MAKING THE CASE FOR SUPPORTIVE SERVICES FOR OLDER ADULTS IN GOVERNMENT SUBSIDIZED HOUSING
Portland, OR

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Making the Case for Supportive Services for Older Adults in Subsidized Housing

**MAKING THE CASE FOR SUPPORTIVE SERVICES FOR OLDER ADULTS IN SUBSIDIZED HOUSING**

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Introduction

The next few decades will mark unprecedented population growth among adults over age 65, unlike anything the U.S. or our region has ever experienced. This growth is the result of the size of the Baby Boomer Cohort combined with longer life expectancies of Americans. The U.S. Centers for Disease Control and Prevention notes that from 1900-2003 life expectancy increased from 48 to 75 years for men and from 51 to 80 years for women (DHHS, 2006). They attribute improved access to health care, advances in medicine, healthier lifestyles and better health before the age of 65 as the underlying factors for the longer life expectancy of Americans (DHHS, 2006). This pending demographic shift represents new challenges for housing providers across the country, particularly providers of subsidized housing who will be expected to adapt to the changing needs of residents.

For many years housing and services have operated in separate domains, leaving both sides reluctant to take on new roles and responsibilities. Unfortunately, this separation has resulted in fragmented systems that do not always consider the needs of an individual holistically. Efficiently linking services with subsidized housing allows older residents to remain in their homes as they age, an alternative to costly and premature nursing home admission. With an emphasis on the Portland region, this paper examines a decade worth of research on the topic, considering both the benefits and challenges of adding supportive services to existing subsidized housing.

Portland, Oregon

Before delving any further, it is important to understand the demographic landscape and existing conditions in the Portland region. The City of Portland is located within Multnomah County, a county of approximately 714,567 people (ACS, 2008). The city itself has a population of 537,081 (ACS,
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2008). Today there are approximately 70,000 older adults in Multnomah County (Holcomb, 2008); however the Oregon Department of Human Services predicts that the older adult population will rise to about 125,000 by 2025, an increase of 44% in twenty years (Holcomb, 2008). At the same time the proportion of seniors in the county will increase by over 25%, from about 11% to 16% of the county’s total population (Holcomb, 2008).

The Portland area’s population growth over the past two decades has had serious implications for housing values and affordability. From 2000 to 2007, the median Portland housing price rose almost 75%—from $166,000 to $288,900—and monthly housing costs rose roughly 40% (Portland Plan, 2009). There is much debate about the ways in which Portland’s Urban Growth Boundary (UGB) has affected housing values, with some scholars arguing that by limiting the amount of developable land in the region, the UGB has driven up demand, thus increasing the overall cost of housing (Phillips and Goodstein, 2000; Staley, Edgens and Mildner, 1999). While most homeowners have benefitted from the increased value of their property, others have felt the negative ramifications. In particular, it is often renters who have been adversely impacted by higher rents and fewer affordable units in close-in locations.

Along with the shortage of affordable units, many renters in the region are significantly rent-burdened, spending more than 30% of their income in rent. The annual income required for the average market rate 1-bedroom rental apartment in Multnomah County is $25,520 (Oregon Housing Alliance, 2009). However, the average annual Social Security income for retired workers in Multnomah County is only $12,858, and individuals receiving Supplemental Security Income (SSI) are only eligible for an average of $7,644 each year (Oregon Housing Alliance, 2009). At 13.5%, the poverty rate for older adults in Multnomah County exceeds the rate for the state as a whole (8.5%) (Holcomb, 2008).
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It seems that many older adults are well aware of the difficult predicament this leaves them in. A 2008 survey of Multnomah County residents age 55 and over with household incomes at or below 200% of the federal poverty level, found that housing affordability was a major concern. Eighty-six percent of renters and 68% of homeowners in the sample were spending more than 30% of their income on housing (Baggett and Neal, 2009). While the majority of those surveyed said they wanted to stay in their current residence for as long as possible, 44% of those who had moved in the past five years had done so to reduce their housing costs (Baggett and Neal, 2009). Many of the older adults surveyed were also very concerned with their ability to find affordable housing when needed, with only 13% of renters believing it would be possible (Baggett and Neal, 2009). As segments of the private rental market become further out of reach for low-income renters, many look to the few affordable housing alternatives still available.

Housing Authority of Portland

A major provider of affordable housing in the Portland region is the Housing Authority of Portland (HAP). Established in the early 1940s, today HAP is the largest provider of affordable housing in the State of Oregon. HAP oversees 3,771 units of subsidized housing throughout Multnomah County, as well as an additional 2,468 units of public housing (HAP, 2009). HAP also administers approximately 8,000 HUD-funded Housing Choice Rental Vouchers (Section 8) annually. As of November 2009, approximately 22% of HAP public housing households were classified as elderly (with one resident over age 62) and 41% were considered non-elderly, but disabled (HAP, 2009). Elderly households make up 4.4% of HAP’s current waiting list for public housing, whereas non-elderly, disabled households account for 39% of the waiting list (HAP, 2009). Waiting lists for Housing Choice vouchers tell a similar story, with about 18% of recipients classified as elderly and 30% non-elderly, but disabled (HAP, 2009). Currently, the waiting lists for HAP public housing units are closed. The units set aside for elderly and
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disabled adults were last opened for new applicants for a five day period in October, 2009 (Har, 2009). After getting on a waiting list, applicants will typically have to wait anywhere from one to three years before a unit becomes available (Har, 2009). Wait list times for the 3,771 subsidized units that HAP oversees were unavailable, as they are maintained at the individual property level.

Why Target Older Adults in Government Subsidized Housing?

Nationally, around 1.8 million older adults reside in subsidized housing in the U.S. This includes 320,000 households in Section 202 units, 358,000 in public housing units, 557,000 with Section 8 Project Based Rental Assistance, 190,000 in the rural housing service, and another 300,000 living in units subsidized by programs like Low Income Housing Tax Credits (LIHTC) or Section 236 (Kochera, 2002). Forty-two percent of LIHTC properties completed in the U.S. between 1987 and 1998 were designated for older adults (Kochera, 2002). Interestingly, there are more older adults living in government subsidized housing nationally, than there are in nursing homes (1.4 million) or in assisted living facilities (1 million) (Redfoot and Pandya, 2003). Among subsidized housing programs, there is only one federal financing source specifically designated to provide housing for older adults, the HUD Section 202 program (Stone, Harahan and Sanders, 2008). Waiting lists for Section 202 units are long, especially when compared to the number of housing units that become vacant each year. The high demand for this housing means that applicants frequently must wait over two years before a unit becomes available (Haley and Gray, 2008).

Personal Choice and Independence

Identifying interventions that support the aging in place of subsidized housing residents makes sense on a number of levels. Like the majority of older adults in the U.S., residents of subsidized housing want to remain in their homes as they age. According to a survey conducted by AARP in 2000, more than 90% of adults age 65 and older would prefer to stay in their current residence as long as possible.
Making the Case for Supportive Services for Older Adults in Subsidized Housing (Kochera, 2002). Not only do many older persons wish to avoid the trauma of relocation, they also want to retain the social bonds they have developed with friends and neighbors (Stone, Harahan, and Sanders, 2008). Unlike other individuals with more resources, residents of subsidized housing often have limited choices because of their inability to afford most private-pay options (Stone, Harahan and Sanders, 2008). Research shows us that when older adults come to a point when they can no longer live alone and are able to vote with their wallets, they are increasingly choosing assisted living as an alternative to in-home care or nursing homes (Doty, 2008).

Premature Nursing Home Admission

In addition to providing choice to those who would have few options otherwise, it makes sense to target interventions to this population because they are at greater risk of nursing home admission than other older adults. Research has shown us that subsidized housing programs have effectively, albeit inadvertently, targeted individuals who are at a heightened risk of nursing home admission compared to the rest of the older adult population (Redfoot and Kochera, 2004). The most observable risk factor contributing to nursing home admission is disability, with trends showing disability levels worsening as individuals continue to age (Redfoot and Kochera, 2004). It is estimated that 79% of women and 58% of men who turn 65 today will need some form of caregiving during the remaining years of their lives (Golant, 2008). And the prevalence of disability among subsidized housing residents is even greater than the general public (Redfoot and Kochera, 2004). In a 1999 survey of HUD Section 202 properties, managers estimated that 22% of residents were disabled or frail compared with only 13% ten years earlier (Heuman, Winter-Nelson and Anderson, 2001). The survey also showed that the proportion of residents having difficulty preparing meals or performing personal care tasks increased almost fourfold between 1988 and 1999 (Heuman, Winter-Nelson and Anderson, 2001). A 2001 survey of LIHTC properties asked managers to estimate the number of tenants who were frail or disabled
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(defined as having difficulty walking or performing everyday tasks) and their responses indicated that close to one-third of the residents were frail or disabled (Kochera, 2002). According to John Keating, Director of Strategic Partnerships at HAP, these trends have been observable among HAP residents as well. Several decades ago HAP began to see many more disabled individuals and fewer older adults in their housing (J. Keating, personal communication, November 18, 2009). Today, this presents a new challenge for HAP and many other housing providers who find themselves in a similar situation. Rather than simply preparing for older adult residents, HAP must now be prepared for the residents who have aged in place – those with multiple challenges and perhaps even more complex supportive service needs, including those who have aged with a disability.

Other factors that indicate higher outcomes of premature nursing home admission include gender and race. Women and minorities, who typically make up a disproportionate number of aging residents in subsidized housing, are also at greater risk for nursing home admission (Redfoot and Kocher, 2004). Having few informal supports from family members or spouses is also frequently a determinant of early institutionalization. Older renters in subsidized housing are much less likely to have a spouse present than older homeowners or other older renters (Redfoot and Kochera, 2004).

Medicaid Cost Savings

For policymakers looking to save taxpayer dollars and prevent unnecessary institutionalization, the high concentrations of Medicaid eligible individuals living in subsidized housing create enormous potential for interventions that can produce cost savings. Although the eligibility requirements among subsidized housing programs and service provision through Medicaid differ, there is substantial overlap between those who are eligible to be served under both programs (Redfoot and Kochera, 2004). A number of studies have shown that providing independent housing with services is typically less costly
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to taxpayers than providing room and board at a skilled nursing facility. For instance, a study conducted by HUD in 2004 found that a year-long stay in a nursing home funded by Medicaid cost an average of $49,000, while a HUD Section 202 unit, plus the most frequently provided services – food, transportation and housekeeping – cost only $13,000 (Haley and Gray, 2008). Furthermore, a fuller set of personal services plus the cost of housing in a 202 unit was still estimated to be about half the cost of institutionalization (Haley and Gray, 2008). The State of Oregon predicts that over the next twenty years Medicaid caseloads for older adults in Multnomah County will almost double, from 5,500 to 10,000 (Holcomb, 2008), producing an incentive locally to develop less expensive alternatives to premature or unnecessary nursing home admission. Though the promise of Medicaid savings sounds appealing, it may not carry much weight for housing providers, who operate independently of the Medicaid system.

_Economies of Scale in Subsidized Housing_

Aside from the risk of premature admittance to nursing homes and the personal choice factor, the potential for economies of scale within subsidized housing is also an incentive to target interventions to this population. This means that providing on-site supportive services to residents in a concentrated area is much more cost-effective than trying to provide the same services to residents in scattered locations. In most cases, subsidized housing units are already clustered into complexes and multi-unit dwellings. Economies of scale make partnerships more attractive to private and public sector service providers because they allow a provider to serve more people at lower marginal costs (Stone, Harahan and Sanders, 2008).

_Benefits to the Housing Provider_

Ensuring that older residents can successfully age in place generates a number of benefits for subsidized housing providers as well. Providing supportive services can keep older adults in their
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current residence longer, reducing unnecessary tenant turnover. Light housekeeping and service
coordination can also be effective in preventing eviction and reducing the physical deterioration of a
unit. Additionally, developing linkages to supportive services can mitigate pressure on property
managers, many of whom are not trained in social services or gerontology. Research shows that simply
by responding to certain help requests, many property managers are already directly providing
caregiving assistance to some older residents (Prosper, 2004). As part of the CASERA Project (Creating
Affordable and Supportive Elder Renter Accommodations), housing providers were asked about their
roles and capacity to meet the needs of older residents (Golant, 2000), with many acknowledging that they lacked the expertise and social service knowledge to be truly effective. By incorporating supports
into housing, managers are better able to focus on property management issues and are less frequently
interrupted with off-hour emergencies and other issues unrelated to property management (Stone,
Harahan and Sanders, 2008). Finally, bringing in another party to coordinate the social service
component can help alleviate resident fears of eviction or discrimination.

Linking Housing and Services

Public, private, and nonprofit owners of senior housing have attempted to bring supportive
services into their conventional multifamily housing models through a variety of programs, two of which
are highlighted here.

Congregate Housing Services Program (CHSP)

Though many public housing authorities have avoided providing resident services outside of the
normal property management realm, HAP has received national recognition for its successful
implementation of a HUD program called the Congregate Housing Services Program (CHSP). When HAP
started CHSP in 1981 it originally only served one residence, Northwest Tower, but quickly expanded to
include three additional locations (J. Keating, personal communication, November 18, 2009). CHSP was
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designed to assist older and disabled adults with the necessary supports to keep their independence by incorporating housekeeping, personal care, case management, daily meals, and companionship services. As a resident of one of the four buildings, an individual can participate in CHSP if they are eligible to receive in-home services through Medicaid. For these individuals, the CHSP service fee is completely covered by Medicaid. Non-Medicaid eligible residents are also accepted into the program if they are approved by an assessment committee and are able to pay for services out of pocket, never more than 15% of their income. CHSP services are provided to residents through a contract with local non-profit provider, Impact Northwest. A national evaluation of CHSP found that one outcome of the program was a reduction in placement in nursing homes. Specifically, for every recipient of CHSP services admitted to a nursing home, 1.5 vulnerable tenants in non-CHSP buildings were admitted (Haley and Gray, 2008). Despite its success, HUD has not been very proactive in ensuring the program’s continuation. In 1990, through the National Affordable Housing Act, HUD began to require that grantees provide a 50% match to receive CHSP funding. Since 1995, HUD has neither solicited nor funded applications for new grants under CHSP. Congress, however, has provided funds to extend expiring CHSP grants on an annual basis (HUD, 2009). As of November 2009, HAP’s CHSP program served 89 individuals at a monthly cost of approximately $503 per participant (HAP, 2009).

Service Coordination

Over the years resident service coordination has become a commonly used strategy to incorporate resident supports into housing. It was first introduced into HUD-assisted housing in 1990 under the Cranston-Gonzalez National Affordable Housing Act (HUD, 2009). Rather than providing direct assistance, service coordinators typically assess residents’ needs and then connect them with existing organizations or agencies within the community. HUD funded service coordinators cannot act as recreational or activities directors, provide supportive services directly, or assist with other
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administrative work that is normally associated with housing operations (HUD, 2009). Residents living in properties with service coordination receive approximately 30 minutes of assistance per week (HUD, 2009). Although service coordination is often viewed as a less intensive intervention, evaluations have shown that it can be effective in helping older adults to age in place in subsidized housing (Pynoos et al, 2004). A recent study found that residents in developments with HUD-funded service coordination remained in their own homes roughly 10% longer (equivalent to more than six months) than those residents in developments without a service coordinator (Haley and Gray, 2008). As of early 2008, 3,742 housing developments for low-income older adults and people with disabilities were served by HUD-funded service coordinators (Haley and Gray, 2008).

While both service coordination and CHSP have been somewhat effective in helping vulnerable residents maintain their housing and avoid premature nursing home admission, it is unlikely that these programs will be able to sufficiently meet future needs. The most recent HUD Section 202 survey (2008) showed that when residents vacate Section 202 properties, those designated for older and disabled adults, three-quarters of the time it is because they need additional support.¹ Moreover, managers of Section 202 properties estimated that close to 30% of their residents are ultimately transferred to nursing homes (Heumann and Nelson, 2001). In spite of the relative success of these two programs, mounting evidence suggests that a significant number of older adults living in subsidized housing would benefit from a more comprehensive set of supportive services, those more consistent with an assisted living model. Currently, there are very few subsidized housing developments that provide the intensive level of services needed by residents at high risk of nursing home admission (Redfoot and Kochera, 2004).

¹ This is after deaths have been excluded as a cause for vacancy.
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Becoming Licensed to Provide Services

Integrating services into existing subsidized housing requires extensive strategic planning on the part of the housing provider. Understanding the needs of residents and determining the scope of services to be offered is the first critical step. Various regulations and licensure requirements apply depending on the type and level of service offered and the state in which the service is taking place. Because of the types of services they provide, nursing, residential care, and assisted living facilities in Oregon are required to be licensed by the Oregon Department of Human Services, Division of Seniors and Persons with Disabilities. This means that in order for an agency like HAP to directly offer certain services to residents, like medication administration for example, they would have to be licensed as an assisted living facility (ALF) or have a license to provide such services. If licensed as an ALF, they would then be required to provide a whole range of services, from three meals a day to 24-hour on-call emergency staffing (Mollica, 2009). Moreover, ALFs must abide by a series of other directives and regulations not traditionally required of providers of independent housing. ALFs in Oregon are expected to provide personal and other laundry services; a program of social and recreational activities; services to assist with ADLs; medication administration; transportation coordination and other household services (Mollica, 2009). They must have the capacity to assist residents in performing all ADLs on a 24-hour basis, including mobility and transfer assistance; help with personal hygiene and dressing; assistance with eating and so on (Oregon SPD, 2009). In addition, ALFs in Oregon must offer apartment-style units with private bathrooms, lockable doors, and kitchenettes, and they must be at least 220 square feet in size (Mollica, 2009).

Developing Partnerships to Provide Services
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An alternative approach to providing enriched services, that would not require a residence to be licensed as an ALF, would be to initiate a formal partnership with a community-based agency to provide on-site services. While this approach still requires intensive coordination and upfront planning, it can be significantly less burdensome than obtaining licensure to operate as an ALF (Milbank Memorial Fund, 2006). When a housing provider partners with an outside service provider many of the regulatory requirements associated with Medicaid are borne by the service provider. This type of partnership lends itself to a simpler implementation and less complicated start-up process. Additionally, collaborating with a service provider and sharing responsibilities reduces the risk and liability for housing providers (Milbank Memorial Fund, 2006). A similar, lower-cost approach to bringing supportive services into subsidized housing relates to the idea of co-location services within existing housing. Co-locating various services within subsidized housing developments allows both residents and community members to benefit. Commonly co-located services include meal sites, senior centers or health and wellness programs (Harahan, Sanders and Stone, 2006).

**Implementation Challenges**

Before a subsidized housing provider embarks on a journey to integrate supportive services, it is important that they understand the upcoming challenges they are likely to encounter. Unfortunately, the historical division between housing and health/human services sectors does not make this type of collaboration easy. The following section highlights some of the more common challenges of integrating supportive services into existing subsidized housing.

**Funding Constraints**

Obtaining funding adds another layer of complexity to this already challenging process. Getting funding for the upfront costs of development, such as a feasibility study, tenant needs assessment, and
market studies can be a major roadblock for subsidized housing providers (Milbank Memorial Fund, 2006). Acknowledging the barriers and the funding constraints faced by housing providers wishing to incorporate services, in 2000 HUD came out with a program called the Assisted Living Conversion Program (ALCP) (Perl, 2008). ALCP provides grants to convert some or all units in an existing housing development into an Assisted Living Facility (ALF). Retrofitting a building to make it more accessible for older adults, while meeting the regulatory requirements associated with licensure for assisted living, can be a complicated and expensive process (Redfoot and Kochera, 2004). ALCP grants can be used toward the development process and any necessary unit remodeling, they cannot, however, cover the costs of service provision. In order to receive ALCP funding, applicants must first demonstrate commitments from other funding sources to support service provision (Stone, Harahan and Sanders, 2008). To complicate things further, ALCP projects are required to obtain licensure upon completion, however in most cases assisted living licensure will not be granted until a facility is fully operational. If a housing provider is not able to coordinate conflicting construction, licensure and funding requirements, they risk losing ALCP funds (Pynoos et al, 2004). Despite its availability, very few subsidized housing providers have taken advantage of ALCP. In its first five years ALCP has assisted with the conversion of only 2,318 units in publicly subsidized properties (Stone, Harahan and Sanders, 2008). Some researchers attribute the low utilization of ALCP to the difficulties in obtaining Medicaid waiver funds, as well as a general reluctance of many housing providers to operate licensed assisted living facilities (Stone, Harahan and Sanders, 2008).

As mentioned above, obtaining adequate funding to cover the provision of services is often another major roadblock. Housing providers have few resources to invest in resident services and in most cases, subsidies and funding sources must be creatively patched together to acquire adequate funds to pay for service provision (Stone, Harahan and Sanders, 2008). With few exceptions, housing
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Subsidies cannot be used to pay for health or supportive services. The same rule applies to most health and human services programs, particularly at the federal level. Medicaid, the Older Americans Act and the Social Services Block Grant cannot be used to supplement an individual’s rent (Stone, Harahan and Sanders, 2008). Even if a housing provider is able to secure funding for services, there are concerns that such funding may be unreliable over time (Pynoos, et al, 2004). Restrictive funding policies and lack of certainty make it quite difficult for housing providers to piece together enough funding to make on-site service provision feasible.

Medicaid’s 1915(c) Home and Community Based Services (HCBS) Waiver has begun to be widely used in some states, including Oregon, to pay for supportive services for low-income older adults. Oregon is one of 37 states that utilizes the HCBS waiver to cover the costs of services in residential settings (Mollica, 2009). A number of other states have effectively used this waiver to integrate services into independent housing; however certain regulatory barriers must be addressed in order to do so. In other states, including Alaska, Michigan, and New Hampshire, subsidized housing providers have successfully utilized Housing Choice Vouchers (formerly called Section 8) in conjunction with Medicaid waivers to fund an assisted living type model for adults who would otherwise have to relocate to skilled nursing facilities (Mollica, 2009).

Regulatory and Coordination Issues

There are a handful of other coordination issues that make it very challenging to link housing and service subsidies. For one thing, housing subsidy programs and Medicaid generally do not have the same eligibility criteria. Housing subsidies are typically tied to the local area median income whereas Medicaid is generally based on eligibility for Supplemental Security Income (Redfoot and Kochera, 2004). Other problems may arise when attempting to make services available to all residents in an existing building. For example, Medicaid requires that recipients of the HCBS waiver be nursing home eligible.
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and clearly not all residents of an existing building will meet those criteria. Though the residents may all be low-income, they will only be eligible for services through the HCBS waiver if Medicaid deems them nursing home eligible.

While not comprehensive, these few examples illustrate how complicated it can be to link housing and services in existing subsidized housing. To bring all of the pieces together successfully, many of the existing models have required special agreements and compromises between state Medicaid administrators and local housing providers. Below are a few examples of programs that have effectively integrated a comprehensive set of services into existing subsidized housing.

**Case Studies**

*Helen Sawyer Plaza*
*Miami, FL*

One of the earliest examples of an existing subsidized housing development converting into a licensed assisted living facility was the Helen Sawyer Plaza, a 104 unit building constructed in 1976. In 1999 the Miami-Dade County Housing Authority acquired HUD funding to modernize the existing structure in order to make it accessible for older residents. Prior to completing the building’s remodel, the housing authority was able to obtain a license from the State of Florida to operate as an assisted living facility, with the cost of services covered by a special state Medicaid waiver allocation. The waiver pays for a variety of resident services, including medication supervision, personal care, and other supportive services primarily provided by on-site staff (Stone, Harahan and Sanders, 2008). Though the program was ultimately a success and still exists today, its creators acknowledged that various levels of government with differing objectives, timelines and funding streams made this a very complex process (Milbank Memorial Fund, 2006).

*Neville Place*
*Cambridge, MA*
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Neville Place is a development of Neville Community Partners, a consortium of Cambridge-based housing and health organizations led by the Cambridge Housing Authority (CHA). Neville Place opened in 2001 as a mixed-income, 71-unit (57 low-income and 14 market rate) assisted living facility (Senior Living Residences, 2009). Through an innovative partnership, Neville Place utilizes Housing Choice Vouchers (Section 8) and the Massachusetts Medicaid Waiver program to provide both housing and services to low-income older adults. The on-site services are provided by a licensed and experienced provider in the community. Some of the services include daily meals, laundry services, housekeeping, dementia care, medication monitoring, personal care, scheduled transportation and recreational activities (Milbank Memorial Fund, 2006).

*Herbert T. Clark House*
*Glastonbury, CT*

The Herbert T. Clark House is a project of the Housing Authority of the Town of Glastonbury, Connecticut. The residence is made up of 25 apartments with a level of care consistent with assisted living. It is adjacent to a 45-unit building, also owned by the Glastonbury Housing Authority, which offers congregate housing with a less intensive level of service provision (Glastonbury Housing Authority, 2009). Similar to Neville Place, the supportive services at the Clark House are provided by an outside agency licensed to provide assisted living services. All apartments are affordable to older adults whose household income is less than 60% of the Area Median Income (AMI), with several units available to households with incomes between 25-50% AMI (Glastonbury Housing Authority, 2009). Funding for services comes from a variety of sources including Medicaid’s HCBS waiver program, Connecticut’s Home Care Elder Program and a special subsidy from the Connecticut Department of Economic and Community Development. Utilizing these various funding sources has allowed for greater flexibility in terms of participant eligibility. Project development costs were also creatively patched together using a
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number of sources including Low Income Housing Tax Credits (LIHTC) and tax-exempt bonds through the Connecticut Housing Finance Agency (Glastonbury Housing Authority, 2009).
Considerations and First Steps for the Housing Provider
Created by Andreé Tremoulet, PhD

An existing housing provider sees that its population is starting to develop more complex needs and wants to investigate how to bring a more intensive level of personal assistance and health services to its residents. What are the potential steps that the housing provider might follow?

1. Medicaid eligibility of existing population
   - How many residents are eligible to receive Medicaid?
   - How many residents are currently receiving services through a Medicaid HCBS waiver?
   - **Potential Barriers**: Can housing provider ask this question of residents? Can County provide this information directly to housing provider? Are information releases needed for County to provide this info?
   - **Possible Intervention**: Can County staff or service provider schedule an info session and/or targeted outreach at the housing complex to help develop a baseline of information and to assess who/how many might be eligible for Medicaid and HCBS waiver? Can special arrangements be made with Oregon DHS to cover certain service costs for all residents of a building (something similar to CHSP)?
   - **Cost Issue as Potential Barrier**: Does this research fall within the scope of existing County or housing provider employee skillsets and duties, or is an outside social worker required? Could a partnership be formed with a service provider (such as Impact Northwest or VNA or even a medical institution near the housing) to do this research and preliminary assessments, with the understanding that this organization would get the contract for providing services within their capabilities to provide?

2. Service needs of population
   - Collectively, what array of planned services (not “on-demand” services) is needed by the population in the housing complex? How many people would utilize each service?
     - Hotel services: meals, laundry, transportation, light housekeeping, recreation
     - Personal assistance services: bathing, dressing, feeding oneself, financial management
     - Skilled care: medication management, health services coordination, nursing oversight
   - Which services will Medicaid cover and for which residents? How much revenue will this generate?
   - What services cannot easily be met at an unlicensed facility?
     - “On-demand” services like toileting
     - Getting in and out of a bed or chair
     - Dementia care?

3. Site potential and limitations
   - Which of the services would require modifications to the existing site? How costly/feasible are these? What are possible sources of funds for this?
   - Which services cannot be provided due to site limitations?
4. **Budget development**

- One-time capital costs for modification
- Service cost models—reimbursement rates, break-even points.

5. **Collaborative Structure**

- Clear roles and “boundaries” for each of the partners (service provider and housing provider)
- Contract
- Policies and procedures
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