Habitat for Humanity®

Bridging the Gap

Between Health and Housing for Older Adults: A Resource Guide for Housing Organizations

Acknowledgments

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Bridging the Gap is a compilation of the information shared, the conversations between participants and presentations from experts from both the housing and healthcare sectors. Many thanks to these contributors who supported the convening and have made this resource guide possible:

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Table of contents

This resource guide is organized in two parts: Partnership Development and Construction Implementation. We know that some of you will be more interested in the partnership aspects while others will be more interested in the practical aspects of incorporating healthcare expertise with construction know-how. This table of contents provides a listing of both parts with page numbers for easy reference. We hope this approach will allow you to browse through each part and focus on the information that is the most useful to you and your organization.

Part 1: Partnership Development

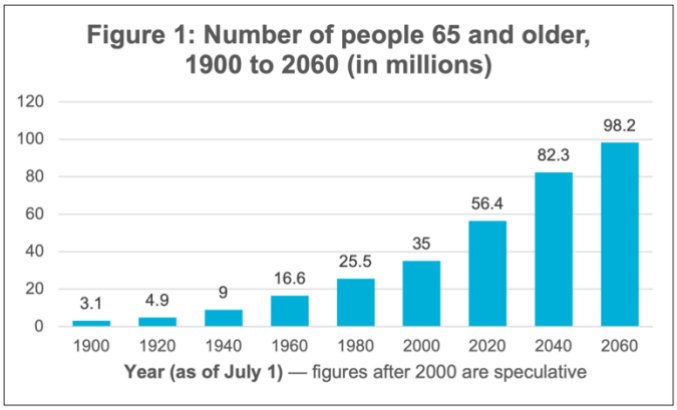
Identifying, Developing, Sustaining

"Getting the relationship in place is the whole key. That is the heaviest lift. You have to find like-minded organizations that are interested in partnering and have that culture to want to build a trusting relationship. That is where a lot of the homework will have to be done for someone who is just starting out. That is where you need to make the biggest investment. It is costly in terms of money but also in time if you start down a path with somebody and it turns out that you aren't really aligned."

— Mike Criner, COO,
Habitat for Humanity
of Metro Denver

Overview

Because of the dramatic increase in longevity over the past 100 years, the United States is experiencing an amazing transformation. As many as 10,000 individuals turn 65 every day, and the fastest-growing age group is women over the age of 85. By 2040, the number of adults 65 and older will represent more than 21% of the population, reaching 98 million people by 2060 (See Figure 1).[1]



According to a 2019 report from the Joint Center for Housing Studies of Harvard University, most older adults live in single-family homes, and the majority of these homes are now at least 40 years old. The maintenance and preservation of these older homes is a challenge, especially for lower-income older adults, posing a risk to the health of older residents.[2]

In 2003, the World Health Organization led the way in identifying the links between health disparities and unequal social and environmental conditions. Increasing evidence has demonstrated that the conditions in which "people are born, live, learn, work, play, worship and age affect a wide range of health, functioning and quality of life outcomes and risks."[3] The domains generally associated with these social determinants of health include housing quality and location, access to quality education and health services, economic stability, and social connections. Housing quality is directly linked to poor health because of the incidence of lead poisoning in older homes, indoor air quality, and lack of accessibility that increases the risk of falls as people age.

As people age, the incidence of disability increases, which not only raises the risk of falling but also makes getting around in the home and performing daily, routine tasks increasingly difficult (see Figure 2 on the next page). According to the Centers for Disease Control and Prevention, non-fatal falls among adults age 65 and older cost about $50 billion each year and often lead to earlier placement into long-term care.[4] AARP research indicates that over 75% of older adults want to age in the communities of their choice.[5] Developing holistic, integrated health and housing solutions that support aging in place is critical for a rapidly aging population.

Racial and ethnic disparities in homeownership, cost burdens, and the effects of COVID-19 on health and income all persist in older adults, making the need to respond with innovative, person-centered solutions more important than ever. Person-centered care is a holistic approach that is grounded in the belief that individuals have a right and should have a voice in decisions regarding their health and well-being. This approach increasingly adopted by health care professionals includes multi-sector coordination and partnership. The concept of partnership extends to the older adult as well as their caregivers, who are increasingly seen as care partners. Values embraced by person-centered care include participation, choice, dignity, respect and self-determination.

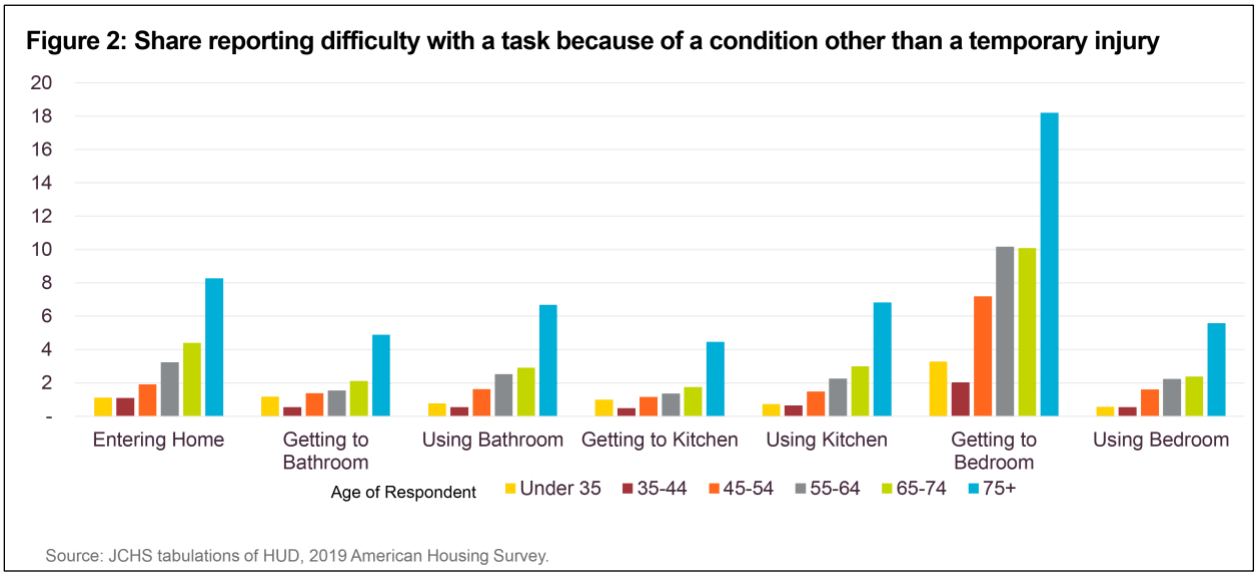


Chart adapted from the Joint Center for Housing Studies of Harvard University.

Viewing health and housing work through this lens ensures a community-led, systems-based approach creating collaborative work that builds health equity.[6]

The Habitat network is actively engaged in supporting older adults who want to age in place and preserve their homes for future generations. Since 2015, local Habitat affiliates have served more than 24,300 older adults across the country with home repairs. Through this work, Habitat has also realized that housing solutions to improve the quality of life of older adults are strengthened when made in the context of the holistic health and mobility needs of older residents.

Seeking opportunities to collaborate with the health care sector, Habitat for Humanity International was fortunate to receive a generous grant from the Harry and Jeanette Weinberg Foundation in 2018 to fund the demonstration of an innovative and evidence-based program developed by **Johns Hopkins University School of Nursing: Community Aging in Place Advancing Better Living for Elders, or CAPABLE**.

The CAPABLE program is based on research showing that people with functional limitations and chronic conditions are four times more likely than the general population to experience high-cost health care utilization. Low-income older adults are at much higher risk of chronic disease and disability because of reduced access to primary care and an increased probability of living in substandard and deteriorating housing. The home environment can be a barrier or an enabler to functioning safely. CAPABLE intervenes on three levels: psychological (personal aspirations and behavior), physiological (physical condition and functional abilities) and environmental (condition and layout of home and use of adaptive devices).

The expertise of an occupational therapist, or OT; a registered nurse, or RN; and a handyperson are used as an interprofessional team that includes the older adult client. Together this team pursues person-driven goal setting and action steps through 10 home visits guided by the CAPABLE model. The person-driven and team approach are core elements of the program.

The OT works with the client to identify and prioritize functional activities of daily living, assess performance, and determine obstacles and environmental barriers. Together, the OT and the client brainstorm ways to attain the client's functional goals, with the OT helping to identify assistive devices, equipment and other supplies that can augment function.

T.J. is happy to have a metal ramp from Gwinnett County Habitat in Georgia. "Now my boyfriend can come over and visit and we can dance again!" she says.

The RN focuses on how or whether pain, depression, strength and balance, or medications are harming daily function. The RN also helps the client set and achieve goals in these areas.

The handyperson provides repairs and home environment modifications in a timely manner to coincide with OT follow-up and training in their use.

With match funding from Wells Fargo, Lowe's and several local donors, Habitat is implementing CAPABLE in five locations, serving 400 older adults over the three years of the grant:

- Habitat for Humanity of Metro Denver (Denver, Colorado).
- Habitat for Humanity Philadelphia (Philadelphia, Pennsylvania).
- Metro Maryland Habitat for Humanity (Silver Spring, Maryland).
- Habitat for Humanity Susquehanna (Maryland).
- Twin Cities Habitat for Humanity (St. Paul, Minnesota).

Other Habitat locations that are implementing CAPABLE through local fundraising also have contributed to this project, including:

- Greater Des Moines Habitat for Humanity (Iowa).
- Habitat for Humanity of Douglas County (Minnesota).
- Habitat for Humanity of Greater Memphis (Tennessee).

CAPABLE implementation has been a testing ground for building meaningful health care and housing partnership. As housing is increasingly being viewed as a platform for community-based health services, breaking down health and housing silos is important work. Developing and sustaining effective health and housing partnerships can be challenging, however. Many of the Habitat locations implementing CAPABLE experienced challenges in finalizing the agreement/contract, streamlining processes and procedures, ensuring cross-sector communication, marketing the program, and building a pipeline of clients.

The purpose of this guide is to bridge the gap in language, systems and financial incentives so that housing organizations such as Habitat can connect and collaborate with the health care sector to be more efficient and effective in supporting — primarily through home repairs and modifications — the many older adults who want to age in their homes and communities.

How to use this guide

Part 1: Effective partnerships

Building cross-sector partnerships between health and housing is both challenging and rewarding. Part 1 focuses on the fundamentals for a nonprofit housing organization to identify, develop and sustain a partnership with health care. The outline below summarizes key sections, which include basic information, how-to guides, tools and case studies featuring Habitat affiliates.

IDENTIFYING POTENTIAL PARTNERS	DEVELOPING THE PARTNERSHIP	SUSTAINING THE PARTNERSHIP

Know the landscape
• Understanding health care: Payers and providers, who's who, key vocabulary and abbreviations.
• Understanding the aging network: Older Americans Act, Area Agencies on Aging, Medicaid waivers.
 	
Prepare to engage
• Know yourself; know your service: Tools for market analysis, analyzing services, pricing, and calculating your true costs.
• Know your outcomes:
  ○ Developing a logic model: What is it, why is it important, and how do you create one?
  ○ Data collection and evaluation: A case study from Habitat for Humanity of Greater Memphis.
• Your value proposition: What is it, why is it important, how do you create one?
 	
Connect with confidence
• Networking tips from Habitat affiliates, and a cross-sector conversation.
	CAPABLE case study from Metro Denver Habitat for Humanity
	• **Finding alignment:** Understanding mutual goals and benefits.
	• **Finalizing the agreement:** Key questions to consider in deciding on the type of agreement, the components of the agreement, and HIPAA considerations.
	• **Getting started:** The referral process, adapting systems and staff training, the importance of regular communication and initial steps in connecting with clients.
		• **Funding pathways:** Funding trends of health care investment in housing, including Medicare and Medicaid; hospital systems investments; and leveraged funding from government, foundations and the private sector.
		• **Sustaining CAPABLE:** Dr. Deborah Paone, implementation and evaluation director for CAPABLE at Johns Hopkins University School of Nursing, summarizes benchmarks for sustaining CAPABLE, tools for integrated systems, and demonstrating value to health care partners.
		• **Continuous improvement:** As an example, this section refers back to the partnership with Metro Denver Habitat for Humanity and the Colorado Visiting Nurse Association, illustrating how they are working to sustain the partnership and grow the CAPABLE program.

Partner identification

Identifying the organizations that best align with your mission, goals and capacity is the first step in developing a strong collaborative relationship with a health care sector partner that grows over time.

Know the landscape: Health care

Information in this section was supplied by Geoff Gregory, senior director of physician practice operations, north market, OhioHealth.

Why this is important

While they vary in size, every state in the U.S. has health systems that incorporate a continuum of care organized around hospitals and physician groups. Understanding the basic components of health care in the United States will help you in your search for the best partner for effective and sustained collaboration. This section will provide a basic understanding of the following:

- Health care structures and key government agencies.
- Who's who in most hospital systems.
- Hospital programs that connect with the community.
- Health care vocabulary and acronyms.

Key facts

The health care sector and the continuum of services that support the health and well-being of older adults are expansive and complex. Some key elements of the sector and those services are outlined below.

HEALTH CARE STRUCTURES: PAYERS AND PROVIDERS

- **Payer:** A company or government entity that pays for an administered medical service. An insurance company is the most common type of payer. A payer is responsible for processing patient eligibility, enrollment, claims and payment. The Centers for Medicare & Medicaid Services is one of the largest health care payers in the United States.
- Medicare: The federal health insurance program for individuals who are 65 and older. There are two ways that older adults receive coverage: Original (Fee-for-Service) Medicare and Medicare Advantage. Medicare Advantage Plans include the basics covered by Medicare but offer extra benefits like vision, hearing or dental coverage. Medicare Advantage Plans are offered by Medicare-approved private insurance companies that must follow rules set by Medicare.
- Medicaid: A health coverage program designed for low-income individuals, including children, pregnant women, older adults and people with disabilities. Although broad guidelines are set by the federal government, each state has the authority to design and administer the program. Therefore, Medicaid coverage and eligibility differs from state to state, depending on policy strategy, goals and needs set by state legislatures and state agencies.
- **Providers:** A health care provider is typically a hospital, primary care center, specialty clinic or other health service delivery point that provides a medical service or procedure. Preventive care, wellness and lowering health care costs are important trends across the health care sector, in part, because longevity has doubled since the mid-1900s. The fastest-growing age group in the United States is individuals 80 years and older.[7]

ABOUT OHIOHEALTH

OhioHealth is a not-for-profit health system in central Ohio with 35,000 associates, physicians and volunteers, a network of 12 hospitals and more than 200 out-patient sites. Services also include hospice, home health and medical equipment. In addition, OhioHealth routinely conducts research that is intended to affect the social determinants of health, addressing concerns that can improve the health of the whole community.

"We at OhioHealth are really focused on a couple of things. One is trying to get the customer the right care at the right place, at the right time and at the right cost. We have a general objective to lower cost of health care and to keep care local. We are trying to develop exactly what patients need locally in their communities, which ties into this program to keep people safe in their homes."

— Geoff Gregory

WHO'S WHO

The hospital leadership typically includes the president or CEO, the vice president of medical affairs, or VPMA, sometimes called the chief medical officer, or CMO; and the chief nursing officer, or CNO.

- The role of the president or CEO of a health system is to be connected to the community and to ensure that the hospital is meeting the needs of the community. This is a great place to start to talk about a program that will benefit the community.
- The VPMA or CMO is responsible for coordinating aspects of medical delivery with the medical staff. The medical staff functions independently and has its own leadership and bylaws for providing services within the walls of the hospital. If primary care physicians or specialists are aware of CAPABLE or similar programs, then patients could be referred as a way of preventing falls or reducing other hazards in the home.
- The CNO provides oversight and leadership to the nursing staff. Frequently, this oversight includes clinical programs, including occupational and physical therapy. For conversations about direct patient care outside of the physician's office, start with the chief nursing officer.

OTHER GROUPS TO BE AWARE OF

- **An employed physician group** is a separate organization from the medical staff and from the hospital. It has its own leadership, rules and organization. Every large system today will have some sort of physician group that operates semi-independently from the hospital. This group is another avenue for informing physicians about CAPABLE as a potential for referrals.
- **Clinical counsels** are led by physicians who work together to discuss care paths, develop standard models of care delivery and consider ways to drive down costs. These groups are not easy to access, but if programs like CAPABLE are adopted by these groups as part of the standard workflow for a particular diagnosis, then they could become standard across the organization.
- **Case managers and quality outcomes managers** work with patients upon admission to the hospital to make sure that the patient will be prepared for discharge. These managers will be interested in programs that support a patient's ability to return to a safe and healthy home environment as quickly as possible.
- **The Office of General Counsel and Ethics and Compliance** are the group of attorneys who would be involved in developing service contracts, the Business Associate Agreement or other nondisclosure agreements.

HOSPITAL PROGRAMS THAT CONNECT WITH THE COMMUNITY

Nonprofit hospitals have a mandate to support the communities in which they work. Here are some programs where CAPABLE or a similar program could help hospitals save costs and improve service to the community:

- **Charity care:** The potential for CAPABLE to reduce falls and emergency medical services, or EMS, visits could save the hospital millions of dollars in charity care. Millions of dollars are written off each year for those who can't afford to pay. If those numbers are reduced through fall prevention, then hospitals would be able to reduce costs and use that funding for other purposes.
- **Community benefit:** To remain tax-exempt, a nonprofit hospital system must adhere to community benefit requirements. The guidelines require a community health assessment every three years, with a plan for interventions that includes input from public health officials and community residents.
- **Community fund:** This fund provides philanthropic sponsorships to projects in the community. In some systems, the fund is managed by the marketing department, but in others, it might be the public relations or community relations manager.

KEY VOCABULARY AND ABBREVIATIONS

As health care providers, payers and policymakers have worked to make the system more efficient and provide coordinated care, different types of organizations have emerged. Understanding the differences in these organizations and being familiar with the abbreviations used to describe them will be helpful in exploring options in your community, region and state.

- **Managed care organization (MCO):** Delivers health care through a system that enhances efficiency and reduces cost by combining the functions of health insurance, delivery of care and administration. Examples of managed care organizations include traditional health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs.
- **Accountable care organization (ACO):** A fairly recent legal arrangement that allows health care entities to work together and share costs and pricing across a region. Historically, this was not allowed in an effort to avoid collusion. An ACO, using a clinically integrated network, or CIN, can enter into contracts with employers to provide a top-to-bottom service for a patient at a set rate. To be successful, the ACO must keep its costs for services below their set rate. An ACO can contract with an employer for a particular service and take care of all aspects of the medical care, bypassing insurance companies. Costs are kept low so that the ACO can profit.

Another result of efforts by providers and payers to bring down costs is different payment structures. Here are two examples and the impact that they have on financial incentives and constraints of providers and payers.

- **Fee for service (FFS):** This traditional model of payment for services has been modified over the years so that now an insurance company can negotiate a contracted rate with the health system. Uninsured people don't have access to the contracted rate. For example, if the actual charge for a service is $100, the insurance provider may contract a rate of $60, and its members will pay a certain percentage as a co-pay. Uninsured individuals will be responsible for the full fee.
- **Per member per month (PMPM):** This is also referred to as capitation. An entity (e.g., a physician group, ACO or health system) is paid a set amount monthly for each member of the insurance health plan. This payment is expected to cover all the costs for all the care each member will need, allowing the insurer to have set costs. The health care provider saves money if people don't come in for services and therefore has an extra incentive to keep patients healthy. Capitated models went out of fashion for a while but are starting to come back.

Other types of providers and resources

While hospitals and hospital systems are central to the health care of every community, there are other types of service providers. Some may be within the hospital system; some are independent nonprofits or private companies; and some, as in the case of the Department of Veterans Affairs, are part of the government. All are useful resources for support, networking and information.

- **Clinics:** A clinic (outpatient or ambulatory care clinic) is a health facility that is primarily focused on the care of outpatients. Clinics can be privately operated or funded and managed as part of the health system in a state or region.
- **Home health agencies:** A home health agency may be privately owned, a nonprofit or part of a hospital system. Their primary service is providing skilled or paraprofessional care to individuals in private homes or residences.

HIPAA AND BAA

The Health Insurance Portability and Accountability Act, or HIPAA, was enacted in 1996. Its original intent was to allow individuals to keep their health coverage throughout life changes, but the HIPAA Privacy Rule has become an important focus. This rule creates widespread protections around protected health information, which includes name, birth date, address, Social Security number and any other information that would identify the individual. Health providers must follow specific rules regarding how to use and share the protected health information of patients they serve. When sharing information across entities, each party enters into a business associate agreement, or BAA, that ensures both parties will maintain and adhere to the privacy rules. HIPAA requires that only the minimum necessary information be shared.

- **Veterans Affairs (VA):** Among a number of other benefits, the VA is responsible for providing lifelong health services to eligible military veterans and administers as many as 1,700 medical centers and outpatient clinics throughout the country.
- **Skilled nursing facilities and rehabilitation centers:** These facilities are options for post-hospital recovery. They offer the same amount of senior care, but a rehabilitation center is intended for short-term care, while skilled nursing homes are for long-term care. They are licensed by the government and must adhere to strict regulations. Skilled nursing facilities are paid on a per diem basis and are allowed a certain number of days to take care of a patient.
- **Universities and medical schools:** Many universities or medical schools require internships for occupational therapy or nursing degrees. Several Habitat affiliates have successfully hosted interns who contribute to their aging in place programs and support interactions with older adults.
- **Departments of public health:** Local and state departments that provide health promotion, regulations, inoculations, emergency response and health data and statistics.

Know the landscape: The aging network

In addition to Medicare and Medicaid, Congress enacted the Older Americans Act in 1965. These pieces of legislation were designed to provide a safety net of services to enable older Americans to age with dignity.

Why this is important

With the Older Americans Act, or OAA, as its foundation, the aging network has emerged as a web of national, state and local organizations that support and advocate for older adults. The OAA supports a network of local Area Agencies on Aging, or AAAs, that provide essential support for older adults to thrive and contribute to their communities. AAAs are potential funders for home modifications, conductors of functional assessments of older adults, and providers of services to older adults. Safe and accessible housing is a critical link if those services are to be delivered in an environment that will support the health and well-being of residents. Housing organizations have an important role and need to be able to understand and connect to others in the field of aging, including their local Area Agency on Aging.

Key facts

OLDER AMERICANS ACT[8]

The Older Americans Act was the first legislation of its kind to create a network of services delivered at the community level. Under the Administration for Community Living, or ACL, the Administration on Aging, or AOA, provides oversight and funnels funding to 56 state units on aging and 618 local Area Agencies on Aging, along with Title VI grants to 244 Indian tribes, two Native Hawaiian organizations and thousands of providers across the country.

Figure 3: Funding and coordination of the aging network

Source: USAging

OAA programs include information and personalized assistance, along with access to a broad array of services. As per the act's requirements, AAAs provide a set of core services, including nutrition, health and wellness, caregiver supports, and elder rights, along with supportive services such as transportation and legal services. They also include information and assistance services, care management, adult day care, senior centers and activities, personal care, and evidence-based health promotion programs. The programs also may assist with practical considerations such as home modifications and financial and employment counseling.

MORE ABOUT AREA AGENCIES ON AGING[9]

Established under the 1973 reauthorization of the OAA, Area Agencies on Aging are responsible for planning and coordinating services within their designated planning and service areas as set out in the OAA. In a few small or sparsely populated states — New Hampshire, Delaware, Rhode Island, North Dakota, South Dakota, Wyoming and Nevada — the state government serves the AAA function, but with 618 AAAs across the country, virtually every community in the nation is included in this extensive network.

Figure 4: All Area Agencies on Aging offer five core services under the Older Americans Act

Source: USAging

With local control and decision-making, AAAs vary in structure and carry a variety of names. However, this flexibility enables them to adapt to the unique demands of their communities and provide innovative programs that support the health and independence of older adults. Since the local AAA is an important resource, most health providers and community-based organizations are aware of the name and structure of the AAA in your community and the type of services that are provided.

Don't be surprised if the organization that you are already working with is an AAA. The Eldercare Locator (see the next page) is a useful tool for finding the AAA in your community.

THE MEDICAID WAIVER PROGRAM AND MONEY FOLLOWS THE PERSON

Why this is important

The Medicaid waiver program and Money Follows the Person, or MFP, are part of another important trend to rebalance spending for long-term care away from institutionalization and to home- and community-based services, or HCBS. The intention is to support the desire of older adults to remain in their homes and maintain their independence for as long as possible. Research confirms that older adults not only prefer to remain in their homes but also are able to receive comparable care through HCBS. **However, these rebalancing efforts depend on housing that is safe and accessible.**

Key facts

HCBS waiver program (Medicaid.gov): Each state applies for the waiver and structures the funding according to its policies and state needs. In order to comply with Medicaid requirements, the state HCBS waiver programs must do the following:

- Demonstrate that providing waiver services won't cost more than providing those services in an institution.
- Ensure the protection of people's health and welfare.
- Provide adequate and reasonable provider standards to meet the needs of the target population.
- Ensure that services follow an individualized and person-centered plan of care.

Money Follows the Person was first authorized in 2005 and has been strengthened over the years. This innovative program allows states to identify and work with nursing home residents to relocate back to the community with funding from Medicaid. From 2008 through 2019, more than 100,000 individuals have transitioned from nursing homes to community living in 44 states. A 2017 report by the Department of Health and Human Services to Congress reported the following:

- On average, per-beneficiary per-month costs to Medicaid declined by $1,840 (23%) during the first year of an older adult transitioning to the community with HCBS.
- Quality of life surveys indicate that the older adults "experience increases across all seven quality-of-life domains measured, and the improvements are largely sustained two years post-transition."

Nonetheless, finding affordable and accessible housing is a challenge. According to the HHS report, "states have used MFP funding to support health-housing collaborations, hire housing specialists who work on housing and health policy at the state level, educate and inform health agency staff members and transition coordinators on the availability of housing resources, and help beneficiaries in institutional care locate and secure affordable and accessible housing in the community."[10]

Helpful tools

- **Health care glossary:** The glossary at the end of this section has several terms, definitions and abbreviations that will help you communicate with health care providers and payers.
- 2020 AAA National Survey Report: Area Agencies on Aging fund and support repair and modification work for older adults across the country. Understanding the scope of

HOME- AND COMMUNITY-BASED SERVICES

As defined by the Centers for Medicare & Medicaid Services, or CMS, HCBS are "types of person-centered care delivered in the home and community." While a variety of services can be provided, HCBS programs generally address the needs of people with functional limitations who need assistance with everyday activities, such as getting dressed, bathing or eating. Community-based programs enable older adults to receive care in their homes as an alternative to institutionalization. As noted in the White House Council on Aging report in 2015: "For older adults, their priority is to have care that maximizes their preferences and enables them to live independently, including independence with assistance.

services that AAAs are providing can support outreach to your local organization. According to USAging's 2020 AAA National Survey Report, as many as 61% of the 485 respondents indicated that they either provide home modifications or contract with a provider. While most AAAs provide modifications to increase accessibility and reduce falls, some also offer "repairs to a home's structure (e.g., roofing, plumbing, wiring, etc.) or environment (e.g., fixing loose stair treads)." Another 30% of 300 respondents also indicated that they provide home assessments.[11]

- **Eldercare Locator:** The Eldercare Locator is a nationwide service that connects older Americans and their caregivers with trustworthy local resources that are available through local Area Agencies on Aging and community-based organizations. Services that can be accessed include meals, home care and transportation, among others. The Eldercare Locator is a public service of the Administration on Aging, or AoA, a division of the U.S. Administration for Community Living.

List of age-friendly organizations

There are many organizations and nonprofits that support and advocate for improved and equitable housing, aging in place, the shift to person-centered care, and increasing HCBS to delay institutionalization. Here are a few that have a national footprint and can provide tools and resources. Many of these organizations have state and/or local chapters that could also stand with you as champions and connectors to health and housing partnership opportunities.

- **National Council on Aging:** Provides resources, tools, best practices and advocacy to older adult individuals, professionals and community-based organizations. Focus areas include healthy living and financial security.
- **USAging:** Formerly known as the National Association of Area Agencies on Aging, or n4a, this membership organization for the national network of Area Agencies on Aging provides information, support and advocacy.
- **LeadingAge:** A national association for nonprofit organizations in the field of aging, with more than 5,000 members and partners. It is focused on education, advocacy and applied research.
- **SAGE:** Advocates and provides resources for LGBT older adults, including housing affordability and inclusion.
- **American Society on Aging:** A national organization for professionals in the field of aging, its purpose is to cultivate leadership; advance knowledge; strengthen the skills of members; work on behalf of older adults; and advocate for greater inclusivity, anti-ageism and equity.
- **AARP (Network of Age-Friendly States and Communities)**: AARP serves as the connector for age-friendly states and communities, an initiative of the World Health Organization. AARP provides support and advice and tracks progress for the 522 communities that are engaged in the process.
- **Pioneer Network:** National network of service providers dedicated to change the culture of long-term care, in both institutional and community-based settings, to a person-centered and person-directed approach, valuing relationship, choice, dignity and self-determination.
- **Family Caregiver Alliance:** Provides, resources, support and advocacy for informal caregivers.
- **Meals on Wheels America**: An umbrella organization for 5,000 local chapters that provide home-delivered meals, mitigate against social isolation and provide a check on well-being and in-home safety. Several Meals on Wheels locations also provide home modifications for older adults.

- Village to Village Network: A grassroots organization of older adults who form a community of care, using volunteers and self-help, to support each other with non-medical tasks or services to minimize isolation and support aging in place. The Village Movement started in Boston with the Beacon Hill Village and has spread to other communities across the country.

Now that you have a general understanding of the major players and key terms in the health care and aging landscape, the next section will help you to make your case and prepare to engage potential health care partners.

Prepare to engage

Information in this section was supported by Marisa Scala-Foley, director of the Aging and Disability Business Institute.

Regardless of the type of partner within the health care sector, in order to engage successfully, it is necessary to understand "what is important to them" and then succinctly present the value proposition for your organization's services that align with that need.

Know yourself; know your service

WHY THIS IS IMPORTANT

Knowing your organization and knowing your services are both fundamental steps in developing a strong value proposition for partners in the health care sector. This process will help you present your case and determine if the potential partner aligns with the core values, goals and capacity of your organization.

KEY LESSONS

Marisa Scala-Foley, director of the Aging and Disability Business Institute at USAging, works with community-based organizations, or CBOs, across the country in building their business acumen to partner and contract with health care providers and payers. Here are key lessons from the Aging and Disability Business Institute:

- Your approach needs to include an expanded view of customers, flexibility and data-based decision making.
- Know where your organization fits in relation to other organizations with similar missions and capacity. A market analysis is an important tool for understanding your market and where you fit.
- Know your service lines, the volume you can produce, your capacity to deliver, and the true costs for those services. There should be some minimum guarantees in any contract that you sign, especially if your health care partner will be referring clients to you. Knowing the expectations allows you to plan and staff accordingly.
- Know your standing in the community and your reputation for delivering services.
- Finally, while contracts are typically signed by executive leadership, staff-level buy-in at your health care partner is critical to ensuring that you can generate and sustain client volume.

HELPFUL TOOLS

This section offers questions to begin the process of analyzing your local market and define your service and cash flow with links to tools developed by the Aging and Disability Business Institute.

ABOUT THE AGING AND DISABILITY BUSINESS INSTITUTE

The Aging and Disability Business Institute is an initiative supported by USAging, formerly National Association of Area Agencies on Aging or n4a. The Business Institute provides resources and technical support to build and strengthen partnerships between community-based organizations (CBOs) and the health care system in order to improve the health and well-being of older adults and people with disabilities. Increased access to community services and integrated, evidence-based programs supports the ability of older adults to live with dignity and independence in their homes and communities.

Market analysis process

- What is the scope of the health care market in your community? Who are the players, and what benefits are being offered?
  - **External Market Assessment Tool**
  - **Opportunity Assessment Tool**
- Who are your current customers (homeowners, community leaders, donors, funders, health care payers) and potential partners? What do they want or need?
- What are your network's strengths and weaknesses? Where are the gaps, and where you do you have champions who can support expansion of your network?
  - **Readiness Assessment Tool**
- Who are your competitors — both for funding and for providing services?
  - **Competitor Assessment Tool**
- Are there any regulatory or political factors that might affect your ability to deliver services or attain contracts?
- Who can help you make the case? Who isn't in your network but needs to be? Who are your internal champions?
  - **Building the Case**

Service lines/packages, pricing and cash flow analysis

- What is the full menu of programs, products and services that your organization provides to families, individuals and the community?
- What does it cost to deliver those services — both the true cost to the organization, including indirect costs, and the cost to the client?
- What are your qualifications and experience in delivering those services? What is your stature (reputation and brand) in the community?
- How do your costs compare with other comparable services in the community? Are your services and products priced accurately so that you can deliver what is promised?
- Do you have the capacity to deliver services at the scale required? What resources will be required to increase staffing as you consider the implications of a health care partnership? Are there options for using volunteers, contractors or partnering with another housing organization?

The Aging and Disability Business Institute's **Pricing Resource Guide** provides additional information on financial contracting and competitive pricing models in negotiating with accountable care organizations and managed care organizations. The guide explains some of the implications of different payment models, like per member per month.

"One of the most important things that we have learned when it comes to CBOs building their business capacity is that culture matters — not only on your part as a community-based organization working in housing but on the health care side. This is different for them too. The health care world has just in the last few years really started to pay more attention to social determinants of health. This culture shift is really about having a vision for how your services play into the bigger picture of a holistic approach in addressing the person-centered needs of older adults. Health care can't do it alone; they really need you. You all have the eyes and ears in the community."
— Marisa Scala-Foley

Know your outcomes

DEVELOPING A LOGIC MODEL[12]

Why this is important

Habitat has been privileged to be able to work closely with clients, to go into homes and meet families. We see the results firsthand and join in the celebration when older adults, families and their caregivers share their stories of the difference that Habitat has made. Those stories are important. Of equal importance is the data that shows an intentional and professional approach to setting goals and measuring both short-term and long-term outcomes. Developing a logic model is the first step in being able to talk about housing's impact on the health of older adults.

Key facts

A strong logic model articulates your program outcomes to stakeholders, funders and supporters, along with the activities, processes and experiences that result in those outcomes. With a visual picture of the program design, outputs and outcomes, project managers can then consider the best and most practical ways to collect data and information that will demonstrate that the outcomes have been achieved and to what degree. The logic model also helps you test your assumptions and make corrections as needed. Essentially, a logic model is a guide for continuous improvement.

Developing a logic model entails sequentially thinking through and aligning the following areas:

- **Inputs:** Include resources that are available and directly used for the program activities. This might include human, financial, organizational and community resources.
- **Activities:** Include program activities (i.e., what constitutes the program intervention) with the resources you listed previously that lead to the intended program results or outcomes.
- **Outputs:** Include the direct results of activities (e.g., participation, satisfaction, quantity and quality of services).
- **Short-term outcomes:** Include how participants' beliefs, behaviors, skills, health or decisions could change as a result of the program.
- **Long-term outcomes:** May include the changes occurring in communities or systems as a result of program interventions. Consider how intermediate outcomes drive longer-term outcomes for participants.

When preparing to develop a logic model, it is important to involve key stakeholders to help sequentially think through and align the areas listed above. This process is successful when a sufficient amount of time is allocated to analyze the information and refine the logic model based on what has been learned.

Habitat of South Palm Beach County in Florida worked with 99-year-old veteran William, installing lever door handles, grab bars in his bathroom, and lighting to make his home safer.

Helpful tools

Logic Model Framework: This chart provides the framework for a logic model with key questions to help you identify the types of inputs, activities, outputs and outcomes that are likely for a program like CAPABLE. As you identify and describe specifics and metrics for your program, also consider the systems that will need to be in place to track, count, measure and analyze the results in each category.

Figure 5: Logic model chart

A logic model developed by Habitat for Humanity International is in the Appendix.

Building a Strong System for Data Collection and Evaluation

A Case Study from Greater Memphis Habitat for Humanity

Dwayne Spencer, CEO of Habitat for Humanity of Greater Memphis and a leader in Aging in Place efforts for the Habitat network, shares the affiliate's experience in building a strong system of data collection and evaluation.

Dwayne: All of us have been impacting health outcomes from the very beginning of our work, but we just weren't really talking about it. At Memphis Habitat, we believe strongly in data collection, analysis and evaluation.

What are the data points that you feel are the most significant in telling the story of your impact?

Dwayne: One survey that we administer to all of our AIP (Aging in Place) clients asks the question: *Do you think that your home is a healthier place than it was?*

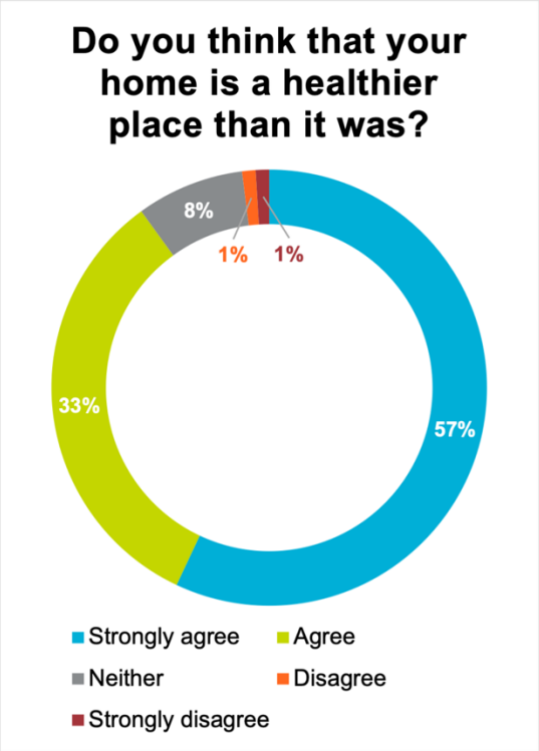
Through this survey, we have found significant changes to our clients' sense of health. Over 90% experienced an increase in sense of health after bathroom modifications. Clients noted improved ability to toilet, to practice consistent hygiene and to just feel safer in the bathroom, which we know can be a scary and dangerous place for anyone with mobility issues.

Over half of our clients are saving between $120 and $720 a year on utility costs. This is a big deal since our families are living on about $1,000 a month.

Also one-third of our clients with significant breathing issues reported improvements.

The biggest question for ourselves: Is this work really helping to keep clients in homes? We know that each year about 25 clients have reported that the condition of their home was so poor that they would have had to move to a nursing home within a year. Issues that were mentioned included fear of falling, inability to toilet, inability to get in or out of their home, high rates of breathing issues because of an inoperable or faulty HVAC system, and inability to manage utility costs.

We believe that each year of our Aging in Place program we are saving about $2.2 million in taxpayer dollars that would have gone to nursing home stays.



Presentation slide from Habitat for Humanity of Greater Memphis.

It is important to emphasize tertiary benefits of Aging in Place. We know that the older adult benefits, but so does the community. There is job creation from construction, and property tax retention when older adults remain in their home, and as we continue to point out, the health savings are significant and a benefit for insurers and payers.

These are some of our big savings:

Reduced admission to long-term care facility	$19.7 million
Preventing falls (medical cost savings)	$1.4 million
Utility bill savings	$800,000
Neighborhood protection value	$17.7 million
Savings on blight impacts (e.g., fire/law enforcement/code)	$11.7 million

With this data available to Memphis, how would you summarize your value proposition to a potential partner?

Dwayne: The work that we are doing in serving older adults is having amazing benefits, including long-term care savings, medical cost savings, saving on utility bills and an increase in home values. Memphis Habitat has invested about $8 million in Aging in Place. The cumulative benefit from improving the housing conditions of 500 seniors is more than $26 million. That's 3.3 times the initial investment. We have now served 1,100 seniors. By my quick math, that means that our impact is now at about $50 million.

By 2019, we were able to save hospitals an estimated $1 million in fall-related emergency department costs for seniors.

How have you built the capacity to collect and verify all of this data?

Dwayne: We have two anthropologists on our team. One specializes in applied housing and community issues and leads all of our evaluation efforts; the other is a medical anthropologist and leads our CAPABLE program.

In 2012, our senior research and evaluation manager conducted a meta-analysis review of 22 global housing and economic studies and interviewed our board and leadership to create the basis of a socioeconomic study, which focuses on individual, familial and community impacts of our programs. We have worked with an economist since 2013 to look at up-to-date and cumulative impacts of our programming. As new and evolved outcomes appear in the latest aging in place research, we add those to our study.

We also have partnerships with other nonprofits that have an interest in collecting and verifying housing outcomes:

- Seeding Success, which focuses on educational outcomes of homeowner children.
- Green and Healthy Homes Initiative, helping us crunch data in relation to CAPABLE.
- A research organization called Three3 (ThreeCubed) that evaluates the statistical impacts of weatherization interventions for older adults, including utility costs.

We are also in talks with a health care expert who works with hospitals and managed care organizations to understand their motivations and value propositions.

How long has it taken to build the capacity for this type of data collection? What would you recommend to an affiliate starting down this road as a first step?

Dwayne: Habitat for Humanity Greater Memphis hired our senior research and evaluation manager in 2009. With a background in applied anthropology, she uses qualitative data collection methods to explore how aging in place modifications impact clients, their families, and their surrounding neighborhoods.

In most cases, affiliates will not be able to bring on a full-time social scientist. However, the work can be supplemented by partnering with research organizations and local universities. Also, affiliates have access to research and Quality of Life evaluation training at Habitat conferences and resources on MyHabitat.

We understand that self-reported data are best presented when bolstered by statistical data such as health care utilization costs, medical assessments of Activities of Daily Living, emergency department use data, and utility data provided by local utility companies. Because of the necessity of including qualitative and quantitative research to see if we are truly impacting lives, our evaluation work is based on peer-reviewed literature and further informed by socio-medical research partners with whom we've collaborated over the last 12 years. Our partners have included experts in the fields of urban planning, occupational therapy, nursing, gerontology, psychology, political science and economics.

Housing and community development sectors don't have the ability to access, manage and disseminate HIPAA-centric impact data; therefore, it is necessary to arrange for data sharing with medical health care utilization experts. Qualitative data alone and statistical data alone can't tell the whole story; it must include both. It is in the best interest of both the housing and health care sector to share data in order to have the full picture and be able to validate outcomes.

Our view on research and evaluation is twofold:

1. We are focused on client-centered research and elevating the voices of the clients we serve.
2. Our work must be reliable, replicable, and contribute to the aging in place knowledge base so that others may learn and exchange with us.

It is important to us that staff are able to share our results and programmatic impacts with other sectors, other affiliates, in publications and at conferences. We have various ways of disseminating analyses for holistic impact so that we are constantly bridging with others and sharing.

WHAT IS AN IRB, AND WHEN IS IT NECESSARY?

In its association with other organizations in collecting and analyzing research results, the Memphis team has undergone the extra due diligence of acquiring an institutional review board, or IRB, approval for its survey activities**.** Under federal regulations, when research is conducted on human subjects, an IRB must be convened and either exempt the activity from its review or review the proposed research activity for approval, modifications or disapproval. The purpose is to protect the individuals who are subjects of the research project. "Research" that requires IRB approval or exemption is "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."[1] For example, the development of the CAPABLE model involved research to support and publish the generalized knowledge that employing the model is likely to produce certain desired outcomes, for example a reduction in difficulty with activities of daily living.

In contrast, Habitat affiliates (and others) conducting evaluations to determine the outcomes of their specific programs are not "research" in this context and do not require IRB review. If your survey is focused on perceptions of the client, client satisfaction, feeling of safety, or fear of falling, then an IRB is probably not necessary. Note: This is independent and in addition to confidentiality and anonymity protocols that Habitat affiliates and their collaborators will need to follow.

DEVELOPING A VALUE PROPOSITION

Why this is important

A value proposition is a clear and concise statement that summarizes why a potential partner (or customer) should contract with you for your services and products instead of some other organization. Having a well-crafted value proposition helps to make the case to a potential partner or donor. Being ready with that statement and being able to adapt it according to the organization you are talking with is an important step in building productive relationships that will support your program.

Key facts

The focus of a value proposition should be on what your organization can do to solve a problem, save money or serve a common constituency in a way that is compelling to the potential partner, whether as a funder or a collaborator.

"We know we are serving clients and making their lives better. We do it because we care about the individuals, but we do need to think about the value proposition for all of the others that we want to bring to the table. What is important for them?"

— Dwayne Spencer, CEO, Greater Memphis Habitat for Humanity

HELPFUL TOOLS

Defining your value proposition[13]

In a nutshell, the Aging and Disability Business Institute's *Value Proposition How-to Guide* says a strong value proposition:

1. Clearly communicates the benefits of the product or services you provide.
2. Focuses on what your customers value, want and need in language that resonates with them.
3. Is compelling and easy to remember.
4. Differentiates your organization (products and services) from the competition.

The following questions (also taken from the *Value Proposition How-to Guide*) will help to collect the information that will define your value proposition, based on your knowledge of the potential health partner or organization that you want to approach:

- What is the problem you intend to address?
- What is the specific intervention that will address the problem?
- How will your service address the potential partner's concerns, pain points or financial risks?
- Who are the beneficiaries that you serve and the challenges that they face? How do these beneficiaries align with those of the potential partner?
- What is your experience in working with this beneficiary, and what is the level of access that you have in reaching the target population?
- What is evidence of your effectiveness in working with the target group and addressing their problems and concerns in a way that will also prove beneficial to the potential partner?
- What is the return on investment for the potential partner? Can it be quantified? (Hard or soft ROI?)

Value proposition example

In this hypothetical example, potential partner is an Area Agency on Aging with a service area covering five counties.

In this five-county area, Habitat's local offices have served more than 100 older homeowners who live on a fixed income and are unable to afford much-needed repairs to their homes. In addition to major repairs, Habitat works with an occupational therapist (or social worker) to identify and prioritize modifications that will enable greater mobility, independence and reduce the risk of falling. The AAA services in this region provide support to the lower-income older adults who want to age in place. Habitat is a trusted brand and can help provide a safe and stable environment for those services.

Connect with confidence

WHY THIS IS IMPORTANT

With a strong value proposition and a clear idea of the landscape, the next step is to make the connection. Sometimes the greatest leads are found in unlikely places. A good rule of thumb is to start with whom you know and ask for an introduction. As illustrated in the networking tips below, board members, clients and current community partners are a great place to start.

NETWORKING TIPS

- **From Habitat for Humanity Metro Maryland: Map organizations in your community that prioritize aging and health.** In order to seek out and enroll older adults to the CAPABLE program, we looked for organizations that were already engaging clients on the basis of their health, both in the government and other nonprofits. The city of Hyattsville is an age-friendly city engaging older adults through exercise programs, community centers and health-based initiatives. There

is also a senior village in Hyattsville that helped with outreach and helped interested applicants through the process. Other helpful contacts were AAA case workers, the Department of Health and Human Services, Fire Rescue and EMS, support groups for caregivers, housing counseling nonprofits, and faith groups.

- **From Habitat for Humanity of Douglas County, Minnesota: Aging in Place clients are a great resource in identifying other aging services organizations.** The affiliate service coordinator had heard of Recover Health from working with Aging in Place older clients. When the affiliate began searching for a CAPABLE partner, Recover Health was very interested, and the affiliate was able to negotiate a service contract for the OT and nurse.
- **From Susquehanna Habitat for Humanity, Maryland: Engage members of your board in making connections.** A member of the Habitat Susquehanna board of directors worked for the hospital system and knew everybody. From that contact, the affiliate was introduced to Christina, who was in charge of all OT/PT through the local hospital. Christina thought CAPABLE was wonderful and had a commitment to the project. Susquehanna Habitat CEO Karen Blandford says, “If we hadn’t had such a wonderful person, it wouldn’t have happened.”

HELPFUL TOOLS

- **Map Your Context Tool**
- **Health care outreach and messaging toolkit from the Aging and Disability Business Institute**

Habitat of Wisconsin River Area helped 86-year-old Roslyn and her husband and caregiver, 82-year-old Bryant, by installing grab bars in their home and suggesting other organizations that have resources to help them in other areas where they have needs.

A cross-sector conversation on how and why to connect

Cross-sector work can highlight the need for equity and systems change. In a conversation facilitated by Fred Karnas from Richmond Memorial Health Fund, Alice Bonner from Johns Hopkins University and Tawkiyah Jordan from Habitat for Humanity International explore the value of partnerships that move the needle of equity and how to develop them.

Fred: What types of partnerships are needed at local, state and national level to sustain investment in health?

Alice: It's not just the usual suspects in housing and health care, but we need to look beyond typical programs designed to help older people, including workforce investment, university systems, community colleges and community-based organizations — AAAs, senior centers, Meals on Wheels and other community organizations. We must think and act beyond the silos, get rid of all the barriers, and aim for integrated and coordinated system of support for older people.

Tawkiyah: We often miss an important step by not mapping the context. Determine who's who and look further upstream at how decisions were made to get us to this point. Who are the influencers in the state and at the city level? In health and hospital systems? Decisions may have been made way upstream in the past. If we know who is who, we are better equipped to address audiences and forge alliances.

Alice: Especially at the state level, it's remarkable how systems and processes differ. In some states there is very close coordination between Medicaid and aging offices, but this is not typical. Within each state where you are working, it's important to understand where the different organizations "sit" and how they work or don't work together. That is critical when you are thinking about funding models.

Tawkiyah: Follow the money – we are spending so much on health care. Similarly, we know we have gaps in how we help people find housing – whether it is supportive housing, transitional housing, combatting homelessness or just needing more affordable housing. There could be good synergy and efficiencies in determining a double bottom line so that funding is meeting both needs with a single approach. Could supportive housing be a model as a starting point? Could we expand that model to meet other housing/health care needs that overlap?

Fred: There is sometimes a difficulty around bringing housing and health together when it comes to partnership. Are there natural ways for these two sectors to be brought together? Are there models you have seen to get people in the room to talk with each other who don't normally talk to each other?

Alice: Age-friendly communities are a way to include the larger community — the municipality, health systems, education systems, public health. Every state has a least one or several organizations working toward either becoming an age-friendly health system or an age-friendly community. It started out with just a handful, but now there are over 2,000 health system sites working on this across the country. Community and health systems are really one ecosystem. If you are an age-friendly community, you need to have all of these different sectors (housing, health care, government) and community leaders across these sectors.

Fred: Philanthropy can also bring groups together. If you can convince one visible leader to invite folks to the table, others will show up. Corporate and sports leaders can also do that. An outcomes focus is important to establish an ROI for partners. Positive PR always helps.

Tawkiyah: Storytelling is a primary tool for communicating needs and the impact we can have on shelter, family and community. We can use the data to help capture the impact and combine it with storytelling.

Fred: Why is the focus on health equity critical for health and housing?

Tawkiyah: There is a history of marginalization and discrimination in housing and health, along with uneven spread of resources and access to resources (those who are underhoused, uninsured) — and this is largely the same population. The equity lens helps identify the core client, and if we can meet their needs better, then it helps to resolve issues in the broader system. Often when we start with those who are struggling the most, it can help untangle challenges facing many others across groups.

Partnership development

For cross-sector partnerships, it is necessary to get beyond stereoptypes to understand perspectives: benefits, costs, contributions, perceptions.[14]

Key questions to explore

- Why each sector may want to partner (drivers and benefits).
- What concerns each may have (risks).
- What each sector can offer to the partnership (contributions).

The following case study from Habitat for Humanity of Metro Denver traces the phases in which the above questions are explored, resulting in strong alignment and agreements that recognize the contributions (strengths and roles) of each partner. Habitat of Metro Denver is one of the first Habitat affiliates to participate in CAPABLE. Over the past four years, the partnership with Colorado Visiting Nurse Association has continued to thrive and grow, attracting new donors and expanding their outreach to older adults across the city of Denver.

BEST PRACTICE

The Denver partnership is a best practice in leveraging the strengths of each organization. Sustainability of CAPABLE is best achieved when the health care entity takes the lead in recruitment, referral, enrollment and scheduling. Construction expertise is incorporated by advising on structural issues, materials and budget management, and timely delivery of modifications that support the client's goals.

Moving from talk to implementing CAPABLE

A case study from Metro Denver Habitat for Humanity

In 2017, the Colorado Visiting Nurse Association, or CVNA, invited Habitat for Humanity of Metro Denver to join in a pilot of CAPABLE with funding received from the Colorado Health Foundation. CVNA was the first home health care agency in Colorado, caring for more than 30,000 patients a year. Services include workplace wellness, vaccinations, home care for chronic conditions, palliative care, hospice and health prevention programs. CAPABLE was seen as a natural addition to its menu of services.

Mike Criner, Habitat of Metro Denver's chief operating officer, describes how the partnership developed.

Mike: The partnership with CVNA came together about four years ago. At that time, Habitat Metro Denver had a pretty strong home repair program. We were doing more than 50 home repairs a year, but all external work and only in three neighborhoods. We had been discussing about expanding in order to have greater impact in the Denver metropolitan area. We were also finding that a majority of the repairs were for older adults, some with disabilities.

CVNA reached out to us because they knew of Habitat, the work that we were doing in Denver and how trustworthy we were. Members of CVNA had volunteered with Habitat. They asked if we wanted to help pilot this new program, called CAPABLE. First, we had to look up what CAPABLE was. As we were reading about the program, we thought that it made a lot of sense and also addressed concerns that we had been discussing internally. We felt like there was good basis for partnership and decided to move forward.

Finding alignment

Alignment is a key piece of a successful cross-sector partnership. Ensuring mutual goals and outcomes, synergy, and clear buy-in from leadership often determines the long-term success of the partnership. Sometimes the first opportunity that presents itself aligns perfectly, but it can take more than one try to find a strong partner. Below is Habitat of Metro Denver's experience finding alignment.

What factors helped you determine alignment?

Mike: First, we both had the same goal of helping older homeowners stay in their homes. We know that many have to go into an institutional setting because their homes are falling down around them, and they don't have resources to make repairs. We

both wanted to give older homeowners the choice to stay in their homes for as long as possible.

We also felt like we could have far greater impact working together than working individually. For us, being able to come into the home and address specific needs that were prioritized by the homeowner was really important.

Finally, we would be participating in an evidence-based program with standard measurements so that we could really understand from clients how their lives had changed. Those factors were really important.

In addition, I have had some experience in the health care industry and knew that there would be the possibility of reimbursement for this work from Medicare and Medicaid. We did not want to go through the process of becoming a Medicaid provider. It's a lot of work. CVNA already was a Medicaid provider, so they brought that to the table. That was a real benefit to Habitat.

Having mutual goals that benefit both organizations is really important. We haven't looked for anybody else to work with because we align so well with CVNA and hopefully they feel the same about us.

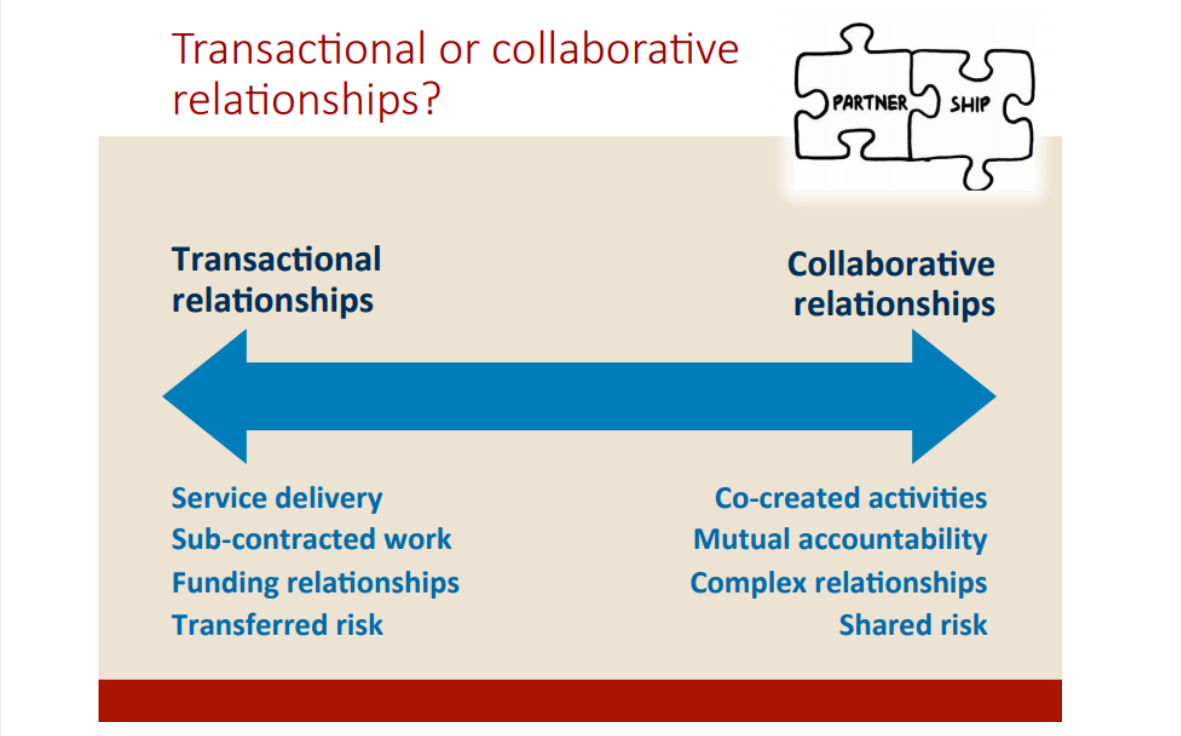
IN A NUTSHELL:
ALIGNMENT PRIORITIES

- Mutual goals and purpose: focused on the same client target group and their needs.
- Synergy: Greater capacity working together to have more impact than working individually.
- No overlap of competencies or competing priorities: Ability to provide value to each other.
- Leadership commitment; compatible culture; clear roles and responsibilities.

Finalizing the agreement

Most partnerships are on a continuum between transactional and collaborative. The type of agreement will depend on where the relationship lies on this continuum.

In the case of Habitat for Humanity Metro Denver and CVNA, there were eventually agreements that defined both the transactional and collaborative relationships that evolved. The partnership started



Source: Partnership Brokers Association

with a memorandum of understanding, or MOU, which is more high level, defining the purpose, goals, the target group, and the responsibilities of both parties. A service agreement was then developed to define and govern the services expected and for the billing and payments, insurance, and risk. The service agreement also included provision for protected health information, or PHI, to meet HIPAA requirements.

What type of agreements did you have with CVNA?

Mike: We started with an MOU and ultimately ended up with a service contract to do the handyperson work since CVNA was responsible for the grant funding. The business associate agreement was part of the service contract. I knew enough about HIPAA that we needed to pay attention to it.

Can you talk a little more about the BAA and HIPAA? Did CVNA bring up the need?

Mike: We jointly agreed that the BAA was in the best interest of both our organizations. I recommend that affiliates have, or engage someone with, a solid understanding of HIPAA so that staff can be trained and appropriate agreements put in place, particularly in regard to disclosures and notifications and what to do if PHI becomes public.

Were expectations around client volume in the contract, or was it discussed in the negotiations?

Mike: For the first pilot, the grant identified 60 households to be served over a two-year period.

How were roles and responsibilities defined?

Mike: Capacities need to be aligned well, based on the strengths and expertise of each partner. For example, from an intake standpoint, CVNA works with other health plans across the state, so they are well-positioned for enrollment and building a pipeline of clients. Habitat focuses on the home modifications.

For the first pilot, since CVNA had secured the grant, they did all of the grant compliance and reporting. Later, when we received funding from the Weinberg Foundation grant, Habitat took the lead for grant management and reporting. Now we also have a contract with the local AAA where CVNA is the lead. We have service contracts going in both directions. If CVNA is the grant lead, then Habitat invoices for services; if Habitat is the lead, then CVNA invoices for services. We have systems set up so that the service reimbursements can go in either direction.

Fundraising is probably the best example of where we are working jointly. It doesn't make sense for both organizations to apply for the same grant. We coordinate those efforts and put in a combined grant request. It's much stronger when Habitat and CVNA submit the grant request jointly than if we did it individually.

IN A NUTSHELL:
CONTRACT CONSIDERATIONS

- **Type of relationship:** Is it transactional or collaborative?
- **Strengths each partner brings to the relationship:** What are the roles and responsibilities of each partner?
- **Expectations around client volume:** How many older adults will be served and in what time frame? How will potential clients be identified?
- **Target population:** What are the requirements around who is served (age, income level, location)?
- **Type of agreement:** Service contract or MOU? If a service contract, what will be the billing/payment requirements, insurance, etc.? What will each party's roles and responsibilities be? What specific services will be provided by each?
- **Evaluation and data collection:** When and how will the project (program) be evaluated? Who will be responsible for collecting and analyzing data? Will data be shared between organizations?
- **HIPAA considerations[1]:** Is a BAA appropriate and necessary? Is there a need for legal advice to make the decision?
- **Termination:** Under what conditions will the agreement be terminated? What exit strategies can be agreed upon?

Getting started

Starting any new program is challenging. Important considerations include:

- Adjustments to procedures and policies.
- Marketing and client enrollment.
- Legal implications, setting up systems and processes for HIPAA.

In this segment, Mike discusses how Habitat of Metro Denver got CAPABLE off to a good start by addressing each of these important considerations.

Were there procedures or policies that needed to be adjusted or modified for working with health care partners and meeting the CAPABLE requirements?

Mike: Because we had an extensive home repair program already, we had a number of policies and procedures in place for doing assessments, scoping work, creating budgets, sign-offs from clients, and doing financial reporting. Most only required minor modifications to work for the CAPABLE program. Some examples are adding branding to public documents, adding new materials and suppliers to orders, and updating workflows to more accurately align with how a CAPABLE project works. Some new documents had to be created, mostly dealing with privacy, HIPAA, and how our two organizations would share information and coordinate work.

How was the referral process set up? Did Habitat need to qualify the client (homeowner family) according to your policies after the referral from CVNA?

Mike: For the most part, client requirements have been determined by the grant funder. Alignment with Habitat's requirement of need and willingness to partner has not been a problem. All clients have met the less than 80% AMI (area median income) requirement for Habitat. Since the CAPABLE program requires the client to set goals and work to meet the goals, we decided that their full participation in the program satisfied Habitat's definition of "willingness to partner." Since so many of these clients are among the lowest income brackets in our area and the program was fully grant-funded, we do not require any client payment for services. "Need" is satisfied by the CAPABLE qualifications as set by Johns Hopkins University of difficulty in performing activities of daily living.

Some funders have required other qualifiers regarding age or lower income requirements than Habitat's less than 80% threshold. CVNA and Habitat have set up systems to identify and track each client according to the qualifications and budget requirements of each funder.

How did you make sure that you were meeting the HIPAA requirements?

Mike: We set up a secure internet connection between our two organizations so that our staff didn't worry if they sent an email that had a client's name or mentioned a client's disability. We also set up a lot of procedures for security on file systems.

For example, I have no business reason for looking at any of the files that Kiersten (Kelley, Habitat of Metro Denver's construction repair manager) and Amanda (Goodenow, manager of occupational therapy for the CVNA) are working with that have information about the client or types of accommodations being made in the home. They need to know that information, but I have no business reason to know it, so I can't even get into those files.

We also did a lot of training for our staff and volunteers. We wanted to train them on how to behave appropriately and what was allowable to talk about in public and what wasn't.

IN A NUTSHELL: BEST PRACTICES IN GETTING STARTED

- Review and modify systems, procedures, documents.
- Set up systems to track clients and budget per client, per donor requirements (especially if there are multiple donors).
- Set up secure email to deal with clients' protected health information.
- Develop staff and volunteer training on any new systems or procedures.

Sustaining the partnership

Funding pathways

In this section, Ruth Ann Norton, CEO of Green & Healthy Homes Initiative, maps the funding landscape for health and housing collaborations, based on the organization's successes and lessons learned. Geoff Gregory of OhioHealth and Marisa Scala-Foley from the Aging and Disability Business Institute also contribute their expertise in analyzing the funding opportunities.

Why this is important

For any nonprofit, program sustainability depends on the sustainability of funding. While there are many health care and housing experts who want to help older adults age in their homes and avoid or delay the more costly solution of institutionalization, the key is engaging those organizations and potential funders that have the capability and also a vested interest. According to Ruth Ann, "Right now, there is a high dependence on government funding and philanthropy. However, the next frontier for funding is Medicaid, Medicare and hospital community benefit investments."

Key facts

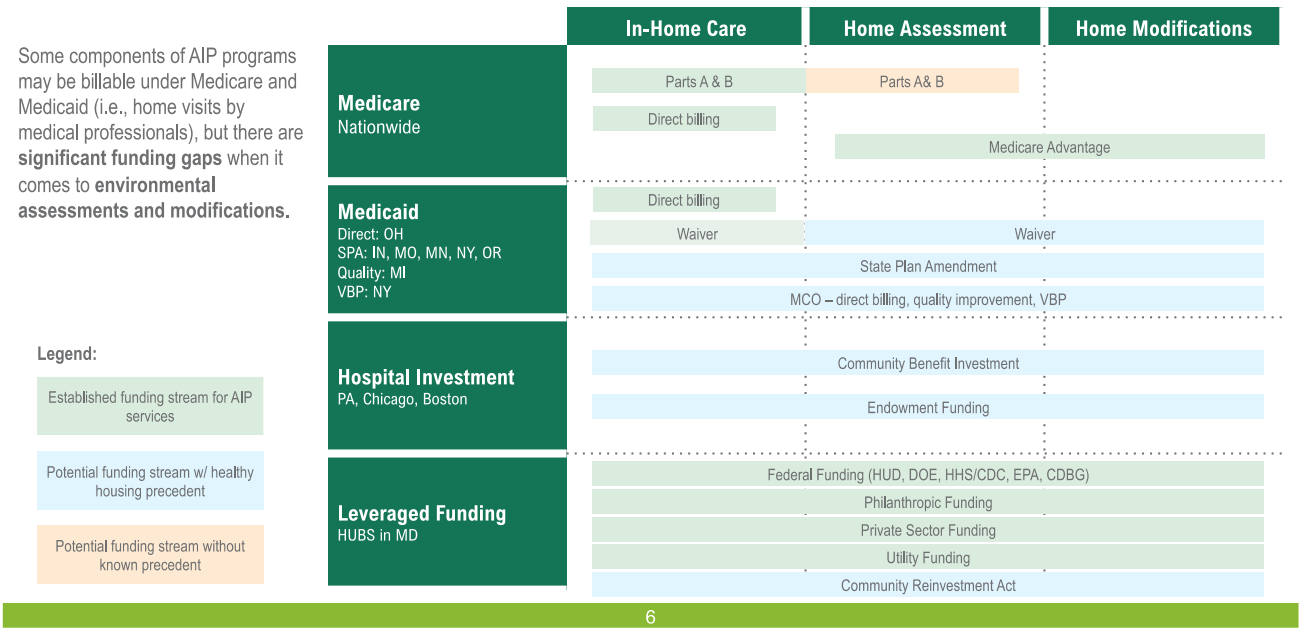
Ruth Ann sees two emerging trends for providers and payers: increased efforts to "recapture" or save money by increasing prevention, and the reinvestment of those savings in the social determinants of health, including housing modifications.

Four pathways for funding are Medicare, Medicaid, hospital investment and leveraged funding.

ABOUT GHHI

The Green & Healthy Homes Initiative is dedicated to addressing the social determinants of health and advancing racial and health equity through the creation of healthy, safe and energy-efficient homes. Founded in 1986 as Parents Against Lead, GHHI creates innovative programs to reduce lead poisoning, asthma and injury in low-income housing. Visit greenandhealthyhomes.org to learn more about program locations and technical assistance.

Green & Healthy Homes Initiative®



Slide courtesy of Ruth Ann Norton.

Depending on the stage of program development, strategy and capacity of your organization, any of the four pathways are potential opportunities for funding CAPABLE or other collaborations that improve health and housing for older adults in your community.

MEDICARE KEY FACTS

Medicare Part A will cover some home health aide services, including occupational therapy if the member is homebound. Medicare Part B will cover "medically reasonable and necessary" home-based services up to "therapy caps."

Some Medicare Advantage plans are starting to offer home modifications, but this is still reasonably new. As shared by Marisa Scala-Foley, the Bipartisan Budget Act of 2018 included the CHRONIC Care Act, which allows Medicare health plans and other kinds of Medicare health care providers and payers to address the needs of people who have complex care needs. The legislation reduced some barriers to care coordination, allowed more in-home services and expanded allowable Medicare Advantage supplemental benefits to include home- and community-based services, giving Medicare Advantage plans new flexibility to expand the kinds of supplemental benefits they offer.

Special Supplemental Benefits for the Chronically Ill, or SSBCI, has been in effect for about two years. Under the definition of "primarily health related benefits," home and bathroom safety devices and modifications have been included. The SSBCI also introduces an expanded list of benefits that includes structural home modifications.

Since SSBCI was offered and the definitions were expanded, many Medicare Advantage plans have included the new benefit options. In 2021, 737 plans nationwide are offering expanded health-related benefits, and almost double that offer benefits for the chronically ill. Plans pick and choose what they offer to specific groups of enrolled beneficiaries. Currently, a limited number of plans offer a structural home modification benefit, but plans change their offerings every year.

Implementing the SSBCI

	Expansion of Definition of 'Primarily Health Related' Supplemental Benefits	Special Supplemental Benefits for the Chronically Ill (SSBCI)
Must be health related?	Yes	No
Examples of Benefits:	• Adult Day Care Services • Home-Based Palliative Care • In-Home Support Services • Support for Caregivers of Enrollees • Medically-Non-Opioid Pain Management • Stand-alone Memory Fitness Benefit • "Home & Bathroom Safety Devices & Modifications" • Transportation • Over-the-Counter Benefits	• Meals (beyond a limited basis) • Food and Produce • Transportation for Nonmedical Needs • Pest Control • Indoor Air Quality Equipment and Services • Social Needs Benefits • Complementary Therapies • Services Supporting Self-Direction • Structural Home Modifications • General Supports for Living
How many Medicare Advantage plans are offering these benefits in Calendar Year 2021? (According to CMS press release)	737	1,351

Sources: ATI Advisory, New, Non-Medical Supplemental Benefits in Medicare Advantage in 2021, https://atiadvisory.com/wp-content/uploads/2021/01/2021-Special-Supplemental-Benefits-for-the-Chronically-Ill.pdf; *ATI* Briefing on Medicare Advantage and the CHRONIC Care Act (http://www.ltqa.org/010720-briefing-medicare-advantage-chronic-care-act/); CMS' Memo 'Reinterpretation of "Primarily Health Related" for Supplemental Benefits' (April 2018) and CMS' Memo 'Implementing Supplemental Benefits for Chronically Ill Enrollees' (April 2019)

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

Slide courtesy of Marisa Scala-Foley.

MEDICAID KEY FACTS

Medicaid programs are structured and administered on a state level, following federal guidelines. Most states now have Medicaid waiver programs that enable long-term service and supports in the home rather than institutionalization. Some waiver programs also include home modifications and improvements. Ruth Ann notes that GHHI is seeing movement in this direction in Indiana, Missouri, New York and Michigan.

Other examples from the Green & Healthy Homes Initiative:

- In Missouri, Minnesota and Oregon, there are examples of using waivers to allow nonlicensed professionals (community health workers, health educators) to be able to do assessments. Some of those waivers include home repairs.
- Another pathway is tapping unused administrative dollars from Medicaid Managed Care for reinvestment to advance quality health outcomes and quality improvements. Examples are in Ohio and Michigan.
- GHHI is starting to build contracts around outcomes-based financing. By analyzing statistical results in lowering hospitalizations and emergency room visits, they have been able to project the outcome savings from a reinvestment standpoint. Many states identify and give priority dollars for demonstration projects or pilots.
- In New York, their Delivery System Reform Incentive Payment program enables value-based payments for community services, such as home repairs.

How do I connect?

Both Ruth Ann Norton and Marisa Scala-Foley recommend sitting at the table with Medicare and Medicaid programs in your state around cost containment and prevention. If you are working in a state mentioned in the summary above, start having the conversation on how to be a service provider and present your value proposition. Start with people you already know. Ask your clients who their Medicare or Medicaid providers are. The first step is to build the relationships at the local and state levels.

HOSPITAL INVESTMENT KEY FACTS

Hospital investments are driven in large part by a focus on reducing hospitalization and emergency room visits, looking at cost containment, and addressing social determinants of health. According to Geoff Gregory, readmissions is a key word in the health care industry. When a patient is discharged from the hospital and is readmitted for any reason within 30 days, the hospital has to cover the cost. If readmissions can be reduced by patients having a healthy, safe home to return to, the hospital saves money that can be reinvested in other ways. When presenting your value proposition, Geoff recommends using the term “decreasing readmissions.”

Everyone wants to ensure that patients are returning to a place where they are safe and can care for themselves. In a case like the orthopedic surgeon quoted at right, the surgeon either extends the length of time in the hospital or sends the patient to a skilled nursing facility for rehabilitation. Skilled nursing facilitates have a per diem rate that will drive up the cost for the payer.

Finally, as mentioned in the earlier section on **health care**, in order for a nonprofit hospital system to remain tax-exempt, it must adhere to community benefit requirements. The guidelines require a community health assessment every three years with a plan for interventions that includes input from public health officials and community residents. This program opens up another pathway for engagement.

“I can’t send him home. I wouldn’t feel comfortable sending him home to that environment.”

— An OhioHealth orthopedic surgeon, expressing concern for a patient, as related by Geoff Gregory

Ways hospitals save money that can be reinvested in the community[15]

- The length of hospital stays can be reduced by ensuring that patients in post-op have a safe environment when they return home. Hospitals save money if hospitalizations are within certain required limits. For example:
  - Remaining within the global surgery period. For a minor surgery, there is a 10-day period; for major surgery, there is a 90-day period. If the patient is not able to return home within that period, there are additional costs for the hospital.
  - Remaining within the length of stay dictated by the diagnostic-related group for a particular diagnosis. The diagnostic-related group determines the length of stay that will be reimbursed by Medicare. If the length of stay can be reduced, the hospital will be able to save money; if the patient has a home that is not suitable for them, they may have to stay longer, increasing costs for the hospital.
- The number of hospitalizations for older adults who aren't covered by insurance or Medicare or Medicaid can be reduced. Charity care can be reduced if there are reductions in falls and in uncompensated care.
- Annual hospital community giving is another opportunity for funding. You just have to ask. Once an organization has been approved for funding, it is likely to be approved for the next year.

Examples of hospital investment[16]

- In Lancaster, Pennsylvania, a $50 million investment ($5 million a year over 10 years) came from a University Health system in a city of 90,000 people and county of 500,000 to improve health and housing for lead remediation.
- In Massachusetts, Boston Medical Center invested $6.5 million.
- In Chicago, AMITA Health (formerly Presence Health) invested in asthma education, supplies and home repairs for uninsured patients.

LEVERAGED FUNDING KEY FACTS

This category of funding is foundational for nonprofits working in the housing sector. It includes government funding programs — Community Development Block Grants, Home Investments Partnership Program, USDA, Veterans Housing Rehabilitation and Modification — and philanthropic funding from foundations, corporations and individuals. Leveraged funding is helpful in program development, innovation and building capacity. While motivations for funding vary greatly, these funders are also increasingly interested in data collection, evaluation and outcomes. Building capacity to successfully partner through the other pathways will increase credibility and access to other funding streams.

"The role of housing organizations in home improvements is not only critical to improving health outcomes while decreasing health care costs, but also for intergenerational wealth transfer, which is important to advance equity and inclusion for those living in underinvested communities."

— Ruth Ann Norton, CEO, Green & Healthy Homes Initiative

Implementing and sustaining CAPABLE

In addition to a strong health care partnership, sustaining an innovative program like CAPABLE depends on continued executive sponsorship and commitment; continuous improvement; and staff capacity to achieve expected results, track and measure impact, and sustain financial support. These factors are interdependent and feed each other, but also require a plan, support and thoughtful decision-making. In this segment, Dr. Deborah Paone, director of implementation and evaluation for CAPABLE at Johns Hopkins University, provides advice and helpful tools to support decision-making and describes the level of program implementation, data collection and reporting that will be required to demonstrate value and retain sustainable financial support from health care payers.

Why this is important

CAPABLE is an evidence-based program that has proven results and demonstrated success in health outcomes, such as improving functional status, reducing depression, and increasing the individual's sense of self-efficacy through achieving goals. Many stakeholders are interested and want to support CAPABLE. For organizations ready to move from the initial stages of implementation to embedding the program as an ongoing service, it is necessary to build a strong operational program with a sustainable funding base.

Key facts

Since CAPABLE is an evidence-based program, an organization interested in implementing CAPABLE must receive the required training and certification through Johns Hopkins University School of Nursing. After the organization has registered with Johns Hopkins, many resources become available, including a *CAPABLE Implementation Manual* written by Deborah and her colleagues. The manual walks through the necessary steps to plan and prepare to launch CAPABLE, set up operations, and maintain the program with fidelity to the tested approach. The Johns Hopkins CAPABLE team provides technical assistance through the manual; regular bimonthly virtual meetings for the program administrator, OT and RN; and customized one-on-one support. This builds a learning community of implementing leaders. Through these venues, Johns Hopkins shares tips and strategies and continues to develop resources and tools based on the experience and lessons from CAPABLE programs across the country.

Deborah identifies four benchmarks that define a "foundational level of program implementation" that needs to be present for organizations interested in approaching an MCO or another payer. Each CAPABLE provider needs to ensure that:

- The organization has a well-defined and structured process around recruitment, referral and enrollment, with the workflows between organizations (e.g., between the health care and housing services organizations) operating smoothly in terms of intake, screening, scheduling and communications.
- The CAPABLE program is delivered with fidelity, with adequate staffing levels and following the protocol/program visit content. The organization must be able to demonstrate to the potential payers that it is following the evidence-based program.
- Data collection and aggregation are sound, accurate and complete. Data are tracked to allow for oversight and evaluation — both in terms of the individual (pre-post measures of function collected, visits received, goals met) and overall outcomes achieved for the CAPABLE participants in the aggregate. That is, the organization should be able to run aggregate reports and share results (by payer or by referrer). The organization needs to look at the whole population of CAPABLE clients over time, and to view results by payer, by dates of service, by region, etc.
- The organization has strong feedback loops for operational oversight and continuous improvement, with evaluation results shared with the CAPABLE professional team so that the clinicians and handyperson are informed.

According to Deborah, payers (such as managed care organizations) will want to see results for their enrolled members who have been referred to CAPABLE. They will want to see improved function, reduced depression, fewer falls, reduced hospitalizations, fewer emergency room admissions and better self-management of health status. Payers will want to see the data on their members — not just the volume of visits provided or the number of clients served. In other words, it is important to collect data consistently on every CAPABLE client, aggregate the data and analyze it. Here are some measurements that demonstrate value:

DATA COLLECTION AND ANALYSIS TO DEMONSTRATE VALUE

- Process and program measures, such as:
  - Number invited, number started, number completed, number refused and why.
  - Referral source and outreach effectiveness.
  - Demographic information: age, gender, ZIP code, health payer.
- Outcome measures, such as pre- to post-change in:
  - Functional status (ADL and IADL).
  - Depression, pain.
  - Falls self-efficacy, self-report of health status.
- Use, health care costs impact:
  - Reduction in ER, hospitalization, nursing home use, TCOC.
- Participant measures (self-report):
  - Goals met, partially met, not met.
  - CAPABLE client experience, (post-CAPABLE survey).

Deborah also recommends the following:

- Be able to demonstrate value by payer, by accounting for the dollars by person and by payer, including the funding you received, how much it cost you to deliver the service, and the results.
- Develop regular dashboard reports that you send to your payers and stakeholders quarterly. At least annually, do a full analysis and include case stories.
- Track and report long-term data (12-24 months post-CAPABLE) if possible. For the health care payers, the total cost of care is a fundamental measure of success. It is the dollars and their use that will drive their interest and maintain a contract. They will ask you to show them data that shows people receiving CAPABLE did better than expected compared with a matched group of people who didn't receive CAPABLE. Work with your payers to set up such a comparison group design.
- Determine the return on investment. The ROI is demonstrated by a comparison of outcomes/benefits to investments/costs. The real benefit is over a longer time horizon — such as 24 months (seen in the randomized control trials of CAPABLE). Payers will need to make a commitment to the program for long enough to see the results. To demonstrate the ROI, take the dashboard indicators that are fundamental in CAPABLE, and assign a dollar value for each metric. The Commonwealth Fund has done a great ROI calculator that assigns dollar values to social determinants of health: **Welcome to the Return on Investment (ROI) Calculator for Partnerships to Address the Social Determinants of Health | Commonwealth Fund**.

Other key capacity requirements for organizations in contracting with payers include:

- Ability to meet service volume expectations.
- Extending the service across a wide region.
- Demonstrating consistency.

Consider how your organization can grow to meet payer demand for this service. Your organization may wish to collaborate with other CAPABLE providers to cover a region. This moves the CAPABLE provider toward building its business acumen to contract with payers as one entity (allowing the MCO, ACO or other payer to write one larger contract rather than many small ones).

Determining your funding strategy

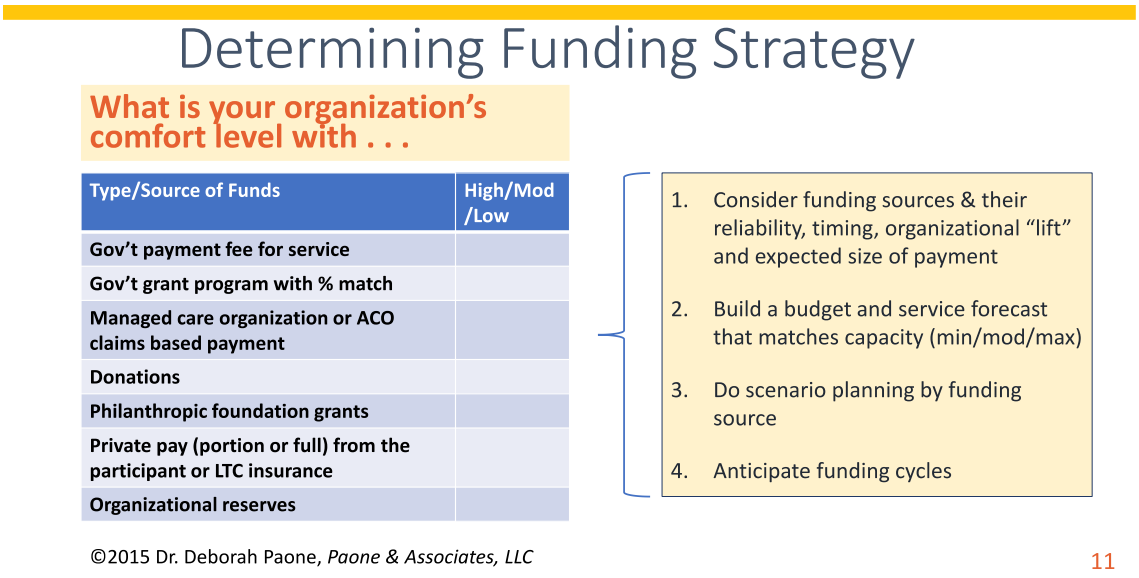
Sustainable funding for CAPABLE requires careful planning and a long-term funding strategy. Ideally, funding will come from a variety of organizations and donors who can provide value and also who value the results of the CAPABLE program from their own perspectives. Deborah advises: "As you build a funding strategy, think about your organization's comfort level with different potential payers or funders."

1. **Start with identifying the possible stakeholders and what they value.** This chart is a good start in listing the various types of stakeholders and why they would be interested in CAPABLE.

Stakeholder	Top value
Potential participant	Life changes for the better.
Your organization's leadership	Service, mission, reputation, cover costs
Your partners	Service, mission, payment
OT, RN and housing repair specialist	Service excellence and satisfaction
Local senior service providers	Ability to refer their clients to a proven, effective program
Private philanthropist or foundation	Community impact
Primary care providers	Fewer patient falls/calls; better patient health
Hospital and ER	Fewer hospital readmissions
Managed care organization	Reduced hospital/ER costs and improved member satisfaction
Federal Medicare program	Reduced Medicare costs due to avoided hospital/ER costs; better quality outcomes
State Medicaid program	Reduced Medicaid costs due to avoiding early admissions to a nursing home; better quality outcomes
City/town services (EMT, fire)	Reduced "pick up from floor" calls

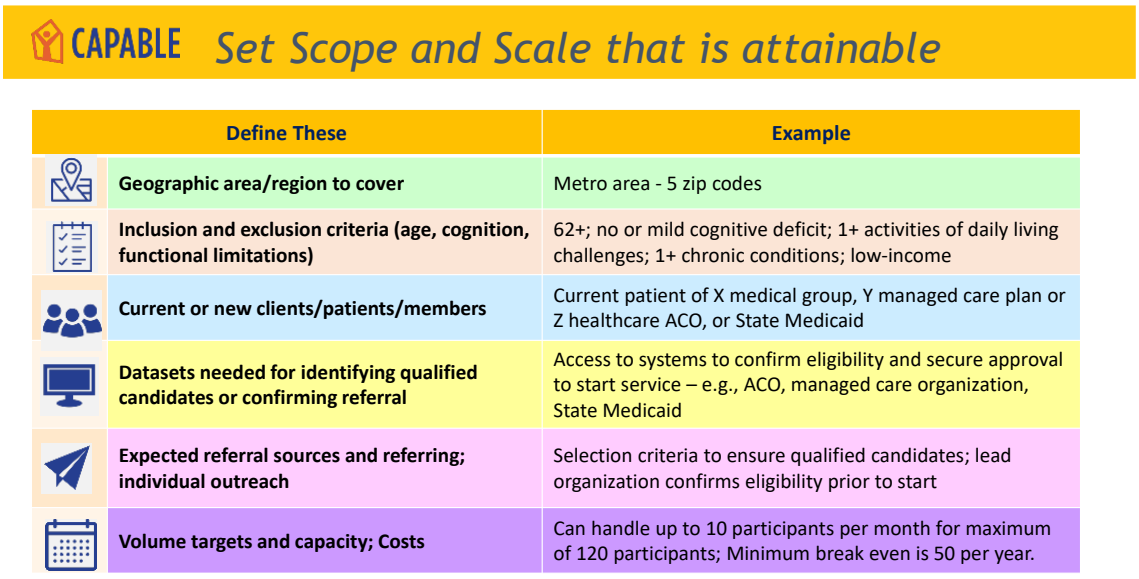
Chart information provided by Deborah Paone, Paone & Associates LLC.

2. **Determine the comfort level (high, medium, low) that you currently have with each type of donor.** For example, to contract with a managed care organization, you might need to be certified in Medicare or Medicaid and set up billing and coding systems, which may require a higher level of organizational capacity than you currently have. However, it is useful to brainstorm and think about capacity requirements in terms of long-term growth. The chart on the next page is an example of how to analyze options and build your strategy.



Slide courtesy of Deborah Paone.

3. **Determine the scope and scale of the program, based on the budget projections and funding strategy.** The following chart summarizes the type of criteria that should be considered in planning for current and future program delivery and the funding that will be needed.



Slide courtesy of Deborah Paone.

JOHNS HOPKINS UNIVERSITY CAPABLE TEAM

Finally, contact the Johns Hopkins University CAPABLE team with ideas, questions and practical experience as organizations build and sustain their programs. Under the leadership of Sarah Szanton, co-founder of CAPABLE, the team is assisting organizations in the pre-adoption, initial implementation, and sustainability stages (see https://nursing.jhu.edu/faculty_research/research/projects/capable/).

Continuous improvement

With more than four years of experience under their belt, the Denver partnership between Colorado Visiting Nurse Association and Habitat for Humanity of Metro Denver has achieved many of the benchmarks that Deborah referenced in the previous section.

- A structured process around recruitment, referral and enrollment, with workflow between organizations working smoothly in terms of intake, scheduling and communications.
- Fidelity in program delivery.
- Data collection, both in terms of the individual goals and overall outcomes, with the ability to aggregate results (by payer or by referrer).
- A feedback loop for continuous improvement among the professional team with good management oversight of the whole process.

Benchmark 1: Structured process for recruitment and enrollment

From the beginning, the Colorado Visiting Nurse Association took the lead, using its connections across the state and its long history of service to older adults. CVNA also used its scheduling system for smoothly managing the intake of new clients, assignment of occupational therapists and nurses, and scheduling of sessions. Through good cross-communication with Habitat, Kiersten Kelley, the repair construction manager, was able to schedule the modifications to align with the timing required to meet clients' goals. Systems were set up so that the recruitment and scheduling process remained the same no matter which organization was responsible for the funding.

Benchmarks 2 and 3: Program delivered with fidelity; data collection is tracked by payer

Over time, funding for the program has included several donors. The Colorado Health Association funded the first two years, then Metro Denver Habitat received funding for two more years through Habitat for Humanity International from the Harry and Jeanette Weinberg Foundation. During that time, an additional grant was awarded to CVNA by the Denver AAA. Both partners are very aware of the deliverables and budget requirements for each grant, but the organization that secured the funding provides financial oversight while the other submits invoices for services, according to a service contract (and vice versa). Data collection and analysis has been continuous, using Johns Hopkins University criteria, but responsibilities for reporting have switched back and forth, depending on the funding lead.

Benchmark 4: Feedback loop for continuous improvement

On a monthly basis, Amanda Goodenow, CVNA's CAPABLE manager, and Kiersten Kelley, Habitat's construction repair manager, meet to discuss issues, review the clients, identify roadblocks and find solutions. Some of the improvements seem small but make a big difference in effectiveness and efficiency for delivering the program and serving increasing numbers of clients as the funding has allowed the program to grow.

Communication and collaborative problem-solving are key. Part 2 of this guide will share several best practices, efficiencies and practical tools that have emerged as Habitat and CVNA have worked together, each bringing their particular expertise and perspective to improving processes and procedures. In addition, the importance of having a person-centered approach and shared understanding of the role of the occupational therapist and the role of the handyperson will be explored.

Part 1 conclusion

WHAT HAVE WE LEARNED?

Cross-sector collaboration is not easy. The information presented in this resource guide is a basic compilation of expertise from professionals who have spent many years working on these issues. There is much more to learn, and there are many constraints, including legal and financial issues and the ability to deliver at scale.

What we know for sure is that one organization, one partnership, one conversation will not solve the problem. The good news is that many of us will be building many bridges. We are aligned in this common purpose: to enable older adults to age with dignity, to remain independent for as long as possible, and to live a life of purpose.

WHAT ARE THE IMPLICATIONS?

The May 2016 Bipartisan Policy Center report *Healthy Aging Begins at Home* summarizes the importance of bridging the gap and cross-sector collaboration: “One of the most important public health findings over the last two decades has been that there are a number of factors, beyond medical care, that influence health status and contribute to premature mortality. Of these factors, social circumstances and the physical environment (particularly the home, whether a single-family home or an apartment) impact an individual’s health. Housing takes on an even greater importance for older Americans, since they spend a significant portion of their days in this setting. The home is also increasingly being seen as a potential site of care for seniors to receive health and wellness services and as an essential tool in chronic care management.”

The report goes on to conclude that affordable housing is “the glue that holds everything together; without access to such housing and the stability it provides, it becomes increasingly difficult, if not impossible, to introduce a system of community-based services that can enable successful aging.”

WHAT IS OUR CONCLUSION?

The Bridging the Gap Convening and this resource guide are not the solution; they are a step along the way. We hope that this publication provides some helpful information and resources for housing organizations and the Habitat network to continue and grow the good work that has begun.

Part 2: Construction Implementation

"We used to think in terms of the health of the structure and the longevity of that structure. With a person-centered approach, you're really re-centering on the occupant, the person. Of course, they are related, but the health of that person and what's going to keep that person healthy in their home is the priority. You are concerned with their daily activities and how they live in the house. Instead of how the building will age, you're thinking more about how the occupant will age. It's a definite shift in mindset and focus. It will shift the priorities as well."

— Emily Lucas,
construction manager,
Habitat for Humanity
Philadelphia

Overview

This section will focus on the construction implementation of person-centered older adult home modification programs. The home environment is an important health factor for all older adults. The primary reason is the risk of tripping and falling due to unnoticed hazards in the home. According to the U.S. Centers for Disease Control and Prevention, falls are a leading cause of medical treatment for older adults. Every 11 seconds, an older adult is treated in the emergency room for a fall; every 19 minutes, an older adult dies from a fall. As individuals age, functional abilities change, and mobility becomes more difficult. Home modifications and repairs may prevent 30% to 50% of home accidents and make it easier to safely navigate and continue to perform activities that are important to well-being and independence.[17] There is a very real and obvious impetus for bridging the gap between construction and health care in serving an ever-increasing older adult population.

Habitat for Humanity's awareness of the need to work with the health care sector has evolved over the past 10 years as local Habitat organizations began helping older homeowners with critical home repairs. To increase knowledge of the field of aging, Habitat sponsored a series of regional learning exchanges for the affiliate network in 2014 and 2015. One of the sessions in Philadelphia, Pennsylvania, featured Dr. Sarah Szanton from Johns Hopkins School of Nursing as the lead speaker. Her presentation on the evidence-based program, **Community Aging in Place Advancing Better Living for Elders, or CAPABLE**, inspired Habitat's leadership and transformed local aging in place efforts.

Among other important outcomes, the Johns Hopkins research confirmed the connection between the independence and well-being of older adults and their lived environment. According to a 2019 issue of *JAMA*, "simple home modifications, such as filling in holes in floors, stabilizing shaky banisters, lowering microwaves to reachable heights, installing tailored bathroom safety equipment, and raising toilet seats, improve older person's daily life by reducing the obstacles and physical demands of their environment."[18] From a construction standpoint, the additional insights of someone trained in the health and mobility needs of older adults leverages the construction work so that even greater outcomes are achieved for the people we are committed to serving.

> *"The partnership with health care is huge. This is doing home modifications that are making significant difference in the lives of the older adults. We have many that have said they would not have been able to stay in their homes without the changes. The depth and breadth of knowledge of the providers working together is more impactful. People really want to live in their homes. They don't want to move. We have to set outside thinking that we know best. We need to be able to listen and ask the right questions."*
>
> **— Pam Johnson, program manager, Twin Cities Habitat for Humanity**

Integrated Housing Plus strategy

With a network of more than 1,100 local organizations across the country, Habitat has an opportunity to serve older adults living in both urban and rural areas, in locations where Habitat has large organizations with many resources available and in volunteer-based organizations in rural towns. These affiliates are adopting a wide range of integrated service models connecting health service to repair work to enhance outcomes for older adults and other vulnerable populations. These Housing Plus strategies at a minimum incorporate the expertise of a health care professional in determining the scope of construction work and include evidence-based best practice models such as CAPABLE. Housing Plus provides an entry point for building capacity to partner with health care providers who are looking for construction expertise in implementing CAPABLE.

The basic components of the Housing Plus strategy include:

- **Partnership with a health care professional** who may be an occupational therapist, social worker or nurse. The health care partner assesses the functional abilities of the older adult, supports the identification of safety issues, recommends modifications, and refers the older adult to other community resources.

- **Collaboration between construction and health professionals to assess the home environment and how the older adult operates within the home** in order to prioritize modifications and home repairs for safety and mobility.
- **Interventions involving one or two visits by the health care professional.** A follow-up visit after modifications are completed is highly recommended.
- **Construction interventions** that may include some critical home repairs in addition to modifications for the overall safety of the home.
- **Regular and systematic qualitative and quantitative evaluations,** which have improved the program over the years.

In order to serve the many older adults who want to age safely in their homes and communities, Habitat is committed to supporting Housing Plus integrated approaches with an emphasis on building capacity to implement CAPABLE.

Key facts: CAPABLE

As a review, here are the basic components of the CAPABLE program from the construction standpoint. For a complete description, please see Page 4 in the Partnership section or the CAPABLE website.

- CAPABLE is an evidence-based program offered through Johns Hopkins University School of Nursing.
- The team includes an occupational therapist, nurse and handyperson. The occupational therapist, or OT, takes the lead in working with the older adult to set goals. The nurse supports underlying issues such as pain or medication concerns. The handyperson provides construction expertise, orders materials and advises if there are structural constraints. CAPABLE training and certification are required for the occupational therapist and nurse.
- The program involves a total of 10 visits by the OT and nurse for assessment and consultation; fidelity to this process is very important in order to achieve the evidence-based health improvements. Construction modifications are usually completed in one day.
- After the modifications are completed, the OT and nurse continue to work with the older adult to achieve goals set in consultation with the OT. By analyzing problems with activities of daily living and brainstorming solutions, the older adult achieves not only the established goals but also a level of independence in addressing future problems.
- The construction intervention is focused exclusively on modifications and assistive devices to support goals set by the older adult client.
- As a best practice, the health care entity takes the lead in recruitment, referral, enrollment, scheduling, data collection and evaluation. The construction expertise in incorporated as detailed throughout this section of the resource guide.

"We love being in on the aging in place work. We think it is so important. To Habitat staff who are used to working in partnership and have a person-centered mentality, it's an obvious fit. We have a large aging population here in Philadelphia. There's a lot of older housing stock and need for this work."

— Emily Lucas, program manager, Philadelphia Habitat for Humanity

Readiness checklist

Here is a checklist of what should be in place before this type of program is launched. Most of these processes are discussed in the Partnership section of this guide:

- ☐ Prior experience in doing repairs and working with older adults.
- ☐ Repair policies that define mission, scope and program parameters with buy-in from the board of directors. (See Appendix 3 for a checklist of policy considerations.)
- ☐ Finalized program design; completed logic model and evaluation process (see pages 16-18).

- ☐ Organizational structure in place, taking into account staffing needs, budget/true costs, market analysis (see page 16).
- ☐ Identification of a health care partner and establishment of agreements/contracts (see pages 25-28).
- ☐ Understanding of the expertise and role of the health care professionals (see page 44).
- ☐ Identification of funding and setting of agreements in place (see page 29).
- ☐ Understanding of the implications of HIPAA, if any (see page 10).
- ☐ Staff training to understand the role of the health care partner and a person-centered approach.

For construction teams, a person-centered program model that includes health care expertise requires a shift in thinking and a willingness to include a different perspective in determining the project's scope. This section will explore what that means and how it has been achieved in various Habitat locations. As in the previous section, best practices and practical recommendations will be shared from the CAPABLE implementation in Denver and from other Habitat locations with experience in providing the construction expertise in coordination with a health and human services provider. The tools and templates that have been developed over the past five years will be helpful in implementing the construction aspect of integrated health and housing program models.

TYPICAL HABITAT INTERVENTIONS

Habitat construction teams typically focus on these three types of interventions to improve durability, energy efficiency, water intrusion issues and structural repair needs:

HOME PRESERVATION	WEATHERIZATION	CRITICAL HOME REPAIR
Home preservation: Exterior work that includes painting, patching, minor repair, landscaping and replacement of exterior building materials for maintaining good or sound condition.	**Weatherization:** Work done to improve the energy efficiency and indoor air quality of a structure. The scope of work of a weatherization project is defined by a comprehensive energy audit and on testing the home upon completion. It should include a homeowner education component.	**Critical home repair:** Extensive interior or exterior work performed to address health and safety issues or code violations. Critical home repairs include such activities as changing or repairing materials or components; reconfiguring a space; making a modification for accessibility; or installing or extending plumbing, mechanical or electrical systems on an existing structure.

How to use this guide

Part 2: Construction Implementation

Having navigated the process for identifying and developing a health care partnership, the next step is to implement the program in collaboration with your partner. Part 2 of this resource guide provides practical recommendations, templates and timelines for operationalizing a person-centered, integrated, holistic home modification program. Many of the best practices, how-to guides and tools carry forward the case study from Metro Denver Habitat for Humanity in their implementation of CAPABLE.

WORKING WITH HEALTH CARE PROFESSIONALS	WORKING IN THE HOME OF AN OLDER ADULT	CONSTRUCTION MANAGEMENT BEST PRACTICES
• **Roles and responsibilities:** Explanation of the expertise and consulting role of an occupational therapist, or OT, in helping the client set goals; overview of the working relationship between the OT and the construction team. • **Decision-making:** Description of the parameters and process for determining the scope of work. • **Communication:** Best practices in clear communication, including record-keeping and documentation, for efficient problem-solving, scheduling and teamwork. • **Scheduling:** Overview of the CAPABLE schedule and timeline. • **Ongoing training:** Best practices in training new staff members and volunteers.	• **Building trust:** Best practices in spending quality time to listen, understand the concerns of the client, and maintain a person-centered approach. • **Managing expectations:** Recommendations for being clear with the homeowner about the budget parameters and decision-making for the scope of work. • **Elder abuse and hoarding disorder awareness:** Definitions and descriptions for identifying these situations in the home; recommendations on how to respond; screening tools for hoarding disorder. • **Self-care:** Recommendations and resources for maintaining health and managing stress.	• **Program management:** Best practice recommendations for program development for growth and sustainability. • **Staff management:** Best practices in training and equipping staff to work in homes of older adults and with health care professionals. • **Budget management:** Best practices in time management and tracking total costs by project for continuous improvement, fundraising and financial sustainability. • **Materials management:** Practical tips for developing efficiency and standardization in ordering and inventory of project materials. • **Project timeline for CAPABLE:** Step-by-step project timeline used by Habitat for Humanity of Metro Denver for the implementation of CAPABLE.

Working with health care professionals

Information in this section was supplied by Amanda Goodenow, the CAPABLE program manager and an occupational therapist with the Colorado Visiting Nurse Association in Denver, Colorado, and Kiersten Kelley, repair manager for Habitat for Humanity of Metro Denver.

Why this is important

Effective teamwork is key to the success of an integrated health and housing program. The professionals who are interacting with the client must demonstrate mutual respect, understand their roles and establish efficient procedures in order to implement the program seamlessly while communicating clear and consistent messages to the homeowner, caregivers and family members.

Key facts: Best practices in working together

- Clear roles.
- Mutual respect and collaborative decision-making.
- Regular and consistent communication (monthly calls).
- Consistent messaging in communicating with the client and setting expectations.
- Efficient use of tools (the work order) to facilitate communication.
- Coordinated scheduling and timeline in supporting the client.
- Training as new staff members are brought into the program.

What is an occupational therapist?

Outside of the health care sector, many have never heard of an occupational therapist, or OT. The role of an OT is important to a program like CAPABLE. The construction manager or handyperson will most frequently interact with the OT, who assesses the functional abilities of the older adult, helps articulate the goals and writes the construction work order.

In simplest terms, an occupational therapist helps people who are experiencing physical or cognitive difficulties participate in the things they want and need to do. An OT may help a child with disabilities participate fully in school or help an individual recovering from an injury to regain skills and independence.[19]

In working with older adults, an OT most often supports activities of daily living, or ADLs, which include dressing, bathing, eating and toileting, or with instrumental activities of daily living, or IADLs, which include housekeeping, meal preparation, shopping, medication management, and using the telephone or computer. These activities are the "occupations" of daily living that contribute to the health and well-being of an individual. An OT has the ability to observe and analyze movement and the physical stress or risks that may occur as the individual interacts with their environment. In other words, an OT is assessing the ability to perform tasks or activities within a particular environment. With this training, an OT can assess the living environment, make suggestions to prevent falls, and recommend assistive devices that will help in adapting and maintaining independence.

By its very nature, occupational therapy is person-centered. As explained in the American Occupational Therapy Association website, "occupational therapy practitioners ask, 'What matters to you?' not 'What's the matter with you?'"[20] An OT starts with the premise that the

> *"In OT school, you analyze tons of activities and write it down on paper. Literally it's drilled into your brain how to do activity analysis without even thinking about it — the muscles used in doing the movements and the planes being moved through. It's amazing how you almost forget you're doing it."*
>
> **— Amanda Goodenow**

individual is an expert on himself or herself. The older adult knows which activities are the most important to independence and well-being but might not be aware of how to make their living situation safer and less stressful. That's where the expertise and coaching of an OT are helpful.

In a medical setting, the occupational therapist is providing what is considered "skilled" care and is working under the order of a physician. In the CAPABLE program, the OT is delivering non-skilled care and assumes the role of a consultant. Rather than "telling" the patient what they should do, the OT uses motivational interviewing. By asking open-ended questions and listening carefully to the responses of the client, the OT establishes a dialogue that leads to brainstorming and mutual problem-solving.

"We're not treating the diagnosis; we are treating the person. When I'm looking at someone with a stroke, we're going to focus on how that stroke has affected them, and we're also going to focus on how to increase their independence and be safe with their daily occupations of dressing, bathing, toileting and also their leisure activities."

— Amanda Goodenow

Roles and responsibilities

In a cross-sector program model, traditional roles shift for both the health care professional and the construction expert. The OT is working in a consultative role rather than providing skilled therapy with the oversight of a physician. Construction teams who are accustomed to identifying and repairing structural problems in the home are focused solely on home modifications, based on the goals of the client.

The OT consults with the client to brainstorm solutions and takes the lead in determining the types of modifications that will address the client's goals. With specialized knowledge, the OT also takes the lead in explaining to the client how the home modifications will support the functional goals and addresses any concerns.

The construction expert advises the OT on any structural limitations in the home and what materials will work best and completes the modifications in a timely way so that the OT can continue working with the client in the new environment. As a best practice in the Denver program, the construction expert explains to the client and/or homeowner what the construction work will entail before it begins, then asks the homeowner to sign off on the scope of work. If concerns come up during that process, the OT is brought back into the discussion to address any additional questions and approve any changes if necessary.

Decision-making

To a large extent, decisions on the scope of the project are determined not only by the client's needs and goals but also by the budget and donor requirements. Guidelines are necessary to determine priorities and apply them fairly to each situation. In the Denver CAPABLE program, construction decisions follow three guidelines:

- Effectively support the client's goals.
- Focus on safety and fall reduction.
- Meet the construction budget for the project, which is set by the donor agreement.

Both the OT and the construction expert assess the fall or trip hazards in the home, each from their own perspective. Since the client's goals are the priority, the OT is the final decision-maker and explains to the client how and why the modifications will support the goals.

In any integrated, person-centered housing and health program model, when weighing the cost and benefits of how the budget dollars should be spent, two considerations are uppermost:

1. **The priorities of the homeowner or older adult client.** The greatest long-term impact will be those modifications or repairs that are the highest priority to the older adult and therefore the most important to their health, well-being and peace of mind.
2. **The overall needs and relative benefit of each intervention.** For example, if all of the budget is spent on a ramp, then there won't be funding for less expensive but

"The older adult doesn't realize right away that we are letting them make the decisions and partner with problem-solving. That happens down the road. What they realize at first is that we let them talk and we listen. We aren't talking over or around them. We are talking to them."

— Amanda Goodenow

impactful modifications such as grab bars, railings or extra shelving for cabinets. Only one area of need will have been addressed versus multiple areas.

Communication

Clear and consistent communication is essential, including communication within the cross-sector team and with the client. Regular calls between the health care professional and construction team are very important. In the Denver partnership, Amanda and Kiersten have a set time every month to talk about the client list, discuss the status of the modifications, talk through the pipeline, and check on the timeline required to meet the expectations for each grant.

Managing expectations and keeping messaging with the client consistent are very important and are the responsibility of both the OT and the construction expert. It is important for everyone to communicate consistently. In the Denver program, the OT is the primary point of contact in working with the client and discussing the recommended modifications. The Denver team is always clear with the client that the construction recommendations are subject to the review of the construction team. For example, the OT and the client might want a grab bar in a particular location, but there may be many reasons why a grab bar cannot be installed in that exact spot. Budget constraints also can prevent modifications on the list from being done.

An important communication tool for the team is the work order or scope of work. A sample work order can be found in **Appendix 4**. In Denver, the work order is filled out by the OT after the goals have been set by the client and the necessary modifications have been discussed. Along with the list of modifications and assistive devices, the Denver team has made these additions to the work order:

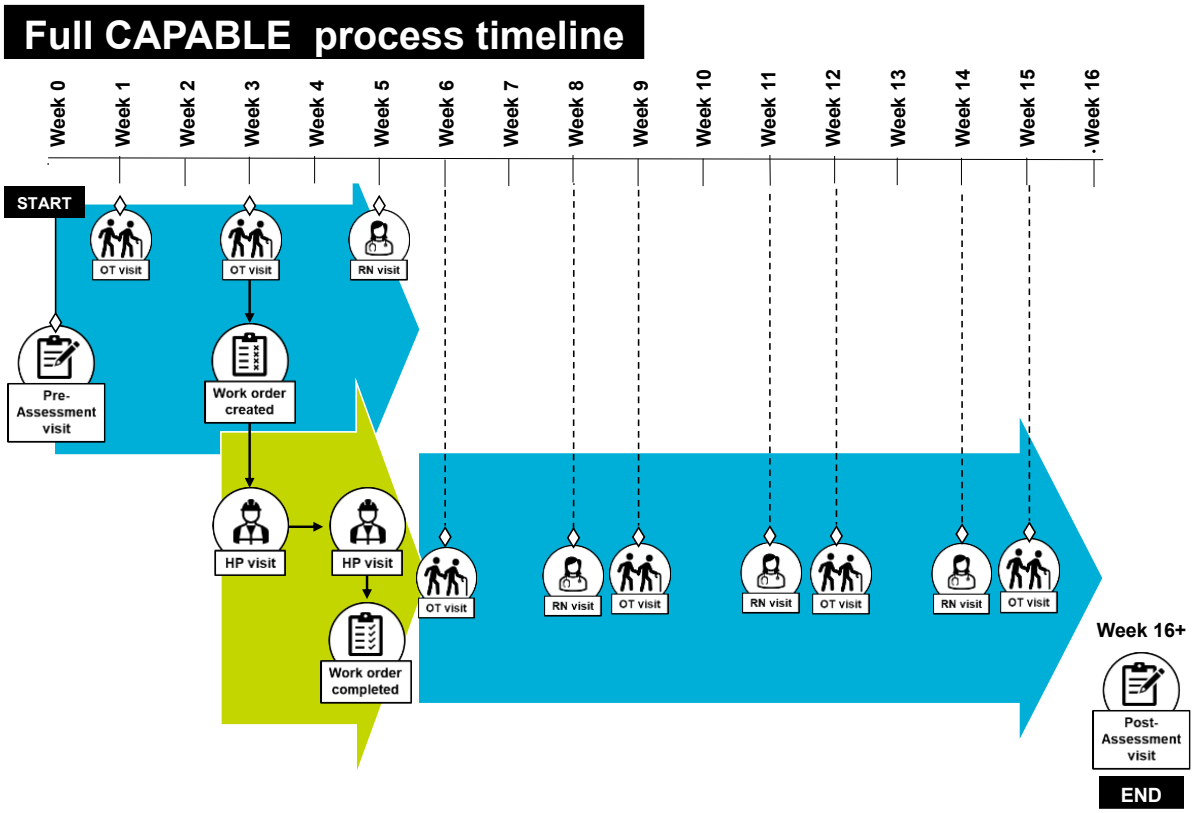
- Adding client goals so that the construction expert knows the reasons for the modifications or assistive devices being requested and understands why the interventions should be completed on a timeline to support achievement of the goals.
- Providing a summary of the situation in the home so that the handyperson has a better understanding of the family dynamics before entering the home.
- Including two signature lines where the client will sign the work order before the construction starts and also after it is completed. This process helps clarify client questions about how the modification will help meet goals and how the construction is prioritized. The handyperson goes through each line with the client to confirm and clarify the work that will be done before starting so that any questions are addressed before the work starts, making sure that the client is comfortable and not overwhelmed by the changes.
- Conducting an evaluation of fall risk (low, medium or high) in order to prioritize getting work done. The handyperson also may notice something that the OT missed in the home assessment, since each member of the team is assessing from their own perspective. Different eyes see different things.

"The client's perspective is always the top consideration. The team must stop thinking about what they think is important and start thinking about what the client thinks is important. It is difficult. As professionals, each member of the team has their own idea of what should be done to increase health and safety of the older adult, but if the intervention is not significant to the client, then it's not going to have the desired impact."

— Amanda Goodenow

Scheduling

Another shift for construction teams is scheduling to accommodate the consultation process of the health care professionals. Successful outcomes often rely on a consistent timeline that includes the client's ability to adapt to the modifications as they are completed. For example, in the CAPABLE program model, the timeline for the OT and nurse visits is integrated with the construction intervention, as illustrated in the sample process map from Denver on the next page.



Ongoing training

As a best practice, Metro Denver Habitat for Humanity provides ongoing training for new construction staff and volunteers. One important part is a Q&A session with the OT to ensure understanding of the OT's role in working with the client. This gives the construction team a better perspective when looking at the work orders and increases their ability to understand the reasons for the modifications. Another best practice is "a ride-along" with the OT to walk through critical steps and understand how priorities are identified from the OT perspective.

HOUSING PLUS STRATEGY

Roles: In broader Housing Plus strategies, the health care partner and construction expert meet with the homeowner or older adult client to conduct a holistic survey that includes both an assessment of the functional abilities of the homeowner and the structural needs of the home. Modifications needed for mobility and fall prevention are documented by the health care professional, with an equal voice given to the structural issues identified by the construction expert. Both professionals listen to the needs of the older adult and observe how the older adult functions within the home.

Decision-making: Decision-making is a collaborative process based on the assessments of the health professional and the construction expert. Options are explored with the older adult to determine what will be most impactful and helpful within the parameters of the budget.

Assessment tools in appendix:

- Home Assessment Guide, sample from Habitat for Humanity Philadelphia
- Home Assessment Condition Standards: minimum, elevated, preserving for years
- Home Assessment, minimum standards

Frequently used older adult assessments

- ADLs: Katz Index of Independence in Activities of Daily Living (alz.org)
- IADLs: Lawton-Brody Instrumental Activities of Daily Living Scale (alz.org)

Working in the home of an older adult

Why this is important

Working in someone's home means entering a very personal space. Home modifications that improve safety and mobility are by definition in the areas of the home that are used most by the client. These changes to the home environment are important and significant — and they can be intimidating. It is important to invest time in building the relationship with the client and establishing trust.

It is also important to be aware of conditions within the home or with the older adult that will require special attention and care. Included in this section is basic information about hoarding disorder and elder abuse. Anyone who is working with older adults has an obligation to be aware of these problems, to be familiar with the facts, and to know how to seek help.

Regardless of the situation, approach every client interaction with respect and understanding.

Key facts

For most projects, construction staff members will make two or possibly three visits to the home. During those visits, the following important tasks need to be accomplished:

- **Build trust with the older adult:** Establish a respectful and personal connection with the homeowner and residents so that they feel comfortable with your presence and understand that they are in control of final decisions on any changes to the home.
- **Perform the construction assessment:** Walk through the home to take measurements, assess structural issues and note any other needs that should be addressed for the project (or in the future).
- **Finalize the work order (or scope of work):** Based on the modifications that have been recommended, determine whether adjustments need to be made (because of structural issues or budget constraints) and review construction plans with the homeowner/client.
- **Schedule the construction day and complete the project.**

Building trust

When you enter the home, prioritize relationship-building with the client. Make time to listen and empathize with the concerns of the client. Focus on interacting with the client and direct all questions to the client. Even if a family member or caregiver is nearby and answers the questions, involve the client in the conversation as much as possible. If language translation is required, maintain eye contact with the client.

Based on their experience in working with older adults, Crystal Spears, community outreach director for South Palm Beach Habitat for Humanity, has put together this list of best practices for building trust with the older adult homeowner:

- Know the demographic and community you serve.
- Genuinely get to know the homeowner.
- Follow the homeowner's pace when entering the home.
- Listen with sympathy/empathy.
- Address any concerns openly.
- Communicate the timeline and changes as necessary.

"Spend time listening; it's an investment, not a waste. Even if the story they're telling has nothing to do with the tub cut, it has everything to do with who they are and why you are there. And for many construction experts partnering with CAPABLE, this interaction is the most rewarding part of the work. Enjoy it."

— Kiersten Kelley

Effective communication, transparency and managing expectations are the keys to building trust and establishing confidence that the construction changes will help the older adult resident maintain independence and safety.

The home visit

Ideally, two construction team members should visit the home together. Construction team members should not enter the home alone, and more than two might overwhelm the client. It is helpful to have one person take notes, measurements and photos while the other staff person engages with the client. The second team member could be a volunteer or AmeriCorps member who is interested in learning more about working with older adults.

- Review all work order (or scope of work) items. Walk around the home to look carefully at each location and take measurements. Be sure to take detailed notes and photos, if possible. Ask the older adult/homeowner for permission before taking photos.
- While in the home, assess any safety concerns or structural problems.
- Review the list of recommended modifications (or repairs) with the client. Ask the client if they have any concerns.
- If appropriate, conduct any initial surveys that are being taken to capture demographic information or other data that will be used to evaluate the program.
- Review the construction process with the client.
- Finalize the scope of work.
- Schedule the installation and any future visits with subcontractors (if necessary).

Managing expectations

Many older homes will have numerous maintenance and structural issues that are a concern to the homeowner. For those who are trying to manage on a fixed income, the opportunity to have a construction expert in their home may raise expectations that are out of the scope of a home modification program. Managing those expectations from the start is very important in order to maintain trust and avoid disappointment. Here are some best practices from the Denver experience:

- Use clear, consistent language that aligns with explanations from the occupational therapist on the factors that determine the scope of work and purpose of the program, including:
  - Modifications and assistive devices that support the client's goals.
  - The budget for the project, as determined by donor agreements.
  - Safety and fall prevention.
- Explain the program's budget limitations and that your work will focus on making functional adjustments and home modifications.
- Consider using a title that will indicate your role in doing small adjustments rather than a large construction project. For example, a handyperson or handy worker may be a better descriptor than construction specialist, construction supervisor or contractor, which implies a larger project.
- Share photos of common modifications to give the client an idea of what the finished product will look like when completed. As a best practice, Kiersten has put together a photo book of common modifications. Showing a photo of a tub cut, for example, helps the older adult visualize the change and understand better how their life will be improved.
- **Tool in appendix**: **Photos of common home modifications from Habitat for Humanity of Metro Denver**

"It's tough on a construction team to stick to the work order when we so often want to do more for our clients. Make it clear to clients early and throughout scope development that the handyperson is there to perform the work order and that is all."

— Kiersten Kelley

INTEGRATING CRITICAL HOME REPAIRS

Depending on the part of the country and age of the housing stock, many homes of older adults have serious repair needs, including roof repair, plumbing, HVAC system replacements and more. In implementing CAPABLE, Habitat affiliates have piloted a variety of ways to integrate critical home repairs. Depending on funding and the extent of repair needs, two approaches are emerging as best practices:

1. Offering homeowners the opportunity to apply to the affiliate repair program once CAPABLE implementation is complete.
2. Identifying and completing the critical home repair before the CAPABLE program starts.

Regardless of the approach, it is important to be clear about the parameters of CAPABLE and/or the repair program and manage expectations. In addition, the timing of the critical home repair should not interfere with the schedule of the occupational therapist and the nurse working with the client and should accommodate the modifications that are supporting the client's goals.

Elder abuse and hoarding disorder

Why this is important

According to the National Center for Elder Abuse, or NCEA, approximately 1 in 10 adults over the age of 60 and living at home experience some sort of elder abuse.[21] Hoarding disorder occurs in approximately 3% to 6% of the population, impacting 1 out of 20 homes.[22] Anyone who is working with older adults is obligated to be aware of both of these problems, to be familiar with the facts, and to know how to seek external help, if necessary.

Elder abuse: Key facts

The NCEA says elder abuse includes physical, sexual, psychological and financial exploitation; neglect; and abandonment. Victims of neglect are usually older women who are cognitively impaired or socially isolated, and the most common form of elder abuse is financial. Perpetrators represent a wide variety of individuals, but usually they are spouses, adult children, other relatives or caregivers. Most cases go unreported.

Experts say elder abuse occurs in the absence of strong social supports. The following factors create an environment where abuse can take root and flourish:

- Social isolation.
- Lack of access to support services and community resources.
- Physical, mental or emotional needs in carrying out daily activities.

Awareness of the problem, education and strengthening of community connections are ways to prevent elder abuse and foster a strong society where all individuals, regardless of age or ability, are valued and treated with respect.

What to look for

Identifying elder abuse can be challenging, since common age-related changes can mask the abuse. For example, older adults bruise easily as their skin becomes thin and capillaries are fragile. A loss of bone density can make older adults more prone to fractures. Memory and reaction time are slower, and many older adults experience sensory loss (e.g., hearing, seeing, ability to feel). It is possible, however, to learn signs of elder abuse through tactful questioning, listening and observing.

Potential markers include an unkempt appearance, poor hygiene, malnutrition and dehydration. Types of injuries include bruises, pressure sores, fractures and burns, combined with a delay in seeking care. Normal bruising will occur mostly on the extremities — the arms and legs. If asked, most older adults will not remember how or when they got the bruise because they might not have even noticed when it happened. Abusive bruises are larger and in multiple areas, including around the face and neck. If the older adult offers an explanation about how they got a large bruise on the face or neck area, that is a red flag.

Emotional behavior signs include increased fear or anxiety, isolation from friends and family, withdrawal from normal activities, unusual behavior or changes in sleep patterns, and a tense or fearful relationship with a family member or caregiver. Signs of financial abuse include unpaid bills and sudden changes in spending patterns.

What to do if you suspect elder abuse

Creating a set of policies and procedures that can be followed if abuse or neglect is suspected helps to provide a framework for responses. Here are some action items, based on recommendations from the Nutrition and Aging Resource Center:

- Speak with your immediate supervisor about the situation to determine if additional actions or advice from an expert is needed.
- In appropriate circumstances, engage the older adult in a private conversation about how things are going and whether they would like any help to improve the situation.
- Review rules about what kinds of cases Adult Protective Services, or APS, investigates in your state. You may need to contact local APS if your state law requires mandatory reporting for your organization. In many states, health care providers and social workers are mandated by law to report instances of elder abuse. Referral to APS, especially without the consent of the older adult, should be considered a last resort.
- Facilitate a meeting with a specialist in elder abuse and neglect to assess concerns and create a plan of action.[23]

One potential source of expertise is your local Area Agency on Aging, or AAA. Most AAAs have elder abuse on their radar and have experience in working with authorities.

The **Eldercare Locator website** is also an excellent way to locate and connect with resources in your community. The Eldercare Locator is open Monday through Friday, 9 a.m. to 8 p.m. Eastern Time. If an older adult is in immediate danger, call 911.

Adult protective services

The Adult Protective Services mandate is to ensure the safety and well-being of elders and adults with disabilities. The agency offers the following services:

- Receiving reports of adult abuse, exploitation or neglect.
- Investigating these reports, case planning, monitoring, and evaluation.
- Assistance arranging for supportive services.

If Adult Protective Services decides the situation may violate state elder abuse laws, it assigns a caseworker to investigate, usually within 24 hours if it is an emergency. If crisis intervention is needed, they will direct the case to the appropriate services and enforcement. If elder abuse is not substantiated, most agencies will work with other community social and health services to ensure that the older adult receives the care that is needed.[24]

Hoarding disorder: Key facts

Hoarding disorder is a mental health diagnosis that frequently occurs concurrently with other mental health conditions, including depression, anxiety, attention deficit hyperactivity disorder, or obsessive-compulsive disorder. In other words, the hoarding behavior may be indicative of other conditions that make it difficult for the individual to focus, make decisions or categorize information.

It is important to distinguish hoarding disorder from an inability to organize and the accumulation of clutter. Hoarding is a mental health issue in that the individual becomes distressed and emotionally unable to cope with the thought or process of discarding items. The accumulation of possessions and clutter is so extreme that the home becomes unlivable and unsafe.

Some older adults will have a collection of items that have taken over a living space, but it will not create the same level of emotional stress as someone with a hoarding disorder. Individuals with a hoarding disorder require the expertise of a mental health professional who can address the underlying issues and support behavior change.

What to do

- Take photos **only** with permission from the homeowner/older adult.
- Speak with your immediate supervisor about the situation to determine if additional actions or advice from an expert is needed. The **Screening tools** on the next page can help you determine next steps.
- Seek information from local sources. Check the Eldercare Locator if you aren't sure where to start. Many states have websites with helpful resources, and most realize that while hoarding is a public health and safety issue, the solution to a hoarding disorder will need to be multidisciplinary and will take time.
- Facilitate a meeting with a specialist or social worker who can provide support, create a plan for action and contact other agencies, if needed.

Creating a set of policies and procedures can be helpful in providing a consistent response.

COMMUNICATION DOS AND DON'TS

DON'T	DO
• **Don't** use judgmental language, intonation or facial expressions that express disapproval, dismay or discomfort. Don't refer to the items as "stuff," "trash" or "garbage." • **Don't** touch anything without explicit permission**. Don't** make suggestions about discarding items or argue with the person. This approach will result in defensiveness and withdrawal of trust.	• **Do** be respectful of the older adult and listen carefully to match the person's language. For example, if the older adult refers to "my things" or "my collections" then refer to the possessions as "your things" or "your collections." • **Do** use encouraging language and acknowledge any positive aspects that may be contributing to safety and mobility. Focus on safety.

Screening tools

These screening tools can be used as an initial assessment to gauge the seriousness of the issue. To diagnose a hoarding disorder, it is important to have the input of a professional who is trained on these screening tools.

CLUTTER IMAGE RATING

This scale, published by Oxford University Press, can be used to assess the degree of severity that exists in the home. Photographs that progressively increase in severity provide a way to compare and determine if the older adult is a "collector" or has a mental health problem that will need professional intervention. Boston University has created a free phone app for the Clutter Image Rating: Clutter Image Rating on the App Store (apple.com).

HOMES MULTIDISCIPLINARY HOARDING RISK ASSESSMENT

Developed with the Massachusetts Statewide Steering Committee on Hoarding, this assessment provides an initial measure of level of risk through a visual scan of the home environment combined with a conversation with the older adult or homeowner. Categories of assessment include heath, obstacles, mental health, endangerment and structure.

UNIFORM INSPECTION CHECKLIST

Developed by the Center for Hoarding and Cluttering, this assessment, also known as UIC, takes a harm reduction approach by applying minimum safety and sanitation standards to the living environment. The checklist is very concrete and specific so that the homeowner understands the basic criteria for health and safety in the home. This link explains the UIC and the approach of harm reduction, including a helpful video: Uniform Inspection Checklist – Center for Hoarding and Cluttering.

Self-care

Key facts

Managing difficult situations can be stressful. In addition to situations like elder abuse or hoarding, COVID-19 has increased anxiety and social isolation for the older adult. Family situations may be strained or in transition. Depending on the program model, the construction team may be in the home to manage very specific modifications without the resources to address all of the potential repair needs.

It is important to be intentional about taking care of staff well-being. Here are some well-worn and proven tips for self-care:

- **Talk to someone.** If you have had a stressful or confusing interaction with an older adult homeowner, family member or caregiver, talk to your supervisor or a trusted colleague and seek a solution that is in the best interest of everyone.
- **Exercise.** The World Health Organization recommends 150-300 minutes of moderate-intensity aerobic physical activity a week for all adults. Physical activity improves overall well-being; reduces symptoms of depression and anxiety; and enhances thinking, learning and judgment skills.[25]
- **Eat a healthy diet.** Enjoy green, leafy vegetables; fruits; nuts; and legumes. Avoid trans-unsaturated fatty acids found in processed foods; also avoid sugar and foods with a high salt content.

- **Sleep seven to eight hours every night.** Exposure to sunlight during the day, following regular sleep routines, and sleeping in a darkened room will support healthy sleep patterns.
- **Intentionally seek healthy ways to relax and spend quality time with family and friends.**

Our health care partners have more experience, more training, and intentionally integrated support systems for this aspect of the work. Nurses and occupational therapists are exposed to these issues more frequently and have access to support resources. Reach out to your health care partners about their best practices for emotional support and self-care. Reach out to your human resources team and your insurance provider to see what resources are available. Mental health is often dismissed and stigmatized in the workplace, and this may be especially true in the construction industry. Recognize these issues and be proactive in using available resources.

Finally, find time to be grateful for the large and small blessings in your life. For more explanation, spend 12 minutes listening to this TED Talk: **Shawn Achor: The Happy Secret to Better Work**.

RESOURCES

- **National Center of Elder Abuse**: Funded under the Administration for Community Living, the NCEA works to increase awareness, provide resources and improve the ability of individuals in the aging network to identify elder abuse and take action. A wide variety of resources are available, including fact sheets, training materials and research on elder abuse.
- **Clearinghouse on Abuse and Neglect of the Elderly**: Located at the University of Delaware and a partner of NCEA, this is the largest digital library of published research, training resources and government documents on elder abuse.
- **Pass It On**: A fraud education campaign hosted by the Federal Trade Commission to prevent scams, including identity theft, health care scams and home repair scams.
- **National Center on Law and Elder Rights:** Funded under the Administration for Community Living, NCLER works to increase awareness, provide resources and assist with information for attorneys and professionals working with older adults.
- **Eldercare Locator**: Locates resources in your community. The Eldercare Locator is open Monday through Friday, 9 a.m. to 8 p.m. Eastern Time. If an older adult is in immediate danger, call 911.
- **International OCD Foundation:** Includes basic information on obsessive compulsive disorder and similarities and differences with hoarding disorder.
- **Center for Hoarding and Cluttering:** Provides training with certification for professionals in diagnosing and treating hoarding disorder, works to dispel stereotypes, and provides other tools and resources.
- **American Bar Association's Commission on Law and Aging**: Works to strengthen and secure the legal rights of older adults through research, policy development, advocacy, education, and consultation with lawyers and professionals working with older adults.

Construction management best practices

Why this is important

Effectively developing and scaling a new program is challenging even as it opens up opportunities to serve a target group in a new and important way. This section outlines critical systems and tools that will need to be in place in order to effectively manage the construction projects that are such an important part of programs like CAPABLE and other cross-sector programs that require careful attention to donor requirements, reporting and budgeting.

Key facts

In the start-up of any new program, keep the future in mind as you build processes and practices that will be scalable for potential future growth. A new program is often relegated to one person who will likely set up systems and processes that work perfectly *for that one person*. If and when the program grows, it can be difficult to transition those specialized, personal systems into a program management system ready to efficiently include other staff members and volunteers. Each of the program management topics below includes best practices for establishing the initial program and preparing for its potential growth.

PROGRAM MANAGEMENT

- Incorporate systems already in place from your repair program.
- Plan for future growth as you think through systems and processes.
- Work with partners to align systems and ensure necessary information is captured from the beginning, like demographics and other data for evaluations.
- Document everything, especially costs and staff time.

STAFF MANAGEMENT

- Consider rotating staff members from other construction programs, if possible.
- Prepare the team with an orientation program and clear instruction guides.
- Equip your team with the right tools — not only construction tools, but also policies, standard procedures and emergency protocols.

BUDGET MANAGEMENT

- For small projects, like modifications, budget management is especially crucial, particularly in terms of tracking the time that the staff is spending on each project.

MATERIALS MANAGEMENT

- The key is simplicity and consistency. Have a standard, default product type and source for all the common modifications.
- Start with product recommendations from your health care partner.
- Document what you've learned as you produce your own standardized product list.
- If possible, buy the standard products in bulk.

Program management

Each project is limited by its budget. The efficiency of the program management is an important factor in the number of modifications that can be completed for each client within the budget. Developing systems that will grow with the program is the key to efficiency and sustainability. Here are some best practices and tips to get started.

1. Don't start from scratch; adapt the systems you already have. Successful program development relies on efficiency and consistency. If you have an owner-occupied repair program, use the systems within that program as a starting point. As the program grows, future support staff and volunteers will already be familiar with tools, spreadsheets and billing processes. If you don't yet have a repair program, match some of the systems in your existing construction program.
2. Develop with your partners. The sustainability of an integrated program model that serves low-income older adults depends on continuing partnership and complex funding sources. Consider the needs of your partner and donors as you develop systems that will be both flexible and efficient. Include input from key stakeholders right from the beginning. For example, if your funding source has specific requirements for collecting client demographics or the number of people in the household, who will be responsible for collecting that information, the construction team or the health care partner? If that's your team's responsibility, how should the information be collected, and when? Will you need a separate survey, or can it be built into your scoping process? When the funding source changes or new ones are added, how will you identify new requirements for tracking client demographics, and how will you incorporate them into existing documents and processes?
3. Set the expectation that program evaluation will be an important part of continuous improvement and that it will be collaborative. After an initial pilot period, get the team back together to review the pilot, identify the greatest successes and any areas for improvement, and make those improvements as a team. Whenever new funding sources are added or new partners join the process, gather the stakeholders for another collaborative evaluation and improvement session.
4. As you develop your new program, document everything you do, everything you learn, and everything you change and improve. The more you document, the more opportunities you have to learn and make gradual improvements. Document each task, who does it, and how each task is done. This process also helps with future growth and turnover. When new staff members join the program, you have efficient, effective training resources ready to use.
5. Pay special attention to recording all project-related costs. The true cost of the program should guide your decisions in effectively scaling the program and bringing in new donors. Begin recording all material costs and staff time spent on each project, right from your first project. Which specific products are you using, and from which suppliers? Can you get a better product for the same price? Can you get the same product at a better price from a different supplier? If you're consistently using the same products, can you get a better per-unit price if you buy in bulk? Does one version of a product require twice as much staff time to install? Does one version require two visits instead of one because the preparatory step requires drying time? The products and processes you use should evolve and improve as you build and grow the program. The decisions should be based on data, and data depends on documentation.

PRO TIP:
USE PROCORE.

Through the Donated Product partnership, affiliates can obtain free access to the ProCORE project management platform. One affiliate uses this platform specifically for the collection, organization, sharing and archiving of project-related photos. The platform is highly mobile and customizable, and dedicated support is available to help affiliates set it up and use it effectively.

Staff management

1. Develop your team through staff rotations. Establishing a process to rotate staff members and volunteers through the new program from other roles, like new construction or traditional repairs, provides a new experience for staff members and helps in identifying individuals whose skills and interests match the program's needs. Some individuals may be good at efficiently implementing modifications, which is critical for maximizing impact within a limited budget. Others may be naturally empathetic, with interpersonal skills that are a good fit for the person-centered approach. Rotation also offers professional development through expanded skills and a more diverse understanding of all construction programs and their impact. Career paths like occupational therapy wouldn't normally have clear overlap with construction experience, but cross-sector programs like CAPABLE offer great opportunity for future professionals to gain field experience.
2. Prepare your team. Orientation programs with clear instructions and guidelines are critical starting points for preparing new program team members. These documents will be easier to develop if you have been proactive about documentation in the program start-up. As your program grows, shadowing can also be a very effective approach to training staff members and volunteers for the home visits and modification aspects of the program. If you send handy people in pairs for both types of visits, you can easily pair more experienced team members with newer program support. This on-the-job training, both in terms of practical construction skills and the interpersonal customer interaction, is critical. New team members can start by being the "extra set of hands" on projects, then progress to performing modifications under supervision and transition into assisting on budgets and work orders. Eventually, these individuals will be ready to take on leadership of projects and train the next incoming team members. Modeling behavior is especially important not only for learning how to do the modifications, but also for seeing good examples of client engagement, understanding the client-centered approach, and solving problems.
3. Equip your team with the right tools — not just tape measures and extra grinding wheels, but also documents, standard operating procedures, emergency action plans and other program resources. The tools that support effective project and program management include standard operating procedures for document collection and management and instructions built into each spreadsheet or template.

A list of documents and tools recommended by Habitat of Metro Denver is in **Appendix 7**.

Budget management

Because of the smaller scale of most construction budgets for modifications, careful management is particularly important for sustainability and impact. A project coming in $100 over budget can be a problem, especially if such overruns become common.

Budget management is directly tied to time management. For smaller modification projects, time management is much more detailed compared with other types of construction projects. In new construction we count time in weeks. For repairs we count days, but for modifications, we are counting each hour spent on a project. Successful time management relies on two things: accurately counting the time spent and accurately assigning cost values to that time.

Before you begin, develop an accurate and consistent way to quantify your labor costs, including administrative time to support the program, general overhead, staff salaries and benefits. The staff and overhead costs are important for accurate construction cost analysis across all programs, but it's especially important for this type of program because of the prevalence of fee-for-service models within funding sources and the need to include program costs in grant applications.

For these reasons, it's critical to accurately document the actual time spent by all team members supporting the program implementation. You can't accurately forecast program costs for the next grant application if you don't count the time you're currently spending. The majority of grants and other funding sources expect to fund your staff time, as long as you can accurately predict and track it. Some donors require detailed documentation of staff time for each project. If the organization is working under a service contract with a fee-for-service model, this type of tracking will be required. The best practice is to begin counting and documenting all time spent right from the first project in order to prepare for all of these needs.

Materials management

The key to successful materials management, especially in terms of supporting accurate budgets and maximized impact, is simplicity and consistency. Have a standard, default product type and source for all common modifications. It takes time to test products and determine which are best for your clients, but the goal as you develop the early program is to establish this list of standardized products. Start with any product recommendations from your health care partners; their experience with specialized products like toilet risers is invaluable. Learn from others implementing similar programs and consider their preferred products based on ease of installation, average installation time and any warranty callbacks. Document what you have learned as you produce your standardized product list.

If you have the capacity to purchase these standard products in bulk, the overall construction schedule is significantly expedited since you don't have to factor delivery times into standard product installations. Bulk purchasing may also create cost savings, depending on your supplier. This practice is best implemented as part of your program growth strategy, after you've tested and vetted your standard product list.

Site safety

Performing construction activities within a person's home while they are living in it presents different challenges to construction safety. Construction tasks have to be adapted to protect residents' health, safety and comfort. Residents and their homes can also present health and safety concerns for affiliate staff members and volunteers. The requirements for safe working conditions need to be established and clearly communicated to the homeowner, older adult client and other family members and residents.

Below are considerations for developing safety guidelines for working in the home:

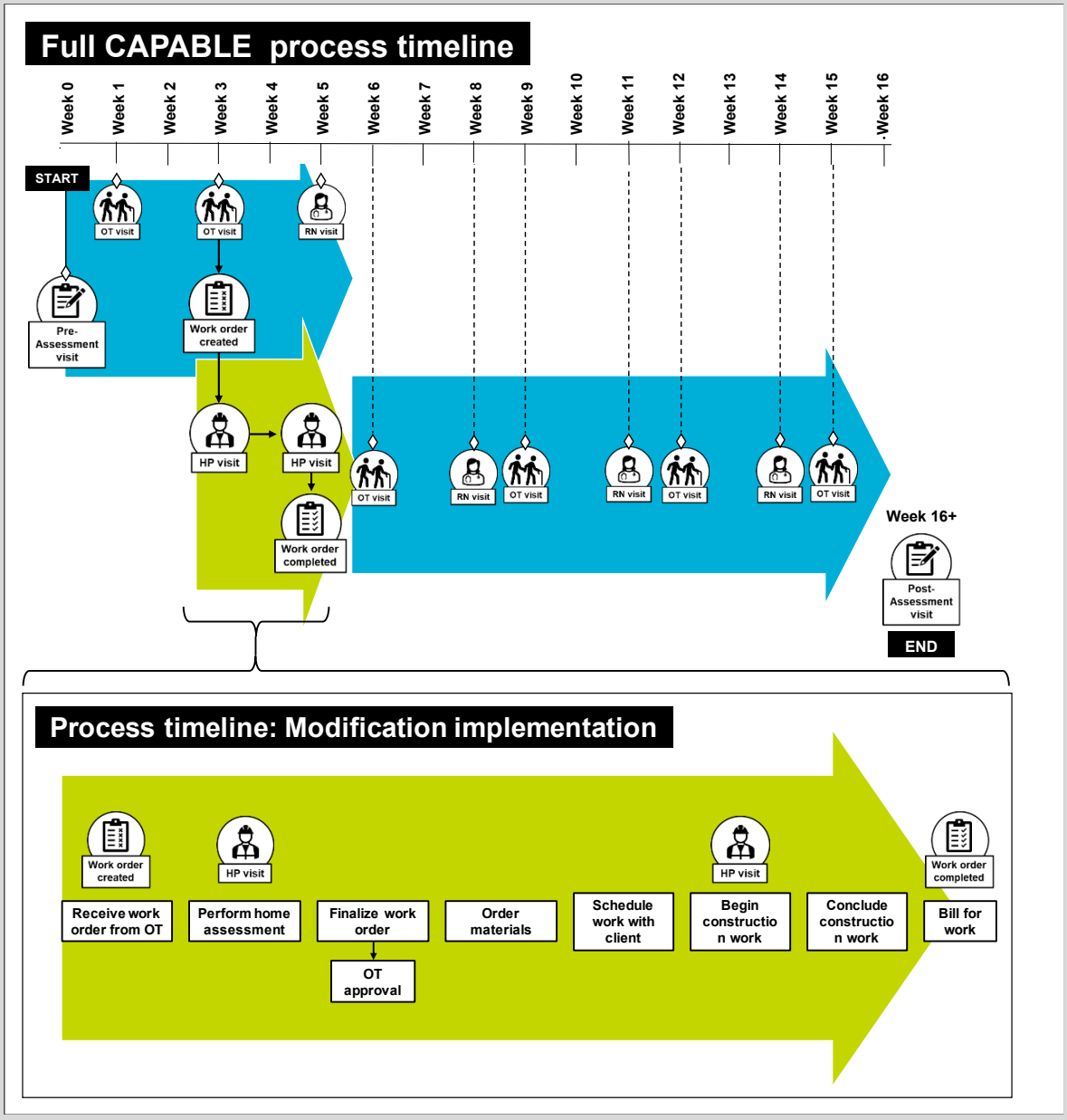
- Are any hazardous materials present, such as lead, asbestos or mold? How are you evaluating home sites for their presence, and what are your mitigation strategies, especially if permanent mitigation is out of scope for the program?
- Are any health concerns present, such as insects, rodents or other pests?
- Are there any pets on the site that could pose a threat to construction staff members or volunteers? What are your expectations for residents' removing such pets from potential contact with staff members/volunteers, and how will you communicate those expectations to residents and enforce their implementation?
- What policies surround conditions in the home that would create an unacceptable or inappropriate work situation, including if a member of the household exhibits threatening behavior, verbal abuse or indecency? Also consider the presence of guns/weapons or any illicit substances.
- Is smoking allowed?
- What is the emergency action plan for construction staff members and volunteers in the event of various plausible emergency situations?

DO WE WARRANTY THIS WORK?

The affiliate best practice is to provide some kind of warranty on modifications. These clients are our partners, just like our repair and new construction families. Habitat for Humanity of Metro Denver provides a one-year warranty on CAPABLE modifications, just like for repair projects. The OT is aware of the policy, and the client knows to reach out to the OT if there is a problem with one of the modifications.

Construction implementation of CAPABLE

This tool provides a detailed outline of the basic process and best practices developed by Habitat for Humanity of Metro Denver for managing a CAPABLE construction project. It provides a sense of the workflow and management process for integrated programs providing modifications as a core component of the work, like CAPABLE.



Preliminary steps:

- ☐ **Pre-assessment survey:** Conducted by someone not involved with the program implementation (i.e., not the OT, nurse or construction partner). A survey at the end of the project evaluates outcomes of the program.
- ☐ **OT visit 1 (evaluation of client activities of daily living and instrumental activities of daily living).**
- ☐ **OT visit 2 (brainstorming with client to establish goals).**
- ☐ **OT creates a work order** based on client goals, in order of priority, and sends it to the construction partner.

Begin construction partner involvement:

- ☐ **Receive the work order from the OT.**
  - Construction partner inputs information into existing client management, budgeting and scheduling systems.
  - Review the work order.

    Best practice: Reach out to the OT if any items on the work order are not immediately obvious to prevent multiple trips to the client's home for the assessment.
  - Construction team schedules the home assessment.
- ☐ **Perform the home assessment.**
  - Approximate time: 1-2 hours.
  - Meet the client and discuss the purpose of the visit and the overall process for modifications.

    Best practice: Perform home assessments in pairs, such as a construction staff person and a construction volunteer. This allows pairing of complementary skills for better customer service. The individual with stronger construction skills can perform the technical assessment and the individual with stronger interpersonal skills can engage the homeowner in meaningful, trust-building conversation.
    - **Tool in appendix: Guidelines for working in the home**.
  - Review all items on the work order and gather all information from the home that will be necessary for the home modification.

    Best practice: Be thorough. It takes less time to gather every measurement that could possibly impact the installation than it does to reschedule a second assessment. Take pictures for future reference, with permission from the older adult client and/or homeowner.
  - Identify any high-priority modifications that should be recommended for the work order. This home assessment is an opportunity for the client to identify and/or request additional items for the work order. It is also an opportunity to conduct a high-level health and safety assessment and make your own recommendations. All of these recommendations go back to the OT to review and approve before assurances are made to the client that these other modifications will be included. All recommended changes are weighed against the client's previously identified goals as the highest priority within the available budget.

    Examples:
    - High-priority health and safety concerns (which are likely to fit within the CAPABLE budget) could include missing smoke and carbon monoxide alarms or open holes in floors.
    - Additional client priorities that may come up outside of their identified goals (which are likely to fit within the CAPABLE budget), e.g., additional handrails, lighting or grab bars.

- Discuss the individual items on the work order, manage expectations, and provide information on the practical application and final appearance of all modifications.

  Examples:
  - What does "tub cut" mean? How is it installed? Can the client select where it goes? What will it look like when complete?
  - What kind of shelves will be installed? Can the client select the height or material? How much finish work will be completed, and what will it look like when completed?
  - What is a toilet riser? What are the different options, and can the client select among them? What do the finished products look like? Can the client remove it if they don't like it?
  - How much time is the modification expected to take? Will it take two visits? Will it be loud or dusty, require subcontractors, or prevent family members from using any parts of the home during installation?

  Best practice: Have photos available from previous projects to show clients examples of how their modification is likely to look.
  - **Tool in appendix: Photos of common CAPABLE modifications**.

- Optional: Evaluate whether the client may be eligible for additional programs within your housing organization, e.g., critical home repair or services provided by community partners, such as energy retrofits.

  Best practice: Have an organization-approved list of related programs and services available to share with the client. Use organization-approved language to manage expectations about eligibility and their responsibility to apply, and make no assurances about the likelihood of eligibility or selection.

☐ **Finalize the work order.**

- Incorporate all notes from the home assessment into the work order to share with the OT, scheduler and construction team.
- Develop the materials list with the estimated cost of each product and create the budget for the project. If the full work order is projected to go over the budget set by the CAPABLE program, identify which items can fit within the budget (based on the priorities established by the client's goals) and which items will not.

  Best practice: Include the full materials list, including any specialty products, in order to increase budget accuracy, provide more accurate expectations to the client, and expedite product ordering in the next step.

- Confirm these priorities and final scope with the OT and get approval.
- Make any necessary changes to the scope of work and send the final work order with a list of modifications to the OT.
- Prepare the work order for internal teams.

Best practices:
- Save the final, approved copy from the OT for reference. Save a new copy that is for your construction team and include all comments and details from the home assessment. Depending on your team's size, capacity, and skills, these should be prepared so that any team member can perform the work, even if they didn't perform the assessment. This flexibility supports the ability to complete modifications within the schedule for best client outcomes.
- Use descriptive language that is accessible to people not involved in construction. If your team uses terms that are different from those the OT uses, include both. If you have another staff member or a volunteer who is scheduling the work with the client, use descriptive language so that the scheduler can explain it to the client.

☐ **Order materials.**

☐ **Schedule the work with the client.**

- **Timing:** The work needs to occur on schedule. For CAPABLE implementation at Denver, construction is generally completed between three to six weeks of the overall schedule, depending on the approval process and material availability. Remember that if the modifications don't occur until later in the process, the client won't have as much time to work with the nurse and OT to practice safely using the modification to reach their goals.

Best practices:
- When scheduling, remind the client of any construction activity expectations.
  - **Examples:** Will it be loud? Will it be dusty? Will there be other subcontractors? Will any material deliveries arrive at the client's home?
- Also remind the client of any standard or specific expectations about the home and/or behaviors.
  - **Examples:** Will the dog need to be locked up? Will the driveway need to be clear? Will the bathroom need to be cleaned?

☐ **Begin the construction work.**

- **Timing:** Construction activities often take between one-half to one full day. If the construction work takes longer than two days, the modification may go over budget because of labor costs. Be careful when estimating the time that construction will take so that it is factored into the budget when the scope of work is decided.
- The most common projects that require multiday visits are exterior projects that include pouring cement for new concrete, such as post holes for exterior handrails or piers for platform stairs. The concrete needs time to cure before the rest of the project can be completed.
- Before beginning work, discuss the full work order again with the client to be sure they understand the work about to be done and still agree with it.

Best practice: Have the client sign the work order before starting work to confirm agreement.

- What happens if they don't agree? Occasionally a client will change their mind on an item on the work order. The client or homeowner is the ultimate approver; if they don't want the work done, we don't do the work.

Best practices:
- Without pressuring the client, clearly communicate that there will not be another opportunity for installation through this program. A return visit will likely make the project over budget.
- If the item is already ordered, consider leaving it with the client so that other arrangements can be made for installation if the client changes their mind.
  - **Example:** Grab bars and toilet risers are not complicated installations, often include helpful instructions, and can be left with a client for optional future installation.

☐ **Conclude the construction work.**

- Verify that all items on the work order are complete.
- If any items on the work order have not been completed, or any issues have emerged as part of the installation, note this on the work order and communicate these updates to the OT for future discussion and resolution with the client during upcoming home visits.
- If any of the modifications include practical changes but don't necessarily include the aesthetic finishes, be sure to discuss this with the client.

Example: Shelves might be installed but not painted.

Best practice: Refer back to the details of the work order and any samples that were shown earlier in the work order development (such as previous projects in the picture book). Reiterate that the affordability of this program depends on minimizing noncritical labor (like painting) in order to prioritize more technical labor (like tub cuts).

- Have the client sign the work order to confirm that the work is complete.

☐ **Bill for the work, as appropriate.**

- Invoicing processes may differ depending on the service agreement or which partner is the owner of the grant or donor funding.

Best practices:
- Invoice documentation should include a scanned, signed copy of the final work order.
- Document and use standard operating procedures for the invoicing process.

After the construction activity is complete:

☐ **The OT and nurse continue to meet with the client**, in alternating visits, to support the client in adapting to the modifications.
☐ **The post-assessment is conducted**.
☐ **The CAPABLE project is complete.**

Part 2 conclusion

To summarize, there are compelling reasons why bridging the health and housing gap is important for nonprofits that are focused on supporting older adults who want to age in place. These reasons include:

- The increase in longevity and the number of older adult homeowners who want to remain in their homes and communities as they age.
- The number of older homes that not only do not have basic accessibility features but also have many hazards that contribute to risk of falling.
- The fact that as people age the incidence of disability increases. Simple modifications can make a big difference in safety and maintaining independence.

The most effective response will require a coordinated approach and expertise from both health care and housing professionals. To present the construction perspective, this resource guide has focused on key lessons and best practices from Metro Denver Habitat for Humanity and other Habitat locations around the country that have been implementing CAPABLE or similar programs.

In brief, here is what we have learned:

- First, communication skills are as important as construction skills. Regular and clear communication, listening, mutual respect, building trust with the client, managing expectations, and solving problems collaboratively are at the heart of effective implementation of an integrated, holistic program model like CAPABLE.
- Second, effective and efficient systems are important for sustainability and growth of the program, continued support from donors, the ability to determine the return on investment, and evaluating short- and long-term impact. Time needs to be invested in setting up effective systems and processes for staff training, time management, budgeting, purchasing of materials, communication, scheduling and data collection. A final word of advice from Kiersten Kelley, construction manager for CAPABLE at Metro Denver Habitat for Humanity: "*Everything* takes longer than you think it will, including conversations with clients, the clients' decision-making process, back-and-forth communication with OTs, playing phone tag with clients, and the work itself. The same task on a new home will inevitably take longer on an older, owner-occupied home."
- And last but certainly not least, a person-centered approach is required. This approach is a shift for most construction experts, who are trained at identifying and correcting the health and safety risks created by the structure of the house. Working with an OT has opened the door to understanding the person-centered perspective.

Habitat construction teams implementing CAPABLE and other locations with integrated programs agree that the person-centered approach has transformed their work. It has helped them partner better with the people and communities they serve. Cross-sector work can be a challenge, but bridging the gap leads to more robust, holistic solutions that strengthen our collective work.

Glossary

Accountable care organization (ACO): A fairly recent legal arrangement that allows doctors, hospitals and other health care providers to give coordinated care at a set rate per contracted member, whether through a Medicare plan or with an employer. The goal is to avoid duplication of services and save money. If it is successful in spending health care dollars more wisely, the ACO will benefit from the savings.

Activities of daily living (ADL): The basic self-care tasks an individual does on a day-to-day basis, including washing, dressing, eating and toileting.

Acute care: A pattern of health care treatment for a medical condition or illness that is of a relatively short duration, usually 30 days or less.

Affordable Care Act (ACA): Also known as the Patient Protection and Affordable Care Act, the ACA is a comprehensive health care reform law enacted in March 2010 with three major goals: to make affordable health insurance available to more people, to expand Medicaid, and to support innovative medical care delivery methods in order to lower costs.

Ambulatory care: Health services delivered on an outpatient basis to a doctor's office or surgical center without an overnight stay.

Business associate agreement (BAA): Under the HIPAA privacy rule, when health care providers and health plans share information across entities, each party enters into a business associate agreement that ensures both parties will maintain and adhere to the privacy rules. (See **HIPAA**.)

Capitation: A payment model for health care services in which a set amount is paid for each enrolled person, per period of time, based on the average expected health care use of the patient group and regardless of whether each member of the group accesses the services.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers Medicare and Medicaid programs and provides regulatory oversight. CMS defers to each state regarding how their Medicaid programs are structured and managed.

Chronic care: Long-term care of individuals with persistent diseases or conditions that are not curable, including measures to address the specific health problem and to encourage self-care, promote health and prevent loss of function.

Clinically integrated network (CIN): A legal entity whereby physicians and hospitals work together across regions, systems and practices to care for patients in the accountable care organization model. A CIN can enter into an insurance contractual arrangement on behalf of its members.

Comprehensive Primary Care Initiative (CPCi): Federal- and State-funded pilot programs for new models of primary care. These models are expected to create and use care teams to manage patients through the care continuum in order to reduce their use of health care services and thus reduce overall cost of care.

Current Procedural Terminology (CPT): A numerical system to support billing for services that is used to describe each billable procedure or service provided in a physician's practice.

Diagnostic-related group (DRG): A system for grouping similar diagnoses that will require similar hospital resources and an expected length of stay, used in standardizing billing for insurance or Medicare. If the patient's length of stay is reduced, then the overall cost of care is also reduced, and the hospital saves money.

Discharge planning: This procedure, required by Medicare for all hospital patients, determines aftercare services prior to discharge. Discharge planning is usually begun upon admission to the facility.

Health Insurance Portability and Accountability Act (HIPAA): Enacted in 1996, HIPAA's original intent was to allow people to keep their health coverage through life changes, but the privacy rule is now more of a focus. The privacy rule creates widespread protection of private health information, or PHI. Health providers must follow specific rules regarding how to use and share PHI.

Health maintenance organization (HMO): A medical insurance group that provides health services for a fixed annual fee. An HMO provides or arranges managed care for health insurance, self-funded health care benefit plans, individuals, and other entities, acting as a liaison with health care providers on a prepaid basis.

Hierarchal Coding Classification (HCC): A newer way to identify higher-risk populations. It is expected that HCCs will soon become a method for setting payment rates to providers who are taking care of sicker patients with more intense needs and resource usage. In traditional payment models, the sickness level is not considered, regardless of the intensity of services needed.

Home- and community-based services (HCBS): Person-centered care delivered in the home to older adults who need assistance with activities of daily living, also known as ADL. These services are especially important for older adults living alone or without a family caregiver.

Institutional review board (IRB): Under federal regulations, an IRB is a group that has been formally designated to review and monitor any research involving human subjects. An IRB has the authority to approve, require modifications, or disapprove a research project in order to protect the rights and welfare of the individuals who are subjects of the research.

Instrumental activities of daily living (IADL): Activities related to independent living, including shopping, cooking, managing medications, managing finances, cleaning and household chores.

Managed care organization (MCO): An organization that delivers health care through a system that enhances efficiency and reduces costs by combining the functions of health insurance, delivery of care and administration. Examples of managed care organizations include traditional health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs.

Management services organization (MSO): Entities that physicians can join to be part of a larger collaborative when negotiating pricing, insurance contracts, malpractice insurance and other services.

Medicare: The federal health insurance program for individuals who are 65 and older. There are two ways that older adults receive coverage: original (fee-for-service) Medicare and Medicare Advantage.

Medicaid: A health coverage program designed for low-income individuals, including children, pregnant women, older adults and people with disabilities. Although broad guidelines are set by the federal government, each state has the authority to design and administer the program.

Medicaid waiver program: A program that enables states to apply for a waiver that will shift long-term care expenses for low-income older adults from institutionalization to home- and community-based services, or HCBS. The HCBS waivers enable older adults to remain in their homes, if they choose, while reducing the costs of long-term care.

Patient-centered medical home (PCMH): A model of care credentialed by the National Center for Quality Assurance to improve health outcomes and reduce costs. In some cases, insurers pay a higher rate of reimbursement for care provided in a patient-centered medical home accredited practice.

Pay for performance (P4P): A contractual agreement between providers and insurers, based on the health outcomes of the insured members. If the provider is able to meet expected health outcomes, they receive additional funding from the insurer for the cost savings.

Per member per month (PMPM): Also referred to as capitation. An entity (e.g., a physician group, ACO accountable care organization or health system) is paid a set amount monthly for each member of the insurance health plan. This payment is expected to cover all the costs for all the care each member will need, allowing the insurer to have set costs.

Preferred provider organization (PPO): A network of preferred providers and hospitals that have a contracted rate for services with the insurer for their members that is below the full fee charged to other patients.

Program of All-Inclusive Care for the Elderly (PACE): A Medicare and Medicaid program that provides coordinated care in the home. A team of health care professionals work together to improve and maintain health. PACE is available only in some states and areas.

Protected health information (PHI): Includes name, birth date, address, Social Security number and any other information that would identify the individual. Health providers must follow specific rules regarding how to use and share the PHI of patients they serve.

Social determinants of health (SDOH): Domains that have been identified as contributing to an individual's health over their life course, including where individuals live, access to quality education and health services, economic stability, and social connections. In 2003, the World Health Organization led the way in identifying the links between health disparities and unequal social and environmental conditions as increasing evidence demonstrated that where "people are born, live, learn, work, play, worship and age affect a wide range of health, functioning and quality of life outcomes and risks."[26]

Appendices

Appendix 1: Logic model example

INPUTS	ACTIVITY	OUTPUTS	SHORT-TERM OUTCOMES	LONG-TERM OUTCOMES
PEOPLE - **Household over age 65** who apply with local affiliate - Qualified Habitat **construction staff** -Engaged **volunteers** including: - Diverse **affiliate board** - Habitat **ambassadors** - **Students and student groups** **RESOURCES** **- Philanthropic funding** - Building **materials** -Policies to identify Habitat's **target population** and **target communities** -**Enabling public policies** (such as supportive zoning) and other land use policies (favorable land disposition) -**Strategic plan**	**REPAIRS (Standard Habitat Repairs Model)**			
	- Strategic **determination of repair support** **-** Provision of **financing options** - Complete the repair with **volunteers and homeowner Sweat Equity** - Source **environmentally sustainable** materials - 3rd party **verification**	➔# of **individuals** and **families served** ➔# of trade **contractors** (roofers, plumbers, electricians)**,** by **trade type** or **activity** ➔# of **repairs** broken down by **type** (weatherization, critical home repair, home preservation) and **cost**	➔Improved **physical safety** ➔↑ # of **physically accessible** and **inclusive** homes ➔Improved short-term **health outcomes** for homeowners and families ➔↑ homeowner **comfort** within the home ➔Mitigation of **hazardous materials in homes**	➔Improved long-term **mental** and **physical health** of homeowner and family
			➔↓ **energy and utility** costs to homeowners ➔↑ prevention of **home deterioration** ➔↑ home **equity** ➔↓ home **repair expense** ➔↑ protection of **home investment** ➔↑ ability to be insured ➔↑ sense of pride in home	➔Financial **stability**, including freeing up resources for **savings** and **other expenditures** ➔Residential **stability** and ↑ **agency** of homeowner to stay or leave their home (inclusive of living and aging in place)
			➔↑ environmental **sustainability** of repaired homes	➔↓ **environmental impact** of repaired home
PARTNERSHIPS - **Partnerships w/ Aging agencies** + nonprofits to identify potential repair projects - Nurse - Occupational Therapist - Local contractors - Municipal governments and state agencies	**HOUSING PLUS**			
	- **Home assessment** to identify repairs and modifications - Holistic **health assessment** of homeowner - Repairs and modifications to make the home more functional and reduce the risk of injury - Age-appropriate sweat equity activities (i.e. reading to kids, hosting a sign-in table or participating in a neighborhood watch) - Present **appropriate financing options** **- Home maintenance** education - Referrals to **other agencies** (i.e. Area Council on Aging, Meals on Wheels, etc.)	➔# and type of Aging in Place repairs (i.e. number of grab bars installed, number of ramps installed, number of energy audits, etc.) ➔**Cost** of repairs and modifications ➔**Homeowner feedback** on experience ➔# of individuals who participate in a **home maintenance training** ➔# of individuals **referred** to other agencies	➔Improved functionality + mobility (ability to live independently) ➔Increased knowledge of home maintenance and how to address maintenance or repair ➔Increased access to health and home maintenance resources ➔Reduced incidence of falls ➔Decrease in depression/stress/anxiety ➔Increased sense of well-being	➔Stable/improved health ➔Decreased health expenses ➔Stable finances **CAPABLE outcomes** ➔Decrease in hospitalizations (+ emergency room visits?) ➔Decrease in nursing home placements

Appendix 2: Map Your Community Context

The chart below is a "starter" list of organizations and agencies that engage with older adults in most communities. Use it as a reference to respond to these questions:

- What organizations in your community support the health and well-being of older adults?
- What are the drivers and benefits? What do they need and want to be successful?
- What benefits could they offer? How could they expand your network?
- Who's who in the organization? Who are the decision-makers?
- Whom do you know who could make the introduction?
- Are there opportunities or events where you could connect?

Type of organization	Drivers and benefits	Possible contribution
Area Agency on Aging	To support the health and safety of older adults so that they can age in place, and to provide a safe environment for home- and community-based services.	Program funding; referrals; champion and connector
Home Health Agency	Provide services (ADL) for older adults in their homes and a safe environment for home- and community-based services.	Partner in program implementation and fundraising; OT and RN staffing.
Hospital or health system	Lower costs by decreasing hospital readmissions; reduce the length of hospital stays; reduce falls and charity care write-offs.	Community health benefit pilot or funding agreement; annual fund contribution; OT/RN staffing.
Fire Department or Emergency Medical Services	Reduction in the number of emergency calls due to falling and injury in the home.	Referrals, dispersal of information/ resources for home safety.
Meals on Wheels	To provide home-delivered meals (nutrition, combatting isolation and addressing safety hazards in the home).	Referrals, volunteers, advocacy partner, program collaboration.
Senior center	Support health and well-being of older adults in the community through a variety of activities and resources.	Referrals, platform for sharing program information, champion and connector.
Senior Village (Village Movement)	Local member support network for daily tasks (transportation, shopping, etc.)	Referrals, volunteers, support, with program applications.
State or local AARP	Support the well-being of older adults and livable communities where older adults can thrive.	Advocacy partner, resources, sponsorship of events, volunteers, champion.
Universities and medical schools	Mission to educate, find employment and provide practical experience for students interested in gerontology, occupational therapy, public health, etc.	Internships, research, special projects.
Veterans Affairs	Provide programs of health care, compensation and commemoration through a wide range of categories that are approved by the Department of Defense and Veterans Affairs.	Funding, referrals, resources/connections.

Appendix 3: Policy development checklist

Documenting processes and policies results in higher-quality care and more equitable application.

Whether these components are codified into policy that governs program implementation or simply documented to ensure clarity and equitable application, they should definitely be discussed and clearly communicated to all partners, from clients to volunteers. Here are some things to consider:

- **Policy development**: Should protocols supporting implementation of your integrated health and housing program be added to existing repair and/or aging in place policies — or does the program merit its own policy?
- **Target group**: How will you define the target group? What are the requirements for participation in terms of income level and/or health status?
- **Home repair programs**: If your organization has a repair program for older adults (outside of CAPABLE), will you make your program available to the client either before or after concluding the CAPABLE program? If so, consider having a documented process for introducing and explaining your repair program repayment schedule to clients as part of their application.
- **Referrals**: Will your housing organization receive referrals from other nonprofits for CAPABLE clients, and if so, how will you handle this intake and/or transfer of this intake to your health care partner?
- **Referrals to other community services**: Will your housing organization provide your CAPABLE clients with referrals to other nonprofits for services not addressed within your program implementation? If so, how will you identify needs within the client base? How will you protect privacy in this referral process, and how will you vet other service providers?
- **Homeowner/client agreements:** In the Denver CAPABLE program, the work order, which is signed by the client before construction starts and after it is completed, serves as the agreement with the homeowner on the scope of work.

Appendix 4: Sample CAPABLE work order

Colorado Visiting Nurse Association
Expert Care Since 1889.

CAPABLE

Scope of Work

Client Name:		PR0#	OT:	Grant: (DRCOG or Habitat)
Address:		Habitat staff:	Nurse:	
Phone #:		Fall Risk level:	OT Purchases: $	Est. Habitat Cost: $
Referral Date:		Client Goals:		
Opening Assessment:		1.		
Visit Dates:		2.		
		3.		
Closing Assessment:				

Project Details (Prioritized)

	Client Goal	Project Description	Construction Comments
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Pre-Install Consent:

I confirm that I understand the scope of the work to be performed and agree to the installation of the above list of home modifications.

_____ _____

Participant Signature Date

Post-Install Confirmation:

I confirm that I received the above housing modifications, safety instruments and have been trained in their proper use.

_____ _____

Participant Signature Date

Appendix 5.1: Home assessment guide — items to look for

(This sample was provided by Habitat for Humanity Philadelphia.)

Area	Check for:
Basement	
Structure	
Stairs	Broken or loose stringers, broken or loose treads
Handrail	Present? Sturdy?
Stair box	Properly sized trim header? Adequate joist header connection?
Joists/joist pockets	Cracked damaged joists, rotted/deteriorated joist ends, termite damage
Stone foundation brick	Bowing stone/brick foundation walls, spalling, deteriorated mortar joints
Electrical	
Panel	Condition, rust, age. Cover present? Grounded?
Service line — condition amperage	Adequate amperage (100+), condition of service line, number of breakers
Distribution	Presence of knob and tub wiring, junction boxes, exposed connections, appropriate install
Subpanel boxes	Condition, knob and tube wiring
Lights	Adequate? Switch controlled?
GFCI protected outlet	Present? Adequate?
Plumbing	
Stack	Original cast iron? Indication of deterioration, cracks, leaks?
Lateral/main sewer line	Original cast iron? Indication of deterioration, cracks, leaks?
Drains	Lead drain lines? Cracks or leaks? Proper pitch
Supply lines	Lead supply line at water meter? Leaks at junctions or shut-off valves?
Gas lines	Gas leaks?
Combustion appliances	
Heater	
Filter	Present? clean?
Combustion chamber	Clean? Pilot light/electronic ignition? Burner condition? Signs of rollout?
Distribution ducting	Size, condition, connections? Opportunity for increased sealing/efficiency?
Distribution hot water supply lines	Condition: Leaks? Opportunity for insulation?
Asbestos	Present on ducting runs, risers, returns or on heater itself
Fuel — oil	Condition of oil tank and heater supply lines? Leaks?
Fuel — gas	Gas line leaks, shut-off valve

Water heater	
Combustion chamber	Presence of rust in combustion chamber
Supply distribution lines	Leaking or corrosion
Chimney	
Flue/chimney	Flue has positive pitch ¼-inch per foot, less than 10-foot run to chimney lateral, flue hood positioning
Draft, spillage	Strong draft, no spillage after 60 seconds
Chimney riser/liner	Chimney liner? Check cleanout for debris buildup that could block flue gases, clear path to roof
Doors and windows	
Doors	Air seal, secure lock, frame condition
Windows	Functional open/close, frame condition, air seal, opportunities for increased efficiency. Water infiltration?
Kitchen	
Plumbing	Condition of sink, faucet, supply lines and drains
Electrical	GFCI protected C-top outlets, designated fridge outlet. Adequate outlets. Lighting.
HVAC heat source	Present? Adequate?
Range hood/exhaust	Present? Vented externally?
Stove	Condition? If gas, condition of flexible supply line? Shut-off valve?
Refrigerator	Condition?
Cabinet/countertop	Condition: Adequate space? Water damage? Gaps and cracks?
Walls	Condition: Water damage? Compromised plaster or lath? Gaps or cracks? Lead paint?
Floor	Dipping and soft spots. Holes, gaps or cracks? Damaged, uneven finish floor? Trip hazards? Asbestos floor tiles?
Pest control	Signs of roach and/or mouse infestation
Windows	Functional open/close, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Door (exterior)	Air seal, secure lock, frame condition. Lead paint?
Safety	Fire extinguisher
Living room/dining room	
Walls	Condition: Water damage? Compromised plaster or lath? Gaps or cracks? Lead paint?
Flooring	Dipping and soft spots. Holes, gaps or cracks? Damaged, uneven finish floor? Trip hazards?
Doors (exterior)	Air seal, secure lock, frame condition. Lead paint?
Windows	Functional open/close, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Electrical	Sufficient number of outlets? Outlets functional? Exposed wiring? Lighting and switches are functional?
Heat source	Present? Sufficient?
Smoke/CO detectors	Units present? Functional?

Bathroom	
Plumbing	
Sink	Condition of supply lines, drain lines and faucet. Leaks?
Toilet	Condition of supply lines and tank guts. Toilet condition: Wobbly? Ideal bend?
Tub/shower	Condition of supply lines, drain lines, faucet, shower head. Lead drain lines?
Tub/shower surround	Condition and areas of water damage and water infiltration
Fixtures	
Vanity cabinet	Condition: Water damage? Function?
Electrical	GFCI protected outlet? Functional light and switch?
Ventilation	Present? Externally vented?
Heat	Present? Adequate?
Floors	Dipping and soft spots (particularly near toilet). Holes, gaps, cracks? Damaged or uneven finish floor? Trip hazards?
Walls	Condition: Water damage? Compromised plaster or lath? Gaps or cracks? Lead paint?
Doors/windows	Functional open/close/lock, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Safety/accessibility	Need for grab bars, hand-held shower head, comfort-height toilet, walk-in shower?
Bedrooms	
Doors	Functional open/close/lock, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Windows	Functional open/close/lock, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Flooring	Dipping and soft spots. Holes, gaps or cracks? Damaged or uneven finish floor? Trip hazards?
Walls	Condition: Water damage? Compromised plaster or lath? Gaps or cracks? Lead paint?
Electrical	Sufficient number of outlets? Outlets functional? Exposed wiring? Lighting and switches are functional?
Heat	Present? Adequate?
Safety	Smoke and CO detectors? Present? Hard-wired? 10-year battery?
Laundry area and/or shed	
Washer condition	
Washer water hook-ups	Condition of supply lines, drains, electric outlet
Dryer condition	
Dryer hook-ups	Condition of gas supply line, electric outlet. Gas supply line with shutoff. Externally vented exhaust?
Walls	Condition: Water damage? Compromised plaster or lath? Gaps or cracks? Lead paint?
Floor	Dipping and soft spots. Holes, gaps or cracks? Damaged or uneven finish floor? Trip hazards?
Electrical	Sufficient number of outlets? Outlets functional? Exposed wiring? Lighting and switches are functional?

Heat source	Present? Adequate?
Windows	Functional open/close/lock, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Hallway/stairs	
Safety	
Smoke/CO detectors	Smoke and CO detectors? Present? Hard-wired? 10-year battery?
Railings	Present, sturdy?
Floor	Dipping and soft spots. Holes, gaps or cracks? Damaged or uneven finish floor? Trip hazards?
Walls	Condition: Water damage? Compromised plaster or lath? Gaps or cracks? Lead paint?
Structure	
Tread/riser	Loose treads, inconsistent cadence.
Porch	
Floor	Dipping and soft spots. Rot and deterioration. Holes, gaps or cracks? Damaged or uneven finish floor? Trip hazards?
Structure	Damaged posts or roof rafters. Lead paint.
Roof	Damaged decking, roof leaks, damaged shingles or rolled material.
Gutter/downspout	Present? Proper pitch and connection? Does downspout drain into rain leader?
Railings	Water damage? Missing? Lead paint?
Steps/entryway	
Railings	Present? Sturdy? Lead paint?
Sidewalk	Consistent, even surface? Trip hazards?
Building shell	
Windows	Functional open/close/lock, frame condition, need for lintels? Lead paint? Capping?
Doors	Functional open/close/lock, frame condition, air seal, opportunities for increased efficiency. Lead paint?
Brick	Bowing? Spalling? Deteriorated mortar? Need for lintels?
Siding	Condition: Age, missing pieces? Areas of water infiltration?
Foundation	Bowing? Mortar deterioration? Major cracks?
Roof	Current leaks? Most recent total-tear-off? Most recent full replacement? Flashing
Gutter/downspout	Present? Proper pitch and connection? Does downspout drain into rain leader?
Exterior	
Electrical	External outlet? Exterior rated? GFCI protected?
Plumbing	External spigot with frost proofing? Rear yard drain and rain leader?
Fencing	Present? Condition? Functional gate?
Landscaping/grading	Grade is below level of first-floor joists? Grade away from house/toward yard drain

Appendix 5.2: Home assessment guide — condition levels

(This sample was provided by Habitat for Humanity Philadelphia.)

	Minimum standard	Elevated standard	Preserving for years to come
ROOF/S	No severe roof leaks and sources of persistent water infiltration through building shell (basement not included).	Main areas of building shell are watertight under normal weather events. Roof and siding have at least five years of functional life expected.	All areas of building shell are solid, secure and weather-tight. Roof and siding have 10 or more years of remaining functional life expected.
HEAT	Present, with central unit working.	Present, working, distribution system servicing house in such a manner that living spaces are conditioned and habitable. Heater has at least five years of functional life expected.	Heater and distribution system are present and working efficiently, servicing all areas of the home. Heater has 10 years of remaining expected functional life.
PLUMBING	Hot and cold running water. No major leaks in stack/lateral or supply line. No lead supply lines present.	Hot and cold running water, with supply and drain leaks resolved. Drain lines and water heater have at least five years of functional life expected. No lead drain lines present.	Hot and cold running water, with no supply or drain leaks. Drain lines, supply lines and water heater have at least 10 years of functional life remaining. All cast iron is in excellent condition; no lead pipes present.
ELECTRICAL	Service line and protective casing intact and weathertight, with 100-amp service breaker box.	Service line in good condition (with weather-tight protective casing); minimum 100-amp service; breaker box in good condition; electric distribution is free of frayed wiring, overloaded circuits and hazards. GFCI-protected outlets are used near water sources. Each occupied room has adequate outlets and lighting.	Service line and breaker box in good working order and expected to last 10 years or more. Minimum 100-amp service. Distribution is in good condition with minimal knob and tube wiring. All required GFCI circuits; all circuits properly loaded. All rooms have adequate outlets and lighting.
PRIMARY BATHROOM	Functional toilet and shower/tub.	Functional toilet, shower/tub. Fixtures are free from leaks and have an expected functional life of at least five years. Tub surround is reasonably watertight. Flooring is free of major dipping/bowing/bounce.	Functional toilet, shower/tub/sink. Fixtures are all in good working order with a functional life of five to 10 years. Tub surround is in good condition. Bath finish set present (towel rods, etc.). Finish walls and flooring are intact and easy to clean; shower surround is in good condition. Bathroom has adequate ventilation.
KITCHEN	Functional sink, stove, fridge, and place to prepare and store food.	Sink, stove, and fridge are all in good working order. Kitchen offers adequate places to prepare and store food. Cabinets, sink and countertop are free of major damage and deterioration. Flooring is free of major dipping/bowing/holes.	Sink, stove and fridge are all in good working order. Kitchen offers adequate places to prepare and safely store food. Cabinets, sink and countertop are all in good working order and have a remaining expected life of five to 10 years. Flooring is intact, solid and easy to clean. Exhaust and/or recirculating fan above stove.

	Minimum standard	Elevated standard	Preserving for years to come
WINDOWS	Intact or covered, with no missing panes.	All windows are intact and can open, close and lock.	Windows are intact; can open, close and lock; and are reasonably airtight and efficient.
DOORS	Intact and functional — able to open, close and lock.	Doors are intact and functional, weather-tight, and free of major deterioration and wear.	Doors are intact and functional, weather-tight, and in good working order.
STRUCTURAL	No structural components within the living building shell are in imminent danger of collapse (walls, floor joists, flooring).	No structural components (in the living building shell) are in danger of collapse, and integrity of members — walls, floor joists, flooring — is sufficient to last at least five years. Finish surfaces of walls and flooring in occupied living areas are intact and sound (no large areas of missing flooring/drywall/plaster). Sources of structural damage such as water/rot and termites are treated/resolved.	Structural components are all solid, free of rot/movement/deterioration. Finish surfaces of walls and flooring in occupied living areas are complete, solid and sound. Sources of structural damage such as water/rot and termites are treated/resolved.
HEALTH/SAFETY HAZARDS	Combustion gases are venting out of home, with no major gas leaks or imminent fire hazards. Smoke and carbon monoxide detectors are present. There are no major sources of mold or chipping lead paint in rooms occupied by children. No major insect or rodent infestation.	Combustion gas appliances have venting that complies with code, with no gas leaks or fire hazards (combustion appliances and/or wiring. Smoke and carbon monoxide detectors are present on each level of the home. No mold in occupied living area, or chipping lead paint in homes occupied by children. Home has adequate ventilation. Rodent and insect infestation is managed.	Combustion gas appliances have venting that is compliance with code, with no gas leaks or fire hazards (combustion appliances and/or wiring). Smoke and CO detectors are present on each level of the home. No mold in occupied living area, or chipping lead paint in homes occupied by children. Home has adequate ventilation. Rodent and insect infestation is managed. Home is free of agents that jeopardize indoor air quality (VOC, formaldehyde, etc.)
CLIENT NEEDS		Client is able to safely enter and exit the home and access sleeping areas, the kitchen and bathroom facilities. If the home has a child with asthma, the home is free of environmental triggers for asthma.	All occupants are able to safely access, use and move about the home. If the home has a child with asthma, the home is free of environmental triggers for asthma.

Appendix 5.3: Home assessment guide — minimum standards

(This sample was provided by Habitat for Humanity Philadelphia.)

1. **Bathroom sanitary facilities are in proper operating condition and adequate for human cleanliness and the disposal of human waste. Kitchen has suitable space and equipment to store, prepare and serve food in a sanitary manner.**
   - ☐ Separate private bathroom with an operating flush toilet.
   - ☐ Shower or tub in operating condition with hot and cold running water.
   - ☐ Approved public or private waste disposal system.
   - ☐ Necessary appliances include a stovetop and refrigerator (hot plates are not acceptable).
   - ☐ Operating kitchen sink drains into an approvable public or private system with a sink trap and hot and cold running water.
   - ☐ Space to store, prepare and serve food.
2. **Adequate space and security for residents.**
   - ☐ At least one operational window that opens on each floor of the property.
   - ☐ Secured exterior doors.
   - ☐ Property is clear enough of clutter that inspectors and contractors can work and access systems.
   - ☐ A working smoke detector is on each floor, in addition to one in each room used for sleeping.
3. **Capacity to maintain a thermal environment healthy for the human body.**
   - ☐ Safe heating system in operating condition that directly or indirectly services each room.
   - ☐ Must not contain unvented room heaters that burn gas, oil or kerosene.
   - ☐ Electric heaters are acceptable as a supplemental source of heat.
4. **Adequate natural or artificial light to permit normal indoor activities and sufficient electrical sources to use essential appliances that are free of visible safety and fire hazards.**
   - ☐ No visible electrical hazards.
   - ☐ Working circuit breaker or fuse box.
   - ☐ At least one working electrical outlet in the kitchen.
   - ☐ Permanent lighting in kitchen and bathroom.
5. **Structure must not present any threat to the health and safety of the occupants and must protect the occupants from the environment.**
   - ☐ Ceilings, walls and floors must not have any serious defects, such as severe bulging or leaning, severe buckling, missing parts, or other indications of serious damage.
   - ☐ Roof must appear structurally sound and free of obvious leaks.
   - ☐ Exterior wall structure and surface must not have any serious defects, such as serious leaning, buckling, sagging; large holes; or defects that may result in air filtration or vermin infestation.
   - ☐ Condition and structure of interior and exterior stairs, halls, porches, walkways, etc., must not present a danger of tripping and falling.
6. **Air may not have pollutants at levels that threaten the health of the occupants, and the property may not be infested with insects, rodents, vermin or other pests.**
   - ☐ Rooms are free of dangerous levels of air pollution from carbon monoxide, sewer gas, fuel gas, dust and other harmful pollutants.
   - ☐ Bathroom areas must have one openable window or other adequate exhaust ventilation.
   - ☐ There is no visual evidence of a bug or pest infestation.
7. **Water supply must be free from contamination.**
   - ☐ Kitchen and bathroom must be served by an approvable public or private water supply that is sanitary and free from contamination (i.e., brown water test).

Appendix 6: Photos of common modifications

(This sample was provided by Habitat for Humanity of Metro Denver.)

Rev-A-Shelf

Wooden steps and rails

Tub cuts

STANDARD

CONVERTIBLE

Toilet rails and risers

Ramps

Appendix 7: Documents and tools list

(This sample was provided by Habitat for Humanity of Metro Denver.)

Binders with the documents and tool bags listed below are standard for each construction team member at Habitat for Humanity of Metro Denver as they visit the homes of older adults and complete construction modifications for CAPABLE.

CAPABLE PROJECT BINDERS

- Copy of OT work order for project.
- Picture book of common modifications.
- Contact info for most common referral partners/agencies.
- One-page recruitment flyer (CAPABLE program).
- General Habitat homeownership/other program information and applications (or link to website).
- “Working in the Home” guidance doc.
- Assessment forms: bathroom, door widening, platform steps, exterior stairs, ramps.
- Stairlift resources.
- Client-facing expectations of safe workspace.
- Best practices installation guide (grab bars, tile, tub cut, wooden step).
- OT contact info (phone numbers and emails for all partnering OTs).
- Building code (IRC) section addressing ramps.

CAPABLE PROJECT BAGS

- Tape measure.
- Boot covers.
- Basic PPE (masks, gloves, safety glasses).
- Basic first-aid kit (if not included in work trucks).
- Flashlight.
- Blue tape.
- Pens, pencils, markers.
- Hand sanitizer.
- Stud finder.
- Clipboard.
- Disinfectant wipes and paper towels.

Appendix 8: Approximate costs for common CAPABLE modifications

(This sample was provided by Habitat for Humanity of Metro Denver.)

All dollar amounts include labor and subcontractor costs and are rounded up to the nearest $50.

Area	Cost	Item
Bathroom	$50	Tub non-skid tape Hand-held showerhead Showerhead mount
	$100	Corner shower shelf
	$150	Seat toilet riser
	$200	Bidet
	$300	Toilet elevator
	$350	Replacement toilet (17 inches high)
	$550	Tub lift chair
	$600	Tub cut, standard
	$650	Convenient height toilet (21 inches high)
	$5,550	Replace tub with walk-in shower
Exterior	$50	Non-skid tape
	$150	Platform step – single
		Threshold ramp (<3" rise)
	$350	3-foot metal handrail (exterior)
	$450	Platform step — two to four steps
	$500	Ramp — 6 feet or less, metal
	$750	Ramp — 6 feet or less, wood
	$1,000	Replace normal stairs with platform steps (three to six steps)
	$1,200	Concrete sidewalk repairs — less than 30 square feet
	$2,750	Ramp — 6 to 16 feet, wood
	$4,650	Ramp — 16 feet or more, wood
Interior	$50	Lever doorknob, interior Smoke or carbon monoxide alarm
	$100	Lever doorknob, exterior Bed cane Offset door hinges
	$200	Closet rod/shelf adjustment
	$500	Two Sisters, per session
	$550	Minor plumbing repairs (small leaks, etc.)
	$600	Orkin — five-week treatment
	$1,100	Door widening

Kitchen	$200	Rev-A-Shelf drawer
	$500	Rev-A-Shelf pull-down shelf
Stairs	$150	Interior stair railing
	$2,100	Stairlift
Grab bars	$50	Grab bar Tub clamp grab bar
	$100	Combo grab bar/towel bar
	$200	Drop-down grab bar
	$250	Floor-ceiling transfer pole
Lighting	$50	Small motion light Large motion light

Appendix 9: Guidelines for working in the home

(This sample was provided by Habitat for Humanity of Metro Denver.)

MILC:

Minimize chaos

- ☐ Assign one staff member to be the main contact for the duration of install.
- ☐ Clearly communicate the project outline and expectations to the client and household.
- ☐ Consolidate tools and products to reduce visual clutter and trip hazards.
- ☐ Anticipate loud noises and warn those nearby (offer earplugs).
- ☐ Limit the number of people inside the home or within common spaces.

Indoor voices

- ☐ Strategize the workday with the team away from the client and caregivers.
- ☐ If an issue arises, consult the team in private to avoid alarming the household.
- ☐ Keep volume to a minimum — chatter, singing, radio, etc. (depending on the site and the client)

Language and conversation

- ☐ Keep conversations “PG-rated” among the staff.
- ☐ Avoid politics and asking personal questions — family life, medical history, etc.
- ☐ Allow time for conversations with the client (depending on the client).

Clean up after yourself

- ☐ Remove all trash and recycling from the workspace, throughout and after each task.
- ☐ Sweep, vacuum or wipe down any surfaces in and around work areas.
- ☐ Return household items to their original location, if moved by the Habitat staff.
- ☐ Thoroughly track Habitat tools. Do NOT use clients’ tools.

End notes

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