A SYNTHESIS OF FINDINGS FROM THE STUDY OF AFFORDABLE HOUSING PLUS SERVICES FOR LOW- AND MODEST-INCOME OLDER ADULTS

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Executive Summary

With the relationship between increasing age, chronic illness and disability, and growing long-term care needs well documented, new models of delivering health-related and supportive services are being sought that are attractive and affordable to low- and modest-income older adults. One promising but under explored strategy, affordable housing plus services (AHPS), links older residents of subsidized multi-unit housing to health and supportive services so that they can "age in place." The U.S. Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) and the A.M. McGregor Home in Cleveland, OH, funded the Institute for the Future of Aging Services (IFAS), the policy and applied research arm of the American Association of Homes and Services for the Aging (AAHSA), to examine the potential of AHPS strategies to meet some of the long-term care needs of low- and modest-income seniors. IFAS defines AHPS as having three elements:

- Independent, unlicensed, primarily subsidized, multi-unit housing where large numbers of low- and modest-income older adults live in close proximity.
- Health-related and supportive services, funded separately from the housing, and available to at least some older residents (e.g., personal care, housekeeping, meals, transportation, health and wellness services, etc).
- A purposeful linkage mechanism connecting residents to needed health-related and supportive services so that they are able to "age in place" in the face of declining health and increasing disability.

The study examined the literature on integrating affordable housing and health and supportive services for older adults, developed an inventory of promising AHPS strategies and programs, and brought together several hundred stakeholders from the fields of affordable housing and aging services in four workshops convened in four regions of the country. The study found a wide variety of AHPS programs in operation, typically at the initiative of individual housing providers. Hard evidence on the impact of these programs is lacking. Stakeholders at the workshops generally agreed that AHPS strategies could be effective in helping some publicly subsidized housing residents maintain independent living, even in the face of declining health and increasing disability. Programs they deemed most successful: (1) bridged the different worlds of housing and aging services; (2) involved housing providers committed to a broader role; (3) possessed the skills to develop collaborative relationships with community partners; and (4) pro-actively sought out funders and overcame regulatory barriers. The study concluded that wider replication and dissemination of AHPS programs will require additional numbers of committed housing providers, increased provider capacity, and concrete demonstration and evaluation of the impact of AHPS programs.

A Synthesis of Findings from the Study of Affordable Housing Plus Services Strategies for Low and Moderate Income Older Adults

I. Introduction and Purpose

The aging of the baby boomers is a significant economic and social issue. By 2030, older adults are expected to make up 20 percent of the population, doubling from 35 to 70 million people. The relationship between older age, chronic illness and disability, and higher use of long-term care services is well established. In response to the rising demand for long-term care, consumer advocates, policy makers, and service providers have encouraged the development of new models of organizing and delivering health-related and supportive services that are attractive and affordable to older adults, particularly those who are poor or of modest means.

Assisted living facilities (ALFs) are a residential model of care that has received considerable attention as a potentially less expensive and more appealing alternative to nursing homes. The Assisted Living Quality Coalition has defined assisted living as a congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services and is designed to minimize the need to move; to accommodate individual residents' changing needs and preferences; to maximize residents' dignity, autonomy, privacy, independence, and safety; and to encourage family and community involvement.[1] While the number of ALFs across the country has rapidly expanded over the last decade, they have remained largely cost prohibitive for older people with limited incomes. Many states have secured waivers allowing Medicaid to cover ALF costs; however, assisted living remains primarily private pay. In 2002, Medicaid helped pay for approximately 11 percent of the total number of assisted living residents in 41 states.[2]

A less well-publicized residential care model providing lower-income seniors with access to health-related and supportive services is emerging in publicly subsidized housing communities. This service delivery model, referred to in this report as "affordable housing plus services" (AHPS), is intended to integrate independent, unlicensed, and primarily subsidized multi-unit housing environments for older adults with services and supports. The goal is to enable older residents who are frail and/or disabled to remain in their housing community even as their health declines and disability increases.

The U.S. Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) and the A.M. McGregor Home in Cleveland, OH, funded the Institute for the Future of Aging Services (IFAS), the policy and applied research arm of the American Association of Homes and Services for the Aging (AAHSA), to examine the potential of AHPS

[1] C. Hawes, M. Rose, and C. Phillips, *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities*, Prepared for the Office of Disability, Aging, and Long Term Care Policy, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, 1999.

[2] Bernadette Wright, *An Overview of Assisted Living: 2004*, In Brief FS62R (Washington, DC: AARP Public Policy Institute, 2004), 2.

strategies to meet some of the long-term care needs of low- and modest-income seniors. IFAS defines AHPS as having three elements:

- Independent, unlicensed, primarily subsidized, multi-unit housing where large numbers of low- and modest-income older adults live in close proximity.
- Health-related and supportive services, funded separately from the housing, and available to at least some older residents (e.g., personal care, housekeeping, meals, transportation, health and wellness services, etc).
- A purposeful linkage mechanism connecting residents to needed health-related and supportive services so that they are able to "age in place" in the face of declining health and increasing disability.

Three reports have been produced in conjunction with the AHPS study:

1. **A Synthesis of Findings from the Study of Affordable Housing Plus Services for Low- and Modest-Income Older Adults** (summarizes findings from the AHPS study).
2. **An Inventory of Affordable Housing Plus Services Initiatives** (describes the AHPS strategies and programs identified by IFAS during the course of the study).
3. **Lessons from the Workshops on Affordable Housing Plus Services** (reports on the findings and lessons learned from the proceedings of four invitational workshops held across the country to analyze the merits of AHPS strategies and the barriers to their more widespread diffusion).

Each of the three reports may be found on the IFAS website (www.futureofaging.org), the ASPE website (http://aspe.hhs.gov/daltcp/reports), and the HUD website (http://www.huduser.org).

The synthesis report is presented below.

II. Methods

The study findings synthesized in this report were generated through a combination of methods, including:

1. A review of the research and evaluation literature.
2. Two informal workgroup meetings, held with AAHSA members and staff and other experts, to develop study definitions and identify policy and practice issues to be addressed in the invitational workshops.
3. Telephone and in-person discussions with AAHSA members, other housing providers, and aging and housing experts to identify exemplary AHPS programs.
4. Four invitational workshops attended by housing and aging services stakeholders to discuss the merits of, challenges to, and opportunities for AHPS.

III. Findings from the Literature

About 1.8 million older adults, mostly low-income single women in their mid-70s to early-80s, live in federally subsidized housing—more than the numbers who live in nursing homes.[3] The majority live in public housing, housing with Section 8 assistance, Section 202 Supportive Housing for the Elderly, Section 515 Rural Rental Housing, and Low Income Housing Tax Credit (LIHTC) properties. Unknown numbers of low-income seniors also live in rental properties subsidized through state and municipal programs and in privately financed unsubsidized housing, rented or sold at market rates without regard to income.

Research shows that many of these older residents need assistance with routine activities. The 2002 American Community Survey found that subsidized older renters were twice as likely to be disabled, as were older homeowners.[4] Over half reported limitations in activities like walking and climbing stairs, compared to one quarter of older homeowners. A third reported difficulty with shopping or going to the doctor, twice that of older homeowners. Likewise, surveys of Section 202 property managers indicate the proportion of residents having difficulty preparing meals or performing personal care tasks increased almost four fold between 1988 and 1999. Managers in the 1999 survey also reported 30 percent of vacancies occurred because of a transfer to a nursing home.[5]

Renters in subsidized senior housing are also less likely than unsubsidized renters to live in properties that offer supportive services. According to analysis of wave 2 of the Study of Assets and Health Dynamics among the Oldest Old (AHEAD), 36 percent of subsidized senior housing properties offer transportation services, 26 percent offer group meals, about 12 percent offer housekeeping and 6 percent offer personal care. In contrast, over 75 percent of unsubsidized elderly renters live in independent senior housing that offers group meals and transportation, 67 percent live in properties that offer housekeeping, and 43 percent offer personal care.[6]

Connecting older residents who are frail and/or disabled to needed assistance is not straightforward. Discontinuities between the agencies responsible for housing and for long-term care are well documented.[7] For example, housing policy is largely about "bricks and mortar."

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[3] Robert Wilden and Donald Redfoot, *Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes* (Washington, DC: AARP Public Policy Institute, January 2002), 6.

[4] Donald Redfoot and Andrew Kochera, "Targeting Services to Those Most at Risk; Characteristics of Residents in Federally Subsidized Housing," *Journal of Housing for the Elderly* 18, no. 3/4 (2004): 141.

[5] Leonard Heumann, Karen Winter-Nelson, and James Anderson, *The 1999 National Survey of Section 202 Elderly Housing* (Washington, DC: AARP Public Policy Institute, 2001), 64.

[6] K. Gibler, "Aging Subsidized Housing Residents: A Growing Problem in U.S. Cities," *Journal of Real Estate Research* 25 (2003): 415.

[7] See J. Pynoos, P. Liebig, D. Alley, and C.M. Nishita, "Homes of Choice: Toward More Effective Linkages Between Housing and Services," *Journal of Housing for the Elderly* 18, no. 3/4 (2004): 5-49; S. Golant, "Political and Organizational Barriers to Satisfying Low-Income U.S Seniors Need for Affordable Rental Housing with Supportive Services, *Journal of Aging and Social Policy* 15 (2003): 21-47; R. Wilden and D. Redfoot, *Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes*, Washington, DC: AARP Public Policy Institute, January 2002; D. Redfoot and A. Kochera, "Targeting Services to Those Most at Risk; Characteristics of Residents in Federally Subsidized Housing," *Journal of Housing for the Elderly* 18, no. 3/4

With few exceptions, federal housing funds cannot pay for services. Conversely, most public funding for health and supportive services, e.g., Medicaid, the Older American's Act, the Community Services Block Grant, cannot be used to cover room and board (the exception being Medicaid, which covers room and board as part of a per diem payment if an eligible recipient is in a nursing home). Regardless of whether the absence of supportive services in subsidized housing can result in the resident's transfer to a nursing home, diverting this transfer is rarely the goal of housing policy. Nor is the availability of AHPS typically considered in developing long-term care policy.

Older residents themselves also face practical barriers to obtaining needed supports.[8] Senior residents of publicly subsidized housing are less likely than older homeowners to have family members they can rely upon. Community providers may incorrectly believe the housing provider, not them, is responsible for service provision. Other tenants may pressure management to evict residents who look too old and frail. Families may face difficulty in locating willing service providers. Housing managers may worry about their liability, for example, if residents with age-related dementias leave on the stove or disturb other residents. Most often, housing providers and community services agencies simply view their missions through different lenses and lack experience working together.

The impact of AHPS is largely untested. In the mid-1990s, HUD evaluated two of its programs designed to help seniors age in place with case management and supportive services—the Congregate Housing Services Program (CHSP) and the Hope for Elderly Independence Demonstration Program (HOPE IV). The evaluation found high levels of satisfaction among the participants of both programs. However, no significant differences were reported for nursing home use or the length of time in independent housing as a result of participation in either program. These findings are not surprising given that participants were found to be less disabled than those eligible for nursing homes.[9] The lack of research leaves policy makers and providers with little guidance on whether or which AHPS strategies are wise investments. However, absent large national research experiments, a wide variety of AHPS programs have emerged in states and localities that could act as natural laboratories for measuring the impact of AHPS strategies with a "critical mass" of older people.

(2004): 137-163; and K. Lawler, *Aging in Place: Coordinating Housing and Health Care Provision of America's Growing Elderly Population* (Cambridge, MA: Harvard Joint Center on Housing Studies, 2001).

[8] See J. Pynoos, P. Liebig, D. Alley, and C.M. Nishita, "Homes of Choice: Toward More Effective Linkages Between Housing and Services," *Journal of Housing for the Elderly* 18, no. 3/4 (2004): 5-49; S. Golant, "Political and Organizational Barriers to Satisfying Low-Income U.S Seniors Need for Affordable Rental Housing with Supportive Services, *Journal of Aging and Social Policy* 15 (2003): 21-47; R. Wilden and D. Redfoot, *Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes*, Washington, DC: AARP Public Policy Institute, January 2002; and K. Lawler, *Aging in Place: Coordinating Housing and Health Care Provision of America's Growing Elderly Population* (Cambridge, MA: Harvard Joint Center on Housing Studies, 2001).

[9] Robert Ficke and Susan Berkowitz, *Report to Congress: Evaluation of the HOPE for Elderly Independence Demonstration Program and the New Congregate Housing Services Program* (Washington, DC: U.S. Department of Housing and Urban Development, 2000).

IV. Inventory of Affordable Housing Plus Services Strategies and Programs

As part of the AHPS study, IFAS developed an inventory of AHPS strategies that have been implemented across the county. The inventory is organized around two broad categories of affordable housing: privately financed and publicly subsidized. The inventory is summarized below. Examples of AHPS programs that incorporate many of the features of each strategy are also identified.

A more detailed description of the inventory can be found at http://aspe.hhs.gov/daltcp/reports ***or*** http://www.huduser.org**.**

A. Privately financed housing refers to multi-unit owner and rental housing that receives no public subsidies, but is still affordable to low- and moderate-income older adults. It may also include neighborhoods of single-family homes with large concentrations of senior households. Strategies include:

1. **Housing Cooperatives** allow residents to own and control their apartment through a corporation in which they own stock and are actively involved in management and programming. Maintaining affordability is difficult and is typically achieved by capping the resale price (limited-equity cooperatives). Services can be informal or formal, involving joint purchasing and/or scheduling of services or a coordinated and managed services program staffed by community agencies or the cooperative. **Penn South Cooperative, New York, NY,** is a limited-equity co-op built in 1961 with 6,200 residents. As Penn South's residents began to age, the co-op set up a collaborative program with community agencies to provide supportive services. Now a separate non-profit agency, Penn South Social Services, Inc., offers cultural and educational programs, case management, adult day care, home care services, personal care, primary health care and wellness services, and a variety of other supportive services.

2. **Shared Housing involves** two or more unrelated individuals living together in a private single-family home. Some programs match up elderly homeowners with individuals willing to help with household chores in return for reduced rent. Others involve small numbers of older people living together and providing mutual support. Accessory housing is a shared housing arrangement where a trailer or portable manufactured home is placed next to a main home, enabling a frail senior to maintain independence and still be close to a family member or other willing caregiver. **HomeShare Vermont, Burlington, VT,** assists seniors and persons with disabilities to live independently by linking them with other people seeking affordable housing or caregiving opportunities. Typically, a student or working-age adult is matched with an elderly homeowner for whom they carry out household chores in exchange for free or reduced rent.

3. **Mobile Home Parks/Manufactured Home Communities** provide homeownership opportunities to some lower-income seniors. Usually the housing unit is owned, the lot is leased, and upkeep and maintenance are included in the lot fee. Social and recreational amenities are often shared. While many mobile home parks have been

disappearing as land values increase, some are being converted to cooperative ownership to preserve their existence and affordability. Formal programs to link residents to services are hard to find, although aging in place is an issue. **Millennium Housing, Newport Beach, CA,** operates several senior parks in California. A monthly magazine is distributed to residents with information on where to get help with meals, bills, etc. A partnership with a community program provides homebound residents with home repairs and emergency response systems.

4. **Single Room Occupancy Hotels (SROs)** rent small private rooms, usually in depressed downtown areas, to low-income individuals on a weekly or monthly basis. Some space—like bathrooms, living rooms, and kitchens—is typically shared. Urban renewal has eliminated many SROs; however, several cities have tried to reverse this trend, converting run down hotels to SROs with supportive services. **Project Alert, Los Angeles, CA,** receives funding from the city's Department of Aging to provide older adults living in SROs a wide range of services, including case management, information and referral, transportation, meals programs, and medical screening. One SRO is specifically designed to serve frail elderly with wheelchair accessible bathrooms.

B. **Publicly subsidized housing** refers to multi-unit rental housing owned or subsidized by federal, state, or municipal governments. Strategies for integrating services include:

1. **Co-location** is a low-cost approach in which the housing manager encourages local providers to locate health and/or supportive services programs on or near the housing property. Often housing and services providers recruit volunteers to fill some services gaps. Commonly co-located services include meal sites under Title III of the Older Americans Act (OAA), senior centers, or health and wellness programs. **Golden West Senior Residence**, **Boulder, CO**, a 255-unit refinanced Section 202 property, provides space to a health care agency for operation of a wellness center. The agency staffs the center with a physical therapist and an exercise physiologist. Golden West also partners with several other programs and volunteers to provide services such as foot care, massage, hearing aid maintenance, and banking services.

2. **Service Coordination** entails a full- or part-time staff person employed by the housing manager or sponsor to help residents identify and arrange for needed services, advocate on their behalf, and provide educational programs. The service coordinator may formally assess service needs or respond to resident identified needs on an ad hoc basis. Services may be arranged by staff or directly by the resident. About 37 percent of Section 202 housing communities employ service coordinators.[10] **National Church Residences (NCR), Columbus, OH,** employs 154 service

[10] Heumann et al., *The 1999 National Survey*, 64.

coordinators serving 194 of their Section 202 and LIHTC properties for seniors. Service coordinators typically conduct an intake evaluation of residents requesting assistance; assess behavior, functioning, and needs; develop a case management plan; and refer residents to community agencies. NCR has also developed a quality assurance system to track service coordinator performance. **Schwenkfeld Manor, Lansdale, PA,** is a Section 202 housing community employing nurses as service coordinators. In addition to traditional information and referral and case management, they informally observe changes in resident status, provide health education, and advise residents when they should call a doctor.

3. **Enriched Services and Formal Services Coordination** are strategies offering residents formal assessment, case management, and a range of personal care and supportive services provided by on-site staff and/or by a service agency owned by or under contract to the housing provider. Although the amount and intensity of services varies, 24-hour oversight, personal care, medication management, home making, and transportation are likely to be available. **Peter Sanborn Place, Reading, MA,** gives priority, with HUD approval, to prospective residents with high levels of need. Frail residents receive a comprehensive assessment, and a care plan is developed and monitored on an on-going basis. Resources freed up from the refinance of a Section 202 loan were reinvested in building renovations and resident services. The property operates its own home care agency, which provides case management, personal care, medication monitoring, homemaker services, and transportation to eligible residents and the surrounding community. Nursing care and rehabilitation services are provided under contract by the Visiting Nurses Association.

4. **NORC Service Programs** target naturally occurring retirement communities (NORCs), defined as a geographic area, neighborhood, or building originally populated by people of all ages, which has evolved over time to contain a high proportion of older adults. In some NORCs, property managers, residents, and community services providers have collaborated to develop service programs to respond to the changing needs of elderly residents. A key characteristic of a NORC service program is that it is available to all NORC residents regardless of income, health, or functional status. **Vladeck Cares/NORC Supportive Services Program, New York, NY,** serves seniors living in Vladeck House, a public housing project with 27 buildings and 3,000 residents, 860 of who are elderly. Funded by the City, the state Department on Aging, and private sources, the program provides preventative health and social services, medical and health services, case management, mental health counseling, and educational and cultural opportunities.

5. **State Supportive Housing Partnerships** involve a collaboration between state housing agencies, subsidized housing properties, and state aging and health agencies to expand services to state-subsidized housing residents, generally with the goal of reducing Medicaid costs by delaying institutionalization. State-designated providers are licensed to deliver personal care and supportive services to residents. **The Marvin, Norwalk, CT,** is a senior congregate housing community funded through the LIHTC program and low-interest loans from the state. Residents have access to

supportive services through Connecticut's Congregate Housing for the Frail Elderly program, including a daily meal, weekly housekeeping, and the assistance of a resident service coordinator. Onsite, 24-hour oversight, an on-call nurse, health and wellness services, and emergency transportation are also available. Residents pay a monthly congregate services fee based on their income. Those who are eligible for assisted living services under the state's Medicaid waiver receive nursing and personal care assistance.

6. **Assisted Living as a Service Program** is a state strategy to provide licensed assisted living as a package of services rather than as facility-based care. In **Minnesota,** most assisted living services are provided in facilities registered with the Department of Health as "housing with services establishments." These facilities offer, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services. If the property provides the services directly, it must have the appropriate home care provider license from the Department of Health. Otherwise, it must contract for services with a licensed home care provider.

7. **A Campus Network Strategy** takes advantage of independent senior housing and licensed assisted living on the same campus to provide low- and modest-income residents some of the benefits of a continuing care retirement community. There is no entrance fee, and residents pay separately for different levels of care. **Eaton Senior Programs (ESP), Lakewood, CO,** operates Eaton Terrace Residence (ETR), a 162-unit subsidized senior housing property funded through low-interest state bonds and an adjoining assisted living facility (Eaton Terrace II). ESP is able to leverage resources across both residential properties. ET II has an assisted living license and a home care license, which allows staff to provide services anywhere in the community. ETR residents may purchase personal care, housekeeping, and medication monitoring services at whatever level they need. Residents pay out-of-pocket, unless Medicaid covers their costs. ESP also has created a "care consultation team" to support resident needs, which includes a nurse, social workers, activities coordinators, pastoral counselors, resident assistants, and other staff. Although each property has staff that focuses specifically on their residents, they are able to leverage expertise and resources across the team. Staff from the assisted living property is also able to provide after hours emergency response to ETR.

8. **Integrated Housing, Health Care, and Supportive Services** enable residents to age in place by offering access to medical, health, and long-term care services. They involve a formal collaboration between one or more affordable housing providers, neighborhood health care providers, and aging services agencies. **Lifelong Medical Care, Oakland, CA,** anchors a collaboration between a Section 202 property, a federally qualified health center, and a Programs of All-Inclusive Care for the Elderly (PACE) program to provide an assisted living level of care. PACE is the federal/state certified program that provides a full range of primary, acute, and long-term care services to a nursing home eligible population under a capitation arrangement with Medicare and Medicaid without special licensing. The health center serves healthy and moderately disabled seniors, providing primary care, mental health services, adult

day care, podiatry, dental care, and other services. PACE serves residents eligible for skilled nursing facilities with a full spectrum of primary, acute, and long-term care services.

9. **Housing/Health Partnerships** are collaborations between one or more health providers and low-income housing sponsors to increase the supply of affordable housing. The potential exists for the two partners to create programs providing residents access to medical and health-related services. **Mercy Housing's Strategic Health Partnerships** is an initiative between Mercy Housing and seven Catholic health care systems to increase the supply of affordable housing for low-income seniors and poor families by leveraging health system resources. **The Sixty Plus Program, Atlanta, GA,** run by Piedmont Hospital, partners with four affordable housing properties to send a nurse to each weekly. Residents can schedule appointments, and the nurse follows up with patients discharged from the hospital.

V. Lessons from the Workshops

As part of the AHPS study, IFAS also convened four invitational workshops across the country. These workshops brought together 230 stakeholders from 14 states to examine the merits of, challenges to, and opportunities for the development of AHPS strategies. Participants represented housing, health care, and aging services providers; federal and state policy makers; investment bankers; insurers; and consumer advocates. The first workshop, targeting the Cleveland metropolitan area, was hosted by the A.M. McGregor Home. The other three, hosted by AAHSA state affiliates in California, Rhode Island, and Georgia, were organized to facilitate statewide and regional participation. The following summarizes lessons learned.

A more detailed report of the workshops can be found at http://aspe.hhs.gov/daltcp/reports ***and*** http://www.huduser.org**.**

Do AHPS strategies work? Although most workshop participants understood that the impact of AHPS programs had not been carefully evaluated, they noted several apparent strengths:

- AHPS programs are attractive to their residents. Vast majorities of seniors want to stay at home, even as their health declines.
- AHPS programs allow health professionals and aging services providers to more efficiently target services because potential consumers are clustered.
- Co-location of services such as adult day care and health services, particularly in larger housing communities, helps seniors with significant disabilities, including dementia, stay in their apartments.
- Exploiting economies of scale through bulk purchasing of services and supplies, and/or coordinated scheduling of providers, might save residents and providers money.
- Since many communities already have a rich array of services, purposefully linking residents to these services helps to meet needs at marginal costs.
- AHPS programs transfer much of the responsibility of caring for aging residents from housing providers to community services agencies, which typically have more capacity.

However, some participants disagreed about the extent to which AHPS can or should support residents, regardless of their health condition or level of disability. Several housing providers believed all residents should be able to live out their lives in the property, maintaining that services comparable to a nursing home can be provided effectively. Others said maintaining residents with significant disabilities who may need access to services 24/7—especially those with significant cognitive and/or mental health problems—is not possible or even appropriate. By and large, most participants agreed that objectively evaluating and comparing the outcomes of alternative AHPS approaches for different populations was important.

What does an effective strategy look like? No one strategy was endorsed as appropriate for all environments and all situations. Some participants said caregiving staff should be employees of the housing property. Others thought housing providers should not engage in direct service delivery, except for services coordination. Most agreed that a wide range of models could work, as long as they were anchored by a services coordination mechanism. Most participants thought the selection of specific AHPS strategies should grow out of the characteristics of the state regulatory environment, the housing provider's capacity, and service availability in the surrounding community. Several also emphasized that AHPS models must be responsive to the changing characteristics of residents, such as the growing prevalence of cognitive impairments and mental health conditions. Participants noted that an increasing number of new residents were entering their housing communities with pre-existing disabilities. Some also said attention should be paid to the differences in the demand for and the availability of services in rural areas in developing new AHPS models.

Which services are critical? Discussants emphasized the need for AHPS strategies to provide residents access to a full range of health-related and supportive services. They ranked transportation as highly important, but also noted the limited capacity of many housing communities to organize access to needed transportation. Much less agreement was expressed about the desirability of incorporating primary health care and chronic care management into an AHPS program. Some thought these services were too complex and risky for many housing providers and were only feasible in partnership with a PACE program. Others noted the growing experience with "house calls" type programs, where physicians and nurses offer primary care, preventative services, and chronic care management in a resident's own apartment. Some espoused house calls programs as ideally suited to affordable housing arrangements with large numbers of seniors who live close to one another.

What are the prerequisites of a successful strategy? Participants identified three fundamentals for AHPS strategies:

- **Informed housing providers who understand the need for services -** Housing providers must see themselves as more than property managers collecting rent and maintaining the physical plant. They must understand their residents' service needs, accept at least some responsibility for meeting these needs, and ensure that service coordinators and onsite managers share this understanding. In addition to employing a service coordinator, many participants believed housing providers must be prepared to make financial and human resource investments to fill gaps in the community's services system and be flexible enough to allow residents to refuse services and make some bad

choices. Learning how to support aging residents to take risks was perceived to be essential to maintaining a truly independent living environment.

- **Persistence and creativity -** The workshops highlighted the importance of leadership at the community level to bring housing and aging services agencies together. Some participants pointed out that successful organizations are proactive—seeking out community partners, networking with policy and practice stakeholders, staying on top of new funding opportunities, and working around policy and regulatory barriers. Participants emphasized the importance of knowing how to "work the system."
- **A catalyst -** Some individual or organization must take ownership of the goal, identify and convene stakeholders, facilitate information gathering, mobilize resources, and coordinate on-going activities. Many participants emphasized that without a catalyst, even well-intended and widely supportive efforts to implement AHPS strategies are likely to fail.

What are the obstacles? Participants noted a number of barriers:

- **Licensing/ regulation –** Licensing and regulation was identified as an impediment to the ability of independent housing providers to support residents' aging in place. For example, Internal Revenue Service rulings appear to limit the level of health and medical services that can be provided in LIHTC properties. LIHTC properties also may not pay for health services with rent proceeds. Some states prohibit independent housing providers from providing direct services. In most states, Medicaid assisted living services can only be provided to Medicaid recipients who live in a licensed facility. Many housing providers at the workshops expressed strong opposition to becoming licensed caregiving facilities to obtain services for residents. Participants said licensing requirements often result in increased costs, forcing them to rely on Medicaid, for which not all residents may be eligible. Participants pointed to assisted living regulations as an example of what they wished to avoid. Publicly reimbursed assisted living services were judged too rigid, serving only a narrowly defined population, which is at odds with the mission of affordable housing providers to serve healthy and frail residents. A number of participants urged the federal government to review their regulations governing Section 202, LIHTC, HUD's Assisted Living Conversion Program, HUD's Service Coordinator Grant Program, and fair housing laws to identify and remove regulatory obstacles to the development of AHPS programs.
- **Liability –** Some participants expressed concerns about how to balance resident choice, including freedom to reject services, with their perception that housing providers would be liable for poor choices that compromised resident health or safety. Obtaining liability insurance was also identified as a difficult hurdle to overcome.
- **Fair housing laws -** Participants expressed a variety of concerns regarding these laws. Some housing providers believed they should be able to give move-in preference to frail and disabled seniors, a point of view at odds with fair housing requirements, unless special HUD waivers are obtained. Some providers also observed that fair housing laws have an unintended effect on their ability to plan services, citing prohibitions against asking prospective and current resident's about their physical and mental health status. Some participants also thought that fair housing rules were unclear about the circumstance under which a tenant can be evicted, particularly when the resident's

decision making is impaired through Alzheimer's disease or other cognitive impairments. Several attendees suggested that HUD should clearly spell out the implications of fair housing laws for AHPS. ***See HUD's clarification of fair housing laws as they apply to AHPS in the Appendix at the end of this document***.

- **Difficulty of bridging housing and aging services -** Participants widely agreed that housing and aging services providers know little about each other's programs or policies. Several said the workshop was the first time they had even been together in the same room. Some participants observed that housing providers rarely participate in long-term care policy forums and vice versa. According to many workshop attendees, both the housing and aging services communities need to be educated about their mutual interests.
- **Resources -** Finding funding was regarded as the major challenge facing AHPS program development. Several participants indicated that relying on a single funding source, such as the Section 202 program or Medicaid, is shortsighted. In their view, future needs cannot be accommodated without putting together a mix of funding, both to develop new housing opportunities and to link them to needed services. Several pointed out that AHPS strategies must be designed around resident needs rather than allowing a particular funding source to determine who is served and how.
- **Limited understanding/capacity of certain housing providers to meet resident services needs -** Housing representatives were more likely than others to observe that a number of their colleagues saw their roles in very traditional terms—leasing, collecting rents, and maintaining the physical plant—rather than as architects of a housing environment that must adapt to changing needs of increasingly frail residents. They said it is not unusual for housing managers to interpret the term "independent housing" literally—if a resident needs help, she must find it herself or move. Housing providers may also lack sufficient knowledge about community resources and have limited skills in developing partnerships with their community service agencies.
- **Resident opposition –** Several housing providers said residents themselves sometimes oppose aging-in-place strategies. Many do not want to be reminded that they may loose independence as they age. To overcome this challenge, residents must be educated about and have sustained involvement in planning AHPS programs.
- **Affordability –** Participants said AHPS programs must minimize costs to residents, the housing sponsor, and public entities. Several participants thought it was valuable to work with a home health agency or other community provider to break down the amount of services that can be purchased in short increments. In their view, residents do not always need, nor can they afford, the two- or four-hour blocks of time typically available.
- **Nursing home influence -** Attendees had differing perspectives on the role of nursing home providers in AHPS. Some thought they would oppose AHPS strategies. Others thought nursing homes could be valuable partners, particularly if the rules that governed their reimbursement rewarded them for maintaining the sickest and most disabled patients.

Funding Opportunities. The workshops clearly demonstrated that funding is a primary challenge in developing new AHPS programs. Having concluded that neither the Medicaid nor Section 202 programs were likely to be reliable future funding resources on their own, participants identified other ideas to expand access to resident services that include:

New Public Initiatives

- Creating a state tax credit or bond program to fund resident services as well as affordable housing.
- Developing health-related and supportive services "savings accounts" where pretax contributions of housing providers and residents could accumulate over time.

Housing Provider Strategies

- Developing mixed-income properties where the costs of services for lower-income residents are cross-subsidized by wealthier ones, as in nursing homes.
- Developing "win-win" partnerships between housing communities and health care entities. These partnerships can enhance resident access to primary care and chronic care management and increase referrals to cooperating providers and improve their ability to monitor and manage the resident's care.

Education and Marketing Opportunities

- Documenting and disseminating the probable "return on investment" for housing providers if they contribute their own resources to resident services.
- Educating service coordinators on how to reduce services costs (e.g., capitalizing on economies of scale, working with community providers to deliver services in smaller, more affordable increments, etc).
- Documenting the benefits of renting out commercial space for needed resident services to housing communities.
- Encouraging wider participation in the HUD-funded service coordinator program.
- Educating Section 202 housing providers about the potential of refinancing old Section 202 loans to invest in services.

VI. Next Steps Recommended by Workshop Participants

The workshops brought together a variety of stakeholders from the fields of housing, health, and supportive services, some of whom were meeting together for the first time, to identify common interests and seek common ground. For that alone, most participants judged them a success. Several broad initiatives were proposed to move an AHPS agenda forward:

1. **Resident and Family Education Programs-** Residents and their families often are not aware of the services available in their community. As one participant put it, many residents see services as a light switch, either "on" or "off." This participant thought the concept of a "dimmer switch" was more appropriate, with residents and families learning how to seek services as they are needed, rather than waiting for a crisis. Some participants suggested AAHSA and its state affiliates, area agencies on aging, AARP chapters, the Red Cross, local Alzheimer's groups, and other community agencies should develop outreach initiatives targeted at subsidized housing residents and their families so they know about the community's service resources and how to use them.

2. **Provider Education and Technical Assistance-** Participants stressed the value of educating affordable housing providers about the service needs of aging residents,

available community resources and how to access them, the characteristics of promising AHPS strategies and programs, and how to overcome regulatory barriers that impede effective implementation. Some participants suggested that AAHSA develop and operate a clearinghouse for its members to provide such technical assistance.

3. **National Awareness Campaign-** There was significant support for raising the visibility of AHPS as a potential vehicle for meeting the long-term care needs of at least some low- and modest-income seniors. Participants spoke of subsidized elderly housing residents as being "off the radar screen" of advocates and policy officials seeking long-term care solutions. Some observed that while funding has significantly grown for home and community-based services over the past several decades, little is known about the extent to which seniors in subsidized housing have benefited. One suggestion was to move AHPS onto the agenda of the Conference of Mayors since municipalities are now dealing with the problem of poor seniors who are unable to maintain independent living. It was also noted that advocates for the homeless have been very effective in educating government at all levels about the importance of linking housing options with services to sustain independent living. Affordable housing providers might consider developing a platform based on a similar model for aging seniors in affordable housing.

4. **Replication of Workshops in Rural Areas-** All workshops were held in urban areas, primarily for an urban or suburban audience. It was noted by some participants that the characteristics of AHPS strategies that work in rural communities may be different than those discussed. Holding one or more workshops in rural areas was suggested, possibly in partnership with the U.S. Department of Agriculture.

5. **Developing AHPS in Market Rate Housing-** The experience of subsidized housing providers dominated the workshops. Participants were unable to identify more than a handful of AHPS programs in privately financed housing arrangements. Several workshop participants thought future work should be directed at identifying and supporting housing cooperatives, mobile home parks, neighborhood-based NORCs, and other market-rate housing to develop AHPS programs.

VII. Applied Research and Evaluation Agenda

The information base on AHPS programs and their impact is extremely weak. Discussions with workshops participants, AAHSA members, and other housing and community services experts over the course of the study identified a variety of questions in need of answers before the widespread replication of AHPS programs is likely. For example:

- What proportion of senior residents living in affordable housing arrangements want and need additional health and supportive services to maintain independent living? What are the characteristics of these seniors? What services do they need?
- Do AHPS programs improve resident access to services over the informal arrangements that now prevail and do they improve resident quality of life and quality of care?
- Are AHPS programs cost-effective from the perspective of housing providers and public policy makers? Are they as or more effective and less costly than ALFs for some

residents? Do they reduce transfers to nursing homes? Do they reduce the use of emergency health services and hospital stays?

- What types of strategies and practices work best and under what circumstances?
- What regulatory and practice barriers impede widespread replication of AHPS and how can they be overcome?

VIII. Conclusion

In the eyes of the authors of this report, the study of AHPS underscores the potential value of AHPS strategies for meeting some of the long-term care needs of low- and modest-income older adults. The study has shown us that committed individuals working at the community level are able to overcome fragmented funding and bureaucratic and policy resistance to implement AHPS programs in all parts of the country, often on a shoestring budget. However, before more systematic and widespread replication of AHPS is likely, the study highlights a number of issues for further consideration. First, greater numbers of affordable housing providers must be convinced of the benefits of supporting older residents who want to "age in place" rather than moving to a higher level of care. Second, the capacity of affordable housing providers to respond to resident services needs must be nurtured and strengthened—by matching them with other more experienced providers and developing and disseminating technical assistance tools. Third, AHPS models and practices must be documented and evaluated, showing how they work, under what conditions, and with what impact on residents, providers, and costs. Finally, governmental and private funders should be encouraged to support the development and evaluation of new AHPS models to help meet future needs.

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Appendix

HUD's Clarification of Fair Housing Laws as They Apply to Affordable Housing Plus Services Programs

1. **If a provider is offering housing which also includes supportive services, what kinds of questions can a provider ask prospective tenants about their health or disability status?**

   Under the federal Fair Housing Act, it is generally unlawful for a housing provider to (1) ask if an applicant for a dwelling has a disability or if a person intending to reside in a dwelling or anyone associated with an applicant or resident has a disability, or (2) ask about the nature or severity of such persons' disabilities. Housing providers may, however, make the following inquiries, provided these inquiries are made of all applicants, including those with and without disabilities:

   - An inquiry into an applicant's ability to meet the requirements of tenancy;
   - An inquiry to determine if an applicant is a current illegal abuser or addict of a controlled substance;
   - An inquiry to determine if an applicant qualifies for a dwelling legally available only to persons with a disability or to persons with a particular type of disability; and
   - An inquiry to determine if an applicant qualifies for housing that is legally available on a priority basis to persons with disabilities or to persons with a particular disability.

   Courts have held that providers should not inquire as to whether a prospective tenant can "live independently," as that inquiry encompasses information which may be unrelated to the eligibility requirements for tenancy, and calls for inquiries into the nature and severity of a person's disability. The inquiry should focus on eligibility for the unit and the ability to meet the requirements of tenancy, i.e. maintenance of the unit, payment of rent, etc.

   Nothing in the Act prohibits providers who offer services from asking applicants interested in the services to demonstrate that they qualify for those services. Housing providers making such inquiries should ask only for the specific information they actually need to determine eligibility for the services, rather than making broad sweeping inquiries about a person's medical history. If the housing provider offers services for persons with disabilities through contractors or other independent enteritis, then only the service provider should be making the inquiries related to qualifying for the services.

2. **In planning for the provision of supportive services, how should a provider go about surveying resident's needs?**

   Providers may ask tenants to participate in voluntary surveys about services that they would like the provider to offer.

3. **What criteria are needed for a provider to evict tenants whose service needs can no longer be met?**

   It is lawful under the Fair Housing Act to refuse to rent or to evict a person with a disability because he or she cannot meet the requirements of the lease (which includes the ability to care for a dwelling apartment and to pay rent). If a resident with a disability needs services that are not part of the housing program to enable him or her to meet the requirements of the lease, and the provider cannot meet those needs, then it would be the resident's responsibility to obtain those services if he or she wishes to remain in the unit.

   If a resident qualifies as a person with a disability under federal civil rights laws including the Fair Housing Act and where applicable, Section 504 of the Rehabilitation Act of 1973, then the resident has the right to request a reasonable accommodation to policies, practices, and procedures of the housing provider. If a provider has a practice of limiting the kinds of services that a resident may use while living in the unit, then the resident with a disability may make a request for a reasonable accommodation that the provider change that policy to allow him or her to obtain and pay for the additional services that are needed. A housing provider must grant the request unless doing so is an undue financial and administrative burden or a fundamental alteration of the housing program. For a full discussion of the Fair Housing Act's definition of person with disability and the right to receive a reasonable accommodation, see, the Joint Statement of the Department of Housing and Urban Development and the Department of Justice: Reasonable Accommodations under the Fair Housing Act, dated May 17, 2004. This joint statement is available at http://www.hud.gov/offices/fheo/disabilities**.**

4. **Once services are provided to prevent institutionalization of a frail resident, do federal civil rights laws require the housing provider to find subsequent services to maintain that resident in their own home?**

   The Fair Housing Act does not require housing providers to provide requested accommodations that constitute fundamental alterations of their programs. Thus, if a resident requested skilled care nursing services in their home as a reasonable accommodation, and the provider only provided limited services such as meals, then the provider would not be required to provide the skilled care nursing services, because such a request would constitute a fundamental alteration of the provider's program. See Joint Statement of the Department of Housing and Urban Development and the Department of Justice: Reasonable Accommodations under the Fair Housing Act, dated May 17, 2004.