LESSONS FROM THE WORKSHOPS ON AFFORDABLE HOUSING PLUS SERVICES STRATEGIES FOR LOW- AND MODEST-INCOME SENIORS

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I. Introduction

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

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[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.

- 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 study findings).
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).

This report presents the findings from the AHPS workshops.

II. Workshop Purposes and Format

IFAS had five objectives in organizing and convening the four workshops:

- Developing a shared understanding of the types of AHPS models emerging across the country;
- Learning how specific programs worked in practice;
- Identifying the perceived impact of AHPS programs on older adults and housing providers;
- Analyzing the regulatory barriers believed to impede implementation and how they might be overcome; and
- Documenting the issues and questions providers and policy makers believed needed to be addressed before large-scale investments in AHPS strategies.

The four workshops, attended by over 230 stakeholders, were held during the summer and fall of 2005. The first workshop, convened in Cleveland, OH, and hosted by the A.M. McGregor Home, was targeted primarily at the Cleveland metropolitan area. The other three workshops, hosted by AAHSA state affiliates in California, Rhode Island, and Georgia, were organized to facilitate statewide and regional participation. Participants came from the states of Arizona,

California, Connecticut, Florida, Georgia, Maine, Massachusetts, New Hampshire, New York, Oregon, Rhode Island, Vermont, and Washington and included:

- Affordable housing providers representing a wide range of properties, including Section 202 Housing for the Elderly, Low Income Housing Tax Credit (LIHTC), public housing, mobile home parks, and cooperatives serving low-income seniors.
- Health and aging services providers representing hospitals, health plans, adult day health centers, Program of All Inclusive Care for the Elderly (PACE), area agencies on aging and other social service organizations.
- State and local government officials with responsibilities for Medicaid home and community-based services, the Older Americans Act (OAA), the development and financing of publicly subsidized housing, and community development programs.
- Federal officials from HHS and HUD.
- Investment bankers.
- Attorneys, insurers, and risk managers.
- Researchers.
- Foundation representatives.
- Consumer advocates.

III. IFAS Ideal Housing Plus Services Model

The context for the workshops was set by IFAS Executive Director Dr. Robyn Stone who presented a definition of AHPS and outlined the components of an ideal system. The IFAS "ideal" model is one in which:

- The housing arrangement is independent, unlicensed, largely multi-unit publicly subsidized housing or other such affordable property(s), where large numbers of low- and modest-income seniors live in close proximity to one another.
- A shared philosophy exists between the housing provider, residents and their families, and the community "to do what it takes" to help residents age in place.
- Residents have access to a full spectrum of primary, preventative, and chronic care services in addition to personal care and supportive services.
- Services are resident centered—privacy and confidentiality are respected, decisions to accept or reject services are voluntary, and the role of housing and community services providers is to partner with residents who want to remain in independent housing, despite increasing frailty and declining health.
- The services system is flexible, supported by multiple funding sources, and able to respond to unpredictable and changing needs.
- The system capitalizes on existing resources of the resident and his or her family, friend and neighbor networks of the housing property, the assets of the surrounding community, and existing state and federal health and supportive services programs.
- Residents have access to individualized assessment and service coordination, delivered by either property staff or community agencies.

- Purchasing and delivery of services takes advantage of potential economies of scale resulting from large numbers of older adults living close to one another.
- The "who" and "how" of service delivery is tailored to fit the capacity of particular housing and aging services providers and the policy and regulatory environments in which they operate.

IV. Highlighted AHPS Strategies

Workshop participants were introduced to a number of AHPS strategies that have been implemented by housing providers across the country and which incorporate at least some of the elements of the IFAS ideal model. These presentations were intended to: (1) showcase promising practices; (2) stimulate debate about the policy and practice barriers to widespread replication and how they might be overcome; and (3) identify new opportunities for developing and funding AHPS linkages.

Presentations at the workshops included:

- **Mercy Housing's Strategic Health Partnerships -** Mercy is a national provider of affordable family and senior housing that operates 46 properties around the country designed specifically for lower-income seniors. Mercy has created strategic health partnerships with seven health care systems to increase the supply of affordable housing for low-income seniors and families. The health care systems provide operating support for the housing projects and often donate the land upon which properties are built. Mercy also maintains service coordinators in its properties who provide residents with information on the services available in the community, refer residents to community providers, and coordinate on- and offsite educational, health and wellness, and community involvement opportunities. Mercy has developed a "senior resident services program model" to measure the impact of service coordination on resident receipt of services and ability to age in place, quality of life, self-advocacy, and civic involvement.

- **National Church Residences (NCR) Service Coordinator Program -** Headquartered in Columbus, OH, NCR has 154 service coordinators working in 194 of its Section 202 and LIHTC properties. The primary role of NCR service coordinators is to provide residents with information and linkages to the resources they need to age in place. NCR adheres to a philosophy of resident-driven service coordination where the service coordinator does not decide and act for the resident, but facilitates the resident meeting their needs to the extent they are able. Service coordinators conduct an evaluation of residents requesting assistance, assessing resident behaviors, functional abilities, and needs based on information from the resident and their own observation. Together they draw up a case management plan that identifies the goals and needs of the resident, and the service coordinator refers them to community agencies, monitors the case management plan and follows-up to ensure the resident's needs are actually met. NCR has also instituted a quality assurance program, which tracks each service coordinator's performance and, through monthly feedback, ensures they are in compliance with all regulations and standards and are providing residents with the highest level of service.

- **Lifelong Medical Care's Integrated Care Model -** Lifelong Medical Care in Berkley, CA, blends health care, social services, and affordable senior housing through a collaboration between a community health center funded through the federally qualified health centers program, a PACE program, and a Section 202 property. (PACE is a capitated benefit that features a comprehensive service delivery system including acute care and nursing facility services and integrates Medicare and Medicaid financing.) As a result, eligible senior residents can obtain a comprehensive range of services in one place, including primary health care services, dental care, physical therapy, and chronic care management. Residents can also participate in activities at the onsite adult day care center where they can obtain a wide range of preventative and supportive services, including personal care. Through this integrated approach, healthier seniors have access to health and wellness services while frailer seniors are able to receive services similar to those available in licensed assisted living programs.

- **The Marvin's Partnership with the State of Connecticut's Congregate Housing Program -** The Marvin represents an innovative approach to meeting the needs of the elderly through an intergenerational program offering affordable congregate housing to senior citizens while providing a school readiness, full-day childcare program to young children. The senior housing component is funded through a combination of LIHTC and low-interest loans from the state, under the auspices of the Department of Economic and Community Development and the Connecticut Housing Finance Authority. Through participation in a special state grant program, the Marvin is able to provide all senior residents with core congregate services including dinner, weekly housekeeping, a full time resident service coordinator, onsite 24-hour staff coverage, an on-call nurse (with some regularly scheduled hours on site), and health and wellness services. In addition, eligible residents participate in the Medicaid home and community-based services waiver program where they have access to assisted living type services such as hands-on assistance with daily living activities. Assisted living services are licensed through the Department of Public Health and are provided through a contract with a private assisted living services agency.

- **Northern California Presbyterian Homes and Services (NCPHS) WellElder Program -** The WellElder program was created by NCPHS to help reduce the need of residents in their HUD-subsidized senior housing to move to board and care homes or nursing homes to obtain a higher level of care. The WellElder program provides an onsite health educator (Registered Nurse or Licensed Vocational Nurse) to work directly with residents to provide one-on-one consultations and health assessments; advocacy on the resident's behalf with doctors, insurance providers, pharmacies and other health services; referrals to medical services; medication reminders; health-related classes and group programs; and information about medical costs and insurance resources. The health educator is also trained to work with the property's service coordinator to refer eligible residents to the home and community-based services they need to remain in their own apartments. Since the housing provider is not the service provider it has been exempted from the state's health facility regulations. Importantly, the participating housing communities have been able to get the costs of the health educator in their operating budget.

- **The Osceola County Council on Aging's Integrated Housing and Services Strategy -** The Kissimmee, FL, based Council on Aging has developed a consolidated AHPS strategy that provides residents access to a comprehensive range of health and supportive services. The Council is both the conduit OAA funds and the owner and manager of four affordable senior housing properties funded through a combination of the Section 202 program, LIHTC, rural development loans, and loans from the state. The dual role of housing and services provider enables the Council to establish relationships with a host of aging organizations, health providers, and community and volunteer groups. Through these partnerships, the Council is able to offer residents living in their housing properties everything from case management, transportation, meals, discounted commodities, homemaking, home repair, and chore services to health and wellness services and personal care.

- **Presentation Senior Housing's Co-location Strategy -** Through collaboration between Mercy Housing California and North & South Market Adult Day Health, Presentation has integrated affordable senior housing with adult day health services to support resident desires to age in place. Located in San Francisco, the Section 202 property has 93 apartments, 60 of which are targeted to very low-income frail elders. Approximately half of the building residents participate in the day health program, which provides a variety of health and wellness services such as daily nursing care, social work services, physical, occupational and speech therapy, podiatry services, mental health support, case management, transportation, and a daily meal. Those not enrolled in the adult day health program receive support and services from a service coordinator, as well as a variety of community organizations. Almost three quarters of residents receive services from the In Home Supportive Services program, a Medicaid-funded program that provides homemaker and personal care services.

- **The Portland Public Housing/Congregate Housing Services Program Partnership -** The Housing Authority of Portland and Multnomah County Aging and Disability Services are collaborating at four public housing sites to link senior residents to the services they need to continue independent living. Through the partnership, senior residents have access to service coordination, evening meals, housekeeping assistance, personal care, medication management, senior companions, transportation, and health and wellness programs. Services are funded through the HUD Congregate Housing Services Program (a grant program that no longer funds new programs, but continues to fund existing grantees), with required matching funds coming from the Medicaid home and community-based services waiver program and participant fees (approximately 15% of adjusted income). Services are also provided through OAA programs, in addition to in-kind donations from community organizations and volunteers.

- **Peter Sanborn Place Comprehensive Health-Related and Supported Services Strategy -** Peter Sanborn's commitment as an independent senior housing provider is to enable residents to live in their property for the duration of their aging years. Located in Reading, MA, the housing community initiated one of the first refinancing of a HUD Section 202 property in the country to free up resources for building repairs, renovations,

and resident services. Peter Sanborn rehabilitated the apartments making them more accessible for seniors with increasing disabilities with features such as walk-in showers, raised lavatories, keyless entry door systems, improved lighting, etc. To ensure the availability of personal care to residents in need, as well as to the surrounding community, Peter Sanborn also created a sister agency, Sanborn Home Care. Sanborn Home Care provides 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. Peter Sanborn also contracts with the Visiting Nurse Association for nursing care and rehabilitation therapy and maintains strong partnerships with state and community agencies. Services are paid for through a variety of methods, including self-pay, state programs, Medicaid, and Medicare. Peter Sanborn gives priority to seniors needing a high level of care, a population they were able to target after getting HUD to agree to such priorities in their tenant selection plan.

- **Cathedral Square Corporation's (CSC) Co-location Services Linkage Model -** CSC manages 15 senior communities in Vermont. It looks for opportunities to co-locate its properties with other entities that can provide resources for its residents, with some properties sharing space with an assisted living residence, an adult day center, or a senior center. For example, Cathedral Square Senior Living (CSSL), a Section 202 senior housing property, is co-located with an assisted living program. If a resident needs help with basic activities of daily living such as bathing, dressing, and toileting, CSSL can license their apartment as an assisting living unit and bring services to them, rather than making them move to the nursing wing. Should they no longer require help with basic living activities, the apartment reverts to independent living. Independent living residents at CSSL may also receive support through the state's Housing and Supportive Services program, which funds service coordination and case management, in addition to wellness activities and homemaker services. These services, as well as the assisted living services, are provided directly by CSC staff. Residents of other CSC properties can purchase homemaker services from CSC. At some properties, CSC funds a VNA nurse to visit the site weekly to provide nursing consultation and wellness services.

- **The Atlanta Regional Commission (ARC)/Georgia Institute on Aging Partnership to Connect Seniors to Services Through Technology:** ARC, Atlanta's area agency on aging, has developed AgeWise Connection, a comprehensive computer database to connect seniors to the array of aging services available in the Atlanta region. ARC partners with the Georgia Institute on Aging, the educational arm of the AAHSA state affiliate in Georgia, to offer AgeWise as a service to senior residents in participating publicly subsidized housing communities. For example, a resident can use the system to search for an adult day center in their neighborhood at a specific daily rate they can afford. Housing staff also can use Care Options, developed by ARC as an online care coordination system. The database allows staff to know which services residents are receiving, enabling them to improve services coordination and prevent unnecessary duplication of services.

V. Lessons Learned

Workshop participants were asked to spend most of their time discussing the merits of linking the residents of affordable senior housing to needed services allowing them to age in place. These discussions focused on identifying the factors contributing to effective AHPS linkages, the practice and regulatory barriers that get in the way and how to overcome them, and funding opportunities and options. The following section summarizes participant observations and conclusions. It should be noted that no attempt was made to reach a consensus on any particular topic.

What Should an AHPS Model Look Like?

The workshops, and the research leading up to them, identified numerous approaches to linking residents of affordable senior housing to needed services. No one approach or model was endorsed as the "right" one for all situations and all organizational and regulatory environments. Some participants believed the housing provider should also be the aging services provider, directly employing caregiving staff who will serve residents, as is typically seen in an assisted living facility model. Some thought it most effective if the housing sponsor also controlled most of the funding for services, as might be the case if the housing sponsor is also an area agency on aging. Others believed that the housing entity should stay out of the service delivery business and instead serve as the link between the resident and health and aging services agencies in the community. Some participants believed that services should be provided in the same building as the housing community, while others believed this was too constraining.

For the most part, participants agreed that a wide range of models could be effective, and that the approach selected should grow out of the state's regulatory environment, the capacity of the individual housing provider, and the services richness of the surrounding community. Participants also largely agreed that the prerequisite for any successful linkage model was the availability of a service coordinator to act as an intermediary between the resident and the services system, helping to identify needs and arrange and coordinate services. Workshop attendees also thought it was important to evaluate and compare the outcomes of various AHPS models and the extent to which they reduce the use of more expensive assisted living and nursing home care and improve resident quality of life.

In discussing the desirable characteristics of AHPS models, participants also emphasized that new models need to reflect the changing characteristics of seniors seeking affordable housing. For example, some housing providers are seeing a growing incidence of residents experiencing significant mental health conditions. They also note that more new residents are coming with pre-existing disabilities. In fact, they believed that many new residents are now seeking out senior housing because of the availability of services. Several attendees also pointed out that the future cohort of low- and moderate-income seniors may not be as likely to own their own homes as today's seniors and, therefore, the demand for affordable rental housing offering services will increase.

Workshop attendees also discussed the importance of looking beyond public funding sources, particularly Medicaid, in developing supportive housing models. While Medicaid is obviously a

key player in reimbursing a wide range of health-related and supportive services, participants were convinced that it could not be the sole funding source for a successful AHPS strategy. One concern is the lack of predictability of Medicaid funding levels from year to year, making it difficult for housing providers and their residents to know who will be eligible for services and what will be covered. In addition, many residents of affordable senior housing are not poor enough to qualify for Medicaid, yet they struggle to buy needed services out of their own pockets and often fall through the cracks. Going a step further, participants said that linkage models should be designed around resident needs, rather than allowing funding sources to drive what services are offered and how they are delivered.

What Services Should Be Provided?

Most workshop participants thought AHPS models should provide residents entree` to a full range of health and supportive services. Transportation services ranked high on the priority list, with several attendees questioning the capacity of some housing providers to provide or arrange access to needed transportation. There was less agreement that the range of available services should include primary health care and chronic care management, as laid out in the IFAS ideal. Some believed this type of model only worked in association with a PACE program, which they perceived as too complex and risky for most housing providers. Others noted a growing experience with "house calls" type programs, where physicians and nurse practitioners offered a range of primary and preventative services to elderly persons in their own homes. Such a model might be ideally suited to affordable senior housing settings where large numbers of seniors live in close proximity.

Workshop attendees also recognized that housing providers vary in their willingness and capacity to support significantly frail and disabled residents, particularly if some services must be available on a 24/7 basis and providers have to meet unscheduled needs. While selected affordable housing properties may be able to support older adults who need a nursing home level of care, this is not likely to be the norm for the foreseeable future. Particular concern was expressed about the capacity of affordable housing providers to address the needs of seniors with moderate to severe Alzheimer's disease or other serious mental health conditions. Developing strategies for serving residents with cognitive problems was considered an important research and technical assistance priority.

What are the Prerequisites of a Successful Strategy?

Many AHPS programs have been initiated by low-income housing providers, aging services providers, and by public agencies at the state and community level. The development of successful programs, however, has largely been the result of individual efforts, rather than widespread and systemic efforts. Many workshop participants observed that bridging the affordable housing and health and aging services worlds to create a comprehensive support system requires strong leadership and organizations with a "do what it takes" attitude. All of the AHPS programs profiled at the workshops started with the premise that their organization's mission was to help lower-income seniors age in place. The leaders of these programs were committed to providing residents and their families a choice about whether to remain in an independent housing setting with needed supports or to move to another living arrangement where a more intensive level of care was available. According to workshop presenters and participants, a "do what it takes" attitude involves a number of elements, including:

- **The commitment of housing providers to a broader role** – Housing communities that are committed to enabling residents to age in place must see themselves as more than property managers collecting rent and maintaining the physical plant. In addition to a service coordinator, the property manager or sponsor must be prepared to make additional financial and human resource investments to fill critical gaps in the community service system. Housing providers must also be flexible enough to allow residents to refuse services and even to make bad choices. Learning how to support residents to take some measure of risk is an important part of maintaining an independent living environment.

- **Partnerships between the housing provider and the surrounding community** – Every model highlighted in the workshop was built around a complex and rich array of community partnerships. Most workshop participants seemed to believe that AHPS strategies were cost effective because they largely drew on resources already available in the community. In most cases, the ability to negotiate effective linkages between the affordable housing community, aging and health services agencies, volunteer and charitable organizations, businesses, community leaders, elected officials, and relevant public agencies was deemed the most important attribute of a successful program.

- **Persistence and creativity** – The regulatory environments and funding streams governing subsidized housing and health and aging services operate independently of one another. In most cases, the focal point for pulling these pieces together is likely to be organizations and individuals at the community level committed to meeting the service needs of low-income older adults. The workshop experience suggests that successful organizations are typically in a "proactive" mode of seeking out new community partners, networking with both policy and practice stakeholders at the state and community level, staying on top of new funding opportunities, and working around policy and regulatory barriers. As one presenter mentioned, housing providers often get hung up on regulations that seem to block what they want to do, so they stop. Other providers find ways to structure their programs to be compliant with the regulatory requirements, they obtain waivers of troublesome regulations, or they are able to get such regulations changed because they know how to "work the system" to achieve their goals. Doing so may take time to build relationships and convince regulators of the safety and efficacy of what you are trying to do. You may not get a "yes" the first time you ask.

- **The need for a catalyst** – Bridging affordable housing and services on a wider scale requires a champion or catalyst to bring very disparate worlds together at many different levels. An organization or an individual must take ownership of the goal, identify and convene stakeholders, facilitate information gathering, mobilize resources, and coordinate on-going activities. Without a catalyst, even well-intended and widely supported efforts to launch AHPS projects may fall through the cracks. Workshop participants had a variety of opinions of who should play this role, ranging from state agencies, to aging services and housing providers, to groups such as local AARP chapters or the AAHSA state affiliate. The "owner" or "catalyst" will be different depending upon the particular state and/or community involved, the leadership capacity of

individuals and organizations, and the origins of the goal of enabling affordable housing residents to age in place.

What Are The Obstacles And How Can They Be Overcome?

The workshops demonstrated that linking affordable senior housing and services is doable, and is widely perceived to be beneficial to senior residents. Participants also identified a variety of obstacles that need to be addressed to achieve more widespread implementation of promising linkage strategies, as well as ways to overcome them.

- **Licensing/regulation** – In the eyes of many workshop attendees, the level of health and supportive services that can be offered by affordable housing providers is unnecessarily restricted by licensing requirements. Numerous housing providers expressed concern that if they push the envelope in gaining access to services on behalf of their residents, they open themselves up to licensure requirements. In California, for example, licensure laws prevent senior housing providers from directly providing supportive services. They are limited to information and referral and services coordination. Such regulations are perceived as preventing housing providers from creating comprehensive support programs for their residents, leaving them for the most part to piece together services from willing community providers.

  A number of housing providers expressed strong opposition to becoming licensed caregiving facilities. They fear that regulatory requirements will increase their costs, making it difficult or impossible to serve their resident base without becoming dependent on Medicaid, a funding stream that cannot be consistently counted on and for which many of their residents are ineligible. Some also cited the rigidity of many regulatory frameworks, which makes it hard to respond to changing resident needs. For example, some state assisted living programs require providers to offer a highly structured service package to a narrowly defined population. Such an approach is at odds with the mission of most affordable housing providers who serve a diverse population of residents, some of whom are healthy and need little or no service and others who are significantly disabled and have substantial personal care needs. Housing providers at the workshop were far more comfortable operating in a services system that allows residents to age in place and where services can be tailored to meet changing needs.

  Liability – Sustaining residents with higher acuity levels in independent housing also raised a number of liability and insurance issues. Providing services to residents may put housing providers in legal and financial jeopardy should a resident receiving services experience an adverse event. Insuring against potential lawsuits is also difficult. A risk manager at one workshop pointed out that the insurance industry has little or no experience in underwriting housing communities that provide services to frail or disabled residents. He urged housing providers to get involved with underwriters and to help them create an experience base, warning that otherwise they will use a nursing home rate-setting model that could prove unaffordable. Some participants also noted that providing access to supportive services could help allay a provider's liability concerns by increasing resident safety and preventing property damage and unsanitary conditions.

- **Consumer choice** - Housing providers who do support frail residents with higher needs must also balance liability concerns with consumer choice. In the IFAS concept of an "ideal" housing with services system, residents are free to accept or reject services. Many workshop participants expressed concerns about granting consumers the right to reject a service if, as a result, their health or safety is compromised. Should a resident reject needed services or make a poor choice, the provider could be liable. Housing providers also told of being caught between the wishes of a resident to reject services and the expectations of his or her family that the housing property ensure the safety of their relative.

- **Fair housing laws** – Many workshop participants stated that fair housing laws cause confusion for housing providers because, as one participant put it, housing with services environments are "neither fish nor fowl." For example, some workshop participants would like to give priority to prospective residents with higher levels of frailty and/or disability. Yet, some believed, fair housing laws can prevent housing providers from admitting persons on the waiting list in any order other than a first-come-first-served basis. Some providers did point out that they were able to obtain waivers from HUD that allowed them to target at least some applicants with higher levels of need. Issues were also raised about the unintended effect of fair housing laws on a provider's ability to discuss with prospective and current residents their needs for health-related and supportive services, believing that such discussions could be perceived as a violation of these laws. Some providers also worry about the implications of reasonable accommodation requirements if they provide a service-enhanced environment. In this case, the concern is that they will be forced to provide more and more services and supports, at great cost to them, as residents grow accustomed to having their needs met within the housing community. It was also noted that linking residents to supportive services can help protect a housing provider against fair housing violations since these laws prohibit them from evicting residents simply because they are not able to live independently. ***See HUD's response to these concerns and clarification of fair housing laws as they apply to AHPS at the end of this document***.

- **Silo mentality** – Housing and aging services providers, regulators, and policy makers usually operate solely within their own world and typically know little about each other's programs or policies. In some of the workshops, it was believed to be the first time that representatives from the state's housing, health, and aging services agencies had been together in the same room. The failure to consider the implications of affordable housing policies for meeting the services needs of aging residents, and vice versa, creates a variety of problems. For example:
    - Housing and aging services programs have different eligibility criteria. A senior housing resident with significant disability may qualify for subsidized housing based on their income, but may not qualify for Medicaid, which funds personal care and other home and community-based services that might keep him or her out of a more expensive institutional setting. A number of workshop participants spoke of their residents being in "no mans land" because they do not qualify for Medicaid, but lack the resources to pay for services out-of-pocket.

- The LIHTC, Section 202, and many state-funded housing programs require sponsors and investors to show that services will be available to residents; however, they rarely allow or sharply limit, funding to be used for direct services (service coordinators are the exception and may be funded within the operating budgets of Section 202 and LIHTC properties).
- The Medicaid home and community-based services waiver program, the largest source of funding for personal care and other supportive services needed by lower-income older adults with physical and/or cognitive impairments, is only available to individuals who already need a nursing home level of care. Most publicly subsidized housing residents do not meet these criteria.
- Without a waiver from HUD, fair housing laws do not allow housing providers who are able to offer a wide range of services to establish admission policies that target older adults with high levels of service need—the very individuals who may most benefit from a service-enriched housing environment.

Workshop attendees placed high priority on convincing stakeholders from both the fields of housing and aging services to get into the act as health, long-term care, aging, and low-income housing policies are developed and funding levels are set at the state and local level. As some participants emphasized, if you are a "no-show" at the important forums where these issues are debated, do not expect outcomes to be of your liking.

- **Funding** – Almost all workshop participants believed that funding for both affordable housing and resident services is inadequate to meet current needs and, in many cases, is declining. For example, the Section 202 program has been level funded for the past few years. With rising development costs, this translates into fewer actual new units each year. In the face of decreased funding from traditional sources, developers must learn to stitch together multiple funding sources (and to work with multiple layers of requirements and regulations) to complete the development of new senior housing communities. The year-to-year uncertainty of funding levels for certain state's share of the Medicaid program also raised concerns among many participants. Several stated that that while Medicaid funding continued to be a critical source of services funding, housing plus services programs must have a much broader funding base to succeed.

- **Limited housing provider understanding, commitment, and capacity** – According to workshop attendees, many affordable housing providers continue to see themselves as only responsible for traditional housing functions—leasing, collecting rents, maintaining the physical plant, etc. They do not see themselves as architects or even supporters of a housing environment that can adapt to the changing needs of increasingly aged and frail residents. While growing numbers of senior housing sponsors hire service coordinators, housing staff may not perceive any responsibility for enhancing or even supporting the coordinator's role of helping residents age in place. In addition, some participants observed that many housing managers and sponsors viewed their jobs as operating independent housing, which they interpret as housing for people who do not need services or supports to live in their apartment. If they need help they should move, or organize it themselves. Discussion also highlighted many housing providers' lack of knowledge of the health and supportive services resources available in their community

or how they might link their residents to these resources. In addition, not all housing providers were perceived to have the skills and training necessary to build partnerships with community organizations to bring supportive services to residents. Some thought that a new set of administrators with different skill sets would be required.

- **Resident opposition** – Several housing providers said it is the residents themselves who may oppose keeping their frailer neighbors in the property. These residents do not want to be reminded that they too may loose some of their independence as they age. There may be even a tipping point when the property begins to look too much like a nursing home, an environment they wish to avoid. Providers also face challenges in convincing some residents to accept services, even if they desperately need them. Residents may be in denial that their health is declining or they may fear eviction if they admit to needing support to live safely on their own. Overcoming this challenge requires sustained involvement of residents in planning the AHPS program, as well as considerable resident education.

- **Affordability** – Workshop discussants also addressed issues of affordability if services were added to the housing community, adding that services programs need to be designed to minimize costs to the payer, whether it is the resident, the housing provider, or a public entity. One housing provider told of helping to make resident services more affordable by working with a home health care agency to break down the increments of services they provide to residents to 15-minute intervals. Residents do not always need, nor can they necessarily afford, two- or four-hour blocks of time. If they can purchase only the amount of time they really need, out-of-pocket costs may be reduced.

- **Nursing home influence** – Participants had differing thoughts on the potential influence of nursing homes on the diffusion of AHPS strategies. Some felt nursing homes have such strong influence over the long-term care system that they would oppose efforts to expand housing with services on a wider scale. Others thought nursing homes could be valuable partners. For example, nursing homes could look for opportunities to collaborate with housing providers to better manage their beds to keep the less frail seniors out of their facility and keep their acuity levels high.

What are the Funding Opportunities?

Workshop members identified funding as the primary issue facing housing and aging services providers and states committed to developing AHPS systems. There was general agreement that traditional funding sources such as the Section 202 program and Medicaid are not likely to be reliable sources on which to build in the future. A wide range of potential funding strategies was suggested, including:

<u>New Public Initiatives</u>

- 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. Workshop Outcomes and Next Steps

The most important outcome of the workshops was that it brought together a variety of stakeholders representing housing and aging services and provided a forum in which they could begin to identify areas of common interest. Several ideas for next steps received widespread support, including:

1. **Resident and Family Education** - Residents and their families are often not aware of the service opportunities in their community. As one participant put it, many see services as a light switch, which is either "on" or "off." This participant thought the concept of a "dimmer switch" was more appropriate. Residents and families need to be educated to seek out appropriate services as they are needed, rather than waiting for a crisis when it may be too late to maintain independent living. Service coordinators, AAHSA state affiliates, area agencies on aging, AARP chapters, the Red Cross and local Alzheimer's groups could all be venues for developing and disseminating awareness and educational materials on the community's services resources to residents and their families.

2. **Provider Education and Technical Assistance** - Participants also emphasized the value of developing a technical assistance program for housing and aging services providers to supply them with detailed information on how the housing and aging services systems work, the characteristics of best practices that support effective program development and implementation, how regulatory constraints can be overcome, and findings from applied research and evaluation studies that help to demonstrate the advantages and disadvantages of various AHPS approaches.

3. **Broad Awareness Campaign** - Participants also saw the need for a broader awareness campaign to increase understanding of the characteristics and needs of the aging residents

of affordable housing and the potential benefits of linking them to health-related and supportive services. Some observed that while funding for home and community-based services for older adults and the disabled has substantially increased over the past several decades, little is known about the extent to which the aging residents of subsidized housing have benefited. Many workshop attendees perceived that this group has been left out– that advocates and policy officials have simply not had subsidized housing residents on their radar screens. One suggestion was to try to move AHPS strategies onto the agenda of the Conference of Mayors since municipalities are now dealing with the problem of poor seniors unable to maintain independent living. Workshop attendees also suggested that the role of AHPS in the larger service system needs to be considered as part of the discussion about future directions for health care policy. It was also suggested that advocates for affordable housing adopt a broader platform that includes the importance of developing both supply and services linkages. Advocates for the homeless have been quite effective in disseminating this message on behalf of their constituency.

4. **Replicating Workshops in a Rural Area -** A number of workshop attendees pointed out that AHPS models that work in urban areas are likely to be quite different than those that work for rural communities. It was suggested that one or more workshops be held to highlight the experience of rural housing providers who are attempting to link their older residents to needed services, the special challenges they face, and ways that these challenges are met. A partnership with the U.S. Department of Agriculture and/or state agricultural extension services might be a good way of organizing such a workshop.

5. **Foster Collaboration Between Market Rate and Affordable Housing Providers and Aging Services Agencies -** The experience of subsidized housing providers dominated the workshops. IFAS staff was unable to identify more than a handful of AHPS examples in the private market. Future work should be directed at identifying and supporting housing cooperatives, mobile home parks, neighborhood-based NORCs, SROs, shared housing, and other market-rate housing arrangements to develop needed linkages to health-related and supportive services.

6. **State-Specific Next Steps -** At each workshop, participants from the same states were given some opportunity to identify state-specific concerns and potential next steps. The goal was to identify a few concrete actions to which stakeholders within each of the represented states could commit, rather than the development of a detailed work plan. Stakeholders in Washington have formed the "Senior Housing + Services Alliance of Washington" that has been meeting regularly to promote community partnerships to expand AHPS options. Participants from Atlanta also expressed interest in forming a working group to promote ideas generated at the workshop, including expanding a successful partnership between an Atlanta area hospital and four senior housing properties. Attendees from Rhode Island are also planning a series of meetings with key stakeholders to outline possible next steps. The McGregor Foundation has provided a grant to pull together the ideas that resulted from the Cleveland workshop and to facilitate stakeholder collaboration to implement them.

7. **Applied Research and Evaluation -** Most workshop members agreed that AHPS options were unlikely to be implemented on a wide scale without demonstrating their effectiveness in improving resident quality of life and reducing the unnecessary use of more expensive health and long-term care services. Participants identified several important issues that need to be fleshed out to garner greater support for expanding AHPS programs. For example:
    - How many senior residents of affordable housing arrangements want and need health and supportive services to maintain independent living?
    - Do AHPS strategies increase the duration of independent living and decrease transfers to assisted living and nursing home facilities without compromising quality?
    - What types of strategies work best (produce the most positive outcomes) and what are the prerequisites for effective implementation?
    - Are AHPS programs cost-effective from the perspective of housing providers and public policy makers?
    - What regulatory and practice barriers impede widespread replication and how can they be overcome?
    - What new models are likely to work best in the future?

VII. 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 themes 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.

References

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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.