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# State Experiences with Affordable Housing Plus Services: Report to Seniors and Persons with Disabilities, On The Move

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# State Experiences with Affordable Housing Plus Services

Report to Seniors and Persons with Disabilities, On The Move

July 17, 2009

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## **Background and Purpose**

Housing developers, providers, policy makers, and advocates, increasingly recognize that for some groups of individuals, access to affordable housing alone is “not enough.” That is, some individuals require more than shelter. Examples include individuals who have chronic health conditions (e.g., HIV/AIDS), those with physical or cognitive limitations (e.g., persons with developmental disabilities, adults with physical disabilities), and those who have a combination of health conditions or who cannot thrive in traditional housing (e.g., persons who have been homeless, individuals with chronic mental illness). Increasingly, housing providers, social service agencies, advocates, states, and federal agencies have recognized the need to combine housing with supportive services designed to address the health and social needs of such groups and individuals.

Older adults want to remain in their homes as long as possible (Bayer & Harper, 2000), and providing supportive services to them in their homes is one approach to preventing or delaying unnecessary institutionalization in an acute or long-term care facility (Gibson et. al., 2003). Increasingly, policy makers and advocates recognize that “homes” includes subsidized rental units occupied by older persons and adults with disabilities.

There are a variety of affordable housing and service models across the United States, and they fall under a range of categories and terms (e.g., permanent supportive housing, enriched housing, affordable housing plus services). Whether or not some combination of housing and services can meet the needs of individuals transitioning out of nursing homes remains a question of interest to current nursing home residents, advocates, and policy makers. The purpose of this report is to describe examples of affordable housing plus services (AHPS) that might serve as models for Oregon’s On the Move demonstration project (a Centers for Medicare and Medicaid Services Money Follows the Person project).

For this analysis, we reviewed existing reports and articles and collected information about policies and programs in several states in order to learn whether older adults and persons with disabilities, including those discharged from nursing homes, might be served by AHPS programs. Given that Oregon has a long history of providing home and community-based

services, we focused primarily on unlicensed housing models rather than licensed residential settings such as assisted living and adult foster care. It is important to note that other states do not have as well-developed a home-and community based care network as does Oregon. Thus, for some states, assisted living is being promoted as a relatively new, and less expensive, alternative to institutionalization. In Oregon, one goal of creating nursing home alternatives is to expand individuals' choices to include affordable housing plus service options.

## **Approaches to Combining Housing and Services**

There is no single type of, or approach to, combining housing and services. The Institute for the Future of Aging Services defines AHPS as comprised of three elements: independent, unlicensed, largely subsidized multi-unit housing where large numbers of low- and modest-income older adults live; available health-related and supportive services, funded separately from the housing, and a "purposeful linkage" between residents and services (Harahan, Sanders & Stone, 2006).

We focus on the addition of services to existing affordable housing because there are several advantages to this approach. First, economies of scale can be achieved by bringing services to large numbers of persons in one place. Second, comprehensive services can be provided more effectively. Third, with this approach, persons who need assistance do not have to seek services alone. Finally, it can extend aging in place opportunities not always available to lower-income persons (Golant, 2008).

In recent years, different groups of practitioners who serve different populations have separately arrived at the approach of AHPS as an optimal living environment for those whom they serve. While the populations served differ in terms of abilities and place in life trajectory, they all benefit from an environment enhanced by supportive services. These populations include older adults, homeless people of all ages, people with chronic mental illness, persons with developmental disabilities, and people in drug or alcohol recovery. While AHPS as a solution spans each of these populations, the philosophy behind program delivery, the specific array of services, the desired individual outcomes to be derived from an AHPS living environment, and the funding streams (especially for services) differ. In this report, we primarily focus on the

research and approaches that serve frail older adults and persons with disabilities or chronic mental illness.

One goal of AHPS is to support individuals to “age in place” despite declining health and increasing disability. At the local level, many different approaches to achieving this goal exist. Researchers have undertaken exhaustive surveys and categorized the various approaches to combining housing and services for older persons. Harahan, Sanders, & Stone (2006), from the Institute for the Future of Aging Services, identified 12 types of affordable housing plus services (see Appendix 3). Golant (2008) identified nine features of affordable housing and services that result in eight types of AHPS (see Appendix 4). Pynoos (2006) has summarized affordable housing and service types and subsidies (Appendix 5). Likely there are other typologies of housing and services in existence. The variety of AHPS types results in large part from the fact that there has not been a national effort to coordinate or integrate housing and services. At the national level, the Department of Housing and Urban Development is primarily a housing agency and the Department of Health and Human Services is a health and social service agency. With limited collaboration between these two agencies, most of the effort to merge housing and health has happened at the state-level, individual housing sponsor level, and at the level of individual projects. Three elements are common among the variety of AHPS projects:

- A living unit that is made affordable by one or more investment strategies (public and/or private)
- Services provided either by the housing operator or by one or more outside agencies to tenants who reside in or near a specific building or neighborhood
- Recognition by advocates, policy makers, and/or providers that individuals prefer to live in the most homelike setting of choice

Given the list of housing and service arrangements listed above, the potential for variety among housing and service options is great. In the following, we summarize specific characteristics (subsidy types, resident populations, services offered) of AHPS programs in several states.

## **Overview of the Extent and Nature of Services in Subsidized Housing for Older Adults**

Four of the primary federal programs that have provided publicly-subsidized rental housing for older persons are Public Housing, HUD Section 202, state bonds coupled with federal rent subsidies and the low-income housing tax credit (LIHTC) program. In addition, HUD Section 811 funds publicly-subsidized housing for persons with disabilities. Two of these programs—Public Housing and state bonds with federal rent subsidies—no longer accept applications for new projects. HUD awards funds to new projects under the Section 811 and 202 programs annually through a national competitive process. The LIHTC program is administered at the state level and provides access to equity financing to help construct affordable housing for low income populations of all ages and abilities. Finally, some older adults are able to access affordable housing through the Section 8 voucher program, which provides a monthly rental supplement.

While all of these programs offer access to apartments with rents that are affordable to low-income older adults, none provides services directly. HUD has had grants available to subsidize the cost of resident service coordinators or case managers. Specifically, HUD offers, on a competitive basis, grants to fund the ROSS Service Coordinator program which provides funding to hire service coordinators who assess needs and coordinate services for residents of conventional public housing or Indian housing. According to a recent NOFA for ROSS grants (FR 5200-N-14; OMB Approval Number 2577-0229), “the ultimate goal of an Elderly/Disabled Service Coordinator is to ensure that residents can maintain independent living and age-in-place in their units and avoid placement in a full-care facility to the greatest extent possible.”

A survey of HUD 202 properties found the need for more supportive services accounted for 52 percent of the reasons that individuals moved out of Section 202 properties (Heumann, Winter-Nelson, & Anderson, 2001). However, just over one-third of properties had a service coordinator. For those that provided services on site, the most frequently offered services were social activities (28.8%), social work (12.1%), case management (8.2%), religious activities (8.2%) and group dining (7.1%). External agencies also provided services, including: medical screening (18.7%), transportation (17.5%), housekeeping (16.6%), religious activities (13.7%), and personal care (12.1%). The other services offered, either on-site or by an external agency, included: medication management, money management, and physical recreation. In addition,

family or friends were the typical providers of money management or budget and external agencies provide transportation in addition to some of the services listed above. These statistics are not surprising based on the limitations imposed by the ROSS service coordinator programs. The grant funds pay for the service coordinator salary, not services. As indicated by the title, the primary role of the service coordinator is to coordinate services provided by outside agencies.

In 2001, AARP surveyed LIHTC-subsidized properties in order to collect information about the types of services provided in these settings. Based on 1,558 surveys, they learned that over half (54%) of properties designed primarily for older persons did not offer any services (Kochera, 2002). About one-third of LIHTC properties for older persons did not have or provide access to a service coordinator, but twenty-one percent of LIHTC properties for older persons had a service coordinator on staff, and forty-seven percent did not have a service coordinator on staff but had access to a community-based service coordinator. Among the properties that did provide services, the most common services were social/recreation activities (41 percent), transportation (20 percent), group meals (16 percent), and housekeeping (13 percent). The external subsidy sources for these services came from charitable organization (62 percent), city or state program (61 percent), and Medicaid (37 percent) (Kochera, 2002).

Golant (2008) identified several common approaches to packaging services provided in affordable housing:

- On-site services from housing provider's hired staff
- On-site services initiated by housing provider from volunteers
- On-site services arranged on an as needed basis by housing provider from various outside providers
- On-site and off-site services, subcontracted (or other partnership agreements) by provider
- On-site and off-site services received from a comprehensive service program (e.g., auspices of a state agency)
- Co-located (separately owned and managed) services offered on housing site or at proximate location (e.g., PACE program)
- On-site and off-site services arranged by tenants' organization
- Various combinations of these service delivery approaches

Common subsidy sources for residents of affordable housing are listed in Appendix 5.

## **Affordable Housing Plus Service: State Efforts and Project Case Studies**

The primary task of this report was to identify state strategies for combining affordable housing and supportive services that might provide options for individuals who currently reside in nursing homes. As described above, some states have taken steps to promote the merger of housing and services, while other efforts have occurred at the level of individual housing sponsors of projects. Thus, this report will begin by describing five states that have very developed AHPS programs (Connecticut, Massachusetts, New Hampshire, New York, and Vermont). The next section profiles efforts that other states have used to take to combine housing and services (Florida, Ohio, Pennsylvania, Washington, Wisconsin). We then profile five specific AHPS projects in Washington that serve as examples of the types of services offered to diverse client groups in subsidized housing. We conclude by summarizing lessons learned. Several appendices include detailed information about housing and service models, subsidies, the methods used to collect the information described in this report, and the individuals who were interviewed.

### **AHPS Across the States**

In this section we summarize state strategies starting with five (Connecticut, Massachusetts, New Hampshire, New York, and Vermont) that have very developed AHPS programs.

#### **CONNECTICUT**

Connecticut, a relatively small state in the nation has an estimated population of 3,501,252 in 2007 (U.S. Census Bureau, 2008). The number of older adults will increase from 472,000 in 2007 to 794,000 in 2030. In 2007, Connecticut ranked 14<sup>th</sup> for the number of persons aged 65 and above in the country and by 2030, it is projected to be 16<sup>th</sup> highest (Houser, 2009). The state is ranked 30<sup>th</sup> in Medicaid HCBS participants (Houser, 2009). In 2007, Connecticut is ranked



46th for the number of persons aged 18-64 living with a disability and 43<sup>rd</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

**Take-away Points for Connecticut:**

- CT provides grants to fund Resident Service Coordinators (RSC) in subsidized housing
- Professional training of RSCs through University of CT
- Assisted living is licensed as a service to be delivered rather than as a residential setting
- The state supports congregate housing, including addition of assisted living services, in order to provide the most comprehensive level of services possible
- Merging housing with health and social services requires planning, training, monitoring, and evaluation of staff

Connecticut currently has three programs that assist residents of subsidized housing, 1) a Resident Services Coordinators program, 2) an Assisted Living Demonstration Project, and 3) the Congregate Housing for the Elderly Program.

The Resident Services Coordinators (RSCs). Each year the state provides grant awards to state elderly financed housing communities in order to fund RSCs. A scale based upon the number of units a community has determines the funds that are allocated. RSCs help residents gain access to supportive services and may provide a variety of activities that help residents remain in the community such as maintaining regular contact with residents, monitoring the delivery of supportive services, advocating on the behalf of residents, providing mediation and conflict resolution between residents as well as helping to improve the relationship between residents and management. The Department of Economic and Community Development is partnering with University of Connecticut to conduct training for RSCs. The Connecticut Association of Resident Service Coordinators in Housing (CARSCH) provides networking, continuing education and resource development for resident service coordinators.

Assisted Living Demonstration Project. The second Connecticut housing and services program is the Assisted Living Demonstration Project, a collaborative effort between the Department of Social Services, Department of Public Health, the Department of Economic and Community

Development, the Connecticut Housing Finance Authority and the Office of Policy and Management. Connecticut licenses assisted living as a service rather than a setting. According to Robin Tofil at the state Department of Aging, this demonstration was designed for people who want to live in a community setting and who need help with activities of daily living but do not need nursing home care. It combines housing, supportive services, personalized assistance and health care to help individuals with daily activities. The project provides subsidized assisted living to persons who reside in particular affordable housing complexes.

Congregate Housing for the Elderly Program. The third program is the Congregate Housing for the Elderly Program. “Congregate housing” (CH) is defined as “a residential environment consisting of independent living assisted by congregate meals, housekeeping and personal services, for persons 62 years old or older, who have temporary or periodic difficulties with one or more essential activities of daily living” (Sheehan & Oakes, 2006). Core services are funded through a state subsidy program which is jointly administered by the Connecticut Housing Finance Authority and the Department of Economic and Community Development. Residents have their own apartments with private kitchens and baths. All units are equipped with an emergency response system and all communities have a resident services coordinator to help residents arrange for community based services as they need them. At a minimum these communities provide one meal in a communal setting, light housekeeping and 24-hour security. Transportation and socio-recreational services may also be provided. Some of these communities participate in the pilot program described above and also provide assisted living services. These communities offer additional services that may include personal care, additional meals, medication management and nursing services.

In 1997, a state task force identified the need for increased support services for frail older persons, and a program for adding assisted living services was implemented. Funding for assisted living services came from the CT Home Care Program for Elders (which oversees Medicaid waiver programs) and the Department of Social Services. Beneficiaries must meet income and assessment eligibility criteria. As of 2003, 15% of all CH residents received assisted living services. The University of Connecticut conducted an evaluation of the Congregate Housing program in order to understand how these settings were affected by adding assisted

living services (Sheehan & Oakes, 2006). Representatives from 13 of the 24 CH programs participated in focus group interviews. Twenty percent of the residents in these settings were over age 90. The main lessons were:

- Assisted living services were beneficial to helping people remain in their homes “as long as possible,” including those who would have had to go to a nursing home because they needed help managing medications.
- Unanticipated costs such as increased time demands on the CH manager who now had to coordinate with the ALS program staff
- CH managers were called on by residents when ALS staff were not in the building. Residents did not always appreciate the “difference” between housing staff and ALS staff. CH managers expressed concerns that their building was beginning to resemble a nursing home.
- Variability among CH with ALS. Each building took a different approach in regard to the total hours of on-site nursing services (4-20), number of days/week aides were available (5-7), percentage of residents receiving services (e.g., should there be a cap?), how aides interacted with non-program participants, and whether new residents should immediately qualify for ALS or if there should be a 6-month waiting period.
- Merging housing and health care models. Housing staff have no training in responding to people with cognitive impairment. How and whether housing and ALS staff share information about residents is an issue that needs to be addressed from the start (Sheehan & Oakes, 2006).

Connecticut had a 2001 Systems Change for Community Living Grant for transitioning individuals from nursing homes to community-based settings. The waiver grant staff worked with the state housing authority to prioritize 50 Section 8 vouchers each year for persons transitioning from nursing homes. Administrative issues with the housing authority resulted in a discontinuation of the vouchers; at this point the State’s Rental Assistance Program began working with the nursing facility transition program to provide housing subsidies to individuals enrolled in the program (O’Keeffe et al 2006).

## **MASSACHUSETTS**

Massachusetts has an estimated population of 6,450,000 in 2007 (U.S. Census Bureau, 2008). The number of older adults will increase from 859,000 in 2007 to 1,463,000 in 2030. In 2007, Massachusetts ranked 18<sup>th</sup> for the number of persons aged 65 and above in the country and by 2030, it is projected to be the 21<sup>st</sup> highest (Houser, 2009). The state is ranked 32<sup>nd</sup> in Medicaid HCBS participants (Houser, 2009). In 2007, Massachusetts is ranked 34<sup>th</sup> for the number of persons aged 18-64 living with a disability and 43<sup>rd</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

Take-away Points for Massachusetts:

- A state program supports the development of independent senior housing with supportive services including one meal, a wellness center, scheduled transportation, light housekeeping, and activities.
- State support for the development of affordable assisted living.

The Massachusetts Development Finance Agency (MassDevelopment) and Massachusetts Housing Finance Agency-MHFA (MassHousing) have a program called ElderChoice to address the need for affordable housing with supportive services for older persons. They offer tax-exempt financing for developments which must then reserve at least 20% of their units for low-income residents (defined as individuals with incomes less than 50% of the median average income). MassHousing's ElderChoice program was created to develop supportive living environments for individuals who would be at risk of nursing home placement. There are two components: independent living units and assisted living units.

The Elder 80/20 Program subsidizes the development of independent senior housing with on-site supportive services. At least 20% of the units in an Elder 80/20 development must be reserved for low-income (households earning less than 50% AMI) occupancy and the remainder can be market rate. Residents must be at least 55 years of age. Developments financed through Elder 80/20 must include apartments similar in size and amenities to traditional elderly housing. These developments differ by including common dining rooms, community and activity areas, and service areas such as a wellness center and professional kitchen. According to MassHousing, the

public areas for Elder 80/20 developments typically represent approximately 30% of the total development in contrast to 50% in assisted living and 15% in conventional elderly housing (Mass EOHED, 2009). Under this program, base rental fees usually cover the lease of a private apartment and a core group of services including one meal per day, an activities coordinator, wellness center, scheduled transportation and light housekeeping. Other services, such as more extensive housekeeping, laundry service, extra transportation, or personal care, may be purchased on an a la carte basis either from the facility or an outside company to address residents' increasing care needs (Mass EOHED, 2009).

In Massachusetts, assisted living is licensed as a residential setting that offers 24-hour access to personal care, three daily meals, and various supportive services (MassHousing 2009).

Massachusetts' approach pools housing and supportive service programs into one program, the MHFA ElderChoice program, so that "developers interested in providing affordable assisted living facilities need not navigate the financing and Medicaid services separately, the funding streams are coordinated by MHFA" (Lawler, 2001). This "one-stop shop" approach supported the development of 14 facilities and 1200 units as of 2001.

The Peter Sanborn Place is one example that used the ElderChoice program. This Section 202 property received an assisted living conversion program (ALCP) from HUD to convert 26 units (of a total of 72 existing units) into accessible assisted living care units. Apartments located on all three floors of the building were converted and an updated fire suppression system was installed. The renovations also included a dining room, a commercial kitchen and laundry facilities. Details on the costs are provided in Appendix 12.

## **NEW HAMPSHIRE**

New Hampshire's estimated population in 2007 is 1,316,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 166,000 in 2007 to 353,000 in 2030. In 2007, New Hampshire is ranked 32<sup>nd</sup> for the number of persons aged 65 and above in the country and is projected to be the 17<sup>th</sup> highest in 2030 (Houser, 2009). The state is ranked 38<sup>th</sup> in Medicaid

HCBS participants. In 2007, New Hampshire is ranked 34<sup>th</sup> for the number of persons aged 18-64 living with a disability and 43<sup>rd</sup> for the number of persons aged 65+ living with a disability (Houser, 2009).

Take-away Points for New Hampshire:

- The state has a system to allow services delivered by a licensed home care agency to residents of public housing who qualify for the Medicaid 1915(c) waiver.
- One public housing authority runs a Congregate Housing Services Program and a licensed home care agency in order to meet the needs of elderly residents.

New Hampshire offers a package of services that includes nursing, nursing assistant, personal care, and homemaking, to individuals who live in a specific subsidized housing unit type and are participants of the Medicaid 1915(c) home and community based care program. According to Susan Lombard with the state Bureau of Elderly and Adult Services, they pay \$36/day to a licensed home care agency to provide the package to eligible people at their setting. She suggested that the program works well for individuals with routine and predictable needs. Currently there is only one city, Laconia, where this program is offered; other housing authorities have not been interested in pursuing the model according to Ms. Lombard.

The Laconia Housing Authority website describes the program this way: "In response to the increasing longevity and sharply rising health care cost, the Housing Authority realized that the needs of seniors were changing. In 1992, they began a Congregate Housing Services Program for low income seniors, providing meals, housekeeping, laundry service, emergency response, transportation and personal care to seniors who would otherwise have to go to a nursing home. This program has served 250 residents... In 2002, LHA started an internal Home Health Agency -- this was among the first in the nation for a housing authority."

The Laconia project was profiled as a "promising practice" by the Centers for Medicare and Medicaid Services. More information is provided in Appendix 13.

New Hampshire, like some other states, is promoting resident service coordinators in subsidized housing. As part of this, they developed a very detailed training manual for RSCs (available at [http://www.nhhfa.org/bp\\_docs/rscdocs/RSCManual.pdf](http://www.nhhfa.org/bp_docs/rscdocs/RSCManual.pdf)) and they provide training workshops on topics relevant to housing with supportive services. The New Hampshire Housing Finance Agency has created a resource list of housing and supportive services for adults with disabilities.

## **NEW YORK**

New York's estimated population in 2007 is 19,298,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 2,546,000 in 2007 to 3,917,000 in 2030. In 2007, New York ranked 21<sup>st</sup> for the number of persons aged 65 and above in the country and is projected to be the 28<sup>th</sup> highest in 2030 (Houser, 2009). The state is ranked 13<sup>th</sup> in Medicaid HCBS participants. In 2007, New York is ranked 34<sup>th</sup> for the number of persons aged 18-64 living with a disability and 27<sup>th</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

### Take-away Points for New York:

- The origins of Naturally Occurring Retirement Communities with Supportive Services Programs were founded in New York City and have been expanded state-wide with state legislation.
- NORCs rely on community support and involvement, economies of scale associated with dense populations of older persons in a neighborhood or building(s), and service subsidies.
- Comprehensive health and social services are provided.
- Replication based on the NY model requires building partnership between residents and community partners, matching funds from several agencies, and identification of a neighborhood (or building) with a high percentage of older persons.

Because New York has become known for the earliest models of a NORC Supportive Services Program (NORC-SSPs) and these programs have been well-publicized, more detail is available about this program than some of the others profiled in this report.

In the mid-1980s in Penn South Houses, a moderate-income, ten-building complex of cooperative apartments housing more than 6,000 residents in New York City, became a NORC. Penn South was originally built in 1962 by the International Ladies garment Workers Union and was underwritten by the United Housing Federation. Most of the residents were union members and they lived in this building complex with common principles of mutual aid and responsibility towards each other (Lawler, 2001). The Penn South Program for Seniors (PSPS) was established in 1986. This program, initially funded for 3 years by the United Jewish Appeal- Federation of New York, brought group services, individual social services and health care services to Penn South residents (Designer Builder Magazine, 2008). The goal of PSPS was to develop programs to avert nursing facility placement and promote the well and frail elderly to remain in their own homes among family, friends and caring neighbors (Lawler, 2001).

PSPS collaborated with three key agencies, Community Services, Inc., Jewish Home and Hospital for the Aged, Inc., and the Educational Alliances, Inc, to offer services to the residents. PSPS began operating under a non-profit agency that was responsible for making policies and overseeing the funding side of the program. Establishing this agency allowed contracting with social service agencies and receiving funding from government and private foundations (Lawler, 2001).

PSPS offers a variety of health and social services: group recreation, cultural and artistic programs, home-care coordination and non-acute nursing care, social day care for those with dementia, volunteer opportunities in all aspects of the program, health education and prevention services, money management and advocacy programs. The staff consists of social workers, nurses and home-care coordinators in addition to the geriatric and psychiatric staff that collaborate from medical centers in the locality (Harahan, Sanders, & Stone, 2006; Lawler, 2001; Penn South, 2001). Penn South also is a training site for students studying geriatric psychiatry. Through this program, residents receive free psychiatric consultations and students receive the practical experience of addressing the mental health needs of older adults. In collaboration with medical centers, geriatric practitioners provide services on site, and through the Visiting Nurse Service of New York, a part-time nurse provides non-reimbursable services to



the NORC residents at Penn South (Institute for the Future of Aging Services, 2006). A key aspect of this initiative is that older adults are active in the leadership, control and participation of this program. For example, some older adults serve as “building captains” to organize residents to participate in programs and empower them to partake in building a community that address their needs and preferences. Building captains also help in identifying residents that needed medical or social support.

*Expansion of NORC-SSP in New York.* Inspired by the experiences of Penn South, New York State passed a legislation providing support for the creation of 14 new NORC-SSPs (Collello, 2007; Vladeck, 2004). New York City followed soon by passing a similar legislation. This created a path to fund housing and social services in a coordinated manner through state and local funds (Colello, 2007). Twenty-eight NORC-SSP were established in New York city alone serving older adults in public housing, moderate income condominiums, low and moderate income rentals and moderate income co-operative housing types. The city’s housing, health and social services joined in the efforts to organize and establish a basket of services within housing facilities to maintain the health and improve quality of life of older adults, and thus let them age in place. Social work services, health-care related services, education and recreational activities and volunteer services are the basic services offered in the NORC-SSPs in New York City (Vladeck, 2004; United Hospital Fund, 2005).

Social work services include case management, referral and information; help with benefits and entitlements, service coordination and linkages based on psychosocial assessments, caregiver service, support to family members, and monitoring clients that are in poor health. These services are free so that all residents can avail these services and prevent crisis situations. Professional staffs with background in gerontology provide these services to the residents.

Some of the health care-related services include direct care for individuals to manage health conditions, physical assessment, helping clients negotiate the health care system, checking vitals, and coordinating with physicians and on-site social workers. Group activities for health promotion and disease prevention and wellness programs (eg. Tai-chi, aerobics, walking clubs,

brain exercises, etc.), as well as a variety of educational, recreational, and volunteer activities are offered.

In addition to the above services, transportation, housekeeping, adult day programs and help with monthly money management services may also be available in some NORC-SSPs. These additional services are determined based on the needs of the community and the availability of funding. Some NORC-SSPs have also brought in specialized services from the larger community. For example, occupational therapy and physical therapy students have provided services to the NORC residents, mobile health screenings have been conducted, vision and audiology testing and device-fitting service have been offered, and legal services to prepare older adults for end-of-life-care have also been brought in. Eligibility for receiving services from a NORC-SSP is determined by age and residence in NORC instead of economic or functional disability criteria. Supported by public-private partnerships, most NORC-SSPs encourage older adults to participate in programs before a crisis takes place, and allow residents to participate in shaping the development and implementation of the NORC-SSP (Vladeck, 2004).

*Lessons learned from New York City NORC-SSPs.* According to New York state legislature, the NORC-SSPs saved the state from spending around \$11 million over three years by avoiding 460 hospital stays and 317 nursing-home admissions (Lawler, 2001). For a NORC-SSP initiative to succeed, it is important that the leaders are committed and share a common vision of supporting older adults' aging in place by building a community that the older adults can identify with.

The staff involved in the NORC-SSPs must be professionally trained to work from a community organizing perspective and have experience working with diverse older adults. In addition, the different agencies that are working in partnership under the NORC-SSP banner must become a part of the NORC-SSP identity. These agencies must appreciate that each provider is responsible for the success of the NORC-SSP and that one provider alone cannot address the different needs of the NORC residents. Also, receiving public funding in starting or continuing a NORC-SSP is vital as it can help in getting more funding from other organizations. It must also be kept in mind that every community is different so the needs of the specific community must be kept in view

when designing a NORC-SSP and also residents and other stakeholders must be involved in the process (Vladeck, 2004).

*Congressional Interest in NORC-SSP.* Between 2001 and 2006, the Administration on Aging (AoA) approved \$21.4 million in grant funding from Older Americans Act , Title IV-research and demonstration appropriations to support the development of NORC programs in 25 states (Colello, 2007). Also, in 2001, Congress granted \$3 million in grants to five demonstration projects to establish and test the replicability of NORC-SSPs in Baltimore, Cleveland, Philadelphia, Pittsburgh, and Saint Louis in partnership with United Jewish Communities (Ormond, Black, Tilly & Thomas, 2004).

*Replicability and feasibility of NORC-SSPs.* The New York experience indicates that NORC-SSPs are a viable initiative to help older adults age in place. However, there are some challenges that need to be kept in mind when designing a NORC-SSP in addition to the lessons learned from the New York NORC-SSPs that are discussed above.

In an evaluation of the demonstration sites, it was observed that residents appreciated the resources in the community, but found the physical arrangement of the community difficult to negotiate. For example, some communities lacked sidewalks for safe walking. Also, in some of the sites, supportive services were established by the service agencies, instead of in partnership between building managers, residents and the service agencies. Getting the input of older adults and establishing some form of communication with the residents is vital for successful program development and service delivery. Ongoing communication with residents is important because resident needs and choices change, and therefore NORC-SSPs must adapt their services based on resident needs. In addition to the AoA , most demonstration sites required complementary funding from Department of Housing and Urban Development (HUD), private foundations, etc. Most programs did well in providing help with immediate health and social needs, but addressing the long-term needs of older adults to age in place is challenging as it requires that residents trust the program and believe that it can address their needs (Ormond, Black, Tilly & Thomas, 2004).

An important feature of a NORC-SSP is to get older adults involved in programs and services before the crisis, rather than react to a situation after the crisis has occurred. A key feature of the NORC-SSP is that services are brought to the older adult in the housing development, unlike the traditional approach in which services are located off-site in a community. Also, residents are able to have a constant relationship with the service providers rather than in an episodic manner. In addition, the relationship of the providers with the community is ongoing as well, so there is an element of trust that is established between the providers and the community. The housing organization must be equally involved in looking after the welfare of their residents, rather than just attending to maintaining the structure of the buildings. Finally, the community is involved in governing the NORC-SSP program through community coalitions and the funding sources are multiple and varied.

NORC communities can arise in many different ways. In the case of New York, the presence of moderate-income housing communities and public housing with large population of older adults made it relatively easy to establish a NORC-SSP. Neighborhoods that have populations that are comprised of at least 25% elderly can be classified as NORCs (Lawler, 2001). Extending the NORC-SSP model to communities that are not as populated or to suburban settings may be challenging, if not impossible (Vladeck, 2004). Applying the strategies used in establishing NORC-SSPs in high-density areas to NORC-SSPs in low density areas may not be straightforward.

The Administration on Aging has financed five demonstration sites [in Baltimore, Cleveland, Philadelphia, Pittsburgh, and St. Louis] with Jewish social services agencies providing supportive services (Ormond et al, 2004). The four grantee sites that implemented programs rely on social workers or activity coordinators as the primary liaison with residents. The most commonly provided services include transportation, reduction of physical barriers in the build environment, and group activities (e.g., social, educational). The Jewish social service agency provides some services directly, but some categories (e.g., home health care or mental health services) are coordinated through contracted agencies. In an evaluation of the program, the grantees explained that because resident preferences change over time, it is important to establish

positive communication between residents and program staff. In addition, all grantees reported that resident mobility, within homes and in the neighborhood, was a challenge.

## VERMONT

Vermont, a relatively small state in the nation has a population of 621,270 in 2008 (U.S. Census Bureau, 2008). The number of older adults will increase from 132,000 in 2005 to 198,000 in 2020. In 2005, Vermont is ranked 18<sup>th</sup> for the number of persons aged 65 and above in the country and by 2020, it is projected to be 7<sup>th</sup> highest (Houser, 2006).

### Take-away Points for Vermont:

- The state has made a strong commitment to reducing nursing home use and uses an 1115 waiver to fund community-based services.
- Intensive service coordination and service are available to residents of subsidized housing.
- Mental health services are available for older persons whose daily activities are impaired by a mental health condition.

In the fall of 1995, Act 160 relating to the coordination, financing and distribution of long term care was passed by the 1996 General Assembly in order to improve independent living options for vulnerable elders and younger people with physical disabilities. The goal was to provide Vermonters the choice to live in the most independent and least restrictive environment (Long Term Care Reform in Vermont, 1998). Originally, the Act 160 funded two long term care coalitions to pilot the “Hope in Housing” initiative. This included the addition of “intensive service coordination and supplemental services” in two public housing facilities. These settings were chosen because “a higher proportion of their residents were admitted to nursing homes compared to residents of other housing projects” (Justice, 2003). The pilot program indicated that service coordination reduced nursing home admissions and so the state allocated Act 160 funds statewide. The new program, named Housing and Supportive Services (HASS), now includes at least 29 housing sites in the state.

The Vermont Resident Service Coordinators is an active group with the goal of improving the quality of life for residents living in congregate housing settings. They serve seniors and people

with disabilities and provide the following services: assessment; connect residents to services and agencies that meet those needs; familiarity with eligibility requirements for public benefits and public services; develop services where there are unmet community needs; work in partnership with the housing property management staff; foster communication between property management, service providers, and resident; and help residents understand lease requirements and develop skills to comply with the lease.

Resident service coordinators are employed by a public or private housing provider or by a home health or other agency contracted by the housing provider to deliver services. HUD funds salaries for some RSC's either wholly or in part. These employees must meet training requirements.

The RSC program involves collaboration among the following agencies: Department of Disabilities, Aging and Independent Living, Department of Children and Families, Department of Mental Health Services, Department of Health, private non-profit organizations, Area Agencies on Aging, home health agencies, Mental Health and Developmental Disabilities Service Agencies, and the Vermont Center for Independent Living.

To further expand Vermont's ability to provide nursing home alternatives, an 1115 Medicaid waiver demonstration program was implemented in October 2005. Called Choices for Care, it pays for care and support for older Vermonters and people with physical disabilities (Kane et al., 2005). This 1115 waiver is an extension of previous initiatives in Vermont to rebalance the state's long-term care system. The program will enroll all elderly and individuals with disabilities currently receiving Medicaid services in a nursing home or through the home and community based services (HCBS) and Enhanced Residential Care Waiver.

According to CMS, "Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been

demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.” These projects are generally approved to operate for a five-year period, with the possibility to apply for renewal for additional periods of time.

There were three types of beneficiaries identified in Vermont’s Choices for Care program: The “Highest Need” group consists of individuals entitled to nursing home or HCBS services. They must have functional need for extensive or total assistance with at least one activity of daily living (ADL). Second, the “High Need” group receive long-term care services as long as funds are available to them. Individuals in this group do not meet the criteria for the Highest Need category but they do still require extensive personal needs and rehabilitation services (Kaiser Commission on Medicaid Facts, 2006). The third category is the “Moderate Needs” group which does not qualify for institutionalized care or HCBS waiver eligibility criteria, but run the risk of admission to a nursing home (Kane et al., 2005).

The state’s Division of Disability and Aging Services lists 7 residential options: assisted living, congregate shared housing, home modification, shared housing, residential care homes, shared home health agencies, and housing and supportive services. Shared home health agencies coordinate funding so that a group of individuals with a high-level disability who reside in affordable and accessible congregate housing may share attendants who are available 24 hours per day. Another program, the Vermont Elder Care Clinician Program, is operated by DDAS and Mental Health Services. This program targets persons aged 60 and over who have a mental health concern that interferes with their daily life. Elder Care clinicians include various mental health professionals who may be trained as social workers, psychologists, or other qualified mental health professionals. Psychiatrists consult, prescribe and monitor medications. The city of Burlington has a Shelter Plus Care program combines housing with supportive services for individuals with mental health needs.

*Vermont: Challenges and Barriers.* One potential challenge to replicating the Vermont Choices for Care Program is the shared risk between the federal government and the states. In Vermont, the funding cap for the program is set at a relatively generous level and covers only long-term



services users, not beneficiaries who access only acute care services (Kaiser Commission on Medicaid and the Uninsured, 2008). This might not be true for other states.

As mentioned earlier, Vermont is a relatively small state, ranked 49<sup>th</sup> in the nation (Houser, 2006) and hence the programs it develops might have unique features that are only applicable to it instead of in other states (Justice, 2003). Thus, enhanced efforts are needed to identify other challenges that may arise in other states.

## **Additional State Efforts to Combine Housing and Services**

### **FLORIDA**

The state of Florida's estimated population in 2007 is 18,251,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 3,098,000 in 2007 to 7,769,000 in 2030. In 2007, Florida ranked first for the number of persons aged 65 and above in the country and is expected to remain in first in 2030 (Houser, 2009). The state is ranked 37<sup>th</sup> in Medicaid HCBS participants. In 2007, Florida is ranked 27<sup>th</sup> for the number of persons aged 18-64 living with a disability and 34<sup>th</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

In response to high vacancy rates and changing service needs among residential elderly populations, in 1995 the Miami-Dade Housing Agency (MDHA) converted one of its buildings into a licensed assisted living facility. The project mission included: (1) to meet the physical and emotional needs of elderly public housing residents and allow them to age in place; (2) to avoid premature transfers to skilled nursing facilities for elderly public housing residents; and (3) to find a way to improve MDHA use of Helen Sawyer (Bretos 2002; Fieldworks 2001; HSP Presentation 2002; Rothman et al 2000).

Miami-Dade Housing Agency subsidizes rent to 50 percent of area median income (HSP Presentation 2002). Resident eligibility requirements include: must be low-income individuals with an income under 90 percent of the federal poverty level; able to perform activities of daily living with supervision or assistance; be at risk of placement in a nursing home; Medicaid eligible; at least 62 years old; do not require 24-hour nursing supervision; and do not require licensed, professional mental health treatment (HSP Presentation 2002).

The Helen Sawyer Plaza houses about 100 residents, mostly women in their eighties, with varying physical and service needs (Fieldworks 2001 and HSP Presentation 2002). The building has 104 renovated efficiency and 1-bedroom apartments with air conditioning and balconies. The apartments have light cooking facilities and individual emergency alarm systems. The

building has a full kitchen with a shared dining area, a community room, administrative offices, a lobby and a maintenance staff area. The property has an electronic entry system and 24-hour security guards. Specific personal care services available to Helen Sawyer Plaza residents include: bathing, grooming, feeding, physical therapy, transportation services, and medication assistance (Fieldworks 2001). Three meals are provided per day, and thirty hours of activities are available each week.

#### *Conversion of Helen Sawyer Plaza into an Assisted Living Facility*

The conversion of Helen Sawyer Plaza into a public housing assisted living facility took three years (1996-1999). The first step in the conversion was receiving an Assisted Living Facility License (AFL)/Extended Congregate Care (ECC) license from the State. Florida statute defines an adult congregate care facility as the following: “any building or buildings, section of a building or distinct part of a building, residence, private home, boarding home, home for the aged or other place, whether operated for profit or not, which undertakes to provide through its ownership or management, for a period exceeding 24 hours, housing, food service, and one or more personal services for four or more adults, not related to the owner or administrator by blood or marriage, who require such services; or to provide extended congregate care, limited nursing services, or limited mental health services... an extended congregate care license is a specialized license which is issued to facilities which have met the basic licensure provisions of adult congregate care facilities” (Mollica 1995).

The Florida State legislature enacted a demonstration project Medicaid waiver for \$1.3 million. This was the first time a Medicaid waiver and case management were allocated to public housing; making funds available to demonstrate the provision of home and community-based services in the Helen Sawyer Plaza facility (Bretos 2002).

#### *Subsidy Sources for Helen Sawyer Plaza*

Helen Sawyer Plaza Assisted Living Facility is supported through several funding sources. HUD funds cover senior housing expenses and Medicaid funds pay for the meals, transportation, and medical, laundry, and other services provided to residents (Fieldworks 2001). Residents pay \$685 per month for services with the cost subsidized through the Optional State Supplement (OSS), a State supplement to Social Security Income (HSP Presentation 2002). Under the

Medicaid waiver reimbursement, Helen Sawyer Plaza received \$28 a day per resident and \$100 per resident per month for case management (Bretos 2002). HUD operating and utility subsidies cover roughly 12 percent of total costs (HSP Presentation 2002). The remaining costs are covered by private pay residents.

A Florida International University Center of Aging evaluation indicated that the health and mental condition of Helen Sawyer Plaza residents significantly improved and that residents were satisfied (Rothman et al 2000). Helen Sawyer Plaza was estimated to have saved the Florida Medicaid budget over \$8 million (HSP Presentation 2002).

### **Pennsylvania**

Pennsylvania's estimated population in 2007 is 12,433,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 1,890,000 in 2007 to 2,890,000 in 2030. In 2007, Pennsylvania ranked third highest for the number of persons aged 65 and above in the country and is projected to be the 11<sup>th</sup> highest in 2030 (Houser, 2009). The state is ranked 39<sup>th</sup> in Medicaid HCBS participants. In 2007, Pennsylvania is ranked 20<sup>th</sup> for the number of persons aged 18-64 living with a disability and 27<sup>th</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

The state is promoting the use of LIHTCs for subsidized housing. In 2008 they had a qualified allocation plan for accessibility and services. Applicants of new construction must build units that are accessible and "visitable." Building renovations must develop 25% of units to be visitable. The latter term describes housing that is designed so that it can be lived in or visited by people who have mobility impairments or other disabilities. The concept is similar to universal design and other design for disability guidelines except that it focuses on visitors to a place rather than persons who reside in a place ([www.visitability.org](http://www.visitability.org)). Pennsylvania's housing plan also seeks to increase the supply of accessible units by doubling the required number of units designed to accessibility standards. These units must be affordable to persons at or below 20% area median income. Finally, the allocation plan calls for creating strategies to address the service needs of residents.

Pennsylvania has a “Regional Housing Coordinator Program” (RHC) that promotes access to housing options and opportunities for people with disabilities. The program facilitates coordination between the Medicaid home and community based waiver programs and housing providers. These coordinators, based in 10 regions throughout the state, work with state agencies, housing professionals, and other organizations as needed. The RHC program was developed by the Self-Determination Housing Project of Pennsylvania (SDHP) and the Pennsylvania Housing Finance Agency (PHFA) in recognition of the barriers that persons with disabilities face in finding affordable, accessible housing. The program provides technical assistance and information on housing and services, educates program administrators and service providers about affordable, accessible housing in their region, promotes collaboration among groups, and offers training about housing, home and community-based services, renter assistance, home modification, and tenant-landlord issues. The RHC program is funded by the Pennsylvania Department of Public Welfare (DPW) and is administered through a collaborative effort of DPW and the Pennsylvania Housing Finance Agency (PHFA). The lead contract agency is Self-Determination Housing Project of Pennsylvania (SDHP).

## **OHIO**

Ohio’s estimated population in 2007 is 11,467,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 1,545,000 in 2007 to 2,357,000 in 2030. In 2007, Ohio ranked 14th for the number of persons aged 65 and above in the country and is projected to be the 24<sup>th</sup> highest in 2030 (Houser, 2009). The state is ranked 35<sup>th</sup> in Medicaid HCBS participants. In 2007, Ohio is ranked 11<sup>th</sup> for the number of persons aged 18-64 living with a disability and 27<sup>th</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

The following information was provided by Janet Hofman at the Ohio Department of Aging (ODA). The ODA has promoted the use of service coordinators in subsidized housing for at least 15 years. They believe that this model can serve the needs of low income tenants of all types (e.g., seniors, non-elderly people with disabilities, single parent families, immigrants). However, the primary source of funding for service coordinators (HUD) limits them to senior housing. The state Housing Finance Agency (OHFA) has an allocation for LIHTC properties that plan to serve "special needs" populations. In such cases, these applicants must include a

service coordinator in their budget (minimum of \$100/unit/year.) Advocates are lobbying OHFA to increase that amount.

The ODA administers a Medicaid waiver called PASSPORT that provides home care services for eligible seniors (60 +). Many PASSPORT clients live in subsidized housing. According to Ms. Hofmann at the ODA, they plan to ask the AAA case managers to identify (by comparing addresses) the number of PASSPORT clients living in particular subsidized senior housing properties, including public housing, private multifamily assisted housing (HUD and USDA Rural Development) and tax credit properties. This should help in targeting supportive services. Under discussion is a new “project-based” PASSPORT Medicaid waiver service. Rather than having 17 different home care provider agencies coming in and out of a subsidized housing property, ODA would contract with a single Medicaid certified service provider for a property. Specifically, according to Ms. Hofman, “that provider would be responsible for services for all Medicaid waiver clients in that building, and the service would be defined in a manner similar to the way most states define "assisted living" as a single capitated service, with individual variation. This new service, administered through PASSPORT, would enable the waiver to serve clients who:

- have needs that cannot be scheduled in advance,
- and/or, need smaller increments of assistance (e.g. 15 minutes several times of day rather than 4 hour blocks of time),
- and/or, need 24/7 access to supervision or who have unpredictable needs.”

Further, current “Ohio law requires that any landlord that provides or arranges for personal care for their tenants must be licensed as a care facility (assisted living/ residential care facility, adult care facility, or nursing home). This new [project-based] service would be structured so that the landlord would not be a party to the contract for services. Instead, the Area Agency on Aging would have an agreement with the landlord, and would contract with/monitor the service provider.” The ODA still has policy and program issues to resolve, including meeting Health Department rules.

The Ohio Housing Finance Agency requires universal design and visitability standards for all

funded LIHTC projects (both single family and multifamily). These standards are believed to support aging in place by removing physical barriers to independence.

Ohio has a Money Follows the Person demonstration called Home Choice administered by the Ohio Department of Job & Family Services (ODJFS). Ohio's Department of Aging and other aging network professionals were involved with development of the MFP protocol. The ODA has worked with the ODJFS group on several projects that serve both younger and older persons with disabilities, including Ohio's rental housing locator web site, efforts to change the residential code of Ohio to require visitability in one, two and three family homes, and efforts to include issues important to people with disabilities (of any age) in local, state, and federal affordable housing policy discussions. Ms. Hofman indicated that the ODHFS works with local centers for independent living to empower them to participate in these efforts. They have used Pennsylvania's approach to collaboration between the state Medicaid agency and the state housing finance agency as a model.

## **Washington**

Washington's estimated population in 2007 is 6,468,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 758,000 in 2007 to 1,564,000 in 2030. In 2007, Washington ranked 43<sup>rd</sup> for the number of persons aged 65 and above in the country and is projected to be the 40<sup>th</sup> highest in 2030 (Houser, 2009). The state is ranked 6<sup>th</sup> in Medicaid HCBS participants. In 2007, Washington is ranked 11<sup>th</sup> for the number of persons aged 18-64 living with a disability and 19<sup>th</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009). In King County, the largest metropolitan county in Washington, the percentage of seniors in poverty was 7.7% (Senior Housing WCRE). A group of six agencies<sup>1</sup> collaborated on a report, entitled *A Quiet Crisis: Age Wave Maxes Out Affordable Housing*, on the need for affordable housing. This topic is one of five current initiatives within the King County Area Agency on Aging. The report noted that more than 6,700 low-income seniors are awaiting assistance from local housing authorities, nearly 1,000 are homeless, and that an

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<sup>1</sup> King County Housing Authority, Seattle Human Services Department/Aging and Disability Services, Seattle Housing Authority, Seattle Office of Housing, King County Housing & Community Development, and King County Community and Human Services Department

additional 936 units will have to be created each year until 2025 to maintain the current ratio of seniors to affordable housing based on census projections (Quiet Crisis, 2009).

Another program that helps seniors to age in place in Seattle is ElderPlace, a PACE (Program for All Inclusive Care of the Elderly) program. This is a national program supported by Medicare and Medicaid with 61 sites nationwide, 5 of which are located in King County managed by the Sisters of Providence health system. ElderPlace is a provider-sponsored health plan with fully integrated health and wellness staff that provides for all needs a person requiring nursing home care might need. Services provided under a PACE program include but are not limited to Adult Day Care, recreational therapy, meals, dentistry, nutritional counseling, social services and social work counseling, primary medical care including doctor and nursing services and coverage for prescription drugs. One of the advantages of this program is that the providers assume full financial risk for the costs of care, no matter person's personal funds. The Sisters of Providence have been able to combine the PACE model with low-income HUD housing to seniors and individuals with disabilities in the Gamlin House. Here, residents live in independent living apartments but have access to the PACE site if needed.

Aging and Disability Services (ADS) of King County presented its Area Plan of 2008-2011 in 2007; affordable housing plus services is a part of that goal. The plan is to concentrate on the basic needs of seniors in greater King County, which is inclusive of affordable, accessible housing with the option of supportive services. ADS plans to work with both housing and community partners to "create more options for support of aging residents in public sector housing in an effort to help people remain at home as long as possible" (Area Plan of 2008-2011, pg. 43). They will require universal design in new construction and when updating existing publicly funded housing developments in order to support "aging in place." They have committed a portion of a 3.5 million dollar budget to work out how best to address this need and have set goals to work toward making their vision for the future of King County a reality. For instance, by 2009 ADS plans to work with King County Housing Authorities and other interested partners and funders to create a plan to best support aging in place. By 2011, ADS will work with housing partners to encourage affordable housing options, educate policymakers and community members regarding the advantages of universal design in public housing



development and advocate for increased funding for low-income housing assistance at both the state and federal levels (Area Plan 2008-2011, pg. 54).

## **WISCONSIN**

Wisconsin's estimated population in 2007 is 5,602,000 (U.S. Census Bureau, 2008). The number of older adults will increase from 736,000 in 2007 to 1,312,000 in 2030. In 2007, Wisconsin ranked 22<sup>nd</sup> for the number of persons aged 65 and above in the country and is projected to be the 19<sup>th</sup> highest in 2030 (Houser, 2009). The state is ranked 10<sup>th</sup> in Medicaid HCBS participants. In 2007, Wisconsin is ranked 34<sup>th</sup> for the number of persons aged 18-64 living with a disability and 49<sup>th</sup> for the number of persons aged 65 and over living with a disability (Houser, 2009).

Wendy Fearnside of the Wisconsin Bureau of Aging and Disability Resources provided the following information. She explained that they encourage adding services to existing subsidized housing for seniors and people with disabilities, but do not have a formal program in place to promote this option.

The LIHTC program has been used to finance rehabilitation of senior public housing in order to add an assisted living component. The Wisconsin Housing and Economic Development Authority (WHEDA) gives extra points for service provision when scoring LIHTC proposals. There is a project currently under development to add assisted living services to senior public housing in Whitehall, Wisconsin that used the tax credit program to finance the conversion. In this case the building is owned by Trempealeau County Housing Authority and the services are being provided by Tri-County Memorial Hospital. Tri-County holds the RCAC assisted living license. According to Ms. Fearnside, most public housing authorities are not interested in being service providers themselves, so finding a way for them to partner with the service entity is a useful way to go.

Example of assisted living services added to public housing: *Brookside Residential Care Apartment Complex (RCAC) Project Summary*

RCAC is one of 3 licensure categories of assisted living in WI – residents may not receive over 28 hours of personal care assistance per week. RCACs must be registered or certified, but not licensed as in the case of community-based residential facilities and adult family homes. This Brookside project includes renovation and addition of assisted living service component to existing public housing for the elderly in Whitehall, WI. There are 57 apartment units in three buildings, located adjacent and/or across the street from each other. At least 29 of the 57 units are to be RCAC units. It was subsidized by a Nursing Home Conversion Demonstration project sponsored by DHFS and WHEDA. The LIHTC program is financing apartment renovations and addition of an elevator, kitchen, dining room and community space. DHFS pledged 10 CIP II slots, generated by closing beds at Trempealeau County Health Care Center in June, 2006. These were converted to Family Care slots on February 1, 2009. The project is being completed in stages because it involves working with existing tenants.

The development included several agencies and programs: Dimension Development, LLC; Housing Authority of Trempealeau County (owner); Tri-County Memorial Hospital (service provider); Trempealeau County Human Services (LTC agency); ADRC of Trempealeau County; Western Wisconsin Cares; WHEDA (LIHTC financing); DHS (CIP II funding); Trempealeau County Health Care (NH partner). These agencies are listed, in part, to show that a large number of agencies must collaborate in order to create subsidized assisted living.

#### *Licensing Threshold for Service Supported Housing in Wisconsin*

Housing that provides services above a statutorily defined threshold must be licensed as a community based residential facility (CBRF) or adult family home (AFH) or be either registered or certified as a residential care apartment complex (RCAC). The following are guidelines for determining whether the services that management provides or arranges for tenants will trigger the regulatory requirements. These criteria do not apply to and in no way limit the types of services which an individual tenant may arrange or receive from a provider other than the housing sponsor.

#### *Services that May be Provided in Unregulated Service-Supported Housing in WI*

- Receive and collect information about tenants' needs and the services and assistance they receive.
- Identify and discuss changes in a tenant's need for assistance with the tenant and, if appropriate, with his/her family or guardian.
- Provide information about or refer the tenant and his/her family or guardian to agencies that provide personal care, medication administration or other nursing care, physical, occupational or speech therapy, or other health related services.
- Arrange or provide hospitality services such as transportation, meals, housekeeping, laundry, and social and recreational activities.
- Provide information about the tenant's needs to agencies to which the tenant has been referred or which provide services to the tenant.
- Provide assistance or take action in case of emergency.

*Services that Require the Facility to be Licensed, Certified or Registered as a CBRF, RCAC or AFH*

- Develop a resident service plan which includes:
  - Supervision
  - Bathing, dressing, or other personal care
  - Medication administration, dispensing, monitoring, or storage
  - Other nursing or health care services
  - Physical, occupational or speech therapy
- Arrange, contract for, or provide any of the services described above.
- Supervise tenants. Supervision means protective oversight of a person's daily functioning, including keeping track of a person's whereabouts and providing guidance and intervention when needed.

*Senior Housing With Co-Located Home Health Services*

The following describes how senior housing providers can facilitate tenant access to care services without themselves providing the care or becoming a Community Based Residential Facility (CBRF) or Residential Care Apartment Complex (RCAC). The Bureau of Quality Assurance regional office makes the final determination.

*What Can be Done in Unlicensed/Uncertified Senior Housing*

- Independent living housing can lease space to a home health agency in the same building.
- Housing staff can refer tenants to home health agencies, including any home health agency located in the same building as the independent living apartments.
- Marketing for the housing may refer to meals, housekeeping or other hospitality services that do not trigger the licensing threshold. Advertising for the housing can also say that a home health agency is located in the same building but must make clear that the on site

*What Cannot be Done in Unlicensed/Uncertified Senior Housing*

- The home health agency cannot be owned by the same parent corporation as the housing.
- The housing and the home health agency cannot have any of the same people serving as administrators or managers or on their respective boards of directors.
- The housing cannot advertise itself as an assisted living facility or as providing health care or any other services that it would be prohibited from providing without being a licensed, registered or certified residential facility.
- Housing cannot make space available to the on site home health agency rent free or at a below market rate.
- Housing cannot give preference to the on-site home health agency when referring tenants for home health services. Tenants should be advised of all available providers in the area.
- Housing cannot give the home health agency preferential access to information about tenants. Other home health agencies in the area must be given equal access to information. Sharing of any tenant-specific information would require the tenant's prior consent.

## Case Studies of AHPS in Washington

In order to learn more about specific models of AHPS, we interviewed housing providers affiliated with six organizations and visited three sites in Seattle, Washington. Each of the organizations had a mission statement to address issues of poverty and illness by combining housing with supportive services. The nature of the housing and services varied, as described in more detail below.

### The Langdon and Anne Simons Senior Apartments

2119 Third Avenue, Seattle, WA

Housing sponsor: **Plymouth Housing Group**

Clients: seniors and military service veterans (20 units reserved for homeless veterans)

Building features: 92 studio apartments (five fully handicap accessible; 11 partially handicap accessible), two tenant lounges, laundry facilities, built in 2006

Primary development source: LIHTC

Other subsidy sources: private donations, county, city housing levy, state housing trust fund

Rental subsidies: Section 8, Veteran’s (half of the residents), LIHTC



([www.plymouthhousing.org](http://www.plymouthhousing.org))

#### Services:

Property manager	Yes
Case management	Yes
Resident service manager	No
Maintenance	Yes
RN Visits	Yes
MD Visits	No
Other health care visits	Podiatrist paid by Seattle Foundation Dentist from county program
Medication management	No
Transportation	Yes
Housekeeping	Yes
Group meals	No
Social/recreational activities	Yes
Partnership with service agency	Yes

Other services: life skills coaching (how to relocate family, connect with services, deal with outstanding warrants); welcome pack (linens, personal hygiene products available at move in, provided by a grant and by church gifts)

Services they would like to provide – a daily meal, medication management, payee service

Staff: four case managers each with a case load of about 25 people. Some of the case managers specialize – one in chemical dependency, one in geriatrics, one with VA population. There is also a building manager, front desk staff, and maintenance staff.

In Seattle, the newly-built Simons residence is considered by other housing providers as the “gold standard” in AHPS for older persons. A fact sheet about this property is included in the appendix.

The Plymouth Housing Group serves approximately 1,500 residents in 11 buildings and through the Shelter-Plus-Care subsidy program, a federal program that is administered on behalf of King County. Their programs are focused on helping individuals “reach out of the cycle of homelessness” by providing case managers who offer services to help residents stabilize their lives, self-advocacy coaching and provide access to additional community resources. They make case management services available to all of their residents (<http://www.plymouthhousing.org>).

**The Theodora**

6559 35th Ave NE, Seattle, WA

Housing Sponsor: Volunteers of America of Western Washington

Clients: seniors and persons with disabilities.

Building features: 114  
60 of the beds (only 20  
but do have private  
needed. Computer  
multiple community  
a city library, grocery  
line.



unit, 134-bed; boarding home license for  
are filled). Rooms do not have showers  
bathroom; handrails can be installed if  
room, personal laundry facilities, Wi-Fi,  
rooms, exercise equipment. Located near  
stores and restaurants, and a major bus

Housing subsidy:  
Rental subsidy: HUD  
(22 units). The  
for transitional

HUD Section 202  
202 and Section 8 project based vouchers  
Veterans Administration leases 19 units  
housing.

Rent: 50 percent of area median income

Services:

Property manager	Yes
Case management	Yes
Resident services manager	No
Maintenance	Yes
RN Visits	Yes, for boarding home residents (40hrs)
MD Visits	No
Other health care visits	Nurse aides on staff 6am – 11pm
Medication management	Yes (FFS or COPES)
Transportation	Yes
Housekeeping	Yes, \$60/monthly fee
Group meals	Yes, 3 meals daily, \$289 monthly fee
Social/recreational activities	Yes
Partnership with service agency	Yes

Other: Residents who do not live in the boarding care-licensed units can pay for health-related services on a fee-for-service basis. At intake, the Theodora conducts a health assessment for DSHS residents in order to establish a nursing care plan. For non-DSHS residents, level of independence and existing health impairments are assessed upon admission; a formal care plan is not required. The Theodora informally monitors a resident’s service needs on a daily basis. If the resident’s service needs exceed those provided by the Theodora, the service coordinator and the Wellness Program supervisor work with the resident’s case manager, family, or guardian to appropriately transfer the resident.

Service they would like to offer: Considering adding payee service. The facility needs to be rehabilitated. They are trying to decide how to redesign it – to be more modern, provide services to permit aging in place. They will provide some services directly and need to contract out others. The building will likely have a mix of independent and AL units along with a kitchen and shared common spaces.

Staffing: The Theodora employs a staff of 40, including a full-time service coordinator and an LPN. The service coordinator provides information and referrals to community agencies and advocates on behalf of the resident’s needs. The LPN works for the agency wellness program, which provides oversight for medication management and minimal health services. Many of those living at The Theodora have external case managers and were referred to The Theodora due to obstacles preventing permanent residency in the community.

They have an increasing number of residents with mental illness, developmental disabilities, and physical disabilities who need supportive services. They like having a nurse on staff for when issues “come up” with other residents. The independent living tenants pay a wellness fee on a fee-for-service basis. For example, they monitor blood glucose levels on a FFS. “A lot of it is the meds – getting prescriptions, ordering, packaging, having a trained eye to see if it came and if the person is taking it.”

They try to avoid evictions and keep people until they die, but in some cases, for example, an individual’s mental illness might result in behaviors that result in eviction. The staff need a “solid mental health” background.

Barriers: the Theodora has a growing number of residents with mental illness, developmental disabilities, and physical disabilities who need supportive services. The increasing need for supportive services by some residents exceed those provided by The Theodora. However, unless the resident self-reports a decline in health or a medical provider illustrates a decreased level of independence, The Theodora cannot evict a resident based upon their physical or cognitive ability. According to the on-site manager, Charles Sheridan, in many cases a resident’s declining level of independence puts them at risk for illness or injury but they try to avoid evictions and, in many cases, keep people until death

Specific issues raised during interviews:

- Boarding care license enables an array of supportive services, otherwise unavailable in subsidized housing
- Collaboration between external case management, wellness program, service coordinator, and administration benefits residents
- Having a staff LPN enhances the health of residents, notably medication management
- Having a staff experienced with mental illness prevents resident evictions





Typical unit, The Theodora



## Martin Court

6188 4th Ave. S; Seattle, WA

Housing Sponsor: **Low Income Housing Institute (LIHI)**

Development subsidies: LIHTC, HUD, the City of Seattle and Washington State

Rental subsidies: LIHTC

Clients: Families who have been homeless, adults with mental illness

Building: 41-unit complex with a common space, two kitchens, computer and Wi-Fi access, free laundry facilities, and camera surveillance. All units include paid utilities, a bathroom, microwave, and a refrigerator, and all but 10 have a kitchen. Martin Court is U-shaped, with a courtyard and a children's playground in the open lot.



Standard unit, Martin Court

Services:

Property manager	Yes
Case management	No
Resident services manager	Yes: "housing case manager"
Maintenance	Yes
RN Visits	No
MD Visits	No
Other health care visits	Yes (mental health case manager)
Medication management	No
Transportation	No (public transit is available)
Housekeeping	Catholic Social Service volunteers
Group meals	No
Social/recreational activities	Yes
Partnership with service agency	Yes

LIHI uses a mutual housing model, in which residents actively participate in the overall management and maintenance of their housing through democratic decision-making. This model attempts to promote community-building through collaboration and commitment. Attendance at monthly meetings is mandatory. They own/operate 50 buildings in five counties; about two-thirds of the buildings have resident services. The mission of the LIHI is to prepare residents for permanent housing, however, permanent housing is not an option for some individuals. As such, Martin Court is beginning to plan a conversion of 28 units to permanent housing and enhance community partnerships in order to deliver supportive services to residents.

Martin Court does not simply provide housing, but operates a housing program. This concept identifies the diversity of needs and the housing case manager works with the residents who have a mental health diagnosis and their assigned case manager to discuss problems and provide solutions and interventions necessary to retain their housing.

At admission, residents work closely with the housing case manager to develop a service plan that prepares residents for permanent housing by addressing personal strengths and challenges in areas such as financial management, conflict resolution, and housekeeping. This plan helps residents distinguish the skills necessary for stability and cooperation within Martin Court but also in the greater community. The service plan also asks to identify their service needs, current linkages to services, and linkages they would like to make. Residents are required to meet with the housing case manager to discuss their service plan on a regular basis.

Charitable donations and a McKinney grant funds one full-time and one part-time housing case manager and various social and community-building expenses, personal hygiene items, cleaning and laundry supplies, items for an in-house food bank, and gift certificates to area thrift stores. Martin Court partners with assorted volunteer and non-profit agencies, such as Bright Spaces, an outreach program that funded the renovation of the children's play area, purchases supplies, and provides a monthly parent-child activity with a following meal. One Economy, a non-profit group, provided free Wi-Fi access to residents.



Courtyard, Martin Court



Apartment kitchenette

Specific issues raised during interviews:

- McKinney grant pays for basic needs, which eliminates numerous service referrals
- McKinney grant provides sufficient funding-- most housing programs lack funding
- Collaboration between external and internal case management and program administration benefits residents
- Mixed population is positive; mentorship and social support amongst residents
- Design of Martin Court (U-shape) encourages community-building
- Mutual Housing and Housing Program models enhance life skills necessary for independent living

**The Chancery**

910 Marion Street, Seattle, WA

Housing sponsor: **Archdiocesan Housing Authority**

Clients: Most are elderly, small number of adults with disabilities. Culturally and ethnically diverse, for about half, English is a second language. The majority have complex medical, emotional, and social needs.

Development subsidy:

Rental subsidy: HUD  
 Building features: built in apartment units 503-550 handicapped accessible handrails and emergency residents’ bathrooms if



HUD Section 202

1982, 17-story, 84 full square feet each; has 8 units and can install pull chords in the needed.

Rent: 30 percent of area median income

Services:

Property manager	Yes
Case management	No
Resident services manager	Yes
Maintenance	Yes
RN Visits	No (“but they would benefit from this”)
MD Visits	No
Other health care visits	No
Medication management	No (“this is needed”)
Transportation	Yes (volunteers and public transit)
Housekeeping	Yes (FFS, COPES, volunteers)
Group meals	No
Social/recreational activities	Yes
Partnership with service agency	Catholic Social Services (COPES)

Other: 24-hour, on-call supervision, welfare checks, computer and laundry facilities, free Wi-Fi provided by a partnership between the City of Seattle and Comcast, a community room with kitchen space, and is located near 4 area hospitals, a food bank, and a free nightly meal program offered by Chancery Place’s religious affiliate, St. James Cathedral. Operation Frontline Seattle, an outreach program that mobilizes local culinary and nutrition professionals to teach cooking and nutrition classes, visits every Tuesday; participants receive a bag of groceries at the end of the class.

Staff: A staff of 12, including a full-time service coordinator who provides information and referral services to health and social service agencies and advocates on behalf of the residents regarding their multiple needs. The service coordinator also plans monthly social and recreational programs for the residents including, pot luck meals and holiday celebrations and teaches computer literacy classes to the residents. Because the building envelop has failed, a major remodel is planned – new windows, low flow toilets, new appliances, other features

Barriers. The mission of the Archdiocesan Housing Authority is to provide client-orientated housing, however, multiple barriers prevent the delivery of essential supportive services. One such barrier is the regulatory structure aimed at prohibiting the exchange of resident health information. Additional challenges also impede the delivery of housing with services and include, the capacity of Chancery Place to provide services (skill/training, staffing level, resources, etc.) and the broad range of resident needs. They could use health services but those resources are not available in the area. The public health agency does offer mental health and behavioral programs but they are targeted toward the homeless rather than senior citizens. Chancery Place works extensively to avoid evictions, but in some cases, for example, an individual's mental illness might result in behaviors that result in eviction. Additional challenges also impede the delivery of housing with services and include the capacity of Chancery Place to provide services (skill/training, staffing level, resources, etc.) and the broad range of resident needs. Specific issues that arose during interviews:

- Chancery Place administrators cannot discuss decompensation with residents or case managers; collaboration is needed to reduce system fragmentation
- The population at Chancery Place is getting younger (mid-60s) and adaptation to this change is an organizational challenge
- Chancery Place cannot alone address the current limitations in their service-delivery model; issues of increasing disability and decreasing health amongst residents in subsidized housing is systemic.

Services they would like to offer: According to Melanie Wycoff, Director of Chancery Place Apartments, they need housing that “meets the needs of their residents”. She indicates residents need comprehensive health services, however, the service coordinator can only provide needed referrals if the resident approaches them. Additionally, community health agencies offer mental and behavioral health programs but they are targeted toward the homeless, rather than senior citizens. Wycoff also states the residents need housekeeping, medication management, meal service, and diet monitoring. Wycoff also believes residents would benefit from mandatory monthly trainings. These trainings would educate residents about aging issues, supportive services within the community, self-advocacy, self-neglect, and elder abuse and fraud.

The Archdiocesan Housing Authority has several housing communities, many of which are specific to seniors and people with disabilities. The residents can receive services through Catholic Community Services, which has a senior nutrition program, volunteer chore services, and (in some areas) non-medical home care. Through a contract with the Area Agency on Aging, they operate the African American Elders Program to coordinate services for low- and very low-income African-American elders who need assistance in accessing social and health services (Catholic Community Services of Southwest Washington, 2009). The specific risk factors for clients include: 60 years and older, chronically ill, frail, or disabled, unable to obtain services or perform activities of daily living, low-income or below poverty level, at risk of premature institutionalization, in need of multiple services in order to remain in their homes, lacking formal and informal support systems, one ADL deficit (Catholic Community Services of Southwest Washington, 2009).



**Chancery Apartment**



**Chancery Bathroom**



**Chancery Dining Room**

**The Genesee**

4425 MLK Way So, Seattle, WA

Housing sponsor: Housing Resource Group

Primary development subsidies: HUD 811 and 4% LIHTC

Additional subsidies: HOPWA, bank loan, City of Seattle OH, Federal Home Loan Bank, AHW Families, King County CTED

Capital Campaign, Sound HIPDD, State of WA

This project was part of Authority HOPE VI Vista.



Seattle Housing redevelopment of Rainier

22 Section 811 units are those units have HOPWA HIV/AIDS and a case that funding). Another 3

Families program sponsored by the YWCA who pays rent and services for families that have been homeless and have an individual who is disabled. The remaining units are affordable as workforce housing for people who work in Seattle.

for disabled persons (4 of funding for persons with manager paid through units are part of a Sound

Building features: 50 total units, 36 1-bedroom, 14 2-bedroom apartments; two HUD 811 units fully accessible and five universal design; community living room; roof terrace; 4500 commercial space leased to community-based social service agencies; built 2006.

Services:

Property manager	Yes
Case management	No
Resident services manager	Yes
Maintenance	Yes
RN Visits	
MD Visits	
Other health care visits	
Medication management	
Transportation	Yes
Housekeeping	
Group meals	
Social/recreational activities	Yes
Partnership with service agency	Yes

Other: On-site services provided to the residents encourage greater resident self-sufficiency (e.g., job training programs, financial management, childcare/educational opportunities, and health education). Additional services are provided from four agencies with whom they have MOUs: NW Family Services, YWCA, Washington State Division of Developmental Disabilities (DDD), and the Lifelong AIDS Alliance. Additional supports are provided by agencies within the

Rainier Vista development. Lauren Bertagna, Acting Field Services Administrator with DDD, indicates that many developmentally disabled residents do not have a lot of paid health resources; however, case managers provide referrals to area agencies to ensure an independent lifestyle. Case management is directly provided by DDD (no subcontract) for the residents with developmental disabilities. Housing liaison is provided to DDD by King County Developmental Disabilities Division. After DDD has identified eligible residents, the County Liaison coordinates the housing referral process, regulates vacancies, acts as a contact for Genesee management and DDD case managers, and establishes referral agreements with agencies. The waiting list is more than 12 months long.

The Housing Innovations for Persons with Developmental Disabilities (HIPDD) funding program was created in 2003 to expand the affordable housing options that are available for persons with developmental disabilities in King County. To date, the program has funded over 40 housing units, with the goal of providing ongoing funding for affordable housing projects that integrate people with developmental disabilities into communities and that help people to live a higher quality of life.



### Take-Away Points Based on Washington Case Studies

- Case management is integral to promoting aging in place.
- On-site staff on a 24-hour basis is important to promoting building and individual safety.
- Organizations must have a stated commitment to preventing evictions and keeping residents for as long as possible.
- To make housing with supportive services work, one participant said that both the housing and the service providers must “respect the expertise of the other.”
- Most residents leave subsidized housing for nursing homes, board and care homes (if available), or due to death. Some are evicted, others choose to move.
- Volunteers provide important services and material goods.
- Housing operators must develop on-going relationships with service providers.
- The range of activities that fall under the heading of “services” is great and needs to be clarified with both housing and service providers.

*Summary of AHPS programs in Washington.* Two of the properties that we visited, The Chancery and The Theodora, look somewhat similar on paper: both are older high-rise buildings subsidized by the HUD Section 202 program. However, the level of services varies widely between these two settings. Most notably, The Theodora has a board and care license for 60 beds (although only 20 of those beds are currently filled). The licensure for board and care requires 24-hour staffing and nurse oversight. Therefore a higher level of services can be provided in this building compared to most standard Section 202 properties. Residents of the independent units can purchase limited health services, such as monitoring of blood glucose levels, from the on-site medical staff. Three daily meals are provided, for a fee of \$289, to all residents. Meal times provide another way for the housing staff to see how residents are doing. The staff at The Theodora are willing to talk to residents about their health. This differs from the Chancery staff who maintain that residents’ health or personal information is a matter of personal privacy that is off topic for housing providers. This stance is common among housing providers who cite Health Insurance Portability and Privacy Act (HIPPA) and Fair Housing rules as two major reasons they cannot and do not inquire into the health or social service needs of residents.

Housing providers expect residents of subsidized housing to be independent and to follow the terms of their lease agreement. Many older residents move into these apartments believing that they will live there until they die. Managers may not share these goals, especially if the

resident's health decline leads to problems that negatively affect the property. For example, an individual with balance and/or vision problems might spill food or other items on the carpet or might burn food on the stove. The individual might become disoriented in the building or have behaviors that infringe on other tenants (e.g., trying to enter the wrong apartment, misusing public spaces, loud noises). There can be conflict between property managers and social service providers because they have different goals. For example, the property manager may want to evict a tenant who has pulled a sink from the wall for the third time while the social service person will argue that the individual is improving and needs to be given another chance. The property manager's first responsibility is to the property while the social service provider thinks first about the client. In reality, as one provider said, "you have to give equal weight to both departments."

The residents of subsidized housing programs are diverse in terms of age, ability, background, health condition, race and ethnicity, and cognitive status. These differences can create a dynamic and interesting place to live, and can lead to conflict between those who believe that people who differ from them "don't belong here." The people we spoke to agree that conflict exists but that, as one said, "there's no science" to solving or preventing such conflict. Most of the housing providers believe that "mixed populations" are generally a good thing and that housing staff need to find ways to create and support community building. At Martin Court, the staff believe that the building design, a u-shape that surrounds a private courtyard, promotes community interaction. Others sponsor quarterly pot-luck socials or encourage involvement from community members outside the building.

One participant with nearly 20 years of housing experience said that "housing is not the end of the story." Instead, housing providers who have residents with chronic health conditions or who have not been able to live in traditional housing need a combination of services. Housing providers are learning as they go, learning what services their residents require, and then finding combinations of service agencies to provide services. However, identifying sources for funding health and social services is an on-going challenge.

## **Housing and Service Lessons from Prior MFP Demonstrations**

The 2001 Systems Change for Community Living Grants program was designed to foster nursing facility transitions. An evaluation reported that each of the 15 grantee states cited the lack of affordable and accessible housing as a major transition barrier (O’Keeffe et al 2006).

Specific state efforts related to housing accessibility include:

### **Maryland**

- offered development incentives for projects that included more ADA units than is required under federal requirements resulting in the creation of 98 new units for people with disabilities;
- developers must have a marketing strategy and to work with disability organizations to help persons with disabilities access the units;
- units set aside for individuals with disabilities must be held for 30 days when they become vacant to allow time to complete all paperwork and activities needed before an individual with a disability can occupy the unit;
- some housing authorities in Maryland counties modified housing voucher set-aside priority criteria such that nursing facility patients on the voucher list could be moved to the top of the list.

### **Washington**

- The Spokane Housing Authority designated individuals leaving nursing facilities as homeless; this designation allowed them to bypass a lengthy waiting list for rental assistance vouchers.
- A Spokane ILC has a new process for assisting nursing facility residents with housing voucher applications (paid for by waiver transition or state general funds).

## **Additional AHPS Models**

Community-based organizations such as Community Development Corporations have long played a role in expanding the supply of affordable housing. They might also build on their community networks to coordinate supportive services. One example is the Nuestra Comunidad CDC in Boston. They work with seniors who own two- to three-family homes so that they can

maintain the property and rent extra units. This program maintains housing stock, creates affordable rental units, and supports older persons in their homes.

## **SUMMARY**

Publicly subsidized housing provides an important resource for persons who have low incomes. Some properties provide affordable rental units for older persons who are independent. In senior housing, providers recognize that their residents are aging and require services in order to age in place. Some of these providers have found ways to either provide services directly or establish formal relationships with service providers. There is no large scale national program to subsidize the cost of services in affordable housing. Instead, a small number of states have taken steps to either create incentives or remove barriers to linking services in housing for low income adults. At the local level, housing providers and health and social service agencies have established partnerships to deliver a range of services. In the following we summarize lessons based on the various state and local efforts described in this report.

The lessons for AHPS are divided into seven topics: 1) access, cost, and quality; 2) assessing the needs and strengths of residents; 3) services; 4) workforce; 5) resident choice; 6) living environment, and 7) community partnerships.

### **1) Access, cost, and quality**

Subsidized housing is in short supply; the most desirable buildings have waiting lists. While the rental rate is affordable to low-income persons, the cost for needed services might not be subsidized. Individuals who qualify for Medicaid, Older Americans Act programs, or other local programs may receive supportive services such as medical transportation, meals, social and recreational activities, and other social services as available in the larger community. In terms of quality, housing providers must provide reports to their financial backers that measure quality in terms of property management (e.g., lease agreements, wait list management, maintenance) rather than tenant outcomes. Individual housing providers may elect to conduct tenant satisfaction surveys. None of the housing providers we spoke to evaluate the services provided

by outside service agencies although some did describe the importance of agreeing upon objective service delivery goals. See appendix for a sample memorandum of understanding.

## 2) Assessing the needs and strengths of residents

Traditionally, housing providers do not assess residents. Residents who have case managers through programs such as aging services, mental health, or developmental disabilities agencies, are assessed through those programs, but the results of such assessments are not shared with the housing provider. One possible exception is housing with professional case management, but no standard approach to resident assessment is in practice. Case managers who have expertise in the population being served in the housing (e.g., mental health, elderly) might be better able to conduct an assessment of resident needs and capabilities that results in an appropriate package of services.

## 3) Services

As mentioned, there is no one type of service package in AHPS. Rather, if services are offered, they are based on the characteristics of the resident population in the specific housing program (e.g., formerly homeless, persons with mental illness, older persons). Based on interviews and literature review, we developed this typology of current service arrangements:

- **Basic services:** information & referral, maintenance, 24-hour emergency response, on-site laundry, community activities
- **Moderate services:** all of the above and case management, at least one daily meal (on-site or arranged at a nearby group meal site), housekeeping, transportation, social and recreational activities, formal partnership with service agencies
- **Comprehensive services:** all of the above and health services provided by a nurse or other health professional who is on-site weekly, three daily meals, on-site medical visits arranged, medication management, aging in place philosophy

Additional service package types and subsidy sources, based on literature review, are included in Appendices 1-7.

## 4) Workforce

Housing providers have traditionally been staffed with people who are expert in housing law and practice (e.g., fair housing, tenant rights, landlord rules), building construction and maintenance, and management. Some housing programs, such as the HUD Section 202 ROSS program described earlier, have funded limited social service staff. Based on the interviews we conducted, the service-based staff that housing providers either offer, or would like to offer if they could afford it, is a professional service coordinator. There is a trade organization called the American Association of Service Coordinators that describes the mission and standards of individuals who receive training and certification in this area ([www.servicecoordinator.org](http://www.servicecoordinator.org)). In addition to a service coordinator, some of the people we interviewed stated that a nurse, either on-site or as a consultant, is a valuable resource to both the residents and staff of subsidized housing. There is a need for training of individuals who work in AHPS – those with housing experience require training on social services, and *vice versa*. Training should include, at minimum, information about the health and social service needs of the target population.

#### 5) Resident choice

States have been seeking ways to shift the balance of long-term care from nursing facilities to various home and community-based service (HCBS) models. Unlicensed AHPS is not officially a type of HCBS, but such housing does expand the variety of choices for individuals who might otherwise be placed in a nursing home for lack of alternatives. Resident choice in housing type, location, and service package, must be included as part of the policy and planning process. This research was limited to providers of AHPS and state agency personnel interviewed for this report. The needs and expectations of individuals who currently reside in or might someday reside in AHPS must be documented in order to best inform solutions that work.

#### 6) Living environment

There is great variety among affordable housing types – some are small, others large, and they are located in many types of neighborhoods. Perhaps most important for this summary is the fact that the majority of living units are not handicapped-accessible, nor are all buildings staffed 24/7. While some of buildings have community spaces, congregate meals sites, laundry facilities, and on-site service agencies (e.g., home health or adult day care), many do not. Many buildings have an emergency call system. Consumers would need to carefully evaluate their individual dwelling

needs in order to identify a building that best fits their needs and expectations. In addition to the physical dwelling, some housing programs serve specific population groups (e.g., formerly homeless only, families, persons with mental illness, older persons).

#### 7) Community partnerships

Collaboration among housing and service providers is a key feature of most AHPS. The housing staff are largely responsible for establishing community partnerships. The majority of partnerships we learned about included combinations of non-profit groups (housing sponsors, service providers), government agencies (Area Agencies on Aging, Divisions of mental health, developmental disabilities, disabilities, and/or aging), and charitable organizations (religious groups, neighborhood groups). Establishing an effective and sustainable partnership requires leadership, formal agreements, and methods of evaluating outcomes.

### **Conclusions: Implications for Individuals Transitioning from Nursing Homes to AHPS**

This report focused on unlicensed, subsidized housing. It is worth noting that some states are seeking to expand access to licensed assisted living settings for low-income adults who might otherwise require nursing home placement. A report published by the Joint Center for Housing Studies of Harvard University (Lawler, 2009) identified several approaches at the federal, state, and local level that combine affordable housing and supportive services. At the federal level, current services and initiatives within HUD and HHS could be better aligned. Examples might include altering HUD's 40% income requirement for individuals who move into an assisted living residence, developing new Section 8 waiting lists for elders who apply to ALRs, integrating Medicare and Medicaid services for individuals eligible for both, review HUD insurance criteria for insuring ALRs, expanding the Medicaid home-modification waiver for home-maintenance needs related to health, establish criteria for ALR developments with LIHTC (Lawler, 2001).

Examples of existing programs that could be expanded include: the HUD service coordinator program, the HUD assisted living conversion program, and PACE. States might consider

creating a new agency that manages federal housing and health monies. Massachusetts (described above) has such an effort, called ElderChoice (Lawler, 2001).

Given that housing and services are rarely an integrated entity, we provide here conclusions that are housing-specific and those that are service-specific. Additional conclusions that cross housing and services are also evident.

*Housing-specific issues.* Most subsidized housing programs have waiting lists, limiting access. Some individuals, such as those who are currently homeless, about to be homeless, or those with a serious medical need, might receive priority placement in subsidized housing. The design of buildings varies widely. Buildings may or may not include handicapped-accessible units, emergency pull cords or other safety features, full apartments, common areas, laundry facilities, or group dining rooms. Diverse populations (e.g., younger and older, people with different disability types) within one building might present challenges to the staff, who are not trained to respond the varied needs of individuals who want to go to school or work, those who need on-going mental health counseling, and those who might be experiencing cognitive decline, depression, or other needs.

*Service-specific issues.* The scope of services available to persons who reside in subsidized housing needs to be carefully defined. Currently, if any service is provided, it is most likely limited to information and referral to community agencies. Health services are rarely provided in subsidized housing and services are rarely provided on a 24/7 basis. Resident assessment and monitoring is not routine in subsidized housing. These facts might place individuals who have unscheduled needs after business hours at risk for injury or poor health outcomes. Subsidies for on-going comprehensive supportive services are not widely available to individuals who reside in subsidized housing.

*Housing and service issues.* Some proactive non-profit housing providers have been successful at raising funds to pay for services. Not all can or will do this. In some settings, the housing subsidy prevents the housing operator from asking about or intervening in residents' health concerns. Supportive services are becoming more acceptable, even expected, in housing for



individuals and families who have been homeless. These housing types are bypassing senior housing in terms of supportive services. There is no evidence that such services are appropriate for former nursing home residents, but the organizational strategies used to partner with social service agencies might provide good models for senior housing. The Program of All Inclusive Care for the Elderly (PACE) has been mentioned as an attractive model for comprehensive housing and supportive services.

Collaboration between services providers and housing providers is critical for success. Even when housing providers want to provide or coordinate services, they must develop strong relationships with the local community of service providers. Volunteers provide critical services such as transportation, friendly visits, skills training, meals, and clothing. Volunteers might need training in order to work with individuals who have cognitive impairment, mental illness, or other disability.

In sum, there are models of AHPS that have overcome various organizational, regulatory, and financial barriers to merging housing and supportive services. Properties that offer AHPS likely provide a compelling choice to persons in nursing home, especially individuals who value privacy and independence, those who can make choices and direct their daily needs (e.g., instrumental activities of daily living), and those who are willing to work with service providers from multiple agencies.

## References: Publications & Reports

- Administration on Aging, "A Profile of Older Americans: 2001," Washington, DC: U.S. Department of Health and Human Services, Administration on Aging (2001).
- Bayer, Ada-Helen, and Leon Harper. *Fixing to Stay: A National Survey on Housing and Home Modification Issues*. Washington, DC: AARP, May 2000. Available [http://assets.aarp.org/rgcenter/il/home\\_mod.pdf](http://assets.aarp.org/rgcenter/il/home_mod.pdf)
- Bretos, C. (2002). Medicaid Waivers and Assisted Living Facilities. *Journal of Housing and Community Development* May/June.
- Colello, K. (2007). Supportive services programs to naturally occurring retirement communities: CRS Report for Congress. Available <http://aging.senate.gov/crs/aging15.pdf>
- Commission on Affordable Housing and Health Facility Needs for Seniors in the 21<sup>st</sup> Century, 2002, [http://govinfo.library.unt.edu/seniorscommission/pages/news/pr\\_020311.html](http://govinfo.library.unt.edu/seniorscommission/pages/news/pr_020311.html)
- Designer Builder Magazine, (2008). *Naturally Occurring Retirement Communities: An interview with Fredda Vladeck, Jan/Feb.*, Available: <http://www.norcblueprint.org/uploads/File/DesignerBuilderFV.pdf.pdf>
- Gibson, Mary Jo, et al. (2004). *Beyond 50.03: A Report to the Nation on Independent Living and Disability*. Washington, DC: AARP. Available: <http://www.aarp.org/research/housing-mobility/homecare/aresearch-import-752-D17817.html>
- Golant, S. (2008). Affordable Clustered Housing-Care: A Category of Long-Term Care Options for the Elderly Poor. *Journal of Housing for the Elderly* 22, 3 – 44.
- Golant, S. (1999). *The CASERA Project: Creating Affordable and Supportive Elder Renter Accommodations*. Tampa, FL: University of Florida. Available: <http://www.geog.ufl.edu/faculty/golant/CASERAREPORTFINAL.pdf>
- Harahan, M., Sanders, A., & Stone, R. (2006). *Creating new long-term care choices for older adults: A synthesis of findings from a study of affordable housing plus services linkages*.
- Heumann, L., Winter-Nelson, K., Anderson, J.R. *The 1999 National survey of Section 202 elderly housing*. Washington, DC: AARP.
- Houser, A., Fox-Grage, W., Gibson, M.J. (2006). *Across The States: Profiles of Long-Term Care and Independent Living, Seventh Edition*. AARP Public Policy Institute.
- Kaiser Commission on Medicaid Facts. (2006). <http://www.kff.org/medicaid/upload/7540.pdf>

- Kane, R.A., Kane, R.L., Priester, R. et al. (2005). *Rebalancing Long-Term Care Systems in Vermont: Experience up to July 31, 2005*.
- Kassner E., Reinhard, S., Fox-Grage, W. et al. (2008). *A Balancing Act: State Long-Term Care Reform: Research Report*. Available [http://www.aarp.org/research/longtermcare/programfunding/2008\\_10\\_Itc.html](http://www.aarp.org/research/longtermcare/programfunding/2008_10_Itc.html)
- Klyszeiko, C. (2007). *Housing and the Needs of Vermont's Aging Population*. Available <http://www.vhfa.org>.
- Kochera, A. (2002). *Serving the Affordable Housing Needs of Older Low-Income Renters: A Survey of Low-Income Housing Tax Credit Properties*. Washington, DC: AARP.
- Lawler, K. (2001). *Aging in Place*. [Report]. Cambridge, MA: Joint Center for Housing Studies of Harvard University. Access on June 2, 2009 at: [http://www.jchs.harvard.edu/publications/seniors/lawler\\_w01-13.pdf](http://www.jchs.harvard.edu/publications/seniors/lawler_w01-13.pdf)
- Milbank Memorial Fund. (2006). *Public Housing and Supportive Services for the Frail Elderly: A Guide for Housing Authorities and Their Collaborators*
- National PACE Association (2008). "Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)." Available: <http://www.npaonline.org/website/article.asp?id=12>
- O'Keefe, J., O'Keefe, C., Siebenaler, K., Brown, D., Anderson, W. (2006). *Real Choice Systems Change Grant Program FY 2001 Nursing Facility Transition Grantees: Final Report*. Washington, DC: ASPE.
- Ormond, B.A., Black, K.J., Tilly, J. & Thomas, S. (2004). *Supportive Services Programs in Naturally Occurring Retirement Communities*. Washington, DC: Urban Institute
- Penchoff, J. (2006). *Vermont's Choices for Care Wins 2006 Innovations Silver Society Award*. <http://www.csg.org/pubs/Documents/sn0611VermontsChoicesforCare.pdf>
- Penn South, (2001). *About us: Weaver of dreams, too*. Available: [http://www.pennsouth.coop/PublicPages/about\\_weave.html](http://www.pennsouth.coop/PublicPages/about_weave.html)
- Pynoos, J., Liebig, P., Alley, D., Nishita, C.M. (2004). Homes of choice: toward more effective linkages between housing and services. In J. Pynoos, H. Feldman, J. Ahrens (Eds), *Linking Housing and Services for Older Adults*. New York: Haworth Press.
- Rothman M, Dunlop B, Seff L, Hebert K and Condon K (2000). *Assisted Living in Public Housing: An Evaluation of Helen Sawyer Plaza*. SE Florida Center on Aging: Florida International University.

Sheehan, N., Oakes, C.E. (2006). Bringing assisted living services into congregate housing: housing directors' perspectives. *Journal of Aging & Social Policy*, 18(1), 65-86.

United Jewish Communities, (n.d.). *History of UJC's aging in place initiative*. Available: <http://www.norcs.com/page.aspx?ID=160579>

United Hospital Fund, (2005). *A directory of NORC supportive service programs in New York City*. Available: [http://www.uhfny.org/usr\\_doc/NORC\\_March\\_2005\).pdf](http://www.uhfny.org/usr_doc/NORC_March_2005).pdf)

Vladeck, F. (2004). *A good place to grow old: New York's model for NORC supportive service program*. Available: [http://www.uhfny.org/usr\\_doc/goodplace.pdf](http://www.uhfny.org/usr_doc/goodplace.pdf)

### **References: Agency and Program Websites**

Archdiocesan Housing Authority/Catholic Community Services, <http://www.ccsww.org>

Catholic Community Services of Southwest Washington (2009).  
[http://www.ccsww.org/site/PageServer?pagename=seniors\\_africanamericanelders](http://www.ccsww.org/site/PageServer?pagename=seniors_africanamericanelders)

Cathedral Square Corporation. <http://www.cathedralsquare.org/>

Columbia Legal Services (Updated July 2009 ). "Questions and Answers on the COPEs Program." [www.washingtonlawhelp.org/documents/1541615102EN.pdf?stateabbrev=/WA](http://www.washingtonlawhelp.org/documents/1541615102EN.pdf?stateabbrev=/WA)

Connecticut Association of Resident Service Coordinators in Housing:  
<http://www.chfa.org/MainPages/CARSCH-HomePage.htm>

Fieldworks (2001). Miami Housing Agency Brings Assisted Living to Frail Elderly.  
<http://www.huduser.org/periodicals/fieldworks/0201/fworks2.html>

Florida Department of Elder Affairs (2008). The Extended Congregate Care Annual Report.

Florida State Legislature (2001). *Senate Bill 1202*. Tallahassee, FL

Plymouth Housing Group, Seattle, WA <http://www.plymouthhousing.org>

Cedar River Group (2009). *A Quiet Crisis: Age Wave Maxes Out Affordable Housing*, King County Washington, 2008-2025.

Helen Sawyer Plaza (2002). [www.hud.gov/offices/pih/pihcc/helensawyerplaza.ppt](http://www.hud.gov/offices/pih/pihcc/helensawyerplaza.ppt)

Laconia Housing Authority: <http://www.laconiahousing.org/HTML/History.html>.

MassHousing. (2009).  
[https://www.masshousing.com/portal/server.pt/gateway/PTARGS\\_0\\_2\\_394\\_0\\_0\\_18/ElderChoice\\_ProgramGuide.pdf](https://www.masshousing.com/portal/server.pt/gateway/PTARGS_0_2_394_0_0_18/ElderChoice_ProgramGuide.pdf)

MassHousing Executive Office of Housing and Economic Development (EOHED) (2009).

<http://www.mass.gov/?pageID=ehedhomepage&L=1&L0=Home&sid=Ehed>

Ohio MFP <http://jfs.ohio.gov/OHP/infodata/MFPGrant/protocol.pdf>

Ohio Vistability: [www.concretechange.org](http://www.concretechange.org)

Ohio rental housing locator: [www.OhioHousingLocator.org](http://www.OhioHousingLocator.org)

Providence PACE: [www.providence.org](http://www.providence.org)

Senior Services of King County, WA. [www.seniorservices.org](http://www.seniorservices.org),

Vermont 1115: Edelman, A. (2009). *Vermont 1115 Waiver Demonstration. Choices for Care Semi Annual Report July 2008-December 2008*. <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-reports-cms/publications-cfc-cms-reports-documents/cms-report-july-2008-december-2008>

Vermont Department of Disability and Aging Services. *Choices for Care (1115 Long-Term Care Medicaid Waiver)*.

<http://ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page>

Vermont Department of Aging and Disabilities. *Legislative Oversight Report (1998)*. Retrieved [www.dad.state.vt.us/Reports/Act160pages/Act160LegisOversightreport.htm](http://www.dad.state.vt.us/Reports/Act160pages/Act160LegisOversightreport.htm)

Long Term Care Reform in Vermont: An Act 160 Update. (1998).

<http://www.ddas.vermont.gov/ddas-archives/division-archives/division-archives-documents/act-160-information-1/act-160-project-report>

Center for Health Policy and Research (CHPR). (2007). *Vermont Choices for Care – Logic Model and Evaluation Plan Outline*.

<http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-reports-cms/publications-cfc-cms-reports-documents/appendix-b-logic-model-and-eval-outline>

Kaiser Commission on Medicaid and the Uninsured. (2008). *Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its Third Year*. <http://www.kff.org/medicaid/upload/7838.pdf>

Volunteers of America, The Theodora, [WWW.voaww.org](http://WWW.voaww.org)

Washington Center for Real Estate Research/Washington State University (2006). "Housing Washington's Seniors – A Profile." [www.seniorhousingwcrer.pdf](http://www.seniorhousingwcrer.pdf)

Washington Aging and Disability Services: Area Plan on Aging, 2008-2011; Pamela Piering,  
Director <http://www1.dshs.wa.gov/pdf/Publications/22-619.pdf>

Wisconsin DHS

<http://www.dhfs.state.wi.us/bqaconsumer/AssistedLiving/ALSreglmap.htm>

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APPENDIX 1. Typical Subsidy Sources for AHPS

<b>NAME OF PROGRAM</b>	<b>DESCRIPTION</b>	<b>ELIGIBILITY</b>
Affordable Housing Trust Funds	Established by legislation, ordinance or resolution to receive public or private revenues that can only be spent on affordable housing.	State and locally determined
Community Development Block Grant Program	Provides HUD funds to states and localities to further community and economic development.	State and locally determined
Home Investment Partnership Program	Provides HUD funds to states and localities to meet strategic goals defined by Consolidated Plan on a needs-based formula.	State and locally determined
HUD Section 202 Program for Non-Profit Housing Sponsors	Provides rental units and may include supportive services such as meals, transportation, and service coordination.	Very low-income persons age 62 or older
Low-Income Housing Tax Credit Program	Provides tax credits to developers who invest in affordable housing; currently the largest funding source for affordable housing.	State-determined
Mortgage Revenue Bonds and 501 (C)(3) Tax Exempt Bonds	Provides bonds for developers through state HFA.	State-determined
Public and Subsidized Housing	Refers to rental units financed by HUD. Families or individuals pay no more than 30 percent of their income on rent.	Low-income families or individuals of all ages
Section 8 Certificates/Vouchers	Covers the difference in rent above 30 percent of the income of the family/individual to live in HUD approved private or subsidized housing.	Low-income families or individual of all ages

Source: Pynoos et al (2004)



Appendix 2. Service Funding Sources for AHPS

<b>PROGRAM</b>	<b>DESCRIPTION</b>	<b>ELIGIBILITY</b>
Medicaid	Funds health care services including health screening, medication management, transportation, some personal care, nursing home care.	Means-tested low-income individuals of all ages
Medicaid Waivers	Funds non-institutional LTC services including health-related expenses, food preparation, personal care, housekeeping, transportation.	Means-tested low-income individuals who meet state nursing home eligibility criteria
Medicare	Funds health care services including post-acute home care, skilled therapy services, medical social services, durable medical equipment.	Age 65 or over
Older Americans Act	Provides services through the Area Agency on Aging including meals, transportation, health screening, case management, and other services.	Age 60 and over targeted to person with greatest social & economic disadvantage
Services Coordination	Provides HUD service coordinators in Section 202 and public housing buildings with sufficient percentage of trail residents.	HUD senior housing residents
Social Services Block Grants	Provides HHS funds to state to promote self-sufficiency, delay institutionalization for all ages.	State-determined

Source: Pynoos et al (2004)

### APPENDIX 3. Types of AHPS Housing Partnerships

1. Shared Housing
2. Mobile Home Parks/Manufactured Home Communities
3. Co-Location and Volunteerism
4. Service Coordination
5. Enriched Services and Formal Service Coordination
6. NORC Service Programs
7. State Supportive Housing Partnerships
8. Assisted Living as a Service Program
9. Campus Network Strategy
10. Integrated Housing, Health Care and Supportive Services
11. Housing/Health Partnerships

Source: Harahan, Sanders, & Stone (2006)

## Appendix 4. Features and Types of AHPS

A. *Features that differentiate housing and service models from traditional forms of long-term care delivery.*

1. Development and Management Origins
2. Setting Context and Composition of Occupants
3. Building Site Characteristics
4. Features for the Physically or Cognitively Frail
5. Long-Term Care Services Offered
6. Service Delivery Modes
7. License and Regulatory Status
8. Affordability of Shelter
9. Affordability of Long-Term Care

B. *Types of affordable housing and service models based upon the features listed above.*

1. Government-Subsidized Project, Basic Service Coordinator Model
2. Government-Subsidized Project, Service Coordinator and Supportive Service Model
3. Government-Subsidized Project, State-Sponsored Assisted Living Service Program
4. Government Subsidized Housing Project Partnering with Selected Co-Located Services
5. Government Subsidized Housing Project Partnering with Co-Located Comprehensive Care Services
6. Government-Subsidized Public Housing or HUD (privately-owned) Project, Licensed as Assisted Living Property
7. NORC/DOUER Housing Arrangements with Supportive Services
8. Private Pay Assisted Living with Subsidized Shelter and Care

Source: Golant (2008)

## Appendix 5. Subsidy Sources for Residents of AHPS

- a. HUD, Service Coordinator program
- b. Medicaid Waivers
- c. Nonprofit/faith-based organization contracted supportive services
- d. Older Americans Act programs
- e. Property refinancing proceeds
- f. Public financed long-term care (e.g., Programs of All-Inclusive Care for the Elderly—PACE)
- g. Social Services Block Grant program
- h. Rental fees (e.g., hospital rents space for care center in building)
- i. State general funds
- j. State supplement to Supplemental Security Income
- k. Tenant fees or contributions
- l. Multiple funding strategies consisting of public programs, private foundations, and nonprofit, often faith-based organizations (Golant, 2008).

Source: Golant (2008)

Appendix 6. Case Management Levels for AHPS

<b>Basic services</b>	
	Food
	Health promotion
	Recreation
	Transportation
	Information and referral
	Medication assistance
	Cognitive assistance
<b>Moderately intensive services</b>	
	Care management for tenants and coordination of services from all partners
	Assistance with ADLs
	Assistance with IADLs
	Medication assistance
	Cognitive assistance
	Adult day care
<b>Most intensive services</b>	
	Physician services
	Home health services
	Rehabilitation services (inpatient and outpatient)
	Assisted living environments and services (24-hour staffing)
	Nursing home environments and services
	Medication administration (as permitted by regulations)
	Cognitive assistance

Source: Milbank Memorial Fund (2006)

## Appendix 7. Prototype Service Packages for Merging Housing and Services

### *Model 1: Skilled and competent service coordinator*

- Focus on empowering consumers
- Collaboration with home- and community-based service providers

### *Model 2: Partnership model*

- Interagency collaboration for effective service delivery
- Written agreements among participating partners
- Maximizes resources through partnerships

### *Model 3 Congregate housing & capitation*

- One-stop shopping for services
- Services provided on site
- Cost of services determined through a capitated system

### *Model 4: Two-tiered assisted living*

- Two levels of services within a facility
- Defined set of services to be provided for each level
- Service coordination with home- and community-based services

### *Model 5: Home modification program model*

- Emphasizes leadership and coalition building
- Assesses needs and identifies strategies of effective home modifications
- Educates providers, health care professions, policymakers, and consumers

Source: Golant (1999)

## Appendix 8. Washington HIPDD Program Guidelines

- Eligible Persons -- Households with incomes at or below 50% of area median income with one or more member who receives services through the Washington State Division of Developmental Disabilities (DDD).

Persons who are eligible to receive services through DDD are individuals who have a developmental disability that appeared before the age of 18, and who, as a result, have substantial limitations that are expected to continue indefinitely. Developmental disabilities include mental retardation, developmental delay, cerebral palsy, epilepsy, autism, and other neurological conditions, including conditions similar to mental retardation.

- HIPDD Set Aside Units -- The set aside units should total no less than 2 units per project, and no more than 5 units for projects with 50 units or fewer, or no more than 10 units for projects with more than 50 units.
- Set aside units can be studio, 1, 2, 3 or 4 bedroom units. The set aside units should include a mix of unit sizes.
- Universal Design -- Units supported with HIPDD funds will be required to include specific universal design features. A checklist of these universal design features will be available at the NOFA Pre-Proposal Information meeting. The Center for Universal Design defines universal design as the design of products and environments to be usable by all people, to the greatest extent possible, without adaptation or specialized design. The intent of the universal design concept is to make housing usable by more people through good design.
- Maximum Subsidy Amount -- The maximum subsidy amount is \$50,000 per unit. Funds are available for:
  - ⇒ Additional capital subsidy to “buy down rents” from 30% to levels that are affordable for persons with DD by offsetting lost cash flow to service debt; (see chart below )
  - ⇒ Costs associated with making Universal Design additions or modifications;
  - ⇒ Capitalized Operating Reserves when not offsetting debt through capital subsidy.
- Rent Affordability – Rent levels for HIPDD funded units are: studios and 1 bedrooms at 16% median income; 2 bedrooms at 24% median income; 3 bedrooms at 30% of median income; and 4 bedrooms at 30% of median income.

Calculating HIPDD capital subsidy amounts to “buy down rents” – The chart below illustrates how the amount of HIPDD subsidy varies according to the original median income level of the unit and the size of the unit:

<b><u>30% Buy Down</u></b>					
	<b>Studio</b>	<b>1 Bedroom</b>	<b>2 Bedroom</b>	<b>3 Bedroom</b>	<b>4 Bedroom</b>
Original Affordability	<b>30% Median</b>	<b>30% Median</b>	<b>30% Median</b>	<b>30% Median</b>	<b>30% Median</b>
Yearly Rental Income	\$4,401	\$4,584	\$5,229	\$5,922	\$6,504
Monthly Rental Income	\$367	\$382	\$436	\$494	\$542
	<b>16% Median</b>	<b>16% Median</b>	<b>24% of Median</b>	<b>30% of Median</b>	<b>30% of Median</b>
Yearly Rental Income	\$2,112	\$2,131	\$3,967	\$4,464	\$6,504
Monthly Rental Income	\$176	\$178	\$331	\$494	\$542
Less Cash flow for debt	(2,289)	(2,453)	(1,262)	0	0
<b>HIPDD Subsidy</b>	<b>\$31,816</b>	<b>\$34,092</b>	<b>\$17,538</b>	<b>0</b>	<b>0</b>

**Assumptions: Utilities have been deducted from rents. Debt assumed at 6% interest with a 30 year term**

- Term of Commitment -- HIPDD funds will be a deferred, forgivable loan with a commitment to serve persons with DD in set-aside units for 30 years. Sponsors would be encouraged to maintain the units at affordable levels for persons with DD beyond the 30-year period. Additional funding may be available after 30 years to extend the affordability period.
- Proximity to Transportation -- The HIPDD housing set aside units must be located within close proximity (less than ¼ of a mile) from a regular, weekday bus route.
- Proximity to Services -- The HIPDD multi-family housing set aside units must be located within close proximity (less than 1 mile) to shopping and amenities.
- Referral Agreements -- Owners receiving HIPDD funds shall enter into a Housing Referral Agreement with the Washington State DDD that outlines the mutual responsibilities of each party. Washington State DDD will provide assurance that people referred into housing will have the necessary supports to live successfully in the community.



## APPENDIX 9. **Research approach**

This research included three components: literature review, survey of state agencies, case study of AHPS in Washington. For the literature review, we searched several library databases for reports and other published literature on affordable housing plus services.

In order to determine whether states were making a coordinated effort toward affordable housing plus service models, we contacted (via email) the directors of state aging service and housing finance agencies and asked them whether the state had a “work plan, work group, a policy study, and/or a similar activity to address strategies for delivering supportive services to older individuals who reside in subsidized housing.” This email was sent to all states and the District of Columbia. We contacted 141 potential participants by email and received a total of 31 responses to our initial email inquiry. From the 31 responses, we were referred to 26 other state agency or non-profit organization contacts with expertise in housing and services. If we did not receive a response from these individuals referred to us, we sent a follow-up email. If we did not receive a response via email, we attempted to contact them by phone. If we did not receive a response from the phone call, we identified other relevant individuals within the same agencies and contacted them via email. In all, 12 individuals responded to our research question either through an email or a telephone interview. Probable reasons for the low response rate include, the states not having a strategy that is developed enough for anyone to discuss, or we did not contact the correct individuals. We interviewed an additional 12 individuals as part of the Washington-based case studies. All participants were informed that the research was being conducted by Portland State University on behalf of Oregon’s Seniors and Persons with Disabilities and all agreed to include their names in the final report.

Because Washington state has a long-term care system and senior population that is in many ways comparable to that of Oregon, we elected to profile AHPS programs in that state. The housing programs profiled in this report were identified based on Internet search and by asking housing providers for suggestions about housing providers that offer supportive services.

Housing providers and state agency participants were interviewed in person or over the telephone in one session that lasted between 1 and 1.5 hours. The interviewer explained the

procedures and obtained informed consent prior to the interview. The interview consisted of roughly 30 questions. Responses were grouped according to the nature of housing and services approach, types and levels of service, populations served by identified housing and service programs and typical subsidy sources for both housing and services. We interviewed both on-site housing managers and senior executives of non-profit housing agencies (see Appendix 10).

## Appendix 10. Individuals Interviewed (total of 20)

**Don Ashlock**, Director of Housing Operation, Seattle Housing Authority

**Lauren Bertagna**, Acting Field Services Administrator with Washington State Division of Developmental Disabilities

**Colby Bradley**, Supportive Services Manager, Low Income Housing Institute, Seattle, WA

**Tara Connor**, Policy Director, Plymouth Housing Group, Seattle, WA.

**Shelley Doolley**, Director of Social Services, Archdiocesan Housing Authority, WA

**Emily Edmiston**, Resident Services Coordinator of the Housing Resource Group, Seattle, WA

**Wendy Fearnside**, Bureau of Aging and Disability Resources, Wisconsin Department of Health Services

**Karen Fitzharris**, Area Agencies on Aging, WA

**Toni Johnson**, Housing Coordinator, DSHS, WA

**Karen Kipling**, VP with Volunteers of America of Western WA, Everett, WA

**Diane Lee**, Housing Program Coordinator, Martin Court, Seattle, WA

**Kathi Liberman**, Housing Coordinator, Connecticut Association of Resident Services, Wethersfield Housing Authority, CT

**Susan Lombard**, Director of Operations, Bureau of Elderly Adult Services, DHHS, Concord, NH

**Lori Pizzola**, Department Commissioner for Inter-governmental Affairs, Division of Housing and Community Renewal, New York State Department of Health, Albany, NY

**Liz Prince**, Project Director, Money Follows the Person, DSHS, WA

**Rick Robbins**, Community Development Administrator of Finances and Housing, State Department of Economic and Community Development, Housing Development and Finance, Hartford, CT

**Charles Sheridan**, Administrator, The Theodora, Seattle, WA

**Karl Tegenfeldt**, Housing Coordinator, King County Developmental Disabilities Division, Seattle, Washington

**Melanie Wycoff**, Program Director, Chancery Place Apartments, Seattle, WA

**Jane Zahnleiter**, Martin Court Housing Case Manger, Martin Court, Seattle, WA

### Email responses

- Pam Catt-Oliason, Idaho Commission on Aging
- Laurie Tomlinson, Service Coordinator, Boise City Ada County Housing Authority (208) 287-1064 [ltomlinson@bcacha.org](mailto:ltomlinson@bcacha.org)
- Janet Hofmann, Older Americans Act Programs, Ohio Department of Aging, 614-466-6366. She “deals with all things housing” and will have a concept paper on their new programs available summer 2009. She recommended that questions regarding the Home Choice housing protocols for non-elderly persons with disabilities should be directed to Brock Robertson at ODJFS, [Brock.Robertson@jfs.ohio.gov](mailto:Brock.Robertson@jfs.ohio.gov)
- Mary Penny, Statewide Housing Coordinator. 610-873-9595. [mary@sdhp.org](mailto:mary@sdhp.org)  
[www.sdhp.org](http://www.sdhp.org)

<b>State</b>	<b>Project or Program name</b>	<b>Scale</b>	<b>Housing category</b>	<b>Housing subsidy</b>	<b>Services</b>	<b>Service subsidy</b>
CA	Over 60 Collaboration	40 units	Section 202		Comp	PACE
CA	Mission Creek			Multiple	Comp	
CA	Presentation Senior Housing	93 units	Section 202	HUD	Mod	Medicaid
CA	Ellis Hotel	56 units	SRO		Mod	LA Dpt of Aging
CA	Capri Hotel		SRO		Mod	City OF San Diego
CA	Potiker Family Senior Residence					
CA	WellElder Program					
CO	Eaton Terrace	81 units	Public housing	Section 8	Mod	
CO	Eaton Terrace II	81 units	Public housing	Section 8	Comp	
CO	The Towers at Golden West	150 units	Public housing	Section 8	Mod	FFS, donation
CO	Assisted Living at Golden West	150 units	Assisted living		Comp	Medicaid & state
CT	Tower One		Public housing	Section 8	Comp	private donors
CT	Tower East		Public housing	Section 8	Comp	private donors
CT	The Marvin		NORC	LIHTC	Comp	Medicaid & state
FL	Osceola County Council Aging	4 properties	Public housing	Multiple	Comp	
GA	Sixty-Plus Program				Basic	
IL	Pat Crowley House	12 units	Shared	Multiple	Mod	Exchange for rent
MA	Peter Sanborn Place		Section 202		Comp	Medicaid & state, FFS
MA	Supportive Sr Housing Initiative	22 locations	Public housing	Public	Mod-Comp	State
MN	7500 York Coop	330 units	Coop	Private coop	Comp	FFS coop
MN	Assisted living service agencies	state	registered with DoH		Comp	
NH	Sunrise Towers		Public housing	Public	Mod	Housing authority
NH	Stafford House		subsidized	LIHTC	Mod	Housing authority
NY	Penn South	2820 units	Coop	Private coop	Comp	
NY	Vladeck Cares	860 units	NORC	Public	Comp	City, state Aging, donations
NY	Fleming House		Enriched housing program			
OH	Home Choice (MFP demo)		subsidized	LIHTC	Mod	Housing Finance Agency
OH	Passport program	state	subsidized	various	Mod	Medicaid waiver
OR	Congregate Housing Services	3 properties	Public housing		Mod	

	Program					
PA	Schwenkfeld Manor		Section 202		Basic	HUD service coordinator
TX	Vega Place Senior Apt		Section 202			
VT	Cathedral Square	80 units	Section 202	HUD ALCP	Comp	Medicaid & state
VT	HomeShare Vermont					
VT	Ruggles House	14 units	Shared	Section 8	Mod- Comp	State & FFS
WA	Plymouth Housing Group	12 properties	SRO/Independent	LIHTC	Mod- Comp	private donors, VA, HUD
WA	Housing Resources Group	manages 1700 units	subsidized	Various	Basic	
WA	Seattle Housing Authority	123 buildings	Senior Housing Program	Public, HUD	Basic	
WA	Archdiocesan Housing Authority	6 senior properties	Section 202	HUD	Basic	HUD RSC program
WA	Low Income Housing Group	43 properties	subsidized	Multiple		
WI	Brookside RCAC	57 units	subsidized	LIHTC	Comp	Nursing Home conversion
WI	Sr Housing w/co-located home health		Various	Public, HUD	Mod	
	Mercy Housing	46 properties	Varies	Varies	Mod	Medicaid, private, other

**Peter Sanborn Place  
Reading, Massachusetts**

**73 Unit Assisted Living Development  
Rehabilitation Project, 100% Affordable**

**To Be Financed by MassHousing with 501(c)3 Bonds**

MASSHOUSING CASE STUDY  
 PETER SANBORN PLACE  
 REFINANCING OF SEC. 202 DEVELOPMENT WITH 501(C)3 BONDS

**PROJECT DESCRIPTION:**

Peter Sanborn Place was originally financed with a direct loan and Section 8 project-based assistance under the HUD 202 program in the early 1980's. The development provides 73 units of studio and one-bedroom apartments to residents who have continued to age in place and who rely on an increasing level of services to be able to remain in their existing apartments. Although generally well-maintained, the development is in need of capital replacements and modernization, such as updating of kitchens and bathrooms (including the addition of low-flow toilets with high seats and conversion of tubs to walk-in showers), and ADA adaptations.

By utilizing MassHousing tax-exempt 501(c)3 financing issued on behalf of the non-profit owner, the current owner can refinance its existing loan, with a balance of approximately \$3.5 million, at interest rates that are substantially lower than rates on the existing loan. In addition, by stretching out the amortization commensurate with a new 40-year loan term, the development is able to support a new loan amount of roughly \$4.84 million, yielding \$1.34 million in new resources for project rehabilitation and related costs. The use of excess replacement reserves and residual receipts provides an additional \$639,000 in project sources and, together with the new loan funds, will enable the owner to fund a reserve to supplement services in addition to funding rehabilitation and physical adaptations. In addition, cash flow from debt service coverage will be deposited on an ongoing basis to the residual receipts account and used from time to time to augment resident services.

**PROJECT SOURCES & USES**

		<u>Total</u>	<u>Per Unit</u>
<b>USES</b>			
Payoff of Existing Debt	\$1.7 million in new sources used for physical improvements, replacement reserves and service funding	\$3,494,419	\$47,869
Construction (including contingency)		1,028,170	14,085
MassHousing Financing Fees		116,461	1,595
Development Consulting/Overhead		96,800	1,326
Other Soft Costs		66,150	906
Capitalized Replacement Reserves	Lower interest rates and extension of amortization result in \$1.34 million gain in loan capital	127,000	1,740
Reserve for Resident Services		<u>550,000</u>	<u>7,534</u>
<b>Total Project Costs</b>		<b>\$5,479,000</b>	<b>\$75,055</b>
<b>SOURCES</b>			
MassHousing Tax-Exempt Mortgage (6.25 + .5%; 40 yrs)	Use of Replacement Reserves and Residual Receipts provides \$639k in project sources	\$4,840,000	\$66,301
Excess Replacement Reserves		628,000	8,603
Residual Receipts		<u>11,000</u>	<u>151</u>
<b>Total Project Sources</b>		<b>\$5,479,000</b>	<b>\$75,055</b>

MASSHOUSING CASE STUDY  
 PETER SANBORN PLACE  
 REFINANCING OF SEC. 202 DEVELOPMENT WITH 501(C)(3) BONDS

**RENT SCHEDULE**

	Low Income Units (Sec. 8 PBA)		Market Rate
# of Bedrooms	0	1	
# of Unit Type	3	70	N/A
Net Square Feet/Unit	480	543	
Monthly Rental Revenues	\$878	\$1,055	

*Rental revenues reflect Sec. 8 project based assistance*

**FIRST YEAR STABILIZED OPERATING BUDGET**

	Total Annual	Per unit Annual
<b>INCOME</b>		
Low Income Rents	\$917,808	\$12,573
Vacancy Factor - Low Income Units (1.5%)	(\$13,767)	-\$189
Market Rate Rents	n/a	-
Vacancy Factor - Market Units (5%)	n/a	-
Other Income: Laundry, Vending, Cleaning fees	\$4,300	\$59
	<u>\$0</u>	<u>\$0</u>
<b>Total Effective Income</b>	<b>\$908,341</b>	<b>\$12,443</b>
<b>EXPENSES</b>		
Operating expenses (includes service coordinator, mtg insurance)	-\$554,806	-\$7,600
<b>NET OPERATING INCOME</b>	<b>\$353,535</b>	<b>\$4,843</b>
<b>DEBT SERVICE @ 6.75+.5%, 40 years, .0774028 constant</b>	<b>(\$321,395)</b>	<b>-\$4,403</b>
<b>CASH FLOW (1.10 debt service coverage)</b>	<b>\$32,140</b>	<b>\$440</b>

*Historical vacancies are less than 2%*





# PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

## *New Hampshire – Care Options for People in Public Housing*

### **Issue: Seamless Delivery of HCBS from Several Funding Sources**

#### Summary

In New Hampshire, a public housing authority has adapted the assisted living model to public housing for older people. Sunrise Towers, a 98-unit public housing complex in Laconia, New Hampshire, offers non-medical home-based services to up to 30 residents. Since the congregate program was established in 1993, the facility has served about 150 people. The program offers a variety of services, including meals and personal assistance, to enable participants to remain in their homes.

#### Introduction

While many programs focus on home and community-based services for people in assisted living facilities and other private, residential settings, the Laconia Housing and Redevelopment Authority in Laconia, New Hampshire, has adopted this model to serve residents in Sunrise Towers, a public housing building for older persons. According to U.S. Census Bureau data (1994-1995), over 40 percent of older people in subsidized housing need assistance with at least one activity of daily living. Sunrise Towers residents benefit from long-term support options and a single point of entry for access to the state's home and community-based service programs. The housing authority works closely with other care providers in the jurisdiction, including the local hospital and public nursing home, to offer coordinated care to program participants.

**The assisted living model was applied to a public housing building for older persons.**

This report briefly describes the structure of the Sunrise Towers congregate housing program, the services the program offers, and funding sources. This document is based primarily on interviews with state officials and housing authority staff who designed and administer the program.

#### Intervention

Under Laconia's congregate housing program, people who are eligible for public housing and need assistance in at least three activities of daily living can apply to be in the program. While most program recipients were residents of Sunrise Towers prior to enrollment, that is not an eligibility requirement. The program does, however, give priority to people who lived in the building before enrollment. The program offers a variety of services: two meals a day, weekly laundry and housekeeping, personal care, transportation to and from all medical appointments, and personal emergency response systems. In addition, an on-site nursing clinic is available once a week.

Because it has been in existence for almost a decade, Laconia's congregate housing program is fairly well known in the town of about 16,000 people. People who may need services learn about the program from a variety of sources, including hospital referrals and congregate housing staff noticing a Sunrise Towers resident who needs help. The program also receives calls from family members, often adult children. For people not already in public housing, the first step is for candidates to apply for public housing and be placed on a waiting list, since the person must live in Sunrise Towers. Then Laconia Housing Authority assesses the person to determine

whether he or she meets the functional eligibility requirements.

Once eligible candidates are identified, a ten-member professional assessment committee (PAC) meets monthly to review their applications and make a final decision as to eligibility. PAC members, some of whom have been involved since the program's inception, include representatives from the local hospital, the public nursing home, and the New Hampshire

Department of Health and Human Services Division of Elderly and Adult Services. This

**Residents can transition seamlessly from the housing agency program to a Medicaid HCBS waiver.**

close working relationship extends beyond PAC meetings, and facilitates coordination of care through short-term hospital stays and transition of program participants, when necessary, to nursing home care.

Like other public housing residents, residents of Sunrise Towers are required to pay 30 percent of their adjusted gross income (AGI) for rent. Those enrolled in the congregate housing program pay up to an additional 20 percent of AGI for the services. The resident co-pay covers about 10 percent of the program's costs. The majority of the funding comes from two sources: about 40 percent from the U.S. Department of Housing and Urban Development (HUD) Congregate Housing Services Program grant. Matching state funds, which are required for the grant, provide the other 50 percent of program funds. While HUD no longer funds new congregate programs, it continues to maintain funding for 42 existing programs serving a total of 591 elderly and 75 non-elderly participants. The Laconia Housing Authority has also established a separate nonprofit foundation in order to tap into charitable donations, including funding from the United Way.

In addition to the congregate care program, residents can use a Medicaid home and community-based services waiver program for older people called Home and Community

Based Care (HCBC). Participants in both programs receive many of the same in-home services, which allows residents to transition seamlessly from the congregate care program to HCBC as their health deteriorates (and they qualify for the level of care provided in a nursing home) and as they qualify financially for Medicaid. A different case manager, from the state Division of Elderly and Adult Services, determines HCBC eligibility and works with the participant to develop a service plan. Since the Medicaid waiver offers a free choice of providers, participants can choose other agencies to provide in-home services if they use HCBC. From October 1, 2001, to September 30, 2002, five Sunrise Towers participants have transitioned from the congregate program to HCBC.

### Implementation

While the Sunrise Towers congregate housing program offers pretty much the same services today as when the program started, the Laconia Housing Authority has taken steps over time to save money and improve operational efficiencies. One example is the recent decision (made possible by a grant from the Samuel P. Pardoe Foundation) to cross-train some staff. This has enabled specific staff members to undertake more than one function – such as housekeeping, food service delivery, and personal care.

In another step forward, the housing authority recently obtained a home health license, enabling the agency to handle personal care services in-house, rather than having to contract that work out. The program's nurse oversees the personal care work performed by licensed nursing aides. In addition, the housing authority is currently training personal care aides, housekeepers, and food delivery people to be licensed nursing aides (so, for example, they can bathe people). This training also enables staff to be universal aides, so that participants can have a single person for all their services.

**Almost all program staff received case management training.**

At Sunrise Towers, almost all program staff, including housekeepers and meal delivery people, have received case management training in recent years, and must take case management notes for daily or weekly review by the program director. This offers more opportunities to check up on residents, talk to them, and make sure everything is okay. In addition, several staff members at Sunrise Towers are licensed nursing assistants. This cross-training has resulted in operational efficiencies as well as improving quality of care. For example, if a housekeeper cleans a refrigerator and finds several apples in there, he may ask why and learn that the person can't chew apples. In that event, he can tell the food delivery people to bring another item, like apple sauce, instead.

### Impact

The congregate housing program has enabled people in public housing to age in place. In the

year ending September 30, 2002, the Sunrise Towers Congregate Housing Program served 39 residents. According to the Laconia Housing and Redevelopment Authority's 2002 report to the Department of Housing and Urban Development, two residents were relocated to a nursing home and one was permanently relocated to the hospital. The previous year, four people were relocated to a nursing home. The Laconia congregate housing program costs approximately \$12,000 per person per year, including housing and services.

### Contact Information

For more information about the Sunrise Towers Congregate Housing Program, please contact Charlotte DuBois, Director, Laconia Housing and Redevelopment Authority, at (603) 524-2112, extension 13 or [charlotte@laconiahousing.org](mailto:charlotte@laconiahousing.org).

### Discussion Questions:

**The housing agency's program requires people to use one provider. Can a housing agency provide a similar model while giving residents freedom to choose providers?**

**What additional funding sources may states or housing agencies use to finance this model?**

This report was written by Daria Steigman of Steigman Communications. It is one of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' web site, <http://www.cms.gov>. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.



## Welcome to the Neighborhood

### Highlights of the Langdon & Anne Simons Senior Apartments

#### **Providing Safe, Decent, Affordable Housing**

- There are a total of **92 tenant and 3 live-in staff units**. All of the studio units have full kitchens and bathrooms, at an average of 460 square feet. Each residential floor has laundry facilities with two washers and dryers.
- Tenants can socialize in **two tenant lounges** on the second floor: one has a full kitchen, and the other features a comforting gas fireplace. **Three staff offices** are located near the tenant lounges, accommodating case managers and the visiting nurse program.
- Tenants can enjoy warm weather on **two outdoor decks** on the second and third floors. These decks are visually and acoustically buffered from Third Avenue traffic, and feature drought-tolerant landscaping.

#### **Helping our Neighbors in Need: *Features for seniors & veterans***

- All of the units feature **wheelchair-accessible bathrooms** with a five-foot turning radius, and can be retrofitted to include grab bars. Of the 92 tenant units, five are fully handicap accessible units with a **full complement of grab bars** in the bathroom and **lowered work surfaces**; eleven are hybrid units with a full complement of grab bars in the bathrooms.

#### **Thinking Green: *Energy efficiency & safety features***

- Architects had energy efficiency and safety in mind when designing the Simons Apartments. The building boasts grab bars along all hallways and color-coded floors for safety, a high efficiency hydronic water heating system, "beyond code" building and window insulation, natural cooling ventilation, large high windows to draw in daylight and occupancy light sensors in common areas to promote energy efficiency.

#### **Being a Good Neighbor: *Improvements to the downtown community***

- A large community meeting space on the street level will be available free of charge to neighborhood community groups for meeting and gatherings.
- The Simons Senior Apartments promotes bicycle and pedestrian commuting. A shower and lockers are available for staff, and the Third Avenue sidewalk is beautifully landscaped for a pleasant environment.

# PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

## *Wisconsin – Supported Housing for People with Disabilities*

### **Issue: Individualized Housing Solutions under Wisconsin's Medicaid Waiver Programs**

#### Summary

The State of Wisconsin employs a supported housing specialist who works with local communities to help people with disabilities and their families to find affordable housing solutions. In addition to assisting individuals in finding housing, the supported housing specialist works with individuals with disabilities and their families, local agencies, developers, real estate agents, housing providers, lenders, consumer groups and other stakeholders to build relationships among the parties to improve housing access for people with disabilities.

#### Introduction

Systems that support people with disabilities traditionally do not include housing policies. When housing and supports are entwined, the two are often combined in institutional or group settings. As a result, housing problems for people with disabilities are often viewed as a result of the disability. The State of Wisconsin's Department of Health and Family Services, Division of Supportive Living, approaches the issue from a different point of view: that poverty – not disability – is the foundation for housing problems. Disability is merely a factor that can exacerbate the problem. As a result, the state has focused on finding *affordable housing*, rather than finding *housing for people with disabilities*.

**Poverty – not disability is considered the foundation for housing problems.**

This report briefly describes the work of Wisconsin's supported housing specialist and how she works with local communities to help people with disabilities and their families to find affordable housing solutions. This document is based on interviews with the supported housing specialist and reports and supporting material on the program produced by the Wisconsin Council on Developmental Disabilities.

#### Background

Wisconsin's supported housing initiative started shortly after the introduction of the Community Supported Living Arrangements (CSLA) waiver, a Medicaid home and community-based services waiver for people with developmental disabilities established in 1992 as a pilot program to offer people greater control over their housing and the services that help them to live independently. CSLA is available to people whose living environment is under their own or their guardian's control. The person may also own a home or be a party to a lease if a home is rented. The success of CSLA was dependent upon the availability of affordable, accessible, safe, and decent housing for people with disabilities. As a result, the state recognized that creating housing solutions was essential.

The state developed a supported housing initiative to address this need. The Wisconsin Council on Developmental Disabilities first funded a supported housing specialist to implement the initiative. The position is now funded through the Wisconsin Department of Health and Family Services. Persons eligible for assistance are children and adults on one of three Medicaid home and community-based services waivers that serve people with

developmental disabilities or people with brain injuries.

### Intervention

Wisconsin's supported housing specialist works with individuals with disabilities and their families to find individualized housing solutions that address their housing needs. The nature of this solution is based on the needs of the person. Examples include home ownership, relocation from a nursing home, and transitional housing for a homeless family including a child with a disability.

The specialist's first step is to understand each customer's needs. The second step is to bring together the right resources to achieve results. Based on a belief that poverty, not disability, is

**The specialist identifies resources to help people with disabilities find affordable housing.**

at the root of people's housing problems, the program identifies financial resources as well as resources from the service system for people with disabilities. The specialist works with Medicaid waiver case managers, local service provider agencies, housing providers, developers, real estate agents, advocacy groups and other stakeholders to build relationships among the parties to improve housing outcomes for people with disabilities.

For example, if a person wants to own a home, the supported housing specialist will help to develop an approach that looks at whether the goal is affordable and makes sense for them and, if so, to design a plan with local partners to turn that dream into a reality. The strategy may include developing long-term plans to help people qualify for mortgages, or perhaps help them learn about financial options ranging from mortgage products to housing rehabilitation benefits to housing adaptation benefits.

Although initially most of the effort involved working one-on-one to help people with disabilities, over the last few years the supported housing specialist's work has increasingly involved building local housing capacity. The

supported housing specialist works with the public and private sectors to develop the relationships and partnerships that bridge the divide between the very different worlds of people with disabilities, the support system (i.e.: case managers, service providers), and the housing sector (i.e., landlords, lenders, developers, local housing organizations, contractors).

The specialist's one-on-one work helps bridge this divide. The specialist's advocacy for particular individuals enables local success stories, and gives contractors, developers, and others positive experiences in working with persons with disabilities. The success stories in turn generate positive public relations within the support system about Wisconsin's supported housing initiative in general and the specific results it has achieved for individuals with disabilities.

When the supported housing initiative started, people primarily heard about the program through their local housing organizations. In the beginning, the supported housing specialist did presentations all over the state, and reached out to housing providers. A decade later, consumers learn about the program from a variety of sources, including housing agencies, case managers, the state's Web site, and parents of children with disabilities who have been helped by the program. The supported housing specialist has also

**The specialist has written a number of materials on supported housing.**

authored or co-authored a number of materials on supported housing, including home-buying and new construction guides for people with disabilities. She has also collaborated on a 4-booklet series on issues related to renting or owning a home, including income supports and the impact of renting or owning on public benefits.

### Impact

Because it is not a formal program with defined outcomes, the effectiveness of Wisconsin's supported housing initiative is perhaps best

measured by its track-record of success in finding individual housing solutions for persons with disabilities. An August 1999 report on the program noted a number of specific success stories, including helping 78 income-eligible people with disabilities in Madison and surrounding counties purchase homes with financial assistance in 1998-1999. The specialist also helped 177 households fund individualized housing solutions in 1996-1999, including the development of 33 units of rental housing for people with disabilities.

Another measure of the supported housing initiative's effectiveness is the increase in cooperation and coordination between the Department of Health and Family Services, local housing agencies, and housing providers. A recent success story is the partnership among a nonprofit housing organization, a nonprofit

developer, the Department of Health and Family Services, and local partners in Madison (including municipal government housing agencies) to build a mixed-income condominium complex in which 5 of the 20 units were designed and sold to households in which one member has a disability. The supported housing specialist also pointed to a new rental development project in a rural community that was specifically designed to be accessible and affordable to people with disabilities.

### **Contact Information**

For more information about Wisconsin's housing specialist for people with disabilities, contact Marcie Brost at (608) 266-9366 or [brostmm@dhfs.state.wi.us](mailto:brostmm@dhfs.state.wi.us). Online information is available at <http://www.dhfs.state.wi.us/bdds/housing.htm>.

### **Discussion Questions:**

**How can a housing specialist's role assist nursing home transition programs, in which housing is a significant barrier?**

**Could this idea be adapted to use regional housing specialists as well as, or instead of, a statewide specialist?**

This report was written by Daria Steigman of Steigman Communications. It is one of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' web site, <http://www.cms.gov>. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.



# **DRAFT DOCUMENT – NOT FOR USE**

## **Residential Services**

### **Housing Referral Agreement between (name of Owner)**

**and**

### **The Washington State Division of Developmental Disabilities**

This agreement is between (name of Owner) (“the Owner”) and the Washington State Division of Developmental Disabilities (“DDD”) to provide housing referrals for (name of project) (“the Project”).

#### **I. Findings**

1. Persons with developmental disabilities have the right to enjoy the same housing opportunities as persons without disabilities through community-based housing options.
2. Persons with developmental disabilities who are covered by this agreement through DDD, benefit from living together in shared houses and apartments, or by themselves in single family homes or apartments.
3. Persons with developmental disabilities who are covered by this agreement through DDD have a need to share support services with others in shared housing, or with others housed in the vicinity.
4. Persons with developmental disabilities who are covered by this agreement through DDD need assistance in finding and keeping appropriate housing that meets their needs.
5. The King County Housing and Community Development Program (KCHCD) administers funds for low-income housing development; and, in collaboration with the King County Developmental Disabilities Division (“KCDDD”) administers a fund program called Housing Innovations for Persons with Developmental Disabilities (“HIPDD”). KCDDD and KCHCD have an interest in ensuring that a referral agreement is in place for projects that receive King County funds in order to make projects successful for DDD clients and housing providers.

#### **II. Description of the Project**

Include: address of the project, expected opening date, number and size of units at each applicable area median income level, and the total number of units set-aside for persons with developmental disabilities.

#### **III. Owner Responsibilities**

1. The Owner will provide DDD with the name of the contact person(s) for the Project that is responsible for rental issues and for ongoing communication, and will notify DDD of a change in the Owner contact person(s).

2. The Owner will notify DDD of the availability of housing units at least 60 days prior to the first day that the units are available to be rented.
3. The Owner will provide DDD with marketing information on vacancies, and household income eligibility criteria.
4. The Owner will provide DDD with regulatory requirements that are applicable to the Project, housing application forms, tenant screening and selection criteria and any updates to this information as it becomes available.
5. The Owner will notify DDD in writing (includes e-mail notification) when there is knowledge of an impending vacancy in a DD set-aside unit. Notice of an impending vacancy shall be given to DDD at least 2 weeks prior to the vacancy, if possible, or as soon as possible, but in no event later than the first day of the vacancy.
6. The Owner will notify both the applicant and the DDD contact person for housing in cases where there are problems with the housing application after a referral has been made. The Owner will work with DDD on reasonable accommodation requests if necessary to help the tenant with access to the housing.
7. The Owner will not unreasonably withhold approval of qualified applicants, and will notify the applicant and DDD of approvals in a timely manner.
8. The Owner will notify both the applicant and the DDD contact person for housing if an application is being denied.
9. The Owner will notify both the applicant and the DDD contact person for housing when an application is approved.
10. The Owner recognizes that residential services clients have a heightened need for assistance from a service provider in order to be successful in their housing, and agrees to sign a housing agreement with the service provider of the residential services clients that are referred to the Project. The housing agreement will obligate the service provider and the Owner to communicate directly with each other regarding tenancy matters, including, but not limited to, repair needs, accommodations and/or modifications and damages. Although the leases are with the tenants with developmental disabilities, the owner and its management agree to furnish the service provider and DDD with a copy of the tenant lease, and agree to respond to requests for repairs and other issues concerning the tenancy from the service provider and/or DDD in a timely manner, pursuant to the WA State Residential Landlord-Tenant Act. The owner and its management agree to make a good faith effort to work with the service provider and DDD to attempt to resolve issues concerning the tenancy, including requests for reasonable accommodation.
11. The Owner agrees to add a provision to the tenant lease that identifies the name of the service provider that will be on-site with the residential services clients and that refers to the Housing Agreement entitled "DD Housing Agreement with On-Site Service Provider of Residential Services Clients."

12. The Owner agrees that it is responsible for keeping the Housing in good repair pursuant to the Washington State Residential Landlord Tenant Act, RCW 59.18. If there is a dispute about whether damage or a repair need(s) is “tenant-caused”, the Owner agrees to work with DDD and the tenants’ Service Provider to resolve the dispute and take care of the repairs. The Owner agrees that if repair costs exceed \$3,000 and DDD has agreed to or may agree to cover the entire cost or a portion of the cost, the Owner will get three (3) bids for the work and submit them for approval from DDD before commencing repairs.
13. The Owner will notify its property management company and on-site manager of this agreement and will develop a system to ensure ongoing compliance with this agreement.
14. Emergency vacancies. The Owner agrees to allow mutual termination of a tenant’s lease when DDD must remove a tenant without notice due to health and safety reasons, or for reasons beyond the tenant’s control; in the rare event that DDD determines that all of the tenants must be moved for health and safety reasons, the Owner agrees to allow mutual termination of all the leases. The Owner agrees to accept payment from DDD for the unit rent or the vacancy portion of the unit rent for up to 90 days or until a DDD referred applicant(s) is approved; the Owner agrees that if DDD determines that they cannot keep the set-aside unit for health and safety reasons, the Owner will accept a 30 day notice to terminate the set-aside agreement from DDD, and can rent the unit to an otherwise qualified household from the public after the 30 day period.
15. Holding units for regular vacancies (vacancies other than emergency vacancies referred to in item #14 above). The Owner agrees that for regular vacancies, there will be an initial 30-day period in which DDD can find a replacement tenant without paying the vacancy portion of the rent. The 30-day period will begin on the date that the unit becomes available. DDD will attempt to fill the vacancy as quickly as possible. The Owner agrees that after the 30-day period, the Owner will accept payment from DDD for the vacancy portion of the unit rent, or the entire rent if the unit had just one tenant household, for up to 90 additional days, or until a DDD referred applicant is approved; the Owner agrees to extend the period of time that DDD may pay the vacancy portion of the rent if requested.

#### **IV. DDD Responsibilities**

1. DDD will provide the Owner with the name of the contact person(s) at DDD for housing, and will notify the Owner if there is a change in the DDD contact person(s).
2. After receiving all of the applicable information from the Owner, as provided in this agreement, DDD will identify appropriate residential services clients to be referred to the Project and will promptly begin the process of making referrals.
3. DDD will advise prospective clients of applicable regulatory requirements for the Project, including income restrictions that may prevent applicants from qualifying for the housing.

4. DDD will give the housing applicant client, his/her guardian, and/or service provider the applicable instructions in order to initiate a rental application with the Owner.
5. DDD will follow up with the Owner's contact person to insure that applications to the Project are proceeding without problems, and will follow up on any problems that are discovered.
6. DDD will ensure that all persons referred to the housing will receive residential, day, and/or other support services essential to their health and safety, and, to the extent possible, services to support ongoing occupancy.
7. DDD will work with the owner and the service provider to determine appropriate reimbursement for tenant-caused property damage pursuant to the Washington State Residential Landlord-Tenant Act (RCW 59.18). DDD will work with the tenant, the service provider and the Owner to help the tenant mitigate the situation that has caused damages, including assisting with reasonable accommodation or modification requests, if warranted.
8. Emergency vacancies. DDD will ensure that when a tenant or all the tenants must be moved without notice due to health and safety reasons, or for reasons beyond DDD's control, DDD will pay the vacancy portion of the unit rent from the time the tenant(s) moves out for up to 90 days or until a DDD referred applicant is approved. DD will request an extension of time, if needed, to find a suitable replacement tenant(s), and will continue to pay the vacancy portion of the rent. If DDD determines that it is better to move all the tenants or the remaining tenants to another location rather than fill the vacancy, DDD will give the Owner, at a minimum, 30 days notice that it will give up the set-aside unit so that the owner can rent the unit to an otherwise qualified household from the public.
9. Regular vacancies (vacancies other than emergency vacancies initiated by DDD as stated in # 8 above). During the initial 30-day period in which DDD is not required to pay the vacancy portion of the rent, DDD will try to find a replacement tenant as quickly as possible. After the initial 30-day period, DDD will pay the vacancy portion of the unit rent for up to 90 additional days, or until a DDD referred applicant is approved. DD will request an extension of time, if needed, to find a suitable replacement tenant, and will continue to pay the vacancy portion of the rent. If DDD determines that it is better to move the remaining tenants to another location rather than fill the vacancy, DDD will give the Owner adequate notice and will give up the DD set-aside unit so that the owner can rent the unit to an otherwise qualified household from the public.
10. DDD will require that service providers notify the landlord and DDD immediately when there are repair needs and/or damages in the housing. DDD will specify that the service provider may be responsible for tenant-caused damages in the following situations: a) the service provider fails to take reasonable care of the premises; b) the service provider fails to report damages to the Owner and/or the Owner's designated property manager and DDD in a timely manner; and c) the service provider fails to

immediately plan for corrective action when a tenant or the service provider causes damage to the premises and fails to notify DDD of the corrective action plan.

**V. Other Conditions**

1. **Liability.** The parties to this Agreement shall indemnify and hold each other harmless from and against any liability, loss, damages or claims that may arise from or may in any way be attributed to any injury or death to any person or damage to any property, caused by, resulting from or otherwise attributable to any willful or negligent acts or omissions on the part of any DDD resident.
2. **Compliance.** The parties agree that each shall at all times remain in full compliance with all of the requirements of applicable provisions of federal, state and local laws and regulations, including, but not limited to Title VI of the Civil Rights Act of 1964, Title VIII of the Civil Rights Act of 1968, the Fair Housing Amendments Act of 1988, Executive Order 11063, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975, as amended.
3. The parties to this Agreement have the right to make amendments by mutual consent at any time.
4. **Change of Circumstances.** If at any time during this agreement DDD determines that it can no longer refer residents to these units, DDD shall inform King County DDD's Housing Coordinator, other funders with an interest in the project and the Owner that it desires to negotiate with the funders and the Owner for the purpose of referring an alternative population to these units.

**For the Owner:**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

**For WA State DDD:**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title