

AGING IN PLACE SUCCESSFULLY WITH AFFORDABLE HOUSING AND SERVICES



**A Report by the Coalition for Senior Housing of Massachusetts
Funded by The Boston Foundation
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EXECUTIVE SUMMARY

The mission of the Coalition for Senior Housing emphasizes the importance of elders being able to age in place with dignity regardless of economic status. The availability of adequate services in affordable housing is critical to the fulfillment of this mission. There is an abundance of anecdotal evidence demonstrating that the provision of services both supports and sustains elders so that they may safely remain a part of their community. In addition, it is clear that elders prefer to live in a familiar environment and postpone institutionalization.

However, there are a number of challenges that must be addressed to successfully meet the needs of an elder population that will continue to grow dramatically in number, have increasingly more complex health service needs, and be comprised of many low to moderate income elders. Is it possible to expand the long-term care system in the community to adequately meet the needs of elders in a cost-efficient manner?

The purpose of this report, funded by The Boston Foundation, is to look at the service needs of elders in affordable, independent elderly housing, which may or may not be service-enriched, and determine the impact of services on the ability of elders to age in place successfully. The hypothesis for the research was that service-enriched housing would experience lower turnover rates because the availability of services would allow elders to age in place successfully. A secondary hypothesis was that housing that is not service-enriched but located in an area that had readily available services for elders would also experience lower turnover rates due to the availability of services in the area.

A part of the research informing this report involved a series of three surveys. The first survey was conducted via mail, the second was conducted online, and the third was conducted by telephone. The goals of these surveys were to ascertain: (1) which sites computerized move-out data, and for those sites that did computerize move-out data (2) what types of services did their residents receive, and (3) what rate of turnover had they experienced within a given period. Findings from these surveys highlighted:

- The variety of methods by which housing developments record data
- The types of data that are computerized versus the data that is kept in paper files
- The difficulty in accessing hard data for service usage through contact with housing developments.

Unfortunately, due to the many obstacles in obtaining hard data, it was not possible to establish a solid causal relationship between receipt of services and low turnover rates which would have been considered evidence of successful aging in place as a result of service availability and usage. However, an independent, on-going study by Jewish Community Housing for the Elderly (JCHE) clearly establishes both the material and non-material value of on-site, in-home services. Their data will prove to be a valuable tool in the effort to inform public policy as well as other housing providers and service providers. Recommendations included in the report call for a broader based application of JCHE's data collection methods.

Given the premise of the research--that readily-available, high-quality services lead to successful aging in place---it was impossible to ignore a discussion on the ramifications of an on-going evolution in long-term care: the increasing reliance on the community-based approach. Two key factors in determining the efficacy of that delivery model are the costs of care together with its ability to provide high quality and complex medical care to a large, frail elder population. This report provides an overview of the concerns associated with the issues of cost and quality and offers examples of what a number of states have done as they grapple with the consequences of a growing, elderly population.

Despite the diversity of approaches, there are common themes that emerge around the basic services that sustain elders in the community. Whether their needs are satisfied with services provided directly by housing owners/managers or by independent entities in the community, the critical determinants in maintaining elder independence are nutrition, health care, socialization and mobility. There are certain factors, however, which affect the availability and the effectiveness of the services including proximity to services, range of services available, and the involvement of informal caregivers, including the ability of informal caregivers to pay for additional services.

Increasing the depth and breadth of services available in the community will not, alone, promote successful aging in place for all of our elders, regardless of their income. The availability of affordable housing options is a critical component. Despite overall support and acceptance of affordable housing for elders, the current number of units is woefully inadequate to serve the burgeoning elder population. Without concerted efforts to increase the number of affordable housing units and expand high-quality and cost efficient services available in the home, the evolution of a long-term care system into one which is community-based and increasingly consumer-directed will be stalled. Moreover, the greatest wish of elders will be denied: that of dignity in old age.

I. INTRODUCTION

The Coalition for Senior Housing was founded in 2005 by Citizens' Housing and Planning Association (CHAPA) and Jewish Community Housing for the Elderly (JCHE). The mission of the Coalition for Senior Housing (CSH) is to advocate for accessible, affordable, and appropriately supported housing without which it is difficult for elders to age in the community with dignity. Currently, the CSH is comprised of seventeen members that include the following:

- AARP Massachusetts
- B'nai B'rith Housing New England
- Boston Partnership for Older Adults
- CenterPoint Foundation
- Citizens' Housing and Planning Association
- HEARTH
- Hebrew Senior Life
- Jewish Community Housing for the Elderly
- MA Aging Services Association
- MA Assisted Living Facilities Association
- MA Association of Older Americans
- MA Chapter of the National Association of Housing and Redevelopment Officials
- MA Councils on Aging
- MA Home Care Association
- MA Senior Action Council
- Milton Residences for the Elderly
- New England Elderly Housing Association

Goals for the Report

The JCHE, acting as fiscal agent for the CSH, in collaboration with CHAPA, applied for and received a grant from The Boston Foundation to accomplish a variety of identified goals, one of which is the publication of this report. This report is intended to document the relationship between the provision of quality, in-home services and the ability of elders to age in place successfully, and study the cost implications of community-based housing with services

Terminology

For the purposes of this report, several frequently-used terms will be defined as follows:

Seniors or *elders* are terms that will be used interchangeably throughout this report. They refer to individuals who are 65 years of age or older.

Very low income individuals are those whose incomes do not exceed 50% of the area median income.

Low Income individuals are defined as those persons whose incomes do not exceed 80% of the area median income.

Moderate Income individuals are those individuals whose income is between 80 and 100% of area median income.¹

Aging in Place refers to individuals living where they have lived for many years; living in a non-healthcare environment; and using products, services and conveniences to allow and enable them to not have to move as circumstances change.²

Service-enriched housing is housing that provides residents with services that are not usually made available to the residents of low income or subsidized independent senior housing by the property management entity. These services may include any or all of the following: transportation, meals, housekeeping, personal care, adult day care, fitness/wellness programs, computer centers and structured social activities.

II. STATEMENT OF ISSUES

Growth of Elderly Population

Nationwide, the elderly population (those 65 years or older) is expected to grow to 53 million by the year 2020, an increase of 18 million (34%) in just 18 years.³ This explosion will also be reflected among the population in the Commonwealth of Massachusetts. By the year 2020, there are expected to be 1,178,852 individuals over the age of 65 living in Massachusetts, an increase of 318,690 or 27% in 20 years.⁴

Median Income of Elderly Population

According to the U.S. Census Bureau as reported in “A Profile of Older Americans: 2003,” median income was \$19,436 for males and \$11,406 for females for individuals over the age of 65.⁵ Based on the poverty threshold of \$9,367 for a one person household over the age of 65 and \$11,805 for a two person household over the age of 65, approximately 3.6 million elderly persons or 10.4%, were below the poverty level in 2002. Another 2.2 million, or 6.4%, of the elderly were classified as “near poor.”

Aging in Place is the Preference

Although changes in lifestyle and advances in medicine have contributed to individuals’ longevity these changes have not removed the likelihood that some form of care will be necessary in order for most elders to live independently in the community. Generally, most adults feel that prolonging the ability of individuals to live outside of an institutional setting is preferable because it not only improves the quality of one’s life and encourages good health but also reduces health care costs. A report by AARP in 2000 entitled “Fixing to Stay: A National Survey of Housing and Home Modification Issues”⁶ states that “the desire to remain in their current residence for as long as possible becomes more prevalent as age increases. Seventy-five percent of those age 45 to 54, and 83 percent of age 55 to 64 *strongly* or *somewhat agree* that they wish to remain in their current homes as long as possible, while 92 percent of those age 65 to 74 and nearly all of those age 75 and over (95 percent) want to do so.”

Availability of Affordable Housing Options

“Decent and appropriate housing is widely recognized as a key to sustaining health, dignity, and quality of life for all human beings, but especially for millions of mentally and physically frail older persons who need safe, affordable, and accessible housing.”⁷ Although the number of seniors, including those with limited means, will rise greatly over the next twenty years, plans for affordable housing production have stagnated, as have subsidies. In Massachusetts, there has been a dramatic decrease of 46% in funds earmarked for housing programs.⁸ The National Low Income Housing Coalition’s report entitled “Changing Priorities: The Federal Budget and Housing Assistance 1976-2007” states, “The bottom line is that between 1976 and 2002:

- Revenue losses from housing-related tax expenditures increased by \$89.8 billion
- Budget authority for housing assistance dropped by \$28.1 billion

- Housing assistance outlays increased by \$24.9 billion, less than one third of the increase in the cost of housing-related tax expenditures.”

Conclusions

Therefore, given that (a) there will be a significant surge in the elder population, (b) a significant percentage of that population will be of limited means, (c) availability of services allows for increased quality of life and long-term cost savings, and (d) development of affordable housing for elders has not kept pace with the need, there must be a re-examination of a strategy to effectively address the needs of the elder population in the years to come.

III. DOES THE AVAILABILITY OF AFFORDABLE HOUSING AND SERVICES LEAD TO SUCCESSFUL AGING IN PLACE?

A. Study by the Research Subcommittee

Given the apparent link between the availability of affordable housing and services and the ability of elders to age in place successfully, the Research Subcommittee of the Coalition for Senior Housing embarked on a research project with the goal of ascertaining:

- Types of services provided directly by individual sites
- Types of services received by elders from community-based entities
- Depth of data collected by elderly housing developments for each elderly resident move-out

Hypothesis

The hypothesis was that service-enriched housing would experience lower turnover rates than housing that provides little or no services directly, as residents aged in place successfully and avoided nursing home placement. We expected the turnover that did take place in service-enriched housing would in large part be the result of mortality. The Research Subcommittee examined data supplied by housing developments serving a largely elderly population that collected and recorded the data necessary to reach conclusions about the impact of those services on the ability of elders to age in place.

Methodology

An initial survey was mailed to 752 housing providers, including some duplicates within organizations. Of those, 177 surveys (24%) were completed and returned by fax or mail. The purpose of this survey was to determine which types of resident data were collected and stored electronically by staff.

A second survey was conducted on-line for those who had responded to the first survey and had stated that they collected data on their computers or had hard copies of information regarding move-outs. There were 37 completed on-line surveys out of the 150 housing providers that were invited to participate.

A third survey, a telephone survey, was conducted with 32 out of the 37 organizations that responded with complete data to the on-line survey. The purpose of this follow-up survey was to confirm the numbers that were provided in the on-line survey and to obtain more details about the services reported in the initial survey. During the telephone interviews, case study information or anecdotal comments were solicited that were relevant for inclusion in this report.

B. Survey Findings

Survey # 1 - Understanding How Information is Stored

Of the 177 surveys completed, 124 respondents (70%) reported they kept data on move-out status and of these, 91 providers (73%) reported it was computerized. Between 29 and 39 of the 177 providers (16% and 22%) reported that their facilities offered meals and/or personal or home-making assistance. However, information about participation was generally kept only on paper copies and not stored electronically. Providers reported they seldom collected other types of information such as medical diagnoses, disability, or health utilization. The one exception was emergency room use, which was recorded by 122 out of 177 providers (69%), but this was generally stored in paper files (75%). Only 15% reported they kept information on mobility status and this also was generally in paper files.

Limitations: A limitation of the survey was that some of the questions may have been interpreted in different ways. When respondents checked off that a service or program was offered, some providers may have been reporting on whether or not data were collected regarding participation in the service or program. The response rate (24%) to the survey was not unusual for a postal survey.

Survey # 2 - Targeting Reasons for Move-Outs

There were 37 online surveys returned and out of those 37 surveys there were 32 facilities that reported complete information regarding residents' move-out status over the previous two years. The number of residents in those facilities at the time of the survey ranged from 24 to 1,324. There was great variability in the move-out rate. On average, 22% of the residents moved out of the facilities in two years, with turnover ranging from as little as 5% to as much as 94%. One-quarter or 8 out of 32 housing organizations met the Research Subcommittee's criteria for facilities where residents were aging in place, meaning that most residents in the facility were aged 85 or older, or at least 40% of the move-outs in the previous two years were due to deaths of the resident. Similarly, 22% of the facilities (7 out of the 32) reported that more than one-half of those who moved out had transferred into nursing homes, with such transfers ranging from 0% to 100% of the move-outs.

Survey # 3 - Qualitative Information

After attempting to contact all 37 developments that responded to the on-line survey, we completed interviews with administrators from 24 developments that were confirmed housing providers. For the remaining 13 facilities, we were either unable to contact them or they were excluded because they were assisted living facilities or rest/nursing homes. Interviews with these organizations were terminated given that our focus was independent housing providers or housing agencies.

Limitations/Barriers to Data Collection

- ***Data Not Computerized*** Several developments did not record the specific cause of move-out in the computer. This was the result of one or more of the following:
 - ◊ Software being used by the site did not allow for such data to be recorded.
 - ◊ Recording of this information was not mandated by the owner/management entity therefore due to time constraints the staff did not record it.
 - ◊ Oftentimes, the reason for a move-out such as death or moving in with family, etc. would be handwritten in the files but due to workload and/or lack of staffing the retrieval of this data would be an unreasonable expectation.
- ***Software*** There are various types of software available for use by property management companies. There is no single version consistently used by all public and private management entities; therefore, the recorded data is inconsistent among housing developments.
- ***Incomplete Data*** Turnover numbers may not include situations where a spouse/sibling/co-resident would die but the remaining resident would stay in the unit if it was a one bedroom and they weren't over-housed. In other words, for some facilities, the turnover statistic is attached to the unit and not to individual residents.

When sites responded to survey #2 and identified the number of move-outs within a specified period, they did not differentiate between younger residents and seniors.

In addition, in some developments there are several building or sites and some of these buildings are service-enriched while others within the same development have no services provided by the property management agency or owner.

- ***Confidentiality*** Site staff was very concerned about revealing information that might breach confidentiality and were reluctant to answer some questions such as the age of individuals at time of move-out. This information would be quite valuable since even a move-out to a nursing home does not necessarily signal unsuccessful aging in place if the person is of an advanced age, 85 or older. Of note, several administrators commented that the majority of their residents were of very advanced ages.

Service Usage

The vast majority of sites reported that even if they, the property management entity, did not provide many services, the residents utilized a variety of services that were available elsewhere in the community. In those regions where services were not readily available either on-site or in the near-by community, some property managers would organize services themselves.

In addition to services, property managers mentioned that the involvement of family members and/or fellow residents were key factors contributing to successful aging in place.

Based on our effort to collect consistent, computerized information from housing providers across the state, the overwhelming conclusion is that much more work needs to be done with

individual organizations to make the collection of accurate data from this source possible. Later in this report we review the valuable information generated by a JCHE Study. It provides a model for data collection and confirms one of the Coalition's recommended next steps. Nonetheless, there are significant issues embedded in the data collected that are worth reporting here.

C. Anecdotes and Best Practices

The surveys began with a hypothesis that service-enriched housing reinforces the ability of elders to successfully age in place. But in fact, elders take advantage of the services available whether offered by the housing provider or other agencies in the community. So, in reality, it may not matter who provides the services, as long as they are of sufficient quality, are available and that elders are made aware of their availability. Along with the provision of services by designated service providers, conversations with property managers helped to identify a number of other informal service providers that make an impact on the lives of elder residents. They include:

Family Members Family members often supplement services provided by agencies or entities in the community such as meal preparation, shopping, bathing or dressing. They may also help by privately paying for additional services that may not be available in a specific community or that the elder may not be deemed eligible to receive. Family members also provide socialization.

Neighbors and Friends Neighbors and friends not only provide a source of social interaction but also directly provide some services such as shopping or meal preparation. They also play an important role by alerting family members, property management or others if their friends' health is declining and some intervention is necessary.

Property Management Some property managers assume the role of direct care provider or coordinator of services. Residents seek them out to provide transportation to medical appointments or grocery shopping and they may comply. They may also organize services for needy residents.

Of the 24 sites contacted as part of the telephone survey, 23 reported they were aware of residents that utilized the services listed below. These services were either provided directly by the property management entity or by an entity in the community such as a home care agency:

- Transportation
- Meals
- Personal care
- Homemaking
- Home health aide

Of these 24 sites, 14 noted that services alone played an important role in helping residents maintain their independence. Another four sites noted that services in combination with family involvement were critical to maintaining elders in their apartments. Two sites identified family involvement alone as the most critical factor in keeping residents from being placed in an

institutional setting. Three other sites noted the important role that fellow residents served in keeping property management aware of the status of some frail elders. At times, elders also provided services, such as shopping or meal delivery, directly to their fellow residents. Three sites also noted the active role some property managers may assume in directly providing assistance to residents such as transportation to medical appointments or organizing volunteers or services to provide assistance.

Several of the sites' respondents shared interesting stories which provide important insights into the practicalities and issues involved in providing independent housing for frail elders in the community.

- A public housing authority located on the North Shore has several hundred units designated for the elderly and younger persons with disabilities. The Executive Director of the housing authority related the following stories (None of the names used are those of the actual residents.):

“I see new tenants move in when they are 60 years of age, live healthy active lives for 20 years and then begin to age. We then take notice, coordinate services and they stay in their home well into their 80s. Their stays in nursing homes are generally very short before they die. This was different 10 to 15 years ago. At that time, I often had residents or their family request that we hold apartments for many months, sometimes up to a year until they could return from a long stay in the nursing home. The assignment to the nursing home resulted from a bad turn in their health or an accident. They would pay the rent holding out hope that the resident would return. They often did not. I never see this happen now because of the short hospital stays and the expectation that services will be provided in their home through coordination or the VNA or the ASAP, Senior Care, Inc. Stories could fall into two different types. There are those residents whose physical health changes for the worse and there are those whose mental health deteriorates. We have many cases of each type.

“Mary was an active leader of the resident organization. She moved in at the age of 60 in 1986 with her husband, Roger. Mary took care of Roger, managing services for him until he died. She was herself a home care worker until last year. She developed health problems affecting her breathing. She had surgeries and returned home. Mary now has a home care worker visit her regularly to maintain her household. She has Meals on Wheels delivered to save her the effort of meal preparation. She has oxygen delivered to her home. Mary can no longer be active in the resident organization but she remains living among her long-time friends who take an interest in her health and visit her every day.

“Judy moved into our housing in 2002 at the age of 65. We allowed her to bring along her dog, Daisy. She walked Daisy each day and visited her neighbors along the way. After a couple of years Judy showed signs of mental health problems. She had conflicts with certain of her neighbors, she complained of people and agencies meddling in her affairs. After many visits by our counselor Judy now sees a private counselor regularly, a psychiatrist who monitors her medications, a nurse to help her take the medications and a home care worker. Occasionally Judy has to check in at the hospital's Senior Adult Unit but she remains a resident of our housing and still walks Daisy in the neighborhood.

“While the above examples illustrate the benefits of health maintenance we also provide preventive care such as flu clinics and blood pressure clinics and other workshops to provide health education. This care also helps our residents remain healthy residents for a longer period of time.”

□ A small HUD-subsidized property located in an under-populated community in western Massachusetts has occupancy restricted to elders and individuals who are mobility-impaired. No services are formally offered by the management team or owners. Due to the community’s rural character, services are located far from the development. The property manager oftentimes organizes services and in one instance organized volunteers, including his/her spouse, to drive a resident to his cancer treatments on a regular basis. At one time this property was a Title III meal site. The property manager felt this provided residents with an important opportunity to socialize, breaking the isolation of this geographically isolated site with a small number of units. The property manager attributes their relatively high turnover of 63% from 01/01/2004 to 12/31/05 to the advanced age of the population and the difficulty of accessing services/family support.

□ An entity owning and operating several affordable housing developments for the elderly and younger disabled persons in the Boston and metro-west area has over 1,000 units. Services provided to the residents at one site include transportation, service coordination, kosher meals, 24 hour on-site staff, a fitness center, on-site adult day care owned and managed by a third party, social programs, volunteerism, pull cords in every unit, a “life line” system, and a nurse practitioner on site. Services provided by entities external to the owner/operator are wide-ranging. Staff related countless stories regarding the impact of services on the many facets of a person’s life. The depth and breadth of services available in the community and directly through owner/manager allow for rich socialization, cultural respect, and the evaluation of residents’ abilities in addition to the monitoring and support of their physical and mental well-being. The opportunity to enjoy so many amenities on-site also insulates them from potentially hazardous situations. The entity points to the average age of their residents at move-out, 85, as evidence of the success of their programming. In calendar year 2006, 42% of their turnover was due to mortality. Only 36% of those residents who left moved to nursing homes.

D. Four Key Factors of Successful Aging in Place

Several common themes emerged from the three surveys conducted for this report and reviewed in the previous section. They can be summarized in the four key factors of successful aging in place: *health care, nutrition, socialization and mobility*.

Chronic diseases exact a heavy burden on older adults, particularly those who have limited resources. Access to *health care* and much needed medications are essential for elders aging in place. When residents have temporary setbacks and are hospitalized, the availability of home care will often be the deciding factor in their ability to safely return home during or following a recuperation period. Also, family support is critical for many elders who prefer to stay in their apartments following acute health episodes.

Poor *nutrition* is a major cause of health problems and can contribute to falls as well as both physical and cognitive impairments. Mobility limitations and other problems can interfere with an elder's ability to shop for groceries or prepare meals. Sensory changes associated with aging and use of multiple medications may reduce appetite and impact interest in eating. Meal programs, either meals served in-house or the delivery of meals (Meals on Wheels), provide an important resource that allows many frail elders to age in place and maintain good nutrition in spite of health problems that place them at nutritional risk.

Social activity or *socialization* has been shown to reduce risk of disablement in older populations.⁹ Senior housing environments generally provide informal and sometimes formal opportunities for socialization. Persons who age in place in a housing environment often develop supportive relationships with other residents. Fellow residents may notice a decline in a friend's health before others become aware of it and trigger a process that will address health/service needs. They also provide support for each other in times of need, an important factor for aging in place into late old age. Although the social climate may vary from facility to facility, even in the absence of an activity program, the physical environment may foster social contact through availability of safe and comfortable communal spaces. Many facilities have residents' clubs with regular activities planned by residents. In addition, housing management and community agencies may offer occasional activities for elder housing residents.

Mobility is perhaps the single most important determinant of an elder's ability to age in place within a senior housing environment.¹⁰ Physically active elders are more likely to maintain mobility and general health compared to more sedentary persons. Some housing sites may offer opportunities for exercise but this is often overlooked as an "extra" in a resource poor environment. Use of adaptive equipment and environmental modifications can allow elders with even severe mobility limitations to continue to live independently. Mobility also includes the ability to get around within the community. Accessible transportation can vary substantially between housing facilities. Both formal and informal transportation options are important for getting elders to medical appointments, shopping, and other errands.

In summary, each of these four factors must be addressed in order for most elders to successfully age in place in senior housing. It is clear from the local surveys that the housing environment will often provide supportive services (i.e. transportation to medical appointments, organizing volunteers to provide services) out of necessity for aging residents. If services help to maintain tenancies and prevent turnover, this represents a cost savings to property management and also supports them in their mission to house an elderly population. When formal programs fall short, property managers and even the residents themselves will attempt to serve the needs of the most frail or at-risk elders. We found that formal programming addressing these four factors was seldom provided in-house, although outside agencies may address one or more of these needs in a housing facility. Often, however, the informal and sometimes haphazard manner by which these needs are addressed jeopardizes persons who for one reason or another are not in the mainstream social culture of a housing facility. Others who are at risk are those who survive the longest, outliving their peers who may have entered the housing around the same time years earlier, thereby losing a significant source of peer support and social connection.

There is an urgent need for formal coordinated programs of supportive services that will allow all elder residents of senior housing to age in place. Efforts that go beyond crisis intervention and meeting only the most basic needs could greatly offset long-term costs of caring for chronically disabled elders in the community and, later, in institutions. Health promotion programs and opportunities for physical activity could be added to the menu of supportive services and contribute to much healthier living for elders who are aging in place.

E. Study by Jewish Community Housing for the Elderly (JCHE)

This report has identified the impediments encountered in retrieving data that may have shown a linkage between the availability of services on-site and successful aging in place. This data was intended to support the belief that aging in place is a cost-efficient and preferable alternative to institutionalization. Jewish Community Housing for the Elderly (JCHE) has recognized for quite some time the value of collecting such data and its use in proving the efficacy of their programs. Their method of data collection and service provision is a model for other management entities and owners.

Recording Data

In 2002, JCHE applied for and received the first of two grants from the Boston Foundation to create a Resident Services database which would:

- Track utilization of resident services and programs sponsored by JCHE
- When available, track utilization of state subsidized services
- Track resident demographics including (a) move-in date; (b) move-out date, and (c) where the resident moved i.e. (i) death; (ii) other housing; (iii) nursing facility, or (iv) family.

The key outcome measure of the database is successful aging in place, which is defined in one of two ways: 1) death as a resident of JCHE; or 2) successfully reaching the age of 85 as a resident of JCHE. Use of services is correlated with success in aging in place to determine the relative contribution of each service. JCHE uses a relational database for collecting information. (Access and Filemaker Pro are both examples of relational database software.)

Cost of In-Home Services

The formula used to determine the cost of keeping a nursing home eligible resident at JCHE was conservative. *Amount of Service:* Each nursing home eligible resident was assumed to have received five days of each service even if the resident, in reality, only used the service a few days per week. For instance, a resident might have someone come in once every weekday to help them put on their support hose and use eye drops. *Cost of Housing:* The government subsidy of the housing unit was also factored into the equation. *Cost of Nursing Home Care:* To determine the alternative cost of a nursing home bed, JCHE contacted several nursing homes in the area and asked them for their rate of reimbursement from Medicaid. Then JCHE took the average of those figures.

The study that began in April of 2003 followed a group of 115 residents who had been determined to be nursing home eligible. At a study checkpoint in February of 2004, 60 participants from the original group of residents were still living in their own apartments at JCHE 22 months after being deemed eligible for nursing home care. When JCHE compared the cost of their housing with supportive services to that of Medicaid-funded nursing home care for the same 22 month period, JCHE found that approximately \$2,500 dollars per resident/per month was saved by enabling residents to remain at JCHE with services instead of residing in a Medicaid-funded nursing home bed. Today, more than three years after the study's start date, 34 of the participants from the original group of nursing home-eligible residents still live at JCHE. JCHE estimates that approximately \$7 million dollars has now been saved with regard to the study group alone. Equally important to JCHE is the knowledge that these elders were able to live the independent lives they chose to, rather than being forced to give up their homes.

Quality of Services

/Caring Choices/ (TM) is the name of JCHE's in-home service program. This program adapts to the changes in an individual's health as it changes. Bi-lingual staff (English-Russian) offer intermittent services in the residents' apartment, twenty-four hours a day, and seven days a week. The program was designed to be personalized rather than a set package of services. */Caring Choices/* allows residents to request the specific service they need. Services include but are not limited to meal preparation, medication reminders, laundry, personal care, light housekeeping, escorts within the building or to doctor's appointments, or even reassurance checks at night. If more or fewer services are necessary they are adjusted accordingly.

/Caring Choices/ staff provide two critical functions for residents-care coordination and direct services. Care Coordinators take phone requests from residents, coordinate state subsidies with JCHE subsidies from donor dollars and grants for services and schedule service provider apartment visits arranged in 15-minute blocks of time. Because of the high concentration of elderly people in JCHE's buildings one home care service provider spends a full day or night on-site, going from apartment to apartment without losing valuable time traveling among service calls. Each year, approximately 200 out of 1,300 residents receive about 13,000 in-home assistance visits through */Caring Choices/*. JCHE also has a sliding fee scale for those who are not eligible for subsidized services or for those who need more services than are available through public resources.

/Caring Choices/ is not only crucial to the elderly residents who live in JCHE's housing but it also represents a viable, cost-effective model for other elderly housing organizations. JCHE is confident that the availability of */Caring Choices/* saves significant funds by enabling those who use the services to avoid or postpone costlier nursing home care. JCHE has been able to document and quantify the effects of this in-home support through a study of nursing home-eligible residents who used */Caring Choices/*. With compatible data from more sites, it would be easier to draw broader implications about the impact of services or ability to age in place. With that in mind JCHE has organized a research roundtable. Housing providers that have joined the roundtable meet periodically with local research professionals to increase the amount of meaningful, computer based information being collected within organizations, and that which might be available for conglomeration in the future.¹¹

IV. IMPLICATIONS OF COMMUNITY-BASED HOUSING AND SERVICES: COST AND QUALITY

A. Costs and Quality of Nursing Home Care Versus In-Home Care

There doesn't seem to be a question as to whether or not seniors wish to remain in their home or in the community as long as possible, reserving nursing home placement as a last resort. Many consider the latter, accurately or not, as a rather impersonal environment and unnecessarily restrictive in which personal control of their circumstances/care is limited. However, is it feasible to assume that home care is capable of providing, to the degree necessary, some of the more medically intense care that is available in nursing homes, meeting the needs of some of the most frail elders in the community? In addition, is there a cost savings associated with the state and federal government providing for long-term care in the community versus a nursing facility? If a significant cost savings exists, it would provide an incentive for states and the federal government to make policy changes that would place emphasis on creating and funding a more efficient, effective and perhaps broader and deeper system of home care.

Cost

On its face, the argument would seem obvious that care in the home is more cost effective if services are made available to individuals that could live safely and comfortably in the community with an adequate range of services available to meet their needs. According to Genworth's Financial Cost of Care survey conducted by CareScout in January and February of 2006 for year 2005,¹² the average annual cost for a private one-bedroom unit in an assisted living facility was \$32,294. The average annual cost of a private room in a nursing home was \$70,912. The average hourly rate for a home health aide for in-home care was \$25.32 per hour. The U.S. Census Bureau's American Community Survey for 2005 found the median gross rent¹³ (includes contract rent plus estimated average monthly cost of utilities) for individuals age 60 and over to be \$600/month or \$7,200 a year. The U.S.D.A. (United States Department of Agriculture), for 2005, reports that the median cost of food for a single female 51 years of age or older is \$197/month or \$2,364 per year for a moderate-cost food plan.¹⁴ Taking these expenses (gross rent and food) into consideration it is possible to conservatively estimate that an individual could still receive several hours of home health aide service on a daily basis and still not reach the average annual cost of nursing home care.

However, there are a variety of determinants that complicate the scenario of a cost-effective, expanded home health system:

- Are there a significant number of nursing home residents who could receive the care they need from an enhanced home care system in the community?
- Would a significant number of nursing facility residents return to the community if richer home care services were available?
- Would an enhanced home care system ultimately result in a decrease in the overall number of nursing home beds (which some argue is the only way to save money in the long-term)?

- Is there a valid concern that that the number of home care clients would grow exponentially if a greater variety of health care services could be received in the home (the so-called “woodwork effect”)?
- Is the network of trained home health professionals adequate to meet an increased demand?
- Is training available for more advanced healthcare techniques to home health professionals?
- How will the issue of retention and related issues of salary, benefits and professional development be addressed?

Quality

Excellence in quality of care is the foundation of a successful home care program. Without quality in care, elders will not choose it as an option or it simply won’t provide the consumer with the support they need to remain in the community. By providing an enhanced level of care in the community it directly impacts both the quality of life of the consumer (the main reason elders would prefer it to nursing home care), as well as the cost of that care.

Robyn Stone, in “Long-term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century” (2000),¹⁵ notes: “A consumer-directed service delivery system must encourage the development of new ways to ensure high-quality care. This includes empowering individuals and their families to monitor the quality of care, providing avenues for rectifying problems through government authorities and other intermediary organizations, and making information on quality outcomes available to elderly customers.”

As the system of long-term care evolves from one that is institutionally based to one that is community-based, elders will be making many more decisions about the care they receive. It is incumbent upon the system to create measures to ensure good quality, such as the following:

- Oversight of the care received
- A system that trains and empowers elders or their representatives to express concerns regarding quality of care and receive redress, if necessary
- A system to provide elders or their representatives with information and/or counseling about care options
- A collaborative/communicative system among all levels of health care provision
- Knowledge of geriatric issues among all levels of health and care professionals

Expanding the home care system into one that serves a greater number of people with more serious medical needs leads to some complex issues related to the infrastructure of the long-term care system.

Exhibits IA and IB illustrate the many inter-related issues associated with expanding the home care system and what some states have done to address these issues.

EXHIBIT 1A
Expanding Community Based Long-Term Care

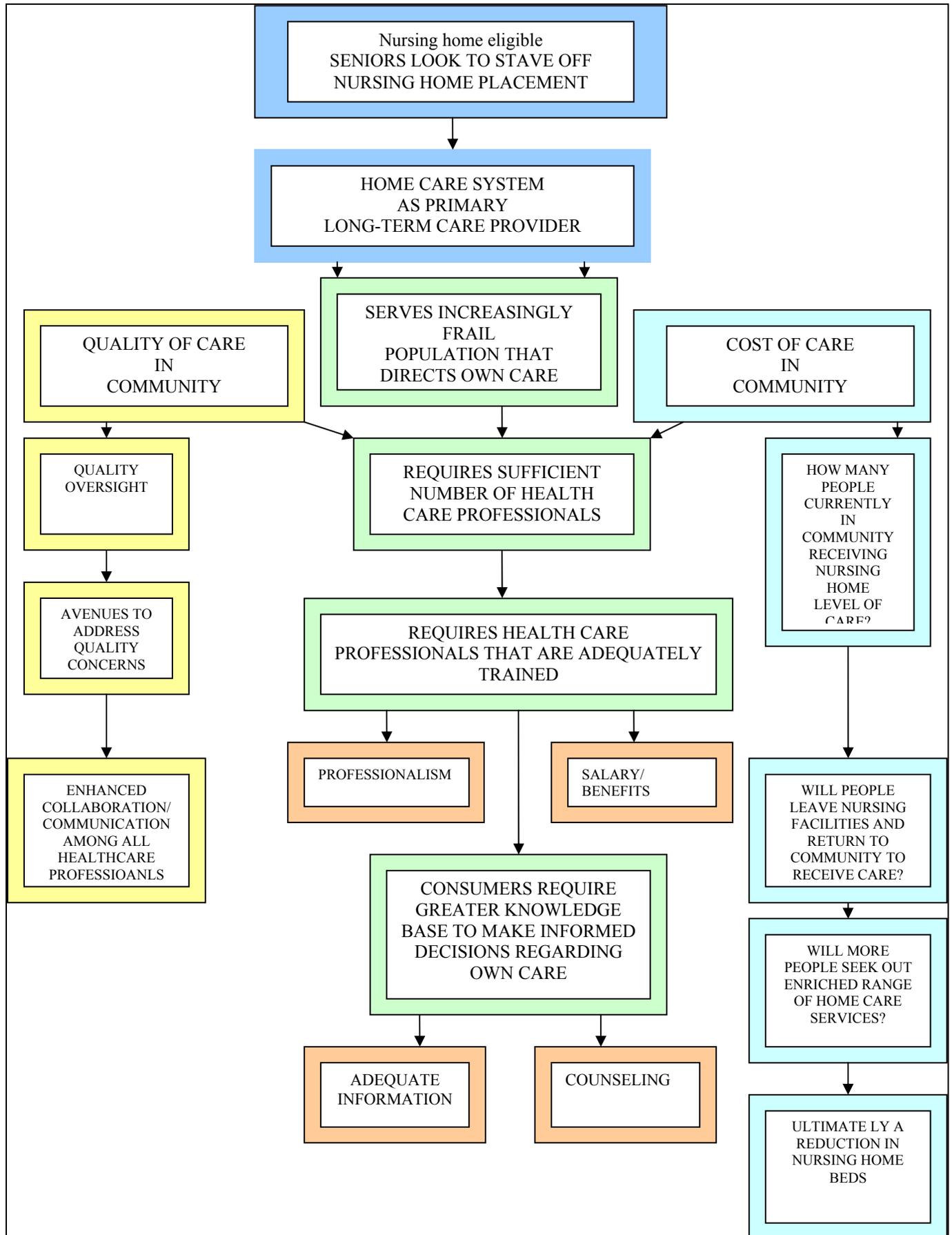


EXHIBIT 1.B.
Strategies for Increasing Long-Term Care in the Community

- Promote fluid transitions between programs with State-wide managed care system.
- Encourage nursing home industry to diversify and develop home care programs.
- Develop more uniform and stringent screening protocols for nursing home eligibility.
- Increase assisted living and other affordable, service-enriched housing options.
- Restrict development of nursing homes and purchase of medical equipment.
- Establish consumer-controlled funds allowing consumers to hire personal aides and purchase necessary equipment.
- Allow consumers to choose setting that is most appropriate for their needs.
- Promote increased recruitment and retention of personal aides.
- Offer enhanced training for health care professionals that allow for professional development and greater quality of care.
- Develop coordination and cooperation among care providers so that the most appropriate care plan is devised for the consumer.

B. What States are Doing to Meet the Challenge

The Commonwealth of Massachusetts currently has a system of 27 local Aging Service Access Points, also known as ASAPs. The ASAPs are non-profit organizations scattered regionally around the state, each one representing a specific geographic area. An ASAP directly provides information, referral, interdisciplinary case management, intake assessment, development and implementation of service plans, monitoring of service plans, reassessment of needs and protective services. They also contract with other agencies and organizations to provide a host of services which include homemaking, adult day health, laundry service, home delivered meals, wanderer location, respite and emergency response and on-call. The Community Care Ombudsman Program responds to inquiries from elders and their families, educates consumers regarding their rights and responsibilities, counsels consumers about service concerns and investigates and resolves complaints through mediation.

Despite the comprehensive system of home care in Massachusetts that has evolved over time, gaps still remain and need to be addressed as the elderly population grows and their needs increase. Filling these gaps, however, means continuing to grapple with the high cost of long-term care and its budgetary impact. Other states must face this challenge as well, and a number of them have undertaken efforts to address one or more issues associated with greater reliance on the home health industry. If the growing population of elders prefers in-home care and in-home care is found to enhance quality of life and have health benefits, then creative approaches to achieving cost-effective in-home care must be explored

The following is a brief sampling of what other states have done to address the issues associated with changing the long-term care system from one that is institution-based to one that is community-based.¹⁶

State-wide Managed Care

Arizona instituted a statewide, managed care system that helps patients avoid improper long-term care choices. “Nursing home eligible” persons can move among different levels of care. There are no waiting lists for home care; only 1.1 percent of the 65-plus population lives in nursing facilities, among the nation’s lowest rate.

Consumer-Directed Care

Arkansas “is a pioneer in consumer-directed programs” according to the February 2004 issue of Governing Magazine. Arkansas gives people in need of care-or their representatives-control over the spending and hiring to meet their needs. Arkansas also does well promoting home and community-based alternatives. Since Elder Choices was put in place in 1992, nursing home residency has decreased by 60 percent.

This newer approach is sometimes referred to as “Cash and Counseling,” where individuals are given cash to purchase the services and equipment they require. These decisions are made after consultation with a counselor who helps them establish their budget and needs.

Screening Protocols

Since 1995, Maine's assisted-living programs and screening protocols for nursing home care have restrained spending growth on long-term care to 17 percent of Medicaid budgets, compared with 53 percent nationally. There has been an 18 percent decline in the number of Medicaid residents in nursing homes and a 24 percent decline in the number of nursing home beds in the state.

Maine's approach offers a streamlined point of entry into the system that tries to ensure that those most in need of care receive care and that the needs of all applicants are judged on a level playing field. In 1998, Maine implemented the MECARE system to determine medical eligibility and inform consumers about LTC options. Centralized access to services and assessments creates a level playing field, according to a study prepared for the New York City Department for the Aging by Allison Armour Garb entitled "Point of Entry Systems for Long-term Care: State Case Studies."¹⁷

Maine has been creative in using the Certificate of Need process to assist nursing home owners to convert excess capacity:

- More than 13,000 nursing home beds have been "banked" or de-licensed since 1994.
- Forty-three (43) nursing homes now offer multiple levels of care, up from 9 in 1995
- 19,340 assessments were completed by Goold Health Systems, the Department's contractor, last year.

Nursing Homes Diversify Services

Oregon boasts the nation's lowest percentage of elderly people in nursing facilities. Its long-term care program provides incentives to the nursing home industry to develop home care programs. Oregon diverts savings in institutional care to community and home care and has encouraged nursing home operators to provide services to a wider range of people, such as younger persons with disabilities, so that it is further integrated into the community. Recent budget cutbacks, however, will limit patient access to the system.¹⁸

Restricting Construction of Nursing Homes

Both Oregon and Vermont have reduced the issuance of Certificates of Need to restrict the growth of nursing homes.

Encouraging the Creation of Service-Enriched Housing

Oregon has encouraged rest home operators to transition their facilities into assisted living facilities and has also experienced an increase in adult foster home beds.

New York State has provided funding for services to so-called NORCs, or Naturally Occurring Retirement Communities. NORCs are densely populated areas such as large apartment complexes or neighborhoods that have a high percentage of elderly residents who require support services in the home.

Recruitment and Retention

To address the shortages of personal aides and other staff that bedevil long-term care, Pennsylvania has been a pioneer in finding out what direct care workers themselves think are the issues in promoting better recruitment and retention. The legislature provides funding so that local agencies can put creative ideas into practice.

Oregon has also lessened restrictions on the tasks only nurses could perform, allowing others to perform the tasks if they are properly trained. This alleviated the workload on nurses.¹⁹

Training

As the care delivered to elders at home becomes more complex, and the need for clear communication between all levels of care professionals becomes increasingly vital, it is essential that direct caregivers such as home health aides and personal care attendants are adequately trained. However, the health care field at this level experiences a great deal of turnover for a number of reasons, including:

- Low wages
- Poor benefit packages
- Stress
- Inadequate training
- Limited advancement opportunities
- Undervalued skills
- Lack of input into the decision-making process related to the care of patients

A strong community-based health care system relies upon direct caregivers to perform the necessary functions so good employees must have some inducement(s) to stay in the field. According to “Recruiting and Retaining a Quality Paraprofessional Long-term Care Workforce: Building Collaboratives with the Nation’s Workforce Investment System,” several communities have tried to address the problem by better utilizing services mandated by the Workforce Investment Act. In Tucson, Arizona, the Direct Caregiver Association (DCGA) has made an effort to work closely with their Workforce Investment Board and develop a joint strategy with the local One Stop Career Center.

The DCGA had focused its attention on four main issues:

- *Recruitment.* The DCGA conducts community-wide recruitment to attract a wide spectrum of potential caregivers.
- *Education.* The DCGA offers comprehensive training in preparation for state CAN certification.

- *Placement.* DCGA works to place trainees in agencies that offer advancement, trying to place some with employers that offer educational benefits.
- *Post-employment Services.* After placement, workers can access social support and continuing education services through their employers or the DCGA's Caregiver Resource Center.

Collaboration and Cooperation

Vermont has a very good track record for getting diverse groups involved with long-term care to work together. Patients are diverted from nursing homes, and the money saved goes into a trust fund, which is then used to develop more community and home care programs.²⁰

Choice of Setting

Massachusetts recently passed the Equal Choice amendment, or officially, "An Act Relative to Choice of Long-term Care." It allows the Commonwealth's Medicaid program to cover the cost of in-home care if a medically and financially eligible person prefers care in-home as opposed to a nursing facility or, as it states, "the least restrictive and most appropriate" care setting.

V. CONCLUSION

It was hoped that the surveys conducted by the Coalition for Senior Housing would collect computerized information about services that are benefiting elders and enhancing residents' ability to age in place. This data, in turn, would be used to inform and shape public policy relative to affordable elderly housing with services. However, numerous challenges, specifically those related to the types and format of data being collected by the housing developments, prevented the survey from yielding the amount of information desired.

Nonetheless, the process of conducting the research for this report revealed several overarching themes:

- (a) There appear to be few studies measuring the quantitative benefits of service-enriched housing.
- (b) Home care is perceived as preferable to nursing home care because it is cost-effective and enhances the quality of life.
- (c) Many states are striving to create systems that will make home care a realistic alternative for all of its citizens who require care that can be effectively administered at home.

The individual surveys conducted by the Coalition for Senior Housing garnered some general findings:

- Seniors will avail themselves of services as long as (a) services are available, (b) they are aware that services are available and, (c) the services are of good quality.
- Informal supports such as family, friends, neighbors and property managers play an important role in providing services directly, organizing services or alerting providers that services are needed and paying for services that might not otherwise be available.
- Service-enriched housing provides elders with another opportunity to receive needed services, not only increasing convenience for both elders and the providers (and thus cost savings), but also providing additional safety for the elders so that they do not need to venture out into unsafe areas or under unsafe conditions such as poor weather to receive needed services.

Recommendations Regarding Data Collection

Although the surveys did not yield the anticipated information, they did highlight the lack of information collected at site regarding service provision. It is understandable that site staff and management at various levels have not made this a priority given the cost, lack of training, and heavy need for regular reporting for compliance. However, property managers have an ideal vantage point from which to observe tenancies that are troubled due to health-related issues. Therefore, the Coalition for Senior Housing recommends the following:

- Develop or revise a software program for property management entities to identify and track residents'
 - age at move-in
 - age at move-out

- reason for move-out
- services received while at the site.
- Conduct a pilot program for a one-year period which would include no less than five and no greater than 10 housing sites. These sites would be asked to use the above-mentioned software to collect the required data.

The Coalition for Senior Housing would be the recipient of this data and would publish the data in an annual report made widely available in order to track trends in service needs.

Final Note

Producing and/or maintaining an adequate amount of affordable housing to host elders who are able to remain in the community with services is the foundation for creating an expansive home care system that assists lower income elders. Advocates for affordable housing and for elder health care must unite in their efforts to make both of these goals a reality. The Coalition for Senior Housing is well poised to make an impact in this area given its success in bringing together active, experienced professionals in both the affordable housing and long-term care fields.

¹⁶ This section includes information retrieved from the following: “The Ticking Bomb,” GOVERNING.com, February, 2004 [journal on line; available from <http://www.governing.com/gpp/2004/long.htm>; Internet. : “States that Stand Out,” GOVERNING.com, February, 2004 [journal on line; available from <http://www.governing.com/gpp/2004/lstates.htm>; Internet.

¹⁷ Discussion of Maine’s long-term care system informed by the following works: Allison Armour-Garb. *Point of Entry Systems for Long-term Care: State Case Studies*, 2004.) State of Maine Long-term Care Status Report, December 2002, Bureau of Elder and Adult Services, Department of Human Services. Available at <http://www.maine.gov/texis/search.main.htm?query=long+term+care&pr>. Internet. Overview of Maine’s Long-term Care System. Bureau of Elder and Adult Services, Department of Human Services. Available at http://www.maine.gov/dhhs/beas/ltc/2000/ltc_2000.htm. Internet. Christine Gianopoulos, Elise J. Bolda, Mollie Baldwin, Louise Olsen, “What Works? Maine’s Statewide Uniform Assessment and Home Care Planning System tells All,” *The Gerontologist* 41, no.3, 309-311.

¹⁸ : “States that Stand Out,” GOVERNING.com, February, 2004 [journal on line]; available from <http://www.governing.com/gpp/2004/lstates.htm>; Internet. Michael E. Fishman, The Lewis Group; Burt Barnow, Johns Hopkins University; Asaph Glosser, The Lewin Group; Karen Gardiner, The Lewin Group, *Recruiting and Retaining a Quality Paraprofessional Long-Term Care Workforce: Building Collaboratives with the Nation’s Workforce Investment System*, paper presented as part of a symposium “Pathway to the Future: How Workforce Development and Quality Jobs Can promote Quality Care.” May 23-25, 2004. [Paper on line]; available from <http://aspe.os.dhhs.gov/daltcp/reports/natwis.htm>. Internet. The Wall Street Journal (New York), 23 October 2006. Available from <http://www.post-gazette.com/pg/06296/732317-255.stm>. Internet. “Oregon’s Long-Term Care System-From Nursing Facility care to Community-Based Care: An Evolution,” *Nutrition Reviews*, January, 1996, 54, no. 1.

¹⁹ Oregon’s Long-term Care System-From Nursing Facility Care to Community-Based Care: An Evolution by Susan L. Dietche, *Nutrition Reviews*, Volume 54, No. 1, January, 1996.

²⁰ “States that Stand Out,” GOVERNING.com, February, 2004 [journal on line; available from <http://www.governing.com/gpp/2004/lstates.htm>; Internet.

APPENDIX A

AFFORDABLE HOUSING IN THE COMMUNITY

Following is a brief summary of Massachusetts state and federal programs that create affordable housing options for seniors through production of units or subsidy:²⁰

A. CURRENT AFFORDABLE HOUSING OPTIONS

FEDERAL

Public Housing was created in 1937 by the federal government to house the neediest of our citizens.

Supportive Housing for the Elderly (Section 202) finances the development of rental housing with supportive services for the elderly.

Housing Choice Vouchers (HCV), formally known as the Section 8 program, allows qualified individuals and families, including elders with very low and extremely low income, to select their own unit, for which they pay no more than 30% of their income for rent. The balance is paid by the Housing Choice Voucher Program. The HCVs come in two forms: (1) mobile vouchers when awarded may be used anywhere in the United States by the recipient within the program guidelines; (2) project-based vouchers are attached to particular developments where some or all of the units are set-aside for households which qualify for the voucher.

Refinancing Program allows sponsors of Section 202 and Section 8 to utilize FHA mortgage insurance to refinance direct loans. Monies saved can be used for a number of purposes including, but not limited to, rehabilitation, modernization or retrofitting of the structure, new construction or an addition to the existing structure, and/or rent reduction.

HOPE VI funds have been used in some cases to convert public housing sites into affordable assisted living for seniors and younger disabled.

Assisted Living Conversion Program provides grants to private, non-profit owners of eligible developments to convert some or all of the dwelling units in the development into an assisted living facility for frail elders.

The *LIHTC (Low Income Housing Tax Credit)* program is a state administered program authorized by the federal government which focuses on increasing the amount of rental housing for low-income persons through the construction of new housing or rehabilitation of existing properties.

In 1981, the Community Development Act of 1974 was amended to include Title 1, allowing individual states to administer *Community Development Block Grant (CDBG)* funds for those areas that did not already receive CDBG funding directly from HUD (Entitlement Cities and

Urban Counties). The eligible cities and counties, or non-entitlement areas, are those with populations of less than 50,000 and 200,000 respectively. The purpose of the CDBG Program is to develop viable urban communities by providing decent housing and suitable living environments and expanding economic opportunity for low and moderate income persons.

HOME funds may be used for a broad range of activities, including the acquisition and/or rehabilitation of rental housing, new construction, and the demolition of distressed properties in order to construct new rental projects.

SSI-G is a joint federal and state rental assistance program administered by the Department of Transitional Assistance (DTA) which provides a supplemental income for eligible recipients residing in a certified assisted living residence in Massachusetts.

The *Affordable Housing Program (AHP)*, funded by ten percent of the Federal Home Loan Bank's (FHLB) net earnings, encourages local affordable housing initiatives through the competitive awarding of grants and low-interest loans through member institutions. Eligible funding initiatives are rental housing projects which allot 20 percent of the units for very low income households.

FHLB member institutions may apply for *Community Development Advances* to be utilized towards the purchase, construction, rehabilitation and predevelopment financing of affordable housing. There are three fixed-rate advances available through this program.

Under Section 538, through the U.S. Department of Agriculture, the *Rural Rental Housing Guaranteed Loan Program* provides loan guarantees for the construction, acquisition, or rehabilitation of multifamily housing in rural areas to both nonprofit and for-profit entities.

Under Section 515, through the U.S. Department of Agriculture, the *Rural Rental Housing Program* makes loans available to non-profit or for-profit corporations, individuals, partnerships and public agencies. These loans are direct, competitive mortgage loans made to provide affordable multifamily rental housing for very low-, low-, and moderate-income families, the elderly, and persons with disabilities.

Section 221(d)(3) and Section 221(d)(4) Mortgage Insurance for Rental and Cooperative Housing, are offered through the Federal Housing Administration (FHA), which is part of HUD. Each of these two mortgage insurance programs may be used for either the new construction or extensive rehabilitation of multifamily rental housing for moderate-income families, the elderly and the handicapped; however, the design may focus specifically on serving the latter two populations.

Assistance under *Section 232 and 223(f)* is through FHA insured mortgages for HUD approved lenders. There are three different criteria that define eligibility for such assistance. The first is under Section 232 and involves the financing of the construction and substantial rehabilitation of assisted living residences as well as the other facilities mentioned above. Second, borrowers

may buy or refinance existing facilities or apartment buildings that do not require extensive rehabilitation under Section 223(f), which provides a 35-year mortgage and a maximum 85% loan-to-value mortgage. Third, borrowers may utilize the program to install fire safety equipment.

STATE

State-Aided Public Housing for Seniors and People With Disabilities was created under Chapter 667 of the Massachusetts General laws. Residents may pay no more than 30% of their income for rent. Successful applicants may not have an income exceeding 80% of area median income and must be 60 years of age or older.

Community Based Housing Program provides funding for the development of integrated housing for people with disabilities, including elders. Eligible recipients are non-profits or entities controlled by non-profits. Priority is given to individuals who are in institutions or nursing facilities or who are at risk of institutionalization.

Housing Innovations Fund (HIF), through the Community Economic Development Assistance Corporation (CEDAC) on behalf of the Department of Housing and Community Development (DHCD), provides “deferred payment loans” of up to \$500,000 (or 50% of total development costs) for the acquisition or construction of innovative housing with a supportive service component.

Housing Stabilization Fund (HSF) is another deferred payment loan program from DHCD. HSF funds may be used for the acquisition, preservation or rehabilitation of affordable housing with an emphasis on funding projects that utilize foreclosed and distressed buildings. HSF can be used as a single source of funding or used in combination with other public funds.

Affordable Housing Trust Fund (AHTF) was created in FY2001 as a revolving trust fund to foster the production and preservation of affordable housing. MassHousing and DHCD jointly administer the funds that are awarded to support private housing. Eligible private housing activities include those that create or preserve housing affordable to people with incomes that do not exceed 110% of area median income.

ElderCHOICE Program, through MassHousing, provides construction and permanent financing at below-market rates for the development of mixed-income assisted living residences. Developments can involve new construction or the renovation of an existing property. A minimum of 20% of the units must be available to residents whose incomes do not exceed 50% of the area median income

Elder 80/20., through MassHousing, offers below-market construction and permanent financing to developers of mixed-income elderly rental properties. Developments are designed to serve seniors aged 55 and older who are able to live in independent apartments, but who may require limited support services.

Permanent Rental Financing Program (PRFP), available to both for-profit and nonprofit borrowers through the Massachusetts Housing Partnership (MHP), provides long-term, fixed-rate loans ranging from \$250,000 to \$9 million for the acquisition with or without minor rehabilitation of multifamily rental properties containing five or more units.

Perm PLUS, through MHP, allows for-profit and nonprofit developers of affordable multifamily rental properties of five units or more to obtain low fixed-rate mortgage financing, in addition to a low-interest deferred payment loan of up to \$60,000 per affordable unit (\$75,000 for nonprofit developers).

Small Scale Rental Production Program (SSRPP) provides long-term fixed-rate first mortgage financing with 0% deferred payment loans of up to \$90,000 per affordable unit for the development of smaller affordable rental housing properties with a minimum of five units.

Massachusetts Tax-Exempt Credit for Housing (MATCH) offers both for-profit and nonprofit owners and developers of affordable multi-family rental housing up to \$10 million of tax-exempt, fixed-rate bond financing. The bonds, which are issued by MassDevelopment, may be used for acquisitions, new construction, and refinancing of existing properties.

B. CURRENT AFFORDABLE HOUSING OPTIONS WITH SERVICES

Summary of state and federal programs that create affordable housing for seniors that are service-enriched:

FEDERAL

Section 202- Supportive Housing for the Elderly provides grants and project-based rental assistance to non-profit developers of affordable supportive housing for very low income elders.

Affordable Assisted Living has been created through use of the Assisted Living Conversion Program (ALCP), which grants funds to cover the physical cost of converting Section 202, Section 221 (d)(3), BMIR, Section 236 and senior developments with project-based Section 8 housing into assisted living facilities. These grant funds may not be utilized for services.

Affordable Housing Plus Services (AHPS) links older residents of subsidized multi-unit housing and supportive services so that they can age in place. The details of this program are provided in a report prepared for the United States Department of Housing and Urban Development and the United States Department of Health and Human Services in August, 2006 entitled "A Synthesis of Findings from the Study of Affordable Housing Plus Services for Low-and Modest-Income Older Adults."

C. SERVICE PROGRAMS FOR RESIDENTIAL SETTINGS

Summary of state and federal programs that fund services for elders in various types of residential settings:

FEDERAL

Multi-Family Housing Coordinators funds positions in Section 202, Section 8, Section 221(d)(3) and Section 236 housing as part of a competitive process through the 1990 Cranston-Gonzalez National Affordable Housing Act.. Service Coordinators provide a link between elder residents and services available within the community. They may also work with the property management entity to address issues that might endanger the residents' tenancy. The service coordinators may also assist residents located in the geographical vicinity of the federally assisted housing properties.

The Resident Opportunities and Self-Sufficiency program (ROSS) also provides grants for supportive services and resident empowerment activities including program coordinators to manage activities that support/enhance independent living for elderly and persons with disabilities living in public housing.

Congregate Housing is a shared living environment designed to integrate the housing and services needs of elders and younger disabled individuals. The goal of Congregate Housing is to increase self-sufficiency through the provision of supportive services in a residential setting. Congregate housing is neither a nursing home nor a medical care facility. It does not offer 24-hour care and supervision. Services are made available to aid residents in managing activities of daily living in a supportive but not custodial environment. Each resident has a private bedroom but shares one or more of the following: kitchen facilities, dining facilities and/or bathing facilities. Throughout the state there are many variations in size and design. A service coordinator is employed and spends time on site.

STATE

Supportive Senior Housing provides funding for services for elders and persons with disabilities who live in state-aided public housing. These services include case management, 24 hour on-site staff, one to two meals daily, medication reminders and structured social activities. Only seniors may be eligible to receive personal care, housecleaning, laundry, grocery shopping, and transportation.

Home Care program provides support services to elders with daily living needs to remain at home in their communities. The services are designed to encourage independence and to ensure dignity. The program also supports families caring for elders in order to encourage and to relieve the ongoing care giving responsibilities. Some of the services provided by the program include homemaker, personal care, day care, home delivered meals, transportation and other community support services to help maintain an elder in their home.

Community Choices Program is a program of the Executive Office of Elder Affairs aimed at ensuring eligible MassHealth members are delayed or prevented from imminent admission into a nursing facility and allowed the opportunity to age in place. Eligible MassHealth elders are aged 60 or older and meet the requirements of the Home and Community Based Waiver. Also, participants must meet clinical criteria, determined by interdisciplinary teams

Adult Foster Care is a program providing daily assistance with personal care and case management oversight by the provider in a caregiver's home.

Group Adult Foster Care is a program providing daily assistance with personal care services and case management oversight by the provider in an Assisted Living Residence (ALR) or some type of elderly/disabled housing complex.

Program of All-Inclusive Care for the Elderly (PACE) is a fully capitated Medicare and Medicaid managed care program which serves frail individuals age 55 and over who meet the nursing facility clinical criteria and who, at the time of admission, are able to remain in the community with supports. PACE sites serve as many as 300 enrollees and utilize an interdisciplinary team of clinicians in an expanded adult day health model to provide and manage all health, medical and social service needs.

Senior Care Options Program (SCO) is a fully capitated Medicare and Medicaid managed care program that is offered to eligible MassHealth members age 65 and older at all levels of need in both community and institutional settings in most areas of the state.

Qualified senior care organizations have been selected and have established large provider networks which coordinate and deliver acute, long term care and mental health and substance abuse services to MassHealth enrollees in accordance with the geriatric model of care

