NATIONAL SUMMIT ON AFFORDABLE SENIOR HOUSING AND SERVICES

Georgetown University Conference Center

May 25, 2010

Washington, DC

Hosted by
American Association of Homes and Services for the Aging

In partnership with
Enterprise Community Partners, Inc.

With additional support from
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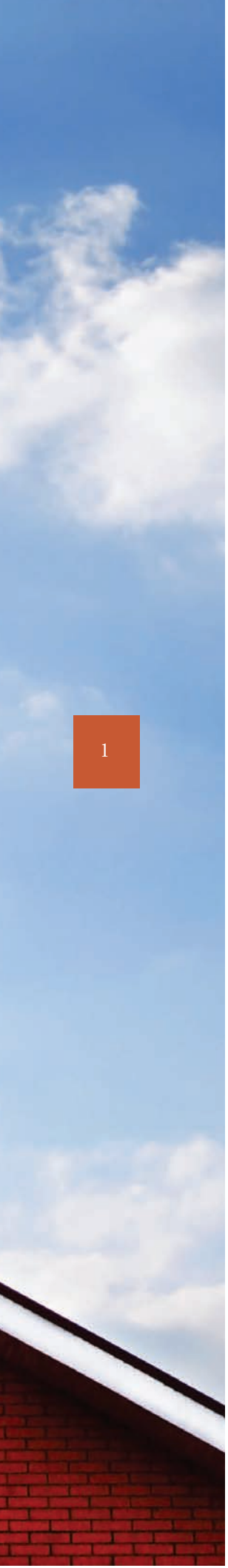


Summit Proceedings

Summary

The American Association of Homes and Services for the Aging (AAHSA), in partnership with Enterprise Community Partners, Inc, convened the National Summit on Affordable Senior Housing and Services on May 25, 2010 in Washington, DC. This "invitation only" meeting brought together nearly 100 experts, including policy officials from the U.S. Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD), the Office of Management and Budget (OMB); state aging, health and housing agencies; senior housing providers; health and aging services providers; foundations; academic researchers and aging and housing advocacy organizations. (See Appendix B for a list of attendees). The summit had the following four objectives:

- To bring together for the first time housing and long-term care policymakers from all governmental levels, low-income senior housing and long-term care services providers and other key stakeholders to begin a national conversation about the role of affordable senior housing and services models in helping low- and modest-income older adults to "age in place" safely and cost effectively in their apartments and communities;

- To share ideas, promising practices and current or planned policy initiatives designed to help develop and foster a range of programs linking affordable senior housing and supportive and health-related services;

- To identify the financing, regulatory and other barriers to the development of affordable senior housing plus services models and to explore strategies for mitigating these barriers; and

- To identify next steps for formalizing the network of stakeholders gathered at the summit to jointly develop, test, disseminate and replicate successful programs.

The morning session began with an articulation of the charge to the group and an outline of the summit goals. Following brief introductory remarks by the summit hosts and major sponsor, federal officials from HHS and HUD provided a national perspective and helped to frame the issues in their keynote speeches. A panel of policy officials and housing/services providers from three states provided the state perspective on the importance of linking affordable senior housing with services and provided examples of current and planned initiatives. The morning session concluded with some comments from two representatives from the National Governors' Association who emphasized the need to provide turnkey ideas with evidence of cost savings to public programs, particularly Medicare and Medicaid. A representative from EverCare—one of the summit supporters and a large managed care organization with extensive senior care experience—noted that housing plus services models need to address the "aging in place" issue from both the individual and the family caregiver perspective. During the afternoon, attendees assembled into breakout groups to address the four goals articulated in the summit charge. The meeting concluded with a summary of the breakout findings and a discussion of next steps in how to build on the momentum of the summit by formalizing partnerships at the federal, state and local levels to develop, test and replicate promising models and programs.

Welcome and Summit Goals

Larry Minnix, President and CEO of AAHSA and Bill Kelly, President of Stewards of Affordable Housing for the Future and chair of AAHSA's National Steering Committee on Affordable Senior Housing and Services, opened the summit by laying out the day's charge. (See Appendix A for the Summit Agenda.) They acknowledged the rare opportunity that this summit provided to break down silos between housing and aging services policies and practices. They also noted that this summit was a very timely event in light of the recent passage of health care reform legislation and HUD's efforts to reinvent affordable senior housing for the 21st century. Mr. Minnix identified the four issues that would be addressed during the course of the summit:

- What are the essential elements of a successful senior housing plus services program and how would success be measured?
- What are the major barriers to advancing successful models and programs?
- What are the pros and cons and policy implications of targeting housing plus services programs to defined populations?
- What are the necessary next steps to formalize partnerships among key stakeholders?

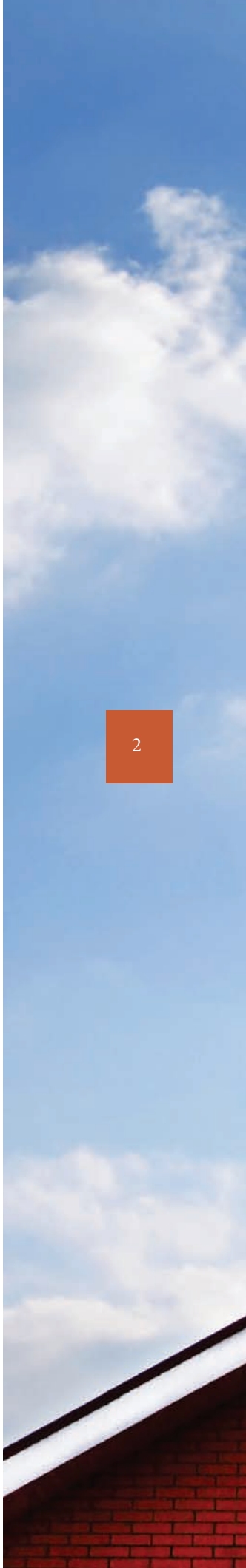
Naomi Bayer, Senior Vice President of Enterprise Community Partners—the summit's major sponsor and co-host—also provided opening remarks. Ms. Bayer commented on Enterprise's commitment to and experience with affordable senior housing and her organization's interest in helping to transform policy. She expressed her hope that the forum would be a wake up call on the importance of bringing affordable housing and services together to meet the needs of vulnerable seniors. She also stressed the Enterprise commitment to combining "green" conservation techniques, technology and affordable housing concepts.

Framing the Issues

The morning sessions framed the issues to be addressed by the summit attendees. Attendees were also sent four issue briefs prior to the meeting as background material for the summit. (See Appendix C for the issue briefs.) The briefs provided an overview of the case for developing effective linkages between affordable senior housing and health-related and supportive services; the policy and practice issues related to the successful development, implementation and sustainability of these programs; highlights of various affordable senior housing plus services models currently in operation or under exploration, and the current research on affordable senior housing with services strategies.

Views from the Federal Level

Kathy Greenlee, Assistant Secretary on Aging in HHS, was the first speaker to provide the federal level perspective. She described HHS' and the Administration on Aging's current and planned efforts to help older Americans live independently for as long as possible in their homes and communities and underscored the enormous potential of affordable senior housing plus services programs in helping low-income older adults to achieve that goal. The Assistant Secretary also noted that the summit symbolizes the vibrant partnership that has developed between HHS and HUD to turn the vision of "aging in place" into a reality for millions of low- and modest-income older Americans across the



country. In her final comments, she indicated her commitment to exploring the reauthorization of the Older Americans Act as a mechanism for establishing an ongoing senior housing plus services agenda.

Fred Karnas, Senior Advisor to the Secretary of HUD, provided the federal housing policy perspective. He indicated that his department views HUD-sponsored housing not just as a physical place but as a platform for improving the quality of life for low-income older Americans and other vulnerable populations. Mr. Karnas noted that over the past year, over 100 people from both HHS and HUD have been working together on how to integrate housing and services for the homeless, younger people with disabilities and the low-income elderly groups. He emphasized the fact that the Secretaries of both HHS and HUD are encouraging their respective staff to "learn each other's language" through joint participation in program design, budget proposals, research and demonstrations. This summit, therefore, was perfectly timed to provide important insights, ideas and models for further joint exploration and development. Mr. Karnas concluded his remarks by underscoring the importance of evidence-based research to demonstrate what models work and do not work, particularly in light of OMB's focus on cost effectiveness in all projects funded at the federal level.

The final introductory keynote was delivered by Richard Frank, Deputy Assistant Secretary for Disability, Aging and Long-Term Care Policy in HHS. Dr. Frank, whose office has worked closely with its counterparts in the HUD policy research division to investigate the "state of the art" in the development of affordable senior housing plus services programs, began his comments by highlighting the prevalence of chronic health conditions and disability among older adults, particularly elderly residents of publicly subsidized housing. He affirmed the basic premise of the summit that coordinating health care and social supports in low-income housing could achieve significant benefits to the elderly individuals and the larger community as well as potential cost savings to the Medicare and Medicaid programs. He also emphasized the opportunity that health care reform offered for testing housing plus services models.

The State Perspective

A panel of housing and service providers and policy officials from Vermont, Oregon and Pennsylvania provided attendees with a "real world" perspective on why states are interested in affordable housing with services, the programmatic strategies they are evolving, and barriers that must be overcome to be successful.

1. **Vermont**

   Presenters: Nancy Eldridge and Molly Dugan, Cathedral Square Corporation; Christine Hart, Battleboro Housing Authority; Craig Jones, Vermont Department of Health; Penrose Jackson, Vermont Health Foundation; and Bea Grause, Vermont Association of Hospitals and Health Systems

   The presenters highlighted the following points:

   - The failure to connect long-term care and home and community-based services to housing threatens its very preservation and the safety of residents. "We are housers of people with significant multi-faceted needs. We need to wrap services around the housing."
   - Rolling out aging in place strategies, however, without the proper infrastructure of services and building accessibility leads to failure.
   - Cathedral Square—one of AAHSA's premier affordable senior housing providers—has developed the "Seniors Aging Safely at Home" (SASH) program to help facilitate aging in place

in the state. SASH is person-centered and incorporates a multi-disciplinary team involving contracts with a home health agency nurse, the local Area Agency on Aging case manager, a community mental health provider, representatives of other home and community based services providers (such as PACE); and a full-time service coordinator and part-time wellness nurse employed by the housing property. SASH includes the administration of baseline and periodic resident functional, health and quality of life assessments, access to health information technology to track hospital and ER admissions, the development of a 'healthy aging plan' for individuals who choose to participate, multiple levels of care coordination and targeting residents most at risk (multiple chronic conditions, transitioning from a hospital or nursing home) and the use of evidenced based practices.

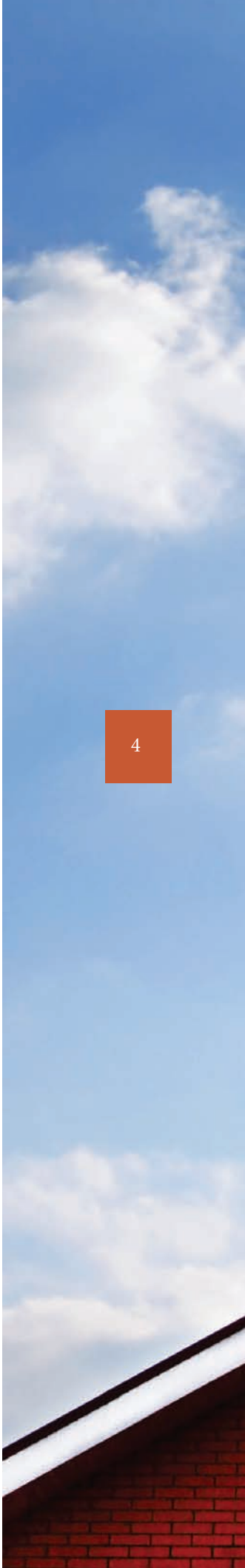
- The Vermont Department of Health is spearheading a proposal to CMS to create regional Medicare medical homes that will include the SASH model as an integral part of the demonstration. Hospitals, health systems, primary care practices, and SASH providers—including Cathedral Square and several other low-income senior housing providers in the state—will be linked through regional health information exchanges and will share in any Medicare savings resulting from better care coordination, avoiding unnecessary hospitalizations. Etc.

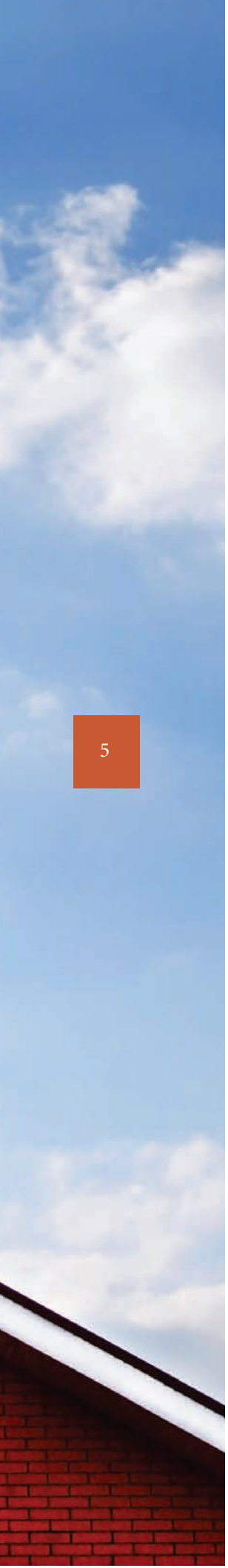
2. Oregon

Presenters: Julia Huddleston, Oregon Department of Human Services; Mauro Hernandez, Concepts in Community Living; David Fuks, Cedar Sinai Park

Presenters made the following key points:

- Oregon is seeking new strategies for delivering long-term care and community based services to older adults. Oregon has already developed an abundance of residential care, including being one of the pioneers in the development of assisted living. State officials and several assisted living providers are exploring ways to encourage and support formal partnerships between assisted living facilities and publicly subsidized senior housing—particularly in rural areas—to meet low-income residents' service needs.
- Cedar Sinai Park, a continuing care retirement community in Portland and an innovator in service delivery and long-term care workforce development, purchased its first Section 202 property in 2007 and is considering the purchase of three more properties. The organization's CEO and management team recognizes the importance of "aging in place" for their low-income elderly (and younger disabled) residents—most of whom are Medicaid eligible—and is committed to developing a comprehensive housing plus services program building on their success with the CCRC. They have begun this journey by working with researchers at Oregon State University to conduct a service needs assessment of the elderly residents in their low-income senior housing units. The CEO is now exploring with the state the development of a capitated Medicare/Medicaid pilot that would provide a flexible array of services to residents on a voluntary basis. As part of this service system, the Sisters of Providence HMO is considering locating a geriatric assessment clinic in the property to provide health education and mental health services.
- The state and providers are very committed to an evidence-based approach, which includes evaluation, dissemination and replication throughout Oregon and to other states as well.





3. **Pennsylvania**

Presenters: Kim Brooks, New Courtland Square; Jim Pfeiffer, Presbyterian SeniorCare; Jennifer Burnett, Pennsylvania Office of Long-Term Living

Panelists highlighted the following:

- The Governor has a commitment to shifting resources away from nursing homes to home and community-based services and views housing as an important component of this reform. The representative from the state's Office of Long-Term Living—the state unit on aging in PA—noted that "in order to shift from nursing homes to home and community-based services, we've had to recognize the housing component. We realized early on that we had to make a connection between services and housing. We have a very progressive Housing Finance Agency, but we have had to learn each other's language." As an example of this partnership, the state is piloting a tenant-based rental assistance program as a bridge to support residents moving out of nursing homes into independent housing until they can get a rental assistance voucher.
- New Courtland Square, part of a multi-site organization in Philadelphia, is a new independent housing property that was built specifically to support persons transitioning out of nursing homes. A local PACE site provides a service package to the residents who are all enrolled in the program. The provider has partnered with the state which is providing temporary two year vouchers for rental assistance.
- Presbyterian SeniorCare (PSC), a large non-profit aging services and housing provider in the greater Pittsburgh area, has been committed to an "aging in place" philosophy since the late 1990s. The organization's Director of Senior Housing noted that "housing is a way to extend our mission, allowing us to serve low-income seniors. Our bias from the beginning was that services are a key component, building on our service coordinators." Based on guidance from the local Pittsburgh HUD office, PSC has used all of the savings accrued from refinancing the properties to support their services program. As the organization has focused more attention on high risk residents, they have contracted with nurses to engage in health education and monitoring and are also have a special emphasis on the hospital discharge process and transitions of residents from hospital back to the housing property.
- The panelists expressed their doubts that a robust housing plus services program is financially sustainable in the long term without significant support (through reallocation of current resources and/or new dollars). At the same time, they acknowledged the importance of partnerships between housing and local services providers in stretching the funds that already exist.

Perspective from the National Governors Association

Kathleen Nolan, Health Division Director at the National Governors Association, and Heidi Tringe, representing the office of the Governor of Vermont—the current NGA chair--concluded the state panels by noting that health care reform—both the implementation process and regulatory/administrative requirements—is the driving force in the foreseeable future. They encouraged the innovators exploring and marketing housing plus services models to focus on how the programs are going to "bend the cost curve"—for Medicare and Medicaid—through a strong focus on care coordination and prevention strategies. Current and potential governors—there will be 36 elections this year—are searching for turnkey ideas that can produce savings over a relatively short period of time.

Perspective from Managed Care

Evan Shulman, Director of Development at Evercare, emphasized the potential role of housing plus services models as a strategy for addressing the needs of many low-income seniors in both an efficient and cost-effective manner. He noted the important role that nurse practitioners play in Evercare's managed care programs in both institutional and a growing number of community-based settings, citing a 50% reduction in hospitalization for nursing home residents and a 40% reduction for assisted living residents. He also underscored the need to consider the impact of housing plus services programs on caregivers, as well as individual residents, as many individuals rely on a caregiver, such as a family member, to assist them in their daily activities and decisions.

Research on Affordable Housing with Services

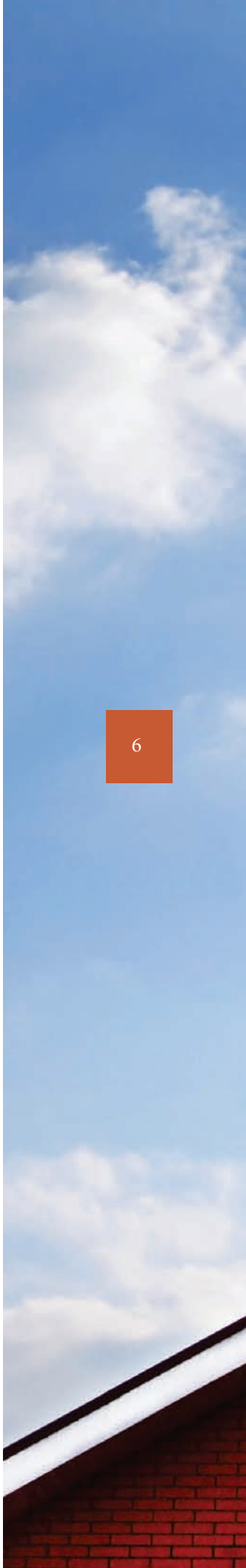
Dr. Robyn Stone, Executive Director of the Institute for Aging Services (IFAS) and AAHSA Senior VP for Research, reflected on her experience in developing a research agenda around affordable senior housing plus services. (See Appendix C for a brief summary of the current "state of the art" in this area.) She pointed out that while there are a growing number of descriptive studies, the evidence base on what works is very weak. She noted that it is incumbent on the research and provider communities to do better than reporting anecdotes or giving opinions based on intuition, particularly in regard to cost effectiveness. One reason for this lack of outcomes research is the absence of baseline data describing who lives in subsidized senior housing, their health and functional trajectories over time and which interventions work for which populations (e.g., the "well" elderly, the moderate at-risk group and the high-risk, chronically disabled group). Another barrier is the difficulties in convincing funders in both the public and private sectors to invest in the descriptive and evaluative research that is required to answer both the policy and practice questions. While randomized treatment control group trials of housing with services models are not likely (given the methodological and cost constraints), it is possible to come to some consensus about desirable outcomes, define the components of housing with services models that are most likely to influence these outcomes, assess how they work and replicate them in more wide scale demonstrations.

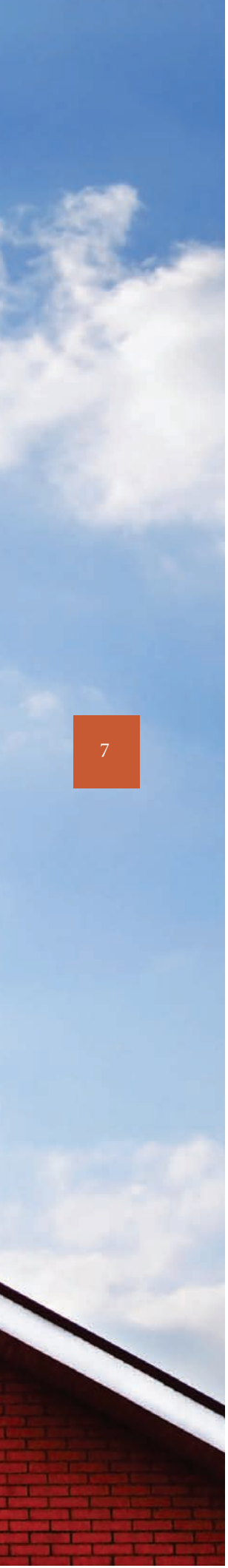
Breakout Discussions and Findings

Attendees were organized into six breakout groups in the afternoon to discuss and debate the four issues laid out in the charge to the group. The findings are summarized below.

1. **Essential Components of a Successful Housing with Services Strategy**

- Elements - Participants identified the following elements as being fundamental to a successful housing with services model:
  - Resident centered – Services should be responsive to the needs and interests of the residents in the property.
  - Choice – Residents must be given a choice of whether or not to use services and which services to use.
  - Assessment – Information on resident status and needs must be available in order to plan for appropriate services and supports and use limited resources in an efficient manner.





- Service coordination or care management – An entity must be available to help residents navigate the service network and identify and access resources to meet their evolving needs.
- Viable and accessible design – The physical plant must accommodate both the delivery of services and residents' physical and functional limitations. The property's placement should also consider residents' ability to navigate and access the community.
- Access to quality services – Although there was no consensus on services that must be available, participants suggested that both health-related and social supports were necessary. Recommended services included preventative/wellness services, assistance with home care needs, help with personal care needs, mental health services, oral health services, and meals programs.

- Drivers – Participants also identified several drivers necessary to facilitate the development and sustainability of a successful housing with services model, including:
  - A catalyst or champion - Visionary and committed leadership is needed to see through the development of models that often require bringing multiple partners together who can work across their silos in a new way.
  - Effective partnerships – Providers, regulators and policy makers from the housing and services worlds must come together and be willing to learn each other's languages and work towards a common goal.
  - Sustainable funding mechanisms – Reliable financing sources must be available for both the housing and the service pieces and must be sustainable beyond an initial start-up period to guarantee a sound investment and continuity of support for residents.
  - Flexibility – Models must be adaptable to the states and communities in which they are located and be able to reflect local need, resources and regulations. One model is unlikely to be acceptable and workable in all places.
  - Adequate workforce – It will be important to ensure staffing is available and trained to meet the service needs. Given the limited availability of licensed professionals, this may require addressing nurse practices acts in some states to allow non-licensed personnel to deliver some types of hands on care.

While discussing the essential components of a successful housing with services model, participants raised various questions and concerns:

- Availability of health services – Participants varied on the type and extent of health-related services that should be available in housing with services models. Some were concerned with the liability, regulatory and licensing impact of having medical services available in a housing property. Others felt that with the level of chronic health conditions experienced by aging residents and the impact that had on all areas of their lives, it is impossible to serve residents without addressing health-related issues.

- Retrofitting older buildings – Participants discussed the merits of retrofitting an entire building to meet accessibility standards versus setting aside only a portion of units to have accessibility features or retrofitting only as accommodations are requested by residents. Some attendees have found that residents do not want units with accessible features.
- Single funding stream – Attendees discussed the value, necessity, and feasibility of having one funding payment cover both the housing and services components. Some believe this is ideal and is the best way to integrate the two components, while others feel this is unnecessary and undesirable.
- Technology – Participants discussed the potential role for technology in housing with services models to assist in the gathering and sharing of information on residents to enhance care coordination, to help monitor and manage residents' care needs, and to help connect residents to their friends and family and the broader community.

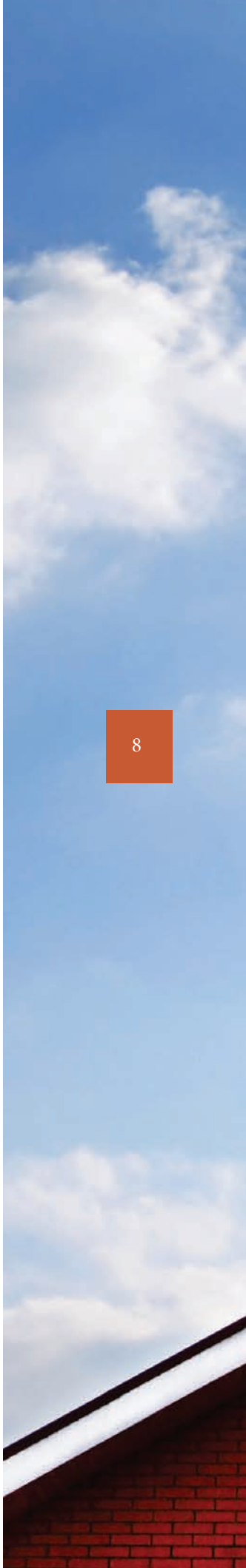
2. Barriers to Creating and Expanding Housing with Services Strategies

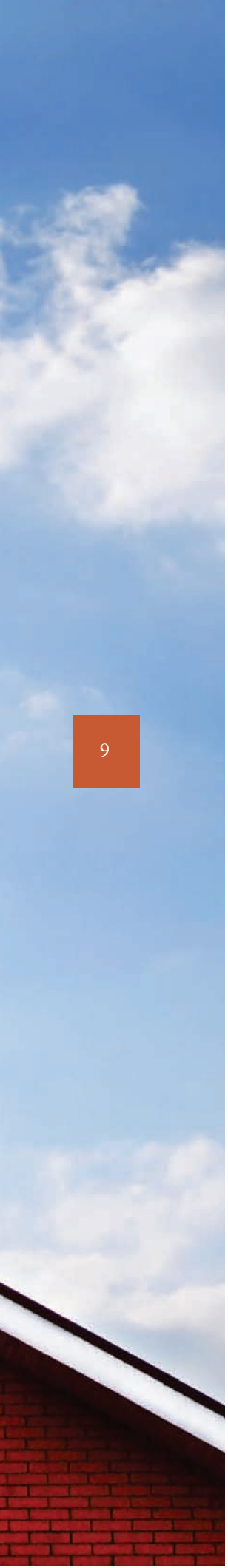
Participants identified a number of barriers to implementing and sustaining housing with services strategies, including:

- Regulations – Participants believed that various federal and state regulations and laws restricted the development of housing with services models. For example, some laws restrict what type of services can be provided and/or who can provide those services in unlicensed settings. Some funding sources restrict what types of services can be provided, such as the low income housing tax credit program, which restricts the provision of health services. There is also concern that defining a more specific model and/or serving a frailer and more chronically ill population will invite regulators to impose licensing restrictions, and destroy the integrity and affordability of the independent housing setting.

- Funding – Attendees believed the lack of adequate and guaranteed funding mechanisms for both the housing and services components inhibited the expansion of housing with services models. Without sustainable funding source investors may be unwilling to invest in the development of housing and services models and providers may be leery of initiating service programs they cannot maintain. Some participants also felt limited funding can make groups unwilling to partner if they sense increased competition and that their funding could be diluted or lost. Attendees also noted that the public funding silos do not reward all players if savings are achieved. For example, if a housing with services model can decrease hospital stays, those savings accrue to Medicare and are not shared with the housing provider.

- Liability – Some attendees expressed concerns about the risks of maintaining and serving a more frail and disabled population in the housing property and the increased chance that the property would be held responsible for adverse events. Others felt that while this is a concern, there are also potential ramifications of letting resident needs go unmet.





- Culture and capacity – Some housing developers and managers see their responsibility as maintaining the bricks and mortar and not as helping residents meet their personal needs. They may be unwilling to take on this role and/or do not have the appropriate skill sets and knowledge of the services world. Nonetheless, many are attempting to expand their service-related capacity directly and/or are partnering with organizations already skilled in providing home and community-based services.

- Fragmentation – The silos of local services delivery systems makes it difficult to organize needed services on behalf of residents. Services must be accessed through various agencies and can have differing eligibility requirements.

- Silo mentality – Housing and services agencies operate independently of each other with little interaction. Agencies often speak different "languages" and are unfamiliar with each other's programs. They often do not think about how the programs may work together or how they may conflict. Because agencies are focused on their own funding levels, they may not see the value of partnering with each other when an intervention may result in savings that accrue to another entity.

- Eligibility requirements – Many of the publicly-funded home and community based services systems—such as Medicaid waivers, adult day programs, and PACE—require participants to be eligible for nursing home level of care. Many residents who could benefit from supports do not meet this eligibility requirement, but cannot afford to purchase services out of pocket.

- Data – We currently have limited information about the characteristics and needs of residents in affordable senior housing settings to help inform the development of housing with services models that can efficiently respond to those needs.

- Limited knowledge – Many housing, health and aging services policy makers and regulators lack an understanding of affordable housing settings, the residents who reside there and the potential of housing with services models that could support the low-income residents in a more cost-efficient and effective manner.

3. Targeting of Housing with Service Models

Participants discussed whether housing with services models should target a certain category of residents or should be designed to serve a range of needs. For example, should strategies target residents who are frail and disabled and at greater risk for repeat hospitalizations and/or transfers to higher levels of care? Or should they serve a more healthy and/or at risk population who may benefit from wellness and prevention services to forestall a decline in their health and functional status?

There was no consensus in this area. Some participants believed housing and services models should target frail and disabled residents because these individuals present the greatest cost to public programs such as Medicare and Medicaid. Preventing these residents from repeat emergency room and hospital visits or transferring unnecessarily or prematurely to a nursing home, they believe, would result in the greatest cost savings. These programs would be most likely to fit with the current health care reform demonstrations and the primary interest of federal

policymakers—including OMB—and state officials. Other attendees believed housing with services models should not target particular groups or needs, but should serve the range of residents who currently reside in housing properties. Those espousing this perspective felt that this approach represents a true aging in place model by supporting residents to remain in their apartment and community as they age and their needs change. Such strategies should provide for a range of services from wellness and prevention services to personal care assistance. Some are concerned that targeting a more frail population could invite licensing of properties and jeopardize the independent nature of the properties that residents value, allows for choice and is more affordable.

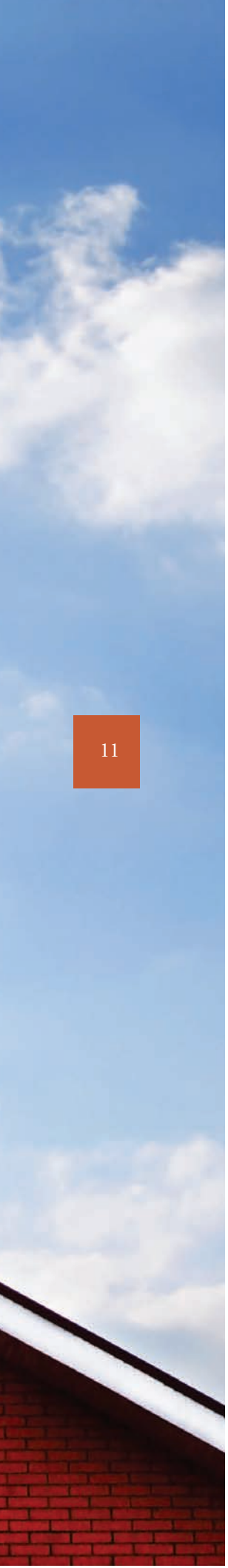
Participants did largely agree that housing with services models must be flexible enough to be adaptable to the local needs, resources and regulatory environment. There should not be just one focus, they felt, but multiple possible strategies that might address different categories of residents and/or needs. This question should also be informed by evaluations of various housing with services models. Currently, the evidence base on housing with services models of any type is very limited. Research should be conducted on differing models to help guide providers in the development of strategies that use limited resources in an effective manner to meet the needs of residents, allowing them to age in place and maintain a high quality of life. These studies can also inform the development or adaptation of programs, policies and regulations that allow for the cost-effective use of various public subsidy programs.

4. Desired Outcomes of Housing with Services Models

Given the range of initiatives described in the morning's state panel and the lack of agreement around the targeting question, it was not surprising that discussion revealed an array of desirable outcomes of housing with services models. The selection of outcomes is tightly intertwined with the question of whether housing with services models should target certain groups of residents and/or needs. Outcomes are obviously driven by the type of intervention deployed; and, therefore, the type of residents assisted and services offered in a housing with services model will directly impact the type of outcomes achieved.

The desired type of outcomes and targeting of residents/needs may be influenced by factors such as individual philosophy or where an individual sits. A state official, for example, may be motivated by the goal of cost savings and their desired outcome would be to lower the use of expensive services such as assisted living and nursing homes that is costly to Medicaid. Federal policymakers would be most interested in savings to Medicare or from HUD's perspective, the ability of the program to preserve the housing stock. Given the wide range of perspectives and interests represented by the summit's attendees, an array of desired outcomes was identified by participants. While all the outcomes generally enhance residents' well being and quality of life, for some participants the ultimate goal was actually to reduce costs to public payor systems. Potential outcomes included:

- Lowering transfer to high levels of care such as assisted living or nursing home facilities
- Lowering emergency room visits and hospital stays
- Better management of chronic diseases and transition from hospital to property
- Improving medication management
- Improving physical functioning



- Improving mental health
- Reducing/preventing falls
- Enhancing physical activity
- Reducing lifestyle barriers through health and wellness activities and better nutrition
- Reducing isolation
- Improving sense of security
- Enabling residents to live in their apartments for as long as they choose

Next Steps

Participants discussed next steps to pursue following this summit to continue advancing the development and expansion of successful housing with services models. There was agreement that the field needs more evidence-based research on the various models to inform policy development and practice. Many also agreed that well-designed, rigorous demonstrations and evaluations could help to elevate this issue among stakeholders who are not aware of the tremendous potential that housing with services programs have for helping elderly and younger disabled people to remain in the community efficiently and cost effectively. Specific recommendations included:

- Explore how housing with services models fit in with health care reform efforts, including opportunities to be a part of the various demonstration and pilot activities proposed.
- Work collectively on a demonstration design and the funding needed to test the effectiveness of various housing with services models.
- Investigate how housing with services strategies can be considered in efforts to address the dual eligible populations through health care reform and other initiatives.
- Expand the evidence base on what works with respect to current housing with services programs and practices.
- Come to consensus on the goals and expected outcomes of housing with services models.
- Define the core elements that are most likely to influence the desired outcomes.
- Develop a typology of housing with services programs and strategies that can help various stakeholders understand how housing with services models can be constructed.
- Develop some common definitions and language that can be used to communicate the potential of affordable housing with services to policy makers, regulators and funders.
- Keep the dialogue going among the various stakeholders.

Summit on Affordable Senior Housing and Services

Georgetown University Conference Center
3800 Reservoir Road NW
Washington, DC

May 25, 2010, 10:00 am – 4:00 pm

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Thanks to all of you for your participation in the May 25th Housing with Services Summit. Below is an agenda for the day.

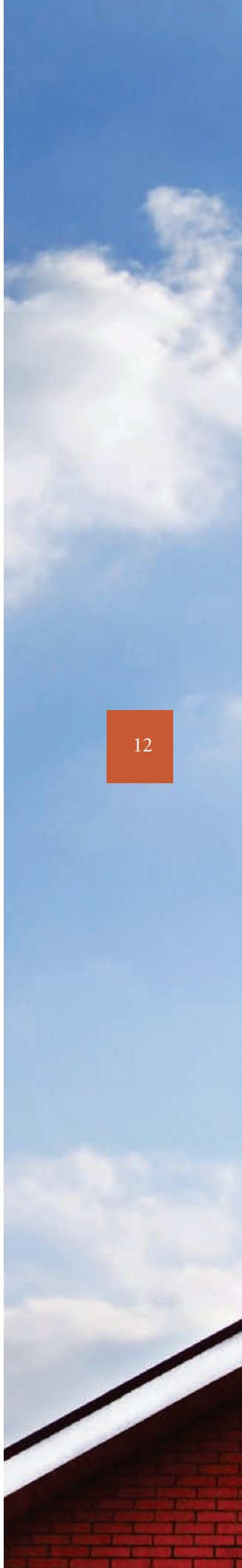
Mission of the Summit:

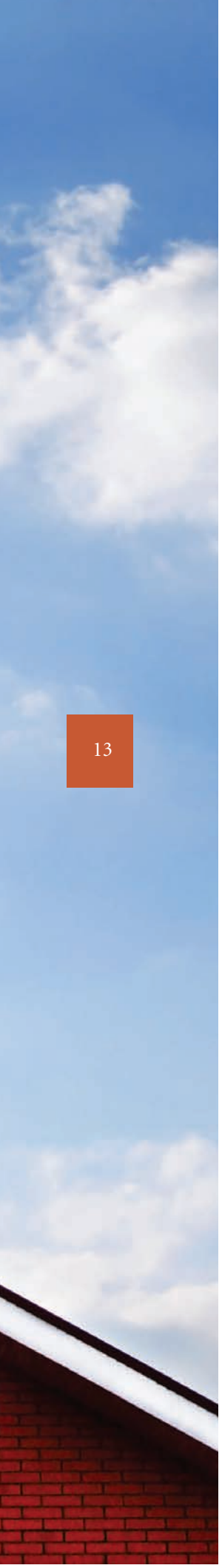
Continue collaborative exchange of ideas, practices, and models of senior housing with services to meet the growing needs of seniors within the context of housing and health reform.

This "invitation only" event builds on the interdisciplinary work of housing and service providers, government, business, and foundation leaders over the past year to advance the potential for scalable, national, statewide pilot and demonstrations of the efficacy of housing and services as a way to improve quality of life for seniors in cost-effective ways.

Outcomes of the Event

- To achieve understanding amongst participants about models of housing with services that show promise
- To discern general principles inherent in successful models (e.g., care coordination, financing, technology, regulation, etc.)
- To understand catalysts and barriers to success
- To achieve common understanding about successful outcomes of promising models
- To advance understanding of how the parties involved can work more effectively together to advance promising models
- To discuss next steps to be taken if a national, scalable pilot/demonstration plan can be defined, implemented and supported by providers, philanthropy, government and business sectors.
- To make new friends and colleagues





Agenda

10:00 a.m. **Mission of the Summit and Introductions**
Larry Minnix, AAHSA

Welcome from Enterprise Community Partners
Naomi Bayer, Enterprise

Summit Outcomes
Bill Kelly, AAHSA, SAHF

Resident Voices
Video

10:20 a.m. **Frame the Issues**
Older Americans Act Renewal
Kathy Greenlee, Assistant Secretary, HHS

10:30 a.m. **Outline of National Commitment to Supporting Best Practices in** Housing and Service
Richard Frank, ASPE, HHS
Fred Karnas, HUD

11:00 a.m. **Three State Experiences:**
Panel from each state
Robyn Stone, PhD, Moderator
Vermont
Oregon
Pennsylvania

Each will address the Questions:

- Why is your state interested in housing with services?
- What innovative models are already in place in your state?
- What is your vision for what can be achieved?
- What evidence do you have to date that quality and costs can be successfully addressed?
- What are the barriers to success?

12:15 p.m. **Working Lunch**
Larry Minnix, Moderator

Remarks, *Heidi Tringe, Office of Vermont Governor Jim Douglas*
Remarks, *Evan Schulman, Evercare United Healthcare Group*

1:00 p.m. **State of Research on Housing with Services**
Dr. Robyn Stone, AAHSA

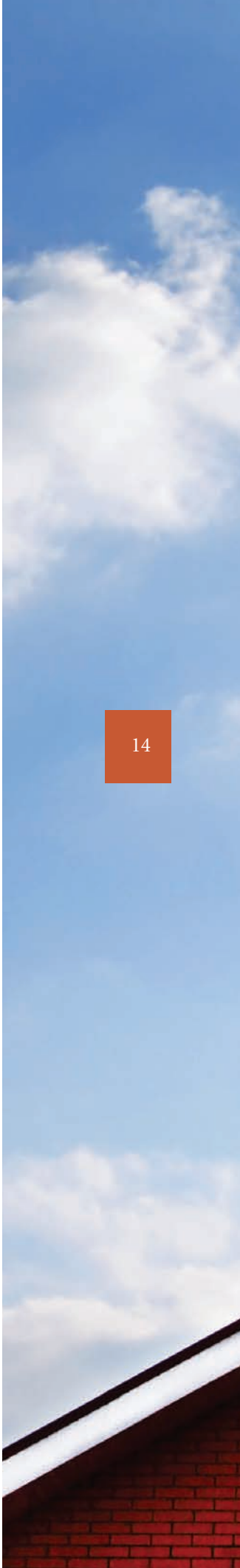
1:30 p.m. **Break-Out Discussions**
Charge: Based on the national commitment articulated, the three state experiences, and your own experience with housing with services, reflect on the following questions:

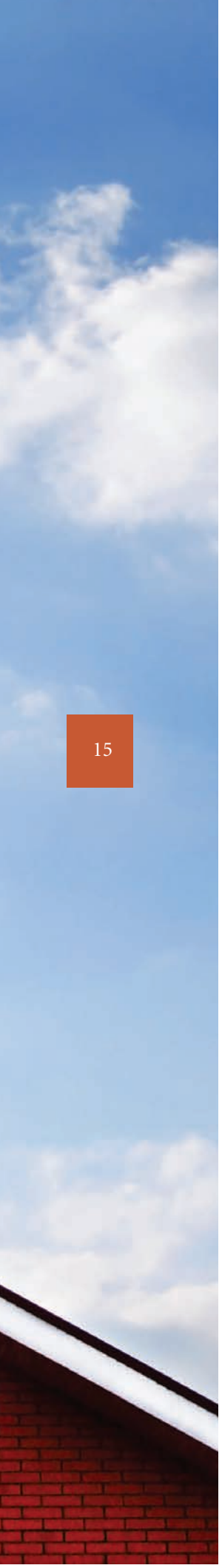
- What seem to be the essential element of a housing with services program?
- What are the major barriers to advance successful models and programs?
- What research and outcomes are desirable?
- Should there be targeting of populations in some defined ways?
- What will it take to create a state/national "climate of partnership" among key parties?

3:00 p.m. **Report of Discussion Groups**

3:30 p.m. **Recommended Next Steps and Summit Evaluation**

4:00 p.m. **Thank You and Adjourn**





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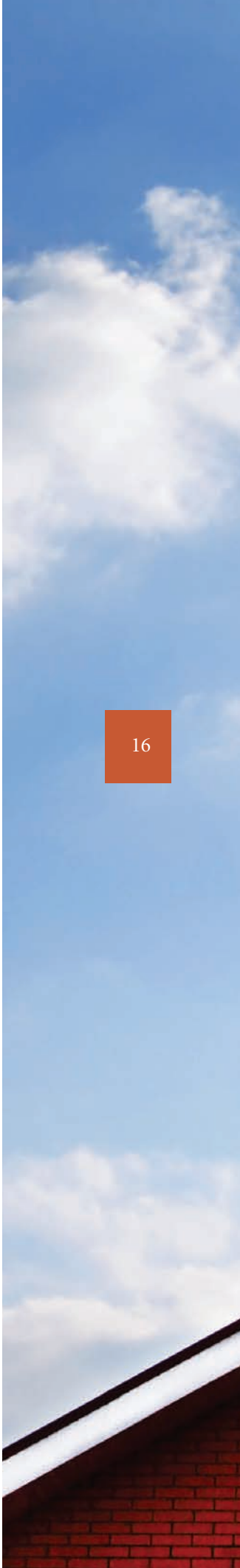

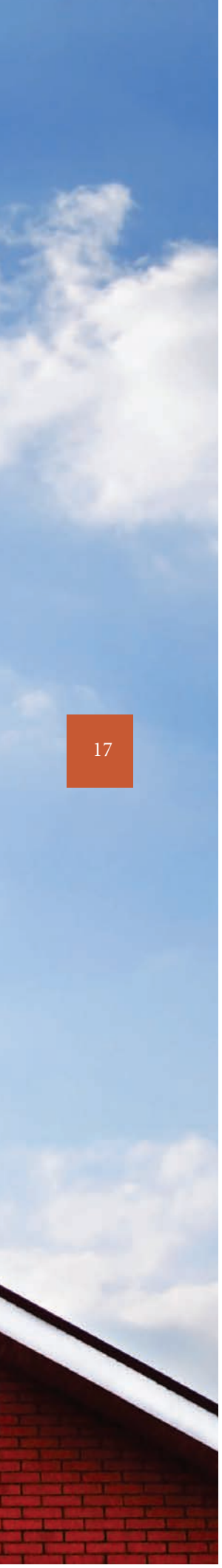

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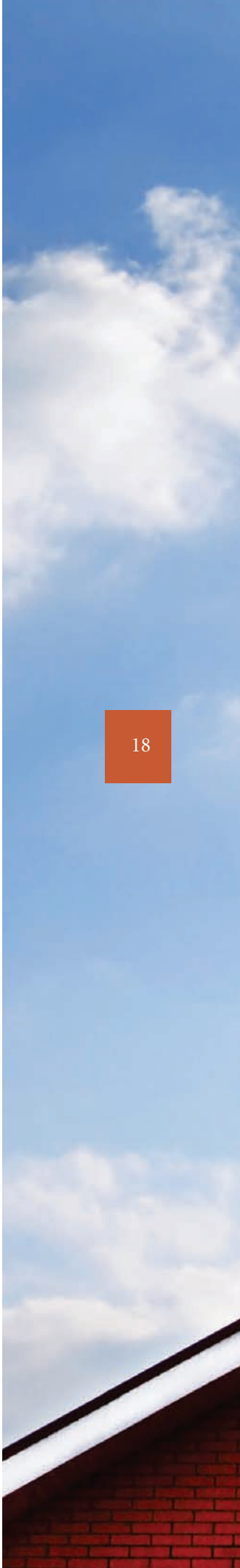

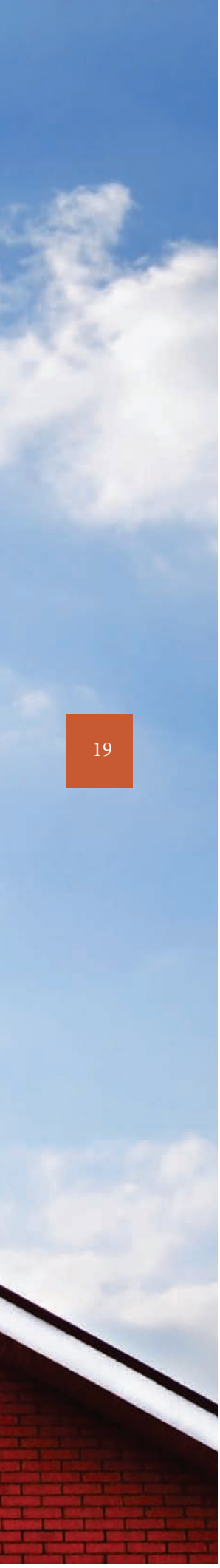

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Prepared for the

National Summit on Affordable Senior Housing with Services
Washington, DC • May 25, 2010

Prepared by
American Association of Homes & Services for the Aging

Supported by
Enterprise Community Partners, Inc.

Affordable Senior Housing: The Case for Developing Effective Linkages with Health-Related and Supportive Services

The problem: For a variety of reasons, many low-income older adults are faced with the dilemma of having to move from the home or apartment in which they have been residing. This may be due to the home's excessive cost burden, poor physical quality or limited accessibility, the loss of family supports (i.e., the death of a spouse) or the individual's need for additional support and assistance. As they age, these individuals also need a variety of health- related and supportive services to maintain their independence and quality of life. Currently, there are few viable alternatives for the low-income segment of America's elderly population that address the dual needs for affordable quality housing and services.

High numbers of very low-income seniors are burden by housing costs: Of the 12.5 million elderly households with very low incomes,[1] an estimated 3.8 million are renters (Haley and Gray, 2008). About 1.4 million pay more than 50 percent of their incomes for housing or live in severely inadequate housing, with nearly all suffering from a high rent burden. Among the 8.9 million very low-income elderly homeowner households, 3.2 million pay in excess of 50 percent of their incomes for housing or live in severely inadequate housing, again nearly all bearing a high cost burden.

Approximately 1.3 million very low-income seniors are fortunate to be assisted through publicly subsidized housing, including Section 202 Housing for the Elderly (263,000), other HUD subsidized private-owner multi-family housing properties (422,000), Public Housing (305,000) and recipients of Section 8 Housing Choice Vouchers (334,000) (Haley and Gray, 2008). Additional thousands live in rental properties subsidized by low-income housing tax credits (LIHTC) restricted to or primarily for seniors.

Significant numbers of seniors in publicly subsidized housing are very old and disabled: It is well documented that the likelihood of frailty and disability dramatically increases with age.

[1] Very low-income is defined as earning below 50% of the area median income.

Compared to 37.4% of those ages 65-69 reporting some disability, 71% of those age 80 and over report a disability (Brault, 2005). The median age of residents in Section 202 properties and other multifamily subsidized senior properties is 74 and approximately one third of residents are age 80 and over (Haley and Gray, 2008).[2] HUD does not collect information on the health status and disability levels or service needs of residents in its senior housing properties. However, some national surveys and small studies provide an indication of residents' physical status and, thus, their potential need for services and supports. These data find a range of health and frailty levels, with a sizable portion experiencing multiple health conditions and limitations in daily living activities.

- The 2002 American Community Survey found over half of subsidized older renters reported limitations in activities such as walking and climbing stairs and one third reported difficulty with shopping or going to the doctor (Huemann, Winter-Nelson and Anderson, 2001).

- The 1996 Study of Assets and Health Dynamics among the Oldest Old (AHEAD, Wave 2) shows that subsidized older residents report being in poorer health than unsubsidized renters, experience more chronic conditions, and have significantly higher numbers of limitations in their ability to carry out basic activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Gibler, 2003).

- A 2006 survey conducted by AARP of Section 202 and LIHTC property managers found an average of 36% of Section 202 residents age 62 and older and 38% of elderly LIHTC residents were perceived to be frail and disabled (Kochera, 2006).

- An Institute for the Future of Aging Services (IFAS) study of three affordable senior housing properties in the Denver area with predominately white populations and median ages from 83 to 85 years old found:
  - 56% of residents reported experiencing two or more chronic health conditions and 19% reported three or more conditions; and
  - 18% reported difficulties with one or more ADL limitations (Washko et al, 2007).

- An independent assessment of residents of a senior housing property in Burlington, Vermont with a predominantly white population and median age of 81 years old found:
  - 19% had difficulty with three or more IADLs and 5% were challenged with two or more ADLs;
  - 48% had been in the emergency room three or more times in the past year;
  - 28% had one or more overnight hospital stays in the past year;
  - 60% had fallen at least once in the past year;
  - 25% screened for mild to severe depression; 25% reported being anxious or nervous a lot in the past month; and
  - 31% failed a cognitive screen(IFAS, 2009).

[2] This median age includes those living in Section 202 properties who are under age 62. If only the population age 62 and older were considered, the median age would be higher.

- An IFAS survey of residents in four subsidized senior housing properties in the San Francisco Bay area with a large culturally diverse population and median age of 78 years old found:
  - 36% reported two or more ADL limitations and 63% need assistance with two or more ADLS;
  - 55% reported three or more health conditions;
  - 35% reported a memory-related disease diagnosed by a doctor;
  - 35% reported falling in the past year, with an average of 2.2 times; and
  - 32% visited the emergency room one or more times during the year and 20% reported an overnight hospital stay (IFAS, 2010).[3]

Few housing choices are available to low-income seniors as they age: Federal and state long-term care policies have long promoted the goal of enabling seniors to stay at home and "age in place." However, the goal may not be desirable or feasible for many older persons with low incomes. As they age, these seniors face a limited number of housing choices. They can try to make due, even as their home becomes increasingly unsafe, inaccessible or unaffordable. They can move in with a family member, if available, which usually involves giving up considerable independence as parent and child roles become reversed. They can move to a subsidized licensed residential arrangement (assisted living, board and care, adult foster care) which combines shelter and assistance. They can enter a nursing home if 24-hour supervision/assistance becomes necessary. Understandably large numbers of older persons are reluctant to move to these settings, either because they are unaffordable unless the individual impoverishes themselves, and/or because of the very high value placed on personal autonomy and the continuing ability to live independently. In many states, options like assisted living are not even available to older persons with low incomes.

"Affordable Senior Housing with Services" rationale and definition: One promising choice for low-income seniors is affordable permanent independent senior rental housing, purposefully organized to meet residents' changing needs for assistance and support. We refer to this option as "affordable senior housing with services". In brief, it is unlicensed, subsidized congregate properties for low-income seniors that provide access to a range of health-related and supportive services available to residents on a voluntary basis when they need and want them. The underlying philosophy is straight forward. Seniors residing in publicly subsidized housing should be able to remain for as long as they wish, even in the face of declining health and increased disability. The promise of this housing option is untested, but exciting:

- Aimed at seniors with low incomes;
- Helps to preserve resident autonomy and independence;
- Addresses some concerns of housing managers who must deal with resident demands to stay in their apartments even as they become more sick and/or disabled (e.g., frequent resident falls and injury, unscheduled ambulance calls and emergency room visits);
- Offers economies of scale in the targeting and delivery of services;
- Relies in part on an existing infrastructure of already developed housing and community services networks potentially yielding some cost savings;

[3] The WellElder program attempts to help residents better manage their health care needs. It is possible that with out the assistance from this program, the level of ER visits and hospital stays might have been larger.

- May help to prolong the duration of independent living while offering states a less expensive alternative to assisted living or nursing homes for some elderly;
- Provides benefits to the housing property and surrounding community.

Platforms for affordable housing with services: The three largest federal programs providing affordable rental housing for low-income seniors are the Section 202, Public Housing and LIHTC programs.

Section 202 is the only federally-funded housing program targeted for persons age 62 and above (some properties allow younger persons with disabilities) and eligibility is restricted to those with incomes below 50 percent of the area's median income. Residents receive a rental subsidy, which caps their share of rent at 30 percent of their monthly income. Many Section 202 properties have at least some features to help accommodate resident needs as they become more frail. Three-quarters of units in properties have grab bars, nearly a third of all units are wheelchair accessible an almost all properties have ramps or a level entrance (Haley and Gray, 2008). Almost 90 percent of properties have one way emergency call systems and one-quarter have 24-hour onsite personnel. Community space for social and recreational facilities is available and used in 90 percent of properties, while space for congregate dining and visiting services are used in about half of facilities. About 38 percent of properties have a service coordinator.

The LIHTC program is the largest producer of affordable housing properties. As of 2003, more than 23,000 projects had been developed with tax credits. An AARP study estimated that about 30 percent of properties are intended "primarily" for older persons, although only 14 percent are explicitly age restricted (Kochera, 2006). The tax credit program is administered by states, who can promote various policy objectives including designating a portion of credits to be allocated for various populations. Tax credit properties set aside a certain share of units for individuals earning less than 50 or 60 percent of area median income. Unlike the Section 202 program, the tax credit program goes not provide rental subsidies, although some projects may be able to obtain Section 8 project based rental assistance slots. As a result, tax credit properties are generally not affordable to the lowest-income seniors. LIHTC properties for older persons are somewhat less likely than Section 202 properties to have features that aid residents to age in place. In 2006, only 26 percent had a service coordinator on staff and 54 percent did not offer any services. However, LIHTC properties are more likely to have major architectural features (such as wheelchair-accessible entry doors, bathrooms and kitchens). This is likely due to the fact that tax credit properties are newer (Kochera, 2006).

Public housing is the largest single federal program offering housing assistance to poor seniors. Public housing is federally funded, but owned and operated by local public housing authorities. Income limits can vary from 50 percent to 80 percent of the area median income. Residents' monthly rental and utilities payments are capped at 30 percent of adjusted income. There are approximately 1.2 million public housing units. Seniors represent 31 percent of households (about 330,000 persons) in public housing properties (CLPHA, 2010). Over half live in projects specifically designated for seniors. As most public housing properties were built more than 30 years ago, many do not have accessible architectural features necessary to accommodate aging residents' needs as they become frail. Service coordination is available in some elderly public housing properties.

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ACKNOWLEDGEMENTS

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Prepared for the

National Summit on Affordable Senior Housing with Services
Washington, DC • May 25, 2010

Prepared by
American Association of Homes & Services for the Aging

Supported by
Enterprise Community Partners, Inc.

Implications and Practice and Policy Issues of Affordable Senior Housing with Services Options

Implications

The supply of affordable housing options must grow. The number one housing issue facing very low-income seniors is affordability. For some this will mean that "aging in place" is not economically feasible. These older persons may have to move to publicly subsidized housing arrangements to maintain their independence and quality of life. As they grow older many will need supportive services to continue to live there. Over the past 30 years, the supply of publicly subsidized housing has actually declined. Constricted supply in turn results in very low vacancy rates and long wait periods for new entrants. A 2006 survey by AARP found that 10 applicants wait for every unit of Section 202 housing that becomes available.[1] Ironically, adding supportive services into existing affordable senior housing properties may actually exacerbate today's shortages unless there is growth on the supply side. The longer seniors are able to stay in their own apartments with assistance, the less turnover, and the less capacity to meet new demand. The graying of America over the next 20 years and the associated rise in the prevalence of disability increases the urgency of bringing new affordable senior housing plus services choices to the housing marketplace.

Affordable senior housing with services options are potentially cost effective additions to state long-term care systems. States are under significant pressure to rebalance their long-term care systems away from expensive nursing home modes of care. Pressure from the federal government, budget concerns, vigorous advocacy from the disability community and the Olmstead decision have pushed states to search for community-based solutions to serving individuals of all ages with

[1] Kochera, A. (2006). *Developing appropriate rental housing for low-income older persons: A survey of Section 202 and LIHTC property managers.* Washington, DC: AARP Public Policy Institute; This may be an underestimation of the demand as some properties close their waiting list after they reach a certain number.

significant disability. Over half the states have implemented, generally on a very small scale, assisted living facilities (ALFs) under the Medicaid program in the belief they would turn out to be a less expensive alternative to nursing home care. More recently some states have become increasingly concerned about the difficulties of financing and implementing ALFs for Medicaid-eligible recipients. These states have every incentive to take a hard look at residential options that build off of existing housing infrastructure and take advantage of existing community service delivery networks. The recent passage of the Class Act, which will enable some publicly subsidized housing residents and/or their families to purchase a low-cost home care insurance product that could be used to pay for supportive services, should further pique state interest.

Affordable senior housing with services options may enhance housing providers' capacity to comply with Olmsted and fair housing laws. Housing finance agencies and housing providers have become increasingly aware that fair housing laws and Olmstead requirements bestow rights on disabled elderly residents that they cannot ignore. Affordable housing plus services programs are a potential tool that can be used by housing managers to insure compliance with these laws. Service linkages may help residents access the necessary supports and resources that enable them to remain safely in their apartment and community.

Successful affordable senior housing with services options require breaking down long-standing silos between housing and services. For many years, knowledgeable observers have pointed out that federal, state and local housing and health and supportive services policy makers largely operate in their own orbits. They have little understanding of how the policies and regulations they promulgate impact the ability of low-income housing providers and aging services agencies to collaborate to assist older residents who wish to remain in independent living environments for as long as possible. While advocates for the homeless have done a good job in advancing their agenda to integrate health, employment, education and other critical services into supportive housing for their constituency, analogous efforts have not taken hold in the aging community.

Aligning affordable senior housing practices and policies with those of home and community-based services to promote successful affordable housing plus services options will not be easy. Many issues and questions must be addressed. For example:

Practice Issues

Effective implementation of affordable housing plus services options also raises many practice issues for housing sponsors, managers and staff and community services agencies and providers.

- There is an overarching difficulty of programmatically and philosophically reconciling resident preferences to remain in independent housing with their growing need for health and supportive services.

- Anecdotal evidence and some research suggests that numbers of housing sponsors, managers and other staff have little interest in or outright rejection of their role in helping residents continue to live independently in the face of declining health and/or increased disability. The

attitudes behind this thinking are likely influenced by fundamental values about the purpose of publicly subsidized housing, constraints placed by employers, inadequate or no training on the aging process, lack of knowledge of the resources that are available to respond to resident needs or how to collaborate with potential community partners, and a lack of time to do so.

- The role of the service coordinator is ambiguous and their capacity uneven. There appears to be little shared understanding across properties about how proactive service coordinators can be in targeting residents most in need, to what extent residents health and functioning can be formally assessed and tracked, and how much hands on help can or should be provided. Training is limited and some service coordinators seem to lack the capacity to address issues related to very frail and/or disabled residents. Many service coordinators are skilled in social work, but do not have health-related backgrounds that may enhance their ability to identify and address resident health issues. Few properties have staff with health-related training, such as nurses.

- Housing finance agencies, housing sponsors and aging services providers lack a track record in establishing and maintaining working relationships.

- The infrastructure is lacking to disseminate information and provide technical assistance to housing providers to capture and share emerging experience.

Policy Issues

- There is no consensus on the goals, outcomes and performance measures funders should expect in return for financing affordable housing with services options. There are many possibilities. Physical and mental health will be improved. More residents will participate in prevention and wellness activities. Quality of life will be improved. Unmet need for services will be reduced. Affordable housing with services options will substitute for ALFs for very low-income seniors at a lower cost. Independence will be prolonged and nursing home use reduced. Accidents and falls will be reduced. Use of unscheduled emergency services (ambulance and ERs) will be reduced.

- There is no consensus on whether and how affordable housing with services options should be targeted. Should targeting reflect a more deliberate focus on very frail residents? Services in publicly subsidized senior housing are now provided on a voluntary basis to whoever requests them, meets eligibility requirements or can pay out of pocket. Currently service coordinators are available to all residents to help with what ever problems they face. A lot of time is spent helping residents decipher and access benefits such as health insurance, Medicare and social security issues, and so on. If affordable housing with services programs were to be more explicitly targeted, it would represent a significant change that could impact staffing, costs, the nature and scope of community partnerships and the satisfaction of current residents.

- The most critical core components of an affordable housing with services program have not been identified. Whether programs are targeted or serve a spectrum of residents will influence what these components will be. The ability to have different components is also impacted by factors such as licensing/regulatory requirements and liability concerns.

- The capacity of housing managers and staff to implement affordable housing with services programs may need to be evaluated.

- Housing finance and reimbursement policies have a significant impact on the ability of policy makers and providers to provide affordable housing with services options. For example, they can affect the size and other physical characteristics of the building, potential economies of scale in service organization and delivery, amenities offered accessibility/ability to be ADA compliant, use of Medicaid waivers to provide supportive services, and the allocation of tax credits to construct properties primarily intended for older adults. How can these policies be aligned with affordable housing with services goals?

- Some policies and regulations appear to make it difficult or impossible for housing sponsors, managers and staff to implement affordable housing with services options. For example: state definitions of living arrangements that require licensing; limitations on the role of the service coordinator and/or other staff employed by the housing provider to conduct assessments and provide care management; provisions which prohibit family members or other caregivers to live in with residents to provide overnight care; federal rules governing data privacy, which may inhibit data collection on resident health, functioning and services needs; insurance requirements and liability concerns; local ordinances such as fire and building codes.

- The costs of planning and operating an affordable housing with services programs has not been explored. It is not clear how costs should be allocated between public and private payers?

- Monitoring affordable housing with services programs must balance the desires of residents for autonomy and the safety concerns of families, providers and regulators.

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Affordable Senior Housing with Services Programs and Models

The U.S. Department of Housing and Urban Development (HUD) currently operates one program that specifically links funding for supportive services to subsidized housing for elderly and persons with disabilities. A small handful of states have also developed such programs. Across the country a number of local providers have implemented programs through their own resources and/or through partnerships with other organizations in their community to bring services to their housing properties to help meet the needs of their residents. Below are descriptions of various programs. This list is by no means exhaustive, but illustrates just some of the potentially promising strategies and models of affordable senior housing with services that have been implemented.

U.S. Department of Housing and Urban Development

HUD Congregate Housing Services Program

The Congregate Housing Services Program (CHSP) offers grants to States, units of local government, public housing authorities, tribally designated housing entities, and local nonprofit housing sponsors to provide supportive services needed by frail elderly residents and residents with disabilities in federally subsidized housing. No new grants have been awarded since 1995; however, funds have been provided to extend expiring grants on an annual basis. Today, 51 public housing agencies and private assisted housing owners administer 63 grants. Services may be used by frail elderly (62 years or older), disabled, and temporarily disabled persons who are unable to perform at least three activities of daily living. At least one daily hot meal in a group setting must be provided. Other services may include service coordination, personal assistance, housekeeping, transportation, preventative health/wellness programs, and personal emergency response systems. An independent professional assessment committee works with a service coordinator appointed by the grantee to determine individual eligibility for services and to recommend a service package to the housing management. HUD provides funds of up to 40% of the cost of supportive services, grantees pay at least 50% of the costs, and program participants pay fees amounting to at least 10% of the program costs. Fees may be up to 20% of a participant's adjusted income.

State Affordable Senior Housing with Services Programs

New Jersey Congregate Housing Services Program
New Jersey's Congregate Housing Services Program (CHSP) is a state-funded program operated by the New Jersey Department of Health and Senior Services that provides a number of supportive services to help eligible individuals living in participating affordable housing buildings remain in their apartments. The program is directed to the frail or at-risk elderly and adults with disabilities. One daily congregate meal must be provided. Other supportive services may include housekeeping, meal preparation, shopping, linen change, laundry, companionship, personal care and assistance with bathing and dressing (available services can vary by building). Each participating housing property is provided an annual budget, and an on-site coordinator determines eligibility and the allocation of services to residents. Housing providers may deliver the services directly or contract with outside providers to provide on-site services. The project-based funding allows the property to be responsive to residents' needs. The property can adapt the services offered to the needs of the overall resident population and can tailor the amount of services to individual resident need. Some residents may receive daily services, while others may only receive services once per week. Services can also be adapted to respond to intermittent needs. For example, a resident returning home from a hospital stay may receive increased services until their functioning level stabilizes. Participants share in the cost of services, paying between a 5% and 100% co-pay based on their income. On average, CHSP spends $1,000 per participating resident annually. CHSP serves approximately 2,700 residents in approximately 60 subsidized senior housing properties.

Maryland Congregate Housing Services Program
Maryland's Congregate Housing Services Program (CHSP) provides support services to residents of subsidized housing properties who are at least 62 years of age and in need of assistance in one or more activities of daily living. The Maryland Department of Aging (MDoA) contracts with housing and senior service provider organizations (such as local housing authorities, non-profit organizations or housing management companies) to operate the program in designated buildings. The program provides meals, weekly housekeeping, and limited personal assistance with activities such as bathing, dressing, and laundry. Providers can offer a variety of service "packages." The standard package includes two meals/day, weekly housekeeping, laundry, personal services and service management. Other packages offer more tailored sets of services. The standard package costs $595/month (in 2009). Participants pay on a sliding scale, with MDoA providing a subsidy to those who qualify based on income and assets. Subsidies are available to seniors with incomes less than 60% of the State's median and with assets less than $27,375 for an individual or $35,587 for a couple. Currently, more than 800 units in 35 properties across the State receive CSHP funding and services.

Connecticut's Congregate Housing for the Elderly Program
Connecticut's Congregate Housing for the Elderly Program offers housing and supportive services to frail elders, age 62 or older. The program is jointly administered by the Connecticut Housing Finance Authority (CHFA) and the Department of Economic and Community Development (DECD) and provides grants or loans to construct or rehab congregate rental housing units, rental subsidy and congregate services subsidy. Residents must have temporary or periodic difficulties with one or more activities of daily living and must meet the established criteria of a local selection committee,

which is approved by DECD. At minimum, communities must provide one main meal in a communal setting, light housekeeping, 24-hour security and service coordination. Transportation and socio-recreational services may also be provided. Residents pay a monthly base rent and congregate service fee, based on their adjusted income. The housing sites can also choose to offer a more extensive package of assisted living services to residents who meet functional eligibility requirements, which may include personal care, additional meals, nursing services and medication management. The assisted living services are provided through the Connecticut Home Care Program for Elders program and paid for through either a Medicaid waiver or partially subsidized through a state-funded component for persons whose income exceeds the Medicaid waiver limits. There are 24 Congregate Housing for the Elderly properties across the state.

Massachusetts Supportive Housing Program

The Massachusetts Supportive Housing Program is a partnership between local housing authorities, the ASAP (the single point of entry to state and federal funded service programs) and a community service provider. The ASAP assigns a case manager to the housing property and designates one service agency to provide services in the building 24/7. Available services include service coordination and case management, personal care, homemaker services, laundry, medication reminders, social activities and at least one meal a day. Services are paid for by a range of funding sources based on the resident's eligibility and might include state funded home care services; Medicaid HCBS services; Medicaid state plan services; Older Americans Act Title III-C nutrition services; Older Americans Act and Title III-B social services. The program is currently available in 27 state-aided elderly housing communities throughout Massachusetts.

Provider-based Affordable Senior Housing with Services Programs

Just for Us, Durham, NC

Just for Us is a collaboration to provide primary care, mental health services, and care management to seniors and disabled adults with multiple chronic conditions who are homebound and cannot access medical care on their own without great difficulty. The program operates in 13 public or subsidized independent housing complexes in Durham, NC. Participants are cared for by an interdisciplinary care team, which includes a supervising physician, physician assistants, social worker, nutritionist, occupational therapist, and community health worker. Partners include the Duke University Medical Center Division of Community Health, the Lincoln Community Health Center (a federally qualified community health center), the Durham County Department of Social Services, the Durham County Health Department, the Council on Senior Citizens, and the City of Durham Housing Authority. Just for Us provides patients with consistent monitoring and treatment of chronic medical conditions, treatment of acute care needs that can be treated at home, lab tests and health education. Participants receive routine visits from the physician or physician assistant every six to eight weeks, or more often when their medical condition warrants. Those with specific needs may also be seen by a nutritionist (particularly diabetic patients) or occupational therapist. A social worker provides case management and helps participants apply for benefits, such as food stamps and Medicaid, and access supportive services, such as Meals on Wheels and home health aids (most of the properties served by the program do not have a service coordinator). The program can also help arrange mental health services.

Lapham Park, Milwaukee, WI

Lapham Park, a 200-unit public housing property, provides a continuum of on-site, health-related services to address residents' preventative, acute, and long-term health care needs. The primary partners in the health-related aspects of the Lapham Park venture include the Milwaukee Housing Authority; the Milwaukee County Department of Aging; Community Care Organization, a PACE program; and St. Mary's Family Practice Clinic. Also participating are the Milwaukee Area Technical College Dental program, St. Mary's Family Practice and Community Education Center Student Program, Marquette University School of Nursing and the YWCA. An on-site clinic meets routine medical needs during weekday hours and special, more critical needs on a 24-hour basis. St. Mary's Family Practice Clinic offers physician care to all residents. Community Care Organization provides acute, primary, specialty and long-term care for residents enrolled in its capitated program. Several educational institutions also send students to the property to provide services. Dental hygiene students from the Milwaukee Area Technical College conduct assessments. Nursing, medical and social work students from St. Mary's Family Practice and Community Education Center Student Program provide home visits, health promotion programs and activities. Nursing students from Marquette University conduct assessments of residents' functional status. In addition, the YWCA provides on-site exercise programs. The housing authority significantly rehabbed the building's basement to accommodate the venture's various services and activities, creating several community spaces and a state-of-the-art medical clinic.

Lutheran Towers, Atlanta, GA

Lutheran Towers, a 205-unit affordable senior housing property, has partnered with the Visiting Nurse Health System's care coordinator program. The program provides a "coach" to work with the service coordinator to assist at-risk residents. "At-risk" is determined by two elements: 1) prior pattern (history of falls, hospitalizations, etc.) and 2) life-risk factors (onset of memory loss, mismanagement of medications, nutritional status change, etc.). With the resident's agreement, the coach conducts a comprehensive geriatric screening and then works with the service coordinator to identify resources and services to meet the resident's needs. The coach helps wrap the health services around the social services side that the service coordinator is generally more skilled at meeting. The coach also helps coordinate residents' transitions back to the hospital following a hospital stay, utilizing Eric Coleman's model. Lutheran Towers also partners with another home health agency to have a psychiatric nurse work with the property. When they identify a resident with mental health concerns they contact the nurse, with the resident's permission, who begins working with the resident to address their issues.

Lutheran Senior Services of Missouri, St. Louis, MO

Lutheran Seniors Services (LSS) of Missouri properties conduct an assessment of their residents after the resident has been approved for occupancy and annually thereafter. Assessments, conducted by the service coordinator, are all voluntary and the resident has the right to decline. The initial assessment helps the service coordinator identify any needs the new resident may have and start to assist them putting services in place. The annual assessment identifies any changes and allows the service coordinator to help the resident access any new needed supports. The LSS tool looks at a range of areas such as physical and mental health, functional status, risk of falls, medication usage, etc. On the individual level, the service coordinator will look at the resident's needs, identify where they might need some additional support and help them get services in place. At a property level,

the service coordinator will look at common problems/needs across the community and try to bring in programming to address them. For example, if a large portion of residents appear to be at risk for falls, they will look for programs to improve balance or other possible solutions.

Mable Howard Apartments, Oakland, CA

Mable Howard Apartments is a 40-unit Section 202 property co-located with a federally funded Qualified Community Health Center and a PACE site. The venture is a collaboration between Resources for Community Development, which operates Mable Howard Apartments; LifeLong Medical Care, which operates the Over 60 Health Center; and Center for Elders Independence, which operates the PACE program. The health center provides preventative care, primary care and case management, including mental health services, podiatry, dental care, health education and screening, physical therapy, and links to home health services. The PACE program provides nursing home eligible residents access to comprehensive medical, social and long-term care services under a capitated system of reimbursement in an on-site adult day health center. PACE staff provide care in the resident's own apartment as needed.

National Church Residences, Columbus, OH

National Church Residences (NCR) has placed an aid from their home health agency, InCare, in each of their Columbus area affordable senior housing properties to be available to assist residents needing assistance with daily living activities. Residents receiving such assistance through a Medicaid waiver or other similar program can select InCare as their provider, if they choose. Through InCare, NCR also staffs a health care liaison nurse and a navigator position to assist service coordinators across the Columbus properties. Service coordinators call the liaison nurse to assist with residents with health-related needs, including those in the hospital so that the nurse can assist with the discharge process. Service coordinators can call the navigator to assist with residents with very complex needs to help identify their options and communicate with the resident and/or family members.

NewCourtland Square, Philadelphia, PA

NewCourtland Square, operated by NewCourtland, is a 26-unit property developed to support the transition of seniors out of nursing homes. As part of the state's nursing home transition efforts, the Pennsylvania Housing Finance Agency assigned rental assistance vouchers to all the units for two years. In addition, residents are receiving assistance through the local Area Agency on Aging to purchase items needed to start a new home, such as furniture. All residents are enrolled in the LIFE program (a PACE program, operated by New Courtland) and receive most of their services and supports through the program. Most residents attend the nearby LIFE center about three days per week. Some residents may also get personal assistance in their home, typically in the evenings or weekends. However, the goal is to create an independent living environment, not assisted living. The property is not staffed around the clock or with any care aids. There is a property manager, who does participate in the LIFE program's weekly interdisciplinary team meetings and a part-time service coordinator. Once identified as appropriate for transitioning out of a nursing home, occupational therapists and others from the LIFE program work with the resident for approximately three to six months to "condition" them for living independently again.

Peter Sanborn Place, Reading, MA

Peter Sanborn Place is a 73-unit refinanced Section 202 property. To ensure the availability of personal care to frail residents, Peter Sanborn created a sister corporation, Sanborn Home Care, which provides a range of personal care and other supportive services. Through a HUD-approved tenant selection plan Peter Sanborn targets 40% of its units for residents needing single to multiple services daily, 30% for residents needing scheduled services during the week, and 30% who may choose to use services. Sanborn Home Care provides residents case management and service coordination; personal care, including assistance with showering, grooming, toileting, meal preparation, feeding, mobility, and medication monitoring; homemaker services such as housekeeping, shopping, and laundry; transportation to medical appointments; companion and respite care; and assistance with local errands and other tasks. Sanborn Home Care also contracts with the Visiting Nurse Association for nursing care and rehabilitation therapy. Services are paid for through a variety of mechanisms, including self-pay, private insurance, state-funded programs, Medicaid waiver programs, and Medicare.

Presbyterian Villages of Michigan

Presbyterian Villages of Michigan (PVM) is implementing evidenced-based wellness and prevention programs in its 13 affordable senior housing properties. For example, they partnered with the Detroit Area Agency on Aging (AAA) to implement the Enhanced Fitness program in five properties. The AAA provided a grant to purchase the equipment and residents were trained and employed through the Senior Service Community Employment program to lead the course in the properties. PVM also partnered with the National Kidney Foundation of Michigan, which received a grant, to offer the Chronic Disease Self Management Program (called Personal Action Toward Health in Michigan) in six properties and the Detroit AAA to offer in another property.

Presentation Senior Community, San Francisco, CA

Presentation Senior Community is a 93-unit Section 202 property co-located with an adult day health center, which serves individuals from the housing property as well as the surrounding community who are at risk for nursing home placement. Sixty units are targeted to frail elders. Presentation Senior Community is a property of Mercy Housing California and the adult day health center is operated by North & South Market Adult Day Health. Approximately half of the housing property residents participate in the day health program, which provides a variety of services, including nursing care; personal care, social work services; physical, occupational and speech therapy; podiatry services; mental health support; case management; transportation; and a daily meal. The day health program is able to coordinate a pool of in-home aids from the state's In-Home Supportive Services (IHSS) program for residents, allowing workers to maximize their efficiency. Residents not enrolled in the adult day health program receive support and services from a service coordinator, the IHSS program and a variety of community organizations.

Simon C. Fireman Community, Randolph, MA

The Simon C. Fireman Community, a 159-unit affordable senior housing property, employs an exercise physiologist 22 hours/week to operate a fitness center offering multiple activities for residents, including two evidence-based exercise classes, tai chi, and a walking program. The property also offers the Chronic Disease Self-Management Program, an evidenced-based behavior modification program developed at Stanford University. This program is designed to help

individuals gain skills and self-confidence in their ability to control their disease symptoms and to lead a full life in spite of their chronic illnesses. The fitness director and the assistant administrator have been trained to teach the course, although trainers are often lay leaders with chronic illnesses themselves. The course meets 2 hour per week for 6 weeks.

WellElder Program, San Francisco, CA

WellElder is a program of Northern California Presbyterian Homes and Services (NCPHS) and the Institute on Aging and is operated in four bay area affordable senior housing properties. The program teams a part-time health educator (RN or LVN) with a service coordinator, providing a comprehensive set of expertise to help residents meet their needs and remain in their own home and community. The health educator monitors vital signs, provides individual and group health and wellness education, helps residents with communicating with their health care providers, assist with understanding medical and insurance programs, monitors residents returning from hospital and rehab stays, and provides referrals for meeting health needs.

Westerly Apartments, Lakewood, OH

Eliza Jennings Senior Care Network operates an on-site wellness clinic at Westerly Apartments, which consists of three high rise buildings (two Section 202s and one Section 236) with a total of 500 units. The clinic is staffed five days a week by a nurse and a nurse practitioner. The clinic provides health education and wellness services, with a goal of helping residents become active in their own health monitoring and care. The clinic has several self-monitoring stations where residents can check their blood pressure, weight, pulse, oxygen level, etc., and the nurse provides education on managing their health and diseases processes. The nurse is also available to answer resident questions about medications and will help coordinate their health care needs. Residents can see the nurse practitioner for regular health care visits. She will see residents in their apartment or the clinic, whichever they prefer. Eliza Jennings also offers physical and occupational therapy services in the apartments of residents to help them work within and adapt to their specific surroundings. The therapy, which must be prescribed by a physician, is billed to Medicare.

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Research on Affordable Senior Housing with Services Strategies

The impact of affordable housing with services strategies is largely untested. Although numerous approaches have been implemented across the country in a wide range of housing settings, there is a paucity of systematic or rigorous evaluation of their outcomes. Studies have found a high level of satisfaction with programs, increased use of services, increased sense of resident well-being, and positive impacts on property management (lower turnover, higher occupancy and improved maintenance of units). Some studies have also found improved health management and monitoring behavior. No studies, however, have been conducted of the cost-benefits of the model.

HUD Congregate Housing Services Program
An evaluation of HUD's Congregate Housing Services Program (CHSP) conducted in 1996 found that elderly participants overwhelmingly reported being satisfied with the services they received from the program. Most also indicated it would be difficult or impossible to live independently without the assistance they received. CHSP grantees also reported that services available through the program contributed to higher occupancy rates, lower turnover and better maintenance of units. CHSP provides services such as congregate meals, light housekeeping, personal care, and transportation to eligible residents of federally assisted congregate housing properties who have three or more limitations in routine activities such as bathing, dressing and housekeeping. A services coordinator is involved in determining resident eligibility, designing a care plan, and linking residents to services.

Research Triangle Institute. (1996). *Evaluation of the New Congregate Housing Services Program: Second Interim Report.* Prepared for the Office of Policy Development and Research, U.S. Department of Housing and Urban Development.

HOPE for Elderly Independence Demonstration
A 1999 evaluation of the HOPE for Elderly Independence Demonstration (HOPE IV) compared elderly residents living in public housing who received services through the HOPE IV demonstration with elderly residents who did not receive HOPE IV services. HOPE VI was a tenant-

based program, administered by public housing authorities, which provided case management through service coordinators and non-medical services such as transportation, personal care and homemaker services to residents with certain limitations in their ability to carry out routine activities. The evaluation found that residents in the demonstration received a significantly higher level of services than the comparison group (although a substantial portion of the comparison group also received services) and reported high levels of satisfaction with the program. Housekeeping was the most commonly used service. The receipt of services in the demonstration group correlated with higher social functioning and well-being and better mental health. However, no significant differences between the comparison and demonstration group were found in nursing home use rates or the amount of time they lived in the subsidized property.

Ficke, R. and Berkowitz, S. (1999). *Evaluation of the HOPE for elderly independence demonstration: Final report.* Prepared for the Office of Policy Development and Research, U.S. Department of Housing and Urban Development.

HUD Section 202 Supportive Housing for the Elderly Program

In 2006, HUD conducted a study to assess the performance of the Section 202 program. One section of the study estimates the costs of Section 202 housing and supportive services compared with those of an institution. The authors estimate that when Section 202 housing is provided along with supportive services consisting primarily of meals, transportation, and housekeeping, the cost of housing and Medicaid-paid services provided to at-risk individuals is about half as expensive as institutionalization over a two-year period (the average nursing home length of stay is 340 days over a two-year period). This is not an actual measure of cost savings, merely a cost comparison between the two settings. Based on estimated frailty (deduced from population estimates by age and income) and availability of informal caregiver levels, the authors estimate 90,000 (of 278,000) Section 202 residents are at-risk of institutionalization.

Haley, B. and Gray, R. (2008). *Section 202 Supportive Housing for the Elderly: Program status and performance measurement*. Washington, DC: U.S. Department of Housing and Urban Development.

HUD Service Coordinator Program

A 1996 evaluation of the service coordinator program interviewed residents and property managers in properties with the program and found a perception that the program increased resident physical and emotional well-being, understanding of and access to services, social interaction among residents, and reduced the number of residents needing nursing home placements.

KRA Corporation. (1996). *Evaluation of the Service Coordinator Program*. Prepared for the Office of Policy Development and Research, U.S. Department of Housing and Urban Development.

A 2008 study of the service coordinator program by HUD conducted a survey and interviews with property managers. The study found a high level of satisfaction with the service coordinator program and a strong perception among property managers that service coordination improves residents' quality of life. The study also found that service coordination appears to lengthen tenure; the average length of occupancy was 6 months longer among residents of properties with HUD-funded service coordination as compared to residents of similar developments without service coordination.

Levine, C.A. and Robinson Johns, A. (2008). Multifamily Property Managers' Satisfaction with Service Coordination. Washington, DC: U.S. Department of Housing and Urban Development.

Resident Opportunities and Self Sufficiency Resident Service Delivery Models Program

A quasi-experimental study was conducted of the effects of HUD's Resident Opportunities and Self Sufficiency (ROSS) Resident Service Delivery Models (RSDM)–Elderly and Persons with Disabilities (EPD) grant program on the health outcomes of seniors and people with disabilities in Seattle public housing. Services funded through the program include grocery delivery, resource referral, case management, communal activities and events, and health and wellness programming. The study found a statistically significant relationship between the treatment group (communities where ROSS funded services are available) and increased social interaction among residents of all age groups, decreased percentage of those going without treatment for certain conditions, and decreased percentage of evictions that result in the tenant's having to leave from the public housing community. It should be noted that a large percentage of participants in this study were under age 62.

Siu, C. (2009). *Impacts of nutrition and human services interventions on the health of elderly and disabled persons in public housing: A study of the HUD ROSS-RSDM - Elderly and Persons with Disabilities grant funded programs in the Seattle Housing Authority's Low Income Public Housing program.* Washington, DC: Congressional Hunger Center.

Senior Living Enhancement Program

The Senior Living Enhancement Program (SLEP) was designed to provide selected services including nursing and health promotion, service coordination, and social and recreational opportunities, to seniors living in 12 high-rise buildings for the elderly. The goal was to improve seniors' health in 10 areas called the 10-Keys to Health Aging. The 10-Keys are strategies aimed at reducing risk factors for subsequent ill-health in the aging population. Over a two-year demonstration period, residents participating in SLEP showed improvements in a majority of the 10-Keys to Healthy Aging (Be Active, Participate in Cancer Screening, Get Regular Immunizations, Combat Depression, Prevent Bone Loss and Muscle Weakness and Lower LDL Cholesterol) compared to those who did not participate in SLEP.

Castle, N. (2008). Service enriched housing and senior living enhancement program. *Journal of Housing for the Elderly*, 22(3), 263-278.

Case Study of Three Affordable Senior Housing with Services Models

This study examined three affordable senior housing communities in Colorado that evolved different strategies to foster independent living and support residents in the face of changing needs. Two developed purpose onsite strategies, while the third left it to residents and family members to organize their services. In the two properties with purposeful resident service strategies, participants in resident focus groups appeared to be more confident they could maintain themselves in an independent living setting, even in the face of declining health/increasing frailty. The study found that residents didn't report using many services, although there were more likely to use services if offered onsite. The study also found that residents in the three properties relied to a significant extent on families to provide support and care.

Washko, M., Sanders, A., Harahan, M., Stone, R. and Cox, E. (2007). Connecting affordable senior housing and services: A descriptive study of three Colorado models. Washington, DC: American Association of Homes & Services for the Aging.

Aging in Place Program

The Aging in Place (AIP) program, a partnership between the University of Missouri Sinclair School of Nursing and the Missouri Department of Health and Senior Services, provides nurse coordination of acute care, Medicaid home and community-based services and Medicare home health services. Care is provided to older adults in senior private and public congregate housing as well as individual homes. The Center for Medicare & Medicaid Services funded a pilot and evaluation of the program. The study compared clinical outcomes between seniors residing in nursing homes and a comparable group participating in the AIP program. The study found significantly better outcomes in cognition, depression, activities of daily living and incontinence in the clients receiving the intervention compared to those in the nursing homes. In the public congregate housing where the program was implemented, officials were so pleased with the reduction in resident conflicts (related to mental illness), police calls to apartments, ER visits for acute illnesses or exacerbations of chronic illnesses, and better social interaction among residents that they obtained grant funding to continue the AIP care coordination program and on-site wellness center for two years after the initial grant ended

Rantz, M. et al. (2008). TigerPlace, a state-academic-private project to revolutionize traditional long-term care. *Journal of Housing for the Elderly*, 22 (1/2), 66-85.

Massachusetts Supportive Housing Program

The Massachusetts Supportive Housing Program provides onsite care coordination and 24/7 personal care services in state funded, elderly public housing properties. A formal evaluation of the program has not been conducted. However, the Massachusetts Department of Housing and Community Development (DHCD) estimates the program saves $3,205 in federal and state spending ($1,287 in net state savings) for every month a nursing home placement is avoided. Interviews with staff describe reductions in vacancy rates, higher demand leading to waiting lists for once less desirable rental units, and substantial reductions in nursing home admissions, hospital admissions and unexpected resident deaths. DHCD officials estimated that the program saves $500-$1,000 for each avoided vacancy, including lost rent and the administrative costs associated with marketing units when there is no waiting list. Officials report the service efficiencies allow the sites to support the costs of expanded services.

Mollica, R. and Morris, M. (2005). *Massachusetts supportive housing program*. New Brunswick, NJ: Rutgers Center for State Health Policy.

Nursing Clinics in Elder Housing

A study of clinics in elderly housing sites staffed by senior baccalaureate nursing students found increased access to care, better identification and management of hypertension, more involvement for residents with diabetes in monitoring and management of their conditions, and better preparation for emergency medical situations.

Ellenbecker, C.H., Byrne, K., O'Brien, E. and Rogosta, C. (2002). Nursing clinics in elder housing: Providing access and improving health care outcomes. *Journal of Community Health Nursing*, 2002, 19(1), 7-15.

Psychogeriatric Assessment and Treatment in City Housing Program

The Psychogeriatric Assessment and Treatment in City Housing (PATCH) program targets elderly persons living in urban public housing developments. The program has 3 elements: (1) training of building staff, such as managers, social workers, groundskeepers, and janitors, to identify those at

risk for psychiatric disorder; (2) identification and subsequent referral of potential cases by these workers to a psychiatric nurse; and (3) psychiatric evaluation and treatment in the residents' homes. An evaluation was conducted to determine whether the PATCH program could reduce psychiatric symptoms among elderly residents needing care and enable them to remain in public housing. Testing the program in six public housing sites in Baltimore, MD, residents in three buildings who screened positive for psychiatric illness were randomized to receive the PATCH model intervention, and residents in the remaining three buildings were randomized to receive usual care (comparison group). After 26 months, psychiatric cases at the intervention sites had significantly lower scores on the Montgomery-Asberg Depression Rating Scale (MADRS), a measure of depressive symptoms, and the Brief Psychiatric Rating Scale (BPRS), a measure of psychiatric symptoms and behavioral disorder. There was no significant difference between the groups in undesirable moves (eg, nursing home placement, eviction, board and care placement).

Rabins, P., Black, B., Roca, R. German, P., McGuire, M., Robbins, B. , et al. (2000.) Effectiveness of a Nurse-Based Outreach Program for Identifying and Treating Psychiatric Illness in the Elderly. J*ournal of the American Medical Association,* 283 (21), 2802-2809.

New York City Cluster-Care Model

In response to rising demand and increased cost for home care services for frail elderly and disabled Medicaid clients, New York City implemented cluster care. Cluster care reorganized care at public and private senior housing sites by establishing a shared-aid service as opposed to a traditional one-on-one attendant care system. An evaluation found cluster care reduced costs by about 10 percent (most savings occurred among clients with five or more ADL/IADL limitations). Clients at cluster care sites who started out with fewer than five ADL/IADL limitations appeared to decline somewhat more slowly than similarly impaired clients at comparison sites, while those with more than five tended to decline more rapidly. Cluster care is associated with a significant decline in satisfaction but appears unrelated to depressive symptoms. The findings suggest that the model has applicability where the needs of residents may not be intense. The cost savings will be modest, but individual outcomes will likely not be compromised.

Feldman, P.H., Latimer, E. and Davidson, H. (1996). Medicaid-funded home care for the frail elderly and disabled: evaluating the cost savings and outcomes of a service delivery reform. *Health Services Research*, 31(4), 489-508.

Senior Housing: Pathway to Service Utilization

This study compared use of formal in-home services of seniors living in age segregated housing to seniors living in age integrated housing. The study found seniors living in age segregated housing were older, poorer, more functionally impaired, more likely to have Medicaid health insurance, and more likely to use formal in-home services than seniors in age integrated housing. In both groups, level of need was the strongest predictor of service use. However, controlling for all variables, housing type was found to be a significant predictor of service utilization.

Rinehart, B. (2002). Senior housing: Pathway to service utilization. *Journal of Gerontological Social Work*, 39(3), 57-75.

Predictors of Nursing Home Placement Among Elderly Public Housing Residents

This study examined data on residents of six urban public housing developments for elderly persons to determine the predictors of nursing home placement during a 28-month period. Analysis found that nursing home placement is primarily predicted by functional status and mental status. Four baseline indicators of need were identified: greater impairment in instrumental activities of daily

living, cognitive disorder, high scores on the General Health Questionnaire (measures mental health), and psychotic disorder. Neither ADL impairments or poor mobility were independently associated with nursing home entry as has been found for elders in general. One likely explanation is that almost all elderly public housing residents live alone and so become unable to live independently before ADLs or gait become impaired.

Black, B.S., Rabins, P.V., and German, P.S. (1999). Predictors of nursing home placement among elderly public housing residents. *The Gerontologist*, 39(5), 559-568.

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