Its goals are to increase the value of long-term care from the standpoint of both residents and public programs, rebalance resources from nursing home to the community, employ long-term care resources more efficiently, improve individual health and functional outcomes, and enhance consumer choice and quality of life.

The initiative began with research by Dr. Robert Kane and Dr. Greg Arling that examined the potential for developing target criteria to promote greater numbers of transitions from nursing homes. The state then developed a service using the criteria, coupled with support provided through the Senior LinkAge Line®, to transition residents who meet the criteria from nursing homes and long-term care facilities back into their communities.

On a weekly basis, target lists of residents who may meet the criteria for transition back into the community are developed in collaboration with the Minnesota Department of Health, Board on Aging, and Department of Human Services. Lists are created based on residents'

RTCI helps private pay nursing home residents return to the community early in their stays.

MDS (Minimum Data Set) admission assessment. Certain criteria are pulled from the MDS to determine if the resident meets the target profile. Residents appear on the list if they:

- Have resided in a nursing facility for at least 45 days,
- Have a goal of returning to a community setting, and
- Have a 70% or higher probability rate of being successful in the community, based on their health and functional characteristics as recorded upon admission.

Community Living Specialists conduct visits to residents on the target list to provide unbiased information regarding the residents' options for residing in the community and to make them aware that they have the right to live in the least restrictive environment. The CLS explains the free service that is available for being discharged back to the community. If the resident agrees to the assistance, release of information is obtained that gives the CLS access to the medical chart, ability to speak with nursing facility staff and other health care providers, and to collect private information for data analysis and evaluation.

Once assistance has been agreed to, an interview is conducted with the resident and primary caregiver to determine the resident's needs, both physically and mentally. The CLS may recommend the resident apply for state assistance through Medicaid or a home and community-based services (HCBS) waiver. Veterans are referred to the County Veteran Service Officer to determine benefit eligibility. If the resident faces barriers to discharge, referral to the Ombudsman for Long-term Care may be necessary.

Community Living Support Plans, which suggest the services that will be provided when residents leave a facility, are developed based on the physical, social and emotional needs of the individual. Because not all individuals will be able to live in a home setting, options such as adult foster care, group homes and assisted living are explored.

Once the resident is discharged, a second visit is conducted within 10 days. If the patient needs more immediate follow-up, the CLS will visit within 72 hours. During the visit the CLS will:

- Verify the patient's understanding of medications,
- Review emergency plans,
- Ensure prescribed medications are filled,
- Conduct medication reconciliation,
- Ensure an appointment with a primary care physician is scheduled, and
- Make additional caregiver and consumer referrals, if needed.

Ongoing follow-up occurs 30, 60 and 90 days after discharge, with further follow-up offered for five years.

Outcomes

Since its inception in 2010, the RTCI has assisted in the transition of 4,500 residents, 95% of whom received formally provided services upon discharge from a facility. 85% received care from a nurse or home health aide. Smaller percentages had alarms or other technology (55%), in-home or home delivered meals (34%), other in-home services (33%), or transportation (21%).

The results are both a higher quality of life for consumers and recognized savings, both for consumers and their families, and for the state. Estimated savings were $9.6 million over the first four years of the initiative, calculated using a fiscal model that assumes savings if (1) residents moved out of a nursing home and remained off of or delayed enrollment into a Medicaid long-term care waiver or (2) transitioned to a Medicaid long-term care waiver for less costly services instead of remaining in a nursing facility. The service was expanded in 2014 with estimated savings of $18 million since the expansion.

Future Goals

On May 30th, the Governor signed into law an expansion of *Return to Community*. The initiative will target new populations, including patients being discharged from a hospital, those who contact the Senior LinkAge Line® because they want to move to assisted living, or those for whom Medicare Home Care has ended.

Minnesota has consulted with other states. As other states think about replicating the model, they will need to consider: 1) strategic engagement with the provider community to ensure it will buy into the model; 2) a single point of entry for initial referrals combined with locally accessible staff that can meet with residents in almost real time. Having referrals come into a single web portal or toll free line allows for quality monitoring to ensure intake is correct and appropriately handled.

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Runner Up

Ride-Share Pilot Program

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Problem Statement

The RIDE, Massachusetts Bay Transit Authority's (MBTA) paratransit service, is a 'safety net' for people whose disabilities prevent them from using public transit. In its current form, the RIDE provides door-to door, shared-ride transportation to eligible people who cannot use fixed-route transit (bus, subway, trolley) all or some of the time because of a physical, cognitive or mental disability. The RIDE runs 365 days a year, generally from 5 AM — 1 AM, in 58 cities and towns. Accessible vehicles serve persons with disabilities, including those who use wheelchairs and scooters. The fare, when booked in advance, is $3.15.

Costs per trip have averaged $9 vs. the traditional RIDE per-trip cost of $59.

Many customers rely on The RIDE as a lifeline, but its shared rides can be long. A customer might get picked up over an hour before they need to get to an appointment, even when the trip might only take 20 minutes by car. There is also not much flexibility to change one's schedule.

Moreover, The RIDE's costs are increasing. In FY2007, the RIDE's budget was $50M. By FY2017, the RIDE's budget reached $109M, a 118% increase over just the last decade. Per-trip costs to the MBTA in FY2017 are $59 ($35 in variable cost and $24 in fixed cost). Expenses are expected to continue rising.

Proposed Solution

The MBTA's solution was to launch a pilot with Uber and Lyft to provide paratransit services in lieu of the shared-ride model. The idea was conceived through partnership with disability advocates whose goal was to identify ways to reduce costs for The RIDE without cutting service.

The pilot was set up to test if the following could be achieved:

- Increased customer mobility,
- Equal or better service at lower cost,
- Full-accessible service (including access to wheelchair accessible vehicles (WAV) and options for individuals who do not have smartphones and/or are un-banked),
- Reduced travel and wait times.

Customers sign up directly with Uber or Lyft and are provided a set number of trips every month, proportional to their trips taken on the traditional RIDE service prior to joining the pilot. For every trip, customers pay the first $2,

the MBTA pays up to the next $13, with customers responsible for any additional costs. Customers can book directly via smartphone or via Lyft's call-in service. Uber and Lyft provide access to wheelchair accessible vehicles (WAVs).

Every trip a customer takes as part of the pilot is paid out of the budget for the traditional RIDE vendors. Since costs are only billed on consumption and the partnership can be stopped at any time, the potential financial downside is limited.

Outcomes

Prior to launch, the MBTA decided that, at a minimum, the pilot would have to provide at least equal or better service for no additional cost. Pilot enrollment was initially limited to the first 400 individuals to enroll so as to ensure that the solution could be tested at a smaller scale until it began to generate savings and improvements both for customers and the MBTA. Due to its initial success, the pilot has since been opened to all customers of The RIDE, with over 1,000 enrolled to date. Collectively, these customers have taken more than 20,000 trips.

Customers save money as well: a same-day trip on the traditional RIDE costs customers $5.25, but pilot costs average only $4.52 a trip.

Costs per trip have averaged $9 vs. the traditional RIDE per-trip cost of $59. Customers save money as well: a same-day trip on the traditional RIDE costs customers $5.25, but pilot costs average only $4.52 a trip.

Customers have expressed satisfaction. The pilot's Net Promoter Score (a measure of customer satisfaction) is 79%. For comparison, the transit industry average is 12% and the MBTA's fixed route average over the last 12 months was 11%. Customer satisfaction was linked to the following improvements:

- **Real-time bookings.** Being able to book on-demand, customers experience increased mobility, freedom, and spontaneity. For customers who would occasionally miss their RIDE trip when a doctor's

"I cannot begin to describe," one customer says, "how thrilled I am with this service. It has given me back something I lost a couple of years ago and thought I would never have again – a sense of independence."

appointment ran long, the pilot has been a savior.

- **Lower wait and travel times.** Customers save 34 minutes on average on their trips. To date, more than 11,000 hours have been saved by pilot customers.
- **Increased Trips.** Because of the per-trip savings the pilot has achieved, the MBTA can allow customers to take more trips and still save money. Pilot user trips are up by over 25% compared to their baseline history, but the MBTA still saves money.
- **Accessible Options.** Both Uber and Lyft provide options for those who may lack familiarity with technology or access to smartphones. For seniors and others who do not have bank accounts, both companies allow payment via prepaid debit card and other non-credit solutions. For customers with mobility devices and wheelchairs, both companies have accessible vehicle options.

"I cannot begin to describe," one customer says, "how thrilled I am with this service. It has given me back something I lost a couple of years ago and thought I would never have again — a sense of independence. I have been using The RIDE for a couple of years but have only been going out for medical appointments because it is so time consuming and exhausting due to my medical issues. For all intents and purposes, I have pretty much been housebound due to the constraints of The RIDE. The great thing about the [pilot] program is if I feel well enough to go out to a store on the spur of the moment, I can go within minutes. I do not have to plan ahead."

Future Goals

The MBTA has set an ambitious goal of delivering 10% of the RIDE's estimated 1.9 million FY18 trips via Uber or Lyft. In addition, it will work to maintain accessibility for riders by integrating Uber/Lyft bookings into the MBTA's call center, avoiding the need for smartphones, and increasing WAV supply as demand increases.

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Boston Medical Center Elders Living at Home Program

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Aging Right in the Community, a joint program of Boston Medical Center's Elders Living at Home Program (ELAHP) and MLPB (formerly Medical-Legal Partnership | Boston), works to prevent homelessness among Greater Boston's most at-risk older residents. The *Aging Right in the Community* (ARC) project provides intensive case management, supported by legal expertise, to individuals age 55+ who are homeless or at risk of homelessness to keep them safely housed and living with as much independence as possible.

In 2016 an estimated 564,700 people in the U.S. were homeless; 50% were over 50 years of age.

A recent Boston census estimated that 2,400 homeless individuals were over 51 years of age.

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Older adults are especially vulnerable to high housing costs because so many are on fixed incomes. A report from Boston's Commission on Affairs of the Elderly and the Gerontology Institute at UMass Boston notes the average annual income of Boston residents ages 60–79 is $18,000, and for those over 80 is $13,100.

Low-income, older adults in unstable housing situations face barriers to health and social services. Many suffer from mental illness, cognitive decline, substance abuse, undiagnosed health conditions, and poor nutrition. They tend to be socially isolated and are often unable to effectively access existing social services on their own. The best way to address the complicated needs of this population and prevent or end elders' homelessness is with specialized, legally informed, intensive case management.

The ARC team approaches the problem of older adult homelessness from three angles:

1. Helping those already homeless to transition back into safe, affordable permanent housing;
2. Providing stabilization services to help those who have been homeless but are now housed maintain that housing, increase their well-being, and maximize their independence; and
3. Engaging in crisis intervention and homelessness prevention services for those at imminent risk of losing their housing and falling through the cracks.

Older citizens in need are referred to ELAHP by BMC physicians and other providers, area shelters and outreach programs, food pantries and meal sites, and community agencies. Eligible individuals meet with a case manager for an assessment to identify immediate needs and barriers to obtaining and/or keeping permanent housing, and to discuss potential solutions. Case managers develop individualized service plans (ISP). The program's Clinical Coordinator, an RN, provides consultation for the clients' medical needs.

Those who are homeless work on a plan to secure housing (submitting applications, securing necessary documentation, attending screening appointments). For those at risk of losing their housing, services include landlord mediation, and support with court appearances and related activities.

All program clients suffer from at least one chronic illness, and currently 65% suffer from two or more, presenting enormous challenges to their abilities to live safely and with some degree of independence.

ARC's goals include:

1. Program clients will be stable in housing, with long-term supports that make it possible for them to maintain housing and live as independently as possible;
2. Clients will have successful resolution of all legal needs; and
3. Individual client needs and legal outcomes will inform systemic solutions preventing housing insecurity through: a) elimination of practical, logistical, and bureaucratic barriers to housing; b) outreach to and education of housing-insecure and at-risk older adults; c) development of an effective screening and advocacy infrastructure that can be exported to other organizations serving older adults; and d) addressing policies that may be creating barriers to housing for vulnerable older adults.

Since its inception, ARC has maintained a homelessness prevention rate of 94%, and 98% of those stabilized with project services have remained in stable housing.

Since its inception, ARC has maintained a homelessness prevention rate of 94%, and 98% of those stabilized with project services have remained in stable housing. 148 clients have been served by the project over its first three years.

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nesterly

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On any given night, more than 50 million bedrooms sit empty across the U.S. Many of these spare rooms belong to those aged 55+ who hope to stay in their homes and communities for as long as possible, but struggle with social isolation, the daily maintenance of their homes, and declining incomes. At the same time, millions of renters struggle to afford high rents in areas close to jobs.

On any given night, more than 50 million bedrooms sit empty across the U.S.

nesterly is a social enterprise focused on alleviating housing insecurity in the U.S. by addressing both of these problems. Through an online marketplace nesterly connects households with extra rooms to those seeking affordable rents. Guests will pay more affordable rent by helping around the house, and elderly homeowners will gain economic stability, security, social connection and support to stay in their homes as they age.

As graduate students, we are acutely aware of how hard it can be to find affordable housing. At the same time, we have watched people around the world open their cars, homes, and hearts to complete strangers as the sharing economy has disrupted life as we know it. We wondered if it might be possible to employ the sharing economy to better use existing resources and increase the amount of affordable housing.

The idea of intergenerational homesharing is not new. In fact, in the mid-to-late 19th century, 1 of every 2 urban

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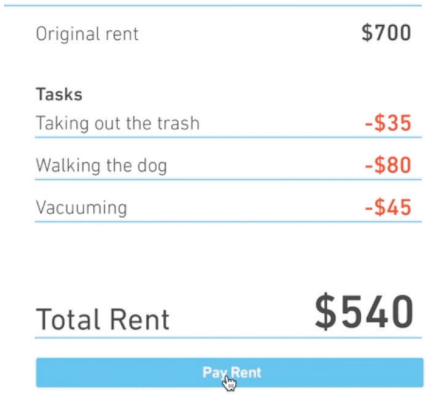

dwellers at some point lived in a boarding house, a form of intergenerational co-housing. Today, there are a handful of small non-profits making senior-youth housing matches in their local communities. However, to our knowledge, no one has tried to leverage technology, and the sharing economy it has helped to create, to scale a homesharing model.

The demand for such a program could not be more timely:

- 1 in 3 U.S. households will be headed by someone aged 65 or older by 2035. (Source: Projection from the Joint Center for Housing Studies).
- 70% of adults over the age of 45 prefer to stay in their homes and communities. (Source: Survey conducted by AARP in 2014).
- Most people's incomes rapidly decline as they enter retirement, making it harder to make ends meet. Nearly 25% of older adults report difficulty paying monthly expenses (Source: United States of Ageing Survey-2015).
- Cities are spending billions of public dollars to subsidize affordable housing construction. In May 2013, New York City announced an $8.2 billion, 10-year affordable housing plan.

nesterly plans to launch a pilot in Cambridge this summer, and expand to the Boston market by fall, to serve the large local student and aging populations in both of those cities. Our goal is eventually to serve populations around the world.

While our product will start with students and older households in the Boston area, we believe nesterly can positively affect the broader community by increasing overall housing supply and thereby relieving pressure on the local housing market.

The shortage of affordable housing, the pressure on the local housing market from growing student populations, and a rapidly aging senior population are all critical challenges that nesterly will help communities face.

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Wisconsin Coalition for Collaborative Excellence in Assisted Living

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Assisted living communities (ALCs) have emerged as an important component of long-term care. Consumer demand, concerns regarding nursing home quality, and the availability of capital for construction and renovation of facilities have combined with states' efforts to reduce long-term care costs. The result has been dramatic growth in the assisted living industry. In some states, there are now more beds in ALCs than in nursing homes.

Initially, ALCs were a market response to consumer demand and demographic trends, without regard to regulatory considerations. More recently, Medicaid developed payment policies and waiver programs for the care of qualified individuals in ALCs. With no federal ALC regulatory authority, states began to implement regulatory standards on their own, often through licensing requirements. However, the sheer size of the ALC market has taxed the capacity of state regulators. In Wisconsin alone there are 3,679 licensed facilities.

Preliminary data show the early adopters have better regulatory compliance and fewer reports of complaints from residents and their respective family members.

The Wisconsin Coalition for Collaborative Excellence in Assisted Living addresses these issues. It is a collaboration of Wisconsin's Department of Health Services' Division of Quality Assurance and Division of Medicaid Services, Wisconsin's four assisted living provider associations, the state's advocacy agency, The Board on Aging and Long Term Care, and the University of Wisconsin-Madison. The four provider associations represent roughly 40 percent of the state's licensed ALCs.

Using a data repository into which all four provider associations and their members feed data, the Coalition employs a comprehensive quality assurance and quality improvement (QA/QI) program that has been approved by DHS. First, ALC residents complete a standardized Resident Satisfaction Survey for Coalition members. The surveys are submitted for data processing and analysis. One standardized satisfaction survey is used for all ALC members, in all four associations.

Next is a set of performance measures that cover structures, processes, and outcomes for Coalition members. These include staffing, quality improvement activities, norovirus and influenza infection rates, falls, and hospital-

[T]he average number of falls with injury per ALC has declined from 1.58 falls with injury/ALC to 1.35 falls with injury/ALC.

izations. Coalition member communities are required to submit a report on these measurements on a quarterly basis. Associations review their member data and intervene to help them improve when necessary, which can result in fewer complaints and overall better regulatory compliance, and better resident and family satisfaction.

The surveys and performance measures demonstrate that Coalition ALC members have made great strides in increasing resident satisfaction while improving health outcomes. As a collaborative for 2016, overall resident satisfaction had the following composite scores (based on a rating of 1-5):

Staff	4.41
Rights	4.43
Environment	4.51
Activities	4.26
Meals and Dining	4.15
Health	4.46
Overall	4.44
Total	**4.38**

Comparing calendar year (CY) 2013 to CY 2016, the average number of falls with injury per ALC has declined from 1.58 falls with injury/ALC to 1.35 falls with injury/ALC. Re-hospitalizations per ALC show a similar decline, from 1.57 to 1.34 re-hospitalization/ALC. Staff retention (68%) and staff immunization rates (67%) were high compared to national averages for ALCs.

One study analyzed the regulatory compliance data of ALCs that have been members of the Coalition for three years compared to non-member ALCs. Preliminary data show the early adopters have better regulatory compliance and fewer reports of complaints from residents and their respective family members. The data also show a marked improvement in the early adopters' quality measurements and resident satisfaction over the duration of their Coalition membership.

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BETTER
GOVERNMENT COMPETITION

Pioneer Institute's Better Government Competition, founded in 1991, is an annual citizens' idea contest that seeks out and rewards the most innovative public policy proposals. The Competition grand prize winner receives $10,000; four runners-up receive $1,000 each, and other proposals receive special recognition. Recent winners have included proposals on pension reform, virtual schooling, job training, housing, and many other pressing topics.

History

2017 Aging in America

2016 Improving Care for Individuals Living with Mental Illness

2015 Fixing Our Troubled Justice System

2014 Leveraging Technology to Improve Government

2013 Revving Up the Great American Job Engine

2012 Restoring Federalism

2011 20th Anniversary – Budget Busters

2010 Governing in a Time of Crisis

2009 Health Care Reform

2008 Sustaining School Reform

2007 Improving Government at the State and Municipal Levels

2006 Better Government Competition 15th Anniversary

2005 Streamlining Government

2004 State and Local Focus

2003 Innovative Ideas on Key Public Issues

2001 Law Enforcement, Education, Housing, Family Preservation

2000 Ideas Into Action

1999 A Wise and Frugal Government

1998 Streamlining Government

1997 Bringing Competition to State and Local Government

1996 Public Safety and Fight Against Crime

1995 Local Solutions to Public Problems

1994 Welfare in Massachusetts

1993 Improving Policies and Programs Affecting Children

1992 Improving Environmental Policies and Programs

1991 Restructuring/Privatizing State Operations

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