Senior-Focused Health Programs for Public Housing Residents

CASE EXAMPLES FROM PUBLIC HOUSING PRIMARY CARE CENTERS

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NCHPH
National Center for Health in Public Housing

Introduction

Public housing residents often have complex health issues that are impacted by their immediate environment and by neighborhood settings. In general, individuals that receive assistance from the U.S. Department of Housing and Urban Development (HUD) are more likely to have chronic health conditions and are higher utilizers of health care than the rest of the U.S. population, even more so than other low-income renters[1]. Public housing residents are twice as likely to report being in fair or poor health or have a disability compared to the general adult population[2].

Figure 1. Health of Public Housing Residents
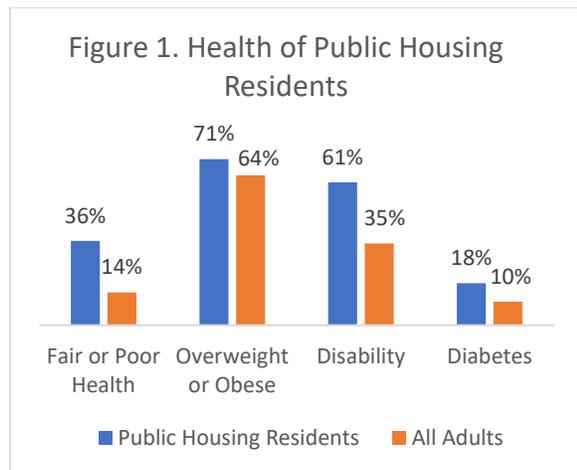
Source: HUD 2017

Seniors, defined as those age 65 and older, are particularly vulnerable because, in addition to the increased risk of physical or mental disability, seniors living in public housing have limited resources and social supports[3]. While they may have physically appropriate housing, they lack access to supportive services that would allow them to age in place or remain in their current living situation for as long as possible[4]. Adults who can age in place exhibit better levels of cognition, better functioning in daily living activities, decreased levels of

depression, and lower levels of incontinence compared to older adults aging in nursing home settings[5].

Health Centers provide comprehensive primary health care services for low-income populations. In 2017, there were 356 Health Centers located in or immediately accessible to public housing that served close to 3.5 million patients[6]. Among those, 106 Public Housing Primary Care (PHPC) Health Centers provided care to 661,777 patients.[7] The percent of elderly patients served at those Health Centers increased by 5% from 2016 to 2017.Therefore, the purpose of this report is to provide Health Centers that are interested in developing new senior programs or enhancing existing ones with concrete examples on how to improve their senior patient interactions, increase access to care, and improve health outcomes for older adult population.

Using a qualitative case study approach, the National Center for Health in Public Housing (NCHPH) interviewed Health Center staff to identify the key components of successful senior programs and lessons learned for addressing the barriers to accessing care in this patient population.

This report highlights best practices from five Health Centers:

- Alivio Medical Center in Chicago, Illinois
- Charter Oak Health Center in Hartford, Connecticut
- Community Health Initiatives in Brooklyn, New York
- Lifelong Medical Center in Berkeley, California
- San Ysidro Health Center in San Diego, California

Why are Senior Health Programs Important?

1. THE SENIOR POPULATION IS GROWING

The number adults age 65 years or older living in the U.S. has vastly increased in the past century, from 3.1 million in 1900 to almost 50 million in 2016[8]. The U.S. senior population is expected to increase to 98 million by 2060[9]; totaling 24% of the population[10].

Enrollment in Medicare is also projected to increase considerably over the next 30 years due to the growth of the aging population[11]. Estimates from the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds conclude that as many as 92.4 million Americans will be on Medicare by 2050[12].

Figure 2. Projected Medicare Enrollment (in millions), 2000-2050
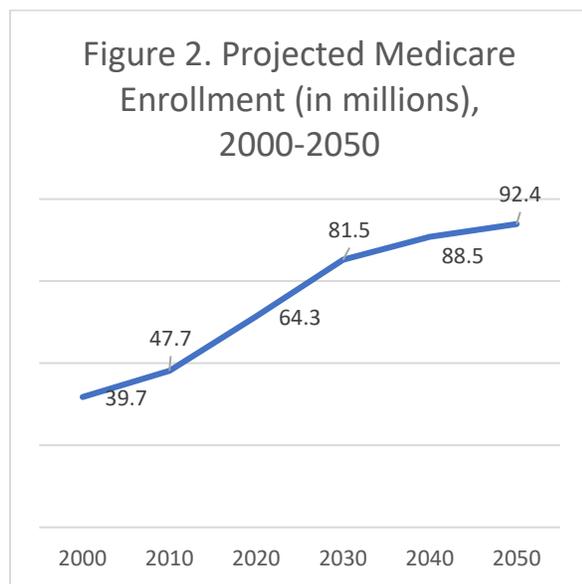
Source: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

These growth projections have strong cost implications. According to the Centers for Medicare and Medicaid Services, national health spending is projected to grow at an average rate of 5.5 percent per year for 2017 to reach $5.7 trillion by 2026[13]. However, Medicare spending is projected to grow the fastest among the major health insurance categories between 2021-2026, averaging 7.7 percent, due to sustained growth in both enrollment and spending[14].

2. SENIORS PRESENT UNIQUE HEALTH NEEDS

Due to the existence of public health insurance, almost all elderly have access to health care. Approximately 93% have Medicare; 7% have Medicaid; and 53% have private insurance[15]. One of the major health concerns for the elderly is a physical disability. Approximately 35% of elderly persons have some type of disability: the most common is ambulation difficulty or difficulty in moving (23%), followed by difficulty with hearing (15%) and reduced ability to sustain independent living (15%)[16].

Figure 3: Percentage of Persons Age 65 and Over with a Disability, 2016
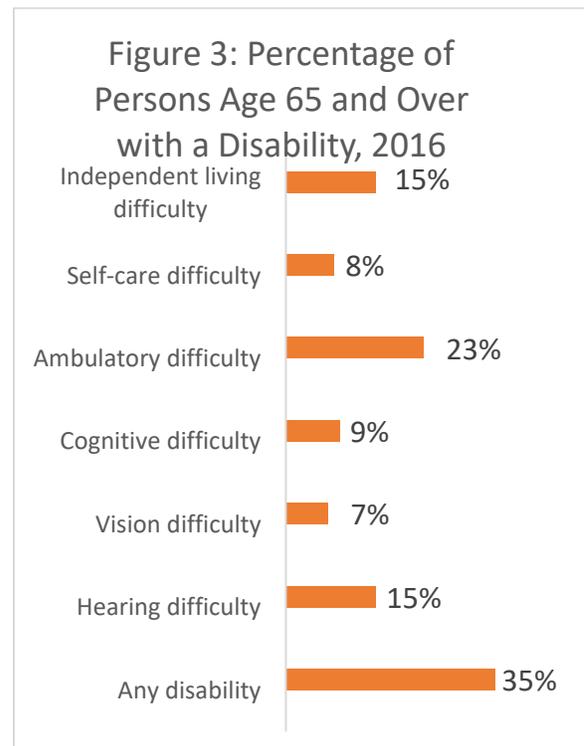
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement

Seniors often live alone, which can add to the challenges of self-care and may increase the risk of social isolation[17]. Social isolation of seniors is associated with long-term illnesses such as chronic lung disease, arthritis, impaired mobility, and depression, with the need for home long-term care services[18]. Medicare spends an additional $6.7 billion annually on socially isolated adults[19].

In addition, close to 75% of older adults have multiple chronic health conditions, and the burden is even higher among low-income and racial and ethnic minority populations[20]. Approximately 23% of older Americans are from a racial or ethnic minority population[21] Presence of chronic conditions in older adults increases the likelihood of limitations in the ability to perform basic activities of daily living, such as bathing, eating, and getting in and out of a bed or chair, making it more difficult to age in place[22].

The Lewin Group found that HUD-assisted Medicare and Medicaid enrollees had more chronic health conditions, which translated into higher health care utilization and costs than unassisted Medicare or Medicaid enrollees in the community[23]. HUD-assisted Medicare and Medicaid enrollees had 31% higher home health visits, 45% higher ambulatory surgery center visits, 26% higher physician office visits, and 13% higher emergency department visits compared to those without HUD-assistance which contributed to the higher payments[24].

3. **THE COST OF PROVIDING CARE TO SENIORS IS HIGH**

The Lewin Group also found that 70% of HUD-Assisted Medicare beneficiaries are dually enrolled in Medicaid, compared to 13% of the general older adult population[25]. Approximately 55% of HUD-Assisted duals or (dual eligible) have five or more chronic conditions compared to 43% of duals without housing assistance[26]. As a result, Medicare spends 16% more on HUD-

Assisted adults and Medicaid spends 32% more compared to per member per month costs for adults that do not receive housing assistance [27].

Figure 4. Medicare Fee For Service Per Member Per Month Payments

$1,222

$1,054

■ HUD-Assisted ■ Unassisted
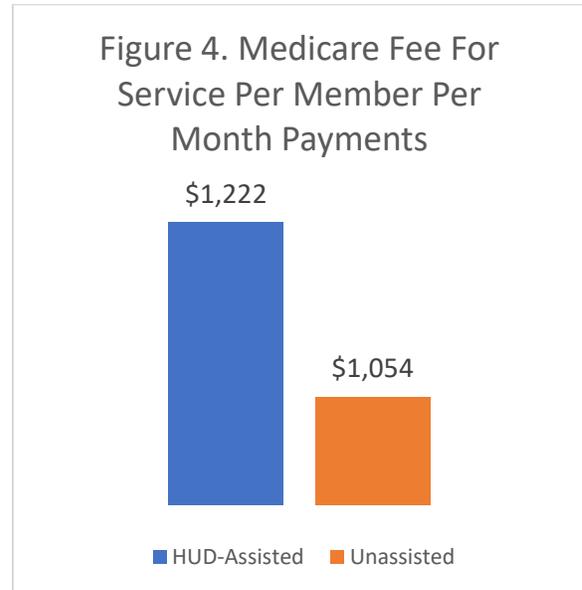
Source: HUD and CMS

4. *SENIORS HAVE LOW INCOMES*

Adults over the age of 65 are more likely to be retired or unemployed with fixed incomes. Around 14% of older persons have annual incomes less than $10,000; 50% of the population have incomes between $10,000-35,000; and 34% have incomes greater than $35,000[28]. The median income for persons over the age of 65 is approximately $24,000[29].

Figure 5. Annual Income for Older Adults

| 14% | 50% | 34% |

■ Less than $10,000 ■ $10,000 o $35,000
■ More than $35,000
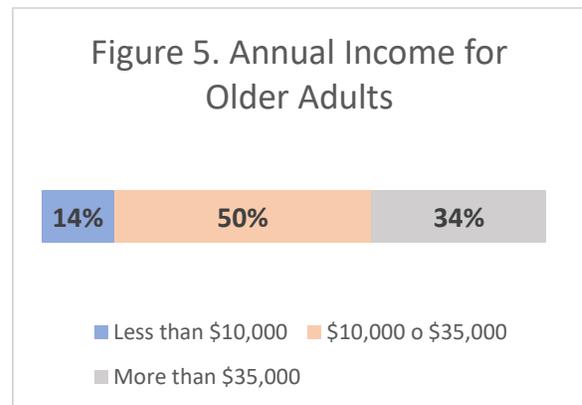
Source: 2017 Profile of Older Americans

This includes incomes from Social Security, assets, earnings, and pensions[30].

Lower incomes make high housing costs more of a challenge and strains the ability of older adults to pay for food, housing, transportation, and medical costs[31]. In 2016, the Supplemental Poverty Measure from the U.S. Census, which factors regional variations in living costs, non-cash benefits received, and non-discretionary expenditures, such as out of pocket medical expenses, showed that 14.5% of adults age 65 and over are in poverty[32].

The combination of limited financial resources for older adults and the rising costs of housing make public housing options a critical component to prevent homelessness for the aging population.

Methodology

Given the growth in the elderly population, and the anticipated increase in senior patients with unique health needs, Health Centers have requested training and technical assistance on strategies and best practices for developing senior programs. Specifically, they have requested strategies that address some of the major challenges in providing elderly care, such as arranging transportation, conducting health literacy activities, and developing customized self-management programs. NCHPH determined that the best method for documenting and identifying senior health programs was through qualitative semi-structured phone interviews. NCHPH conducted a qualitative case study analysis of Health Centers located in or immediately accessible to public housing with notable senior health programs.

NCHPH staff first identified Health Centers located in or immediately accessible to public housing with a large percentage of older adult populations. On average, approximately 7% of patients accessing care at Health Centers are over 65 years of age. Around 40 of the Health Centers located in or immediately accessible to public housing have an elderly population greater or equal to the average, between 7%-21%. The 40 Health Centers were contacted to participate in the study and a total of five Health Centers agreed to participate.

NCHPH staff interviewed key leadership staff at each Health Center and asked the following basic research questions:

o Please describe your senior patient population, what are the major health issues for patients over age 65 visiting your Health Center?
o What programs or services do you offer to patients over the age of 65?
o Can you describe any innovative senior programs at your Health Center and/or any partnerships with other organizations to address the health needs of older adults in your community?
o What are the major challenges or barriers that older adults face in accessing the medical services that you provide?
o How have you worked to address those challenges?
o Do you have any advice for Health Centers that are interested in developing senior health programs?

Executive Directors, Medical Directors, Managers of senior programs, or the person identified as most knowledgeable on senior issues were interviewed. Interviews took place using the GoToMeetings platform, lasted up to an hour, and were recorded, transcribed, and then analyzed for themes.

Case Study Sites

The five Health Centers participating in the case study were Alivio Medical Center in Chicago, IL;

Charter Oak Health Center in Hartford, CT, Community Health Initiatives, Inc. in Brooklyn, NY; Lifelong Medical Center located in Berkeley, CA; and San Ysidro Health Center in San Diego, CA. Three of the health centers involved in case studies were urban-based, while two had an urban-rural mix. This range offered an examination of the provision of senior care from different health practice perspectives.

Table 1. Case Study Sites [33]				
Health Center	**State**	**Patients Near PH**	**Age >65**	**Urban/ Rural**
Alivio Medical Center	IL	unknown[34]	3%	urban
Charter Oak Health Center	CT	4,138	8.5%	urban/ rural
Community Health Initiatives, Inc.	NY	2,433	13.7%	urban
Lifelong Medical Center	CA	26,425	10.4%	urban
San Ysidro Health Center	CA	6,471	11%	urban/ rural

Of the five Health Centers participating in the study, two had long running and innovative targeted senior health programs. The others generally practiced a more integrated care approach, serving seniors as part of their regular patients. One Health Center was just beginning targeted clinical services for specific groups of seniors living in public housing. This variety allowed the study to consider a range of viable, practical and instructive senior care solutions.

Summary of Findings

The following section describes some of the successful senior-focused initiatives at the Health Centers that addressed the importance of integrating social services, offered supportive housing services, provided intensive case management, housing stabilization and eviction prevention counseling, and addressed other critical issues such as benefits advocacy and money management and community building activities. It also includes a discussion of the challenges the Health Centers faced in providing senior care and the demonstrated strategies to address them.

1. *COMPREHENSIVE PROGRAMS THAT LINK SENIORS TO SOCIAL SERVICES*

A recurring theme in discussions with Health Center leadership was the importance of providing comprehensive care that integrated a range of social services for seniors and supportive housing options and services to prevent homelessness.

Support and Services at Home (SASH) Program is a Medicare-funded program available to older adults who live independently. The program draws on a network of social-service agencies, community health providers, and nonprofit housing organizations to provide wide-ranging care to the elderly. Each SASH participant receives a comprehensive health and wellness assessment and an individualized Healthy Living Plan[35]. A Care Coordinator identifies participant's needs and connects them to the available services and resources in the community[36]. A dedicated Wellness Nurse provides health coaching for chronic conditions, such as diabetes, and assists in transitions from hospital in-patient care to home care[37]. An evaluation in Vermont showed that the SASH program reduced the rate of growth in total

Medicare expenditures by $1,536 per patient annually[38].

In New York State, the Office for the Aging funds **Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSP)** in multifamily buildings that have a high concentration of older adults[39]. The program provides supports and services to facilitate aging at home and in communities.[40] Not-for-profit organizations specializing in housing, health or human services that offer supportive services, such as service coordination, case management, counseling, health assessment and monitoring, home delivered meals, transportation, socialization activities, or home care facilitation and monitoring are eligible to apply for state NORC-SSP funding[41]. In 2012, the NORC-SSP in New York served more than 19,000 people age 60 and over[42].

The Affordable Care Act (ACA) created options and incentives for states to offer more **Home and Community Based Services** to Medicaid enrollees in order to reduce overall Medicaid long-term care spending[43]. One such program included the placement of service coordinators in public housing buildings. A service coordinator's role is to coordinate supportive services and assist with accessing benefits, entitlements, and other local resources for residents of public housing[44]. The assistance extends the amount of time an individual maintains independence thereby reducing public long-term care costs[45]. According to the American Association of Service Coordinators, an elderly person living in a subsidized property that receives supportive services through a service coordinator costs 66% fewer taxpayer dollars than the average cost of nursing home care [46].

Program for the All-Inclusive Care of the Elderly (PACE) is a national Medicare program offering a continuum of acute and long-term medical and social services including primary care, occupational and recreation therapy, home health care, and hospital and nursing home care for individuals over 55 years of age[47]. It integrates the delivery and financing of services for older adults who require a high level of care but can live at home independently. PACE providers receive a capitated payment per enrollee from both Medicare and Medicaid and assume the full financial risk for all services[48]. PACE enrollees receive services that are managed and coordinated by a multidisciplinary team at an adult day health center[49]. Providers are required to offer all services in the Medicare and Medicaid programs[50].

Evaluations have shown that PACE enrollees have lower rates of nursing home admissions, shorter hospital stays, lower mortality rates, and better self-reported health compared to non-PACE populations[51]. However, the population is hard to reach. Only 8% of PACE eligible seniors are enrolled in a PACE program[52].

San Ysidro Health's PACE clinic

San Ysidro Health Center currently operates a PACE program and is in the process of opening a second location. Of the 124 PACE program sites around the country, only 6 or 7 are administered by a Health Center. PACE programs come with challenges, including high capital requirements, operating costs, a relatively slow growth rate, and strict regulatory requirements. However, San Ysidro transitioned into the PACE program

because of the overwhelming need in the community and the projected growth of PACE enrollees in the area. Staff at San Ysidro caution other Health Centers to consider the benefits of building capacity to serve this population in advance. One such mechanism is to take advantage of the Community-Based Physician Waiver, which allows the Health Center to expand into other areas by partnering with Health Centers and contracting with physicians in the community to provide services to PACE patients.

The **Senior Network and Activity Program (SNAP)** began in 2012 and is funded by the Contra Costa Mental Health Department. SNAP provides seniors living in public housing in West Contra Costa County with social and recreational activities[53].

The Alivio Medical Center is also a **Benefits Enrollment Center**. Through funding from the National Council on Aging, Health Center staff screen patients and identify eligibility for public programs, such as Medicare, Medicaid, Medicare Savings Program, food assistance, and other local programs. Health Center staff process the application and act as the patient advocate throughout the process.

2. *SUPPORTIVE HOUSING PROGRAMS THAT ADDRESS HOMELESSNESS*

Many of the Health Centers also noted the vulnerability of the senior public housing population and importance of both preventing homelessness as well as supporting the existing homeless population. For example, LifeLong Medical Care has developed a robust permanent **Supportive Housing Program (SHP)** to bring health and social services into subsidized housing, particularly for residents with a history of homelessness[54]. Their SHP collaborates with community organizations, public agencies, housing owners, and property managers to

provide services to nearly 600 residents in Alameda County[55].

They have two programs that provide street outreach to the chronically homeless: **COACH/Square 1 Project** in Berkeley and the **OPRI - Oakland PATH Re-housing Initiative** in Oakland. LifeLong provides primary health care, mental health services, and case management with a focus on finding and maintaining stable housing in the community [56]. Other community partners, such as ABODE services, Operation Dignity, Alameda County Behavioral Health Care Services, Berkeley Mental Health, and the City of Berkeley and the City of Oakland provide support and services[57].

California's Veteran's Administration provides funding for **Every Vet Home – Supportive Services for Veteran Families**. This program provides outreach, case management, and short-term housing subsidies to reduce homelessness for veterans and their families[58].

LifeLong Medical Care works with staff from Highland Hospital and Alta Bates/Summit Hospital to identify and outreach to chronically homeless and mentally ill adults through the **Project RESPECT – Frequent Users of the Emergency Department** program[59]. In collaboration with Homeless Action Center, LifeLong provides case management, primary care, mental health, housing assistance, benefits advocacy, and transportation assistance[60].

3. *ADDRESSING THE CHALLENGE OF TRANSPORTATION*

All Health Centers noted that the major challenge for seniors living in public housing is access to transportation. Specialized transportation is particularly important for improving access to care for high-risk, low-income populations who do not drive and have difficulty taking public transportation because of

disability, age-related conditions, or income constraints[61].

ACA provides transportation support to state Medicaid programs through home- and community-based services[62]. However, relatively few states and municipalities are taking advantage of those opportunities for seniors and adults with disabilities[63]. The transportation support is a mandatory benefit for medical appointments, but state Medicaid programs can also choose to cover nonmedical, community transportation[64]. In 2016, 38 states had Medicaid HCBS 1915(c) waivers that provided optional transportation services[65]. The ACA initiatives states used to fund nonmedical community transportation to include Money Follows the Person, Community First Choice, Balancing Incentive Program, and Section 1915i State Option[66].

Seniors using Dial-a-Ride transportation in Connecticut

In Connecticut, seniors and the disabled access a state and locally-subsidized program called **Dial a Ride.** The Americans with Disabilities Act (ADA) requires transit agencies to provide alternative transportation for those who are unable to use public transit due to a disability. In some areas, residents can use the low-cost door-to-door transportation to go to medical appointments, the grocery store, and visit friends and relatives. Federal legislation authorized funding, but states and localities must provide matched funds to access the resources[67]. Some cities pool their resources with other towns to share drivers and

buses allowing them to serve adults in their area[68].

Many of the Health Centers have, or are in the process of starting, **Mobile Health Services** to serve public housing residents. Charter Oak Health Center is collaborating with the local housing authority and resident coordinators to provide onsite medical care at senior housing sites. The Health Center is planning to hold a health fair in the north part of Hartford in the spring, which will include Hepatitis C screening.

4. *SHIFTING THE CULTURE*

Another trend in the discussion with Health Center staff focused on the challenges of attracting new senior patients. When creating new senior health programs or senior health centers, staff found it difficult to engage with the senior population and encourage them to visit the clinics for health care services. Many of the seniors in the community had developed the habit of visiting their local hospital for all of their health care needs and were reluctant to switch to an unfamiliar health care setting where they did not know the staff or providers.

To address this issue, Community Health Initiatives, Inc. in Brooklyn provides a health education series called the **Senior Club**. The president of Carroll Gardens Senior Citizen Housing, a 101-unit building for low-income elderly, is also a member of the Board of Directors at Community Health Initiatives, Inc. Under her leadership, the Senior Club has organized regular onsite health education discussions with various specialists and primary care providers. For example, a podiatrist discusses foot care and diabetes and nurses provide food security screenings.

Carroll Gardens Senior Citizens Housing

The Senior Club has been well attended and well received. However, the success of the club has only slightly translated to higher attendance at the local Health Center. The CEO of Lifelong Medical Center acknowledged that it can take a long time to develop a rapport with the senior community and even longer to change their behaviors. In addition to engaging with seniors in their homes, he encourages Health Centers that are beginning new senior programs to develop relationships with the discharge staff at local hospitals. Many times, the discharge staff are looking for local services that can benefit their senior patients as they transition from the hospital to their home. He suggests Health Center staff reach out to them, introduce them to the services available at the Health Center, and follow up with them on an ongoing basis to cultivate the relationship.

5. *COLLABORATIONS ARE CRITICAL*

Seniors require multiple types of health and social services; therefore, it is critical that Health Centers engage in partnerships with other organizations in the community. Many of the Health Centers participating in this study have a mixed population of Board members from several industries, including the area agencies on aging, local hospitals, health departments, and the housing authority. This allows them to maintain communication and identify opportunities to better serve their senior patients.

Supportive service programs offered in home and community settings often involve collaborations between housing providers and health providers who understand the important role of stable housing in supporting health and well-being.

Casa Maravilla, a 73-unit senior housing building in Chicago, is a great example of a public and private partnership between Alivio Medical Center, The Resurrection Project, and the City of Chicago Department of Family and Support Services Area Agency on Aging. The Resurrection Project is a nonprofit organization that purchased land from Alivio to build the senior housing project. Alivio allowed the sale of the land with the caveat that affordable units be set aside for seniors. The Resurrection Project agreed and leases out 7,000 square feet of the first floor to the City of Chicago free of cost for a Senior Center, which is managed by Alivio Medical Center. Alivio works with another non-profit to provide monthly onsite wellness and health education programs.

> *"It's been a remarkable experience, one of the things that it enables us to do is to talk to people in the community and young people about how meaningful and fulfilling it is to work with older adults."*
>
> *-Alivio Medical Center Staff discussing Casa Maravilla*

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Enhancing Health Care Delivery for Residents of Public Housing

Casa Maravilla in Chicago, IL

6. MULTIDISCIPLINARY TEAM

The programs and services offered to senior patients at many of the Health Centers participating in the study include: geriatric health care, adult day health services, counseling and mental health services, case management, optometry, podiatry, dementia care, end-of-life care, and geriatric dentistry, and wellness programs. As a result, the Health Centers have developed a robust and diverse staff. At Lifelong Medical, older patients receive care from a team that includes primary care providers, nurses, social workers, and specialists. The clinics offer preventive, educational, and supportive services to keep elders active and independent as well as to support those who need more assistance. Staff provide visits in the home or hospital to maintain a connection when patients are unable to come to the clinic in person. There is also an Adult Day Health Center that provides daytime nursing care, social activities, and therapeutic exercise for patients that need additional support living at home.

Community Health Initiatives has 1 full time Outreach and Enrollment Specialist that is also a Certified Applications Counselor. She lives in the housing development and helps with getting the population access to health insurance.

At Charter Oak Health Center, there is a Public Information Officer whose role is to communicate with the community, provide philanthropic engagement, and external communication and relationship development, including building initiatives with public housing. Having a dedicated staff member to engage in that capacity has increased opportunities to collaborate in the community.

Physicians that specialize in geriatric care provide services at some of the Health Centers sites. However, others rely on internal medicine physicians to provide care for their senior population. Health Centers also participate in residency training programs to improve patient access to specialty care.

Implications

The burden of housing costs for older adults has increased for all income groups [69]. Almost half of all renters over the age of 50 pay more than 30% of their monthly income on housing[70]. One study projected that the national demand for senior housing will increase from approximately 18,000 units per year in 2010 to nearly 76,000 units per year in 2030[71]. Yet, the senior living inventory grew only 1.7 percent over 2014[72]. This indicates that housing markets are not providing older people with affordable options that they need. In 2013, there were only 65 affordable and available units for every 100 very low-income households (with incomes less than 50 percent of the area median), with an even bigger gap for those with extremely low incomes[73]. At the same time, the volume of subsidized housing and housing vouchers has declined. Therefore, housing authorities are not only faced with a growing aging population, but a population that is more likely to remain in public housing for a longer period due to a lack of affordable options. Therefore, it will be critical for public housing authorities and Health Centers to work together to maintain the health and well-being of their older residents.

Findings from this study indicate that there are several senior programs with viable funding mechanisms that Health Centers can implement in their clinics. However, in order to be successful, relationships with the community and the senior patients need to be developed thoughtfully, over time, with a dedicated range of staff providing comprehensive services. The results are worth the effort. Successful programs have been shown to increase the quality of life for seniors, as well as their caregivers.

Recommendations

For Health Centers that are interested in either developing new senior health programs or expanding their services to a senior population, the Health Centers participating in this study offer the following advice:

1. **Identify the needs of your senior population.**

Seniors are not a homogenous group. The needs of those over the age of 80 are different from those persons age 65. Therefore, it is important to understand the needs of the patient population and prioritize those services while still preparing for the variety of needs across this age group.

2. **Create partnerships with other social services and community organizations.**

Rather than trying to recreate or expand service delivery at the Health Center, cultivate and strengthen partnerships with other organizations whose missions are to provide care for the elderly.

3. **Leverage funding**

Identify the state Medicare and Medicaid-funded resources that are available to use in your area and/or any funding streams that are already existing in your community. Consider pooling resources with other Health Centers to expand delivery of services.

4. **Engage seniors**

To increase the number of seniors visiting the health center, create opportunities for providers to meet and develop a trusting relationship with seniors in the community through health education or health fairs. Many current patients may have aging family members in need of care, so create an environment that is open and friendly for aging members.

5. **Prepare and train staff**

Take advantage of training opportunities available for providers through local schools and institutions as well as through telehealth services.

About the National Center for Health in Public Housing

The mission of National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally-funded Public Housing Primary Care (PHPC) health centers and other health center grantees caring for public housing residents by providing training, technical assistance and research.

The PHPC program is built on a foundation of collaboration between Health Centers, Public Housing Agencies, and residents.

For more information visit www.nchph.org

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Appendix A. Best Practices Table	
Best Practice	Example
PROGRAMS THAT LINK SENIORS TO SOCIAL SERVICES	Support and Services at Home (SASH) Program Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSP) Program for the All-Inclusive Care of the Elderly (PACE) Senior Network and Activity Program (SNAP) Benefits Enrollment Center
SUPPORTIVE HOUSING PROGRAMS	Supportive Housing Program (SHP) COACH/Square 1 Project OPRI - Oakland PATH Re-housing Initiative Every Vet Home – Supportive Services for Veteran Families Project RESPECT – Frequent Users of the Emergency Department
TRANSPORTATION PROGRAMS	Medicaid Home and Community Based Services 1915(c) waivers Dial a Ride Mobile Health Services
PROGRAMS THAT ENGAGE SENIORS	Senior Club

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