During a recent field visit for Multnomah County Aging and Disability Services, I arrived at a large apartment complex in inner Northeast Portland, where I found Mr. J waiting in the lobby, pleasantly greeting everyone who entered. Famous in the building for his bushy beard and jovial laugh, Mr. J is a 65 year-old formerly homeless veteran with several chronic health conditions as well as recently developed blindness. As a new resident of the Congregate Housing Services Program, Mr. J rents a government-subsidized apartment that comes with the additional services of daily meals, housekeeping and a bath aide. Through this program, Mr. J has been able to progress from sleeping on the streets to living in an affordable and safe environment that provides essential connections to health and social service supports.

Mr. J is an example of one of many income-challenged older adults with chronic conditions who has faced serious concerns about housing stability. In 2008, as many as 2 million households were headed by an adult over 62 years old who received rental assistance or resided in subsidized public housing (Haley & Grey, 2008). Along with the concerns about serving the rapidly growing aging population, the needs of low-income elders are quickly becoming important considerations for policy makers. Continued development of programs that provide affordable housing with added support services is crucial for at-risk elders who have limited natural support systems and lack the resources to access care in a traditional fashion (Gibler, 2003).

Program components

Affordable housing plus service initiatives are models of care that are characterized by integrated multi-unit public housing for seniors with added health and social support services (Harahan, Sanders & Stone, 2006). The ultimate goal of these models is to allow older residents to stay independent and "age in place" for as long as possible with added provisions to meet
specific needs. Support services include but are not limited to: on-site or delivered meals, housekeeping, personal care, transportation, medication monitoring, case management and service coordination. Such services can be delivered within these housing projects as a package of services or offered individually based on need or desire (Harahan et al., 2006).

Affordable housing programs which offer service combinations are generally federally subsidized and may be supported under grant funding from Housing and Urban Development Section 202, which is specifically geared toward providing affordable housing for senior citizens (Hooymann & Kiyak, 2008). Since 1959, HUD has provided private and public housing complexes with advance funding to establish physically appropriate structures and rental subsidies for adults over the age of 62 (Haley & Grey, 2008). Though Section 202 doesn't pay directly for the support services within buildings, it provides a funding base for well-designed and age-friendly living environments.

It is common that non-profit organizations act as the management for affordable housing plus programs, screening eligible participants and maintaining the residents as part of a caseload under the agency umbrella (Gibler, 2003). This is the case for clients such as Mr. J, a client of the Congregate Housing Service Program, one of four buildings which are co-managed by a local non-profit agency (Impact Northwest) and the Housing Authority of Portland. Clients such as Mr. J are supported by a subsidized housing plus strategy defined as "enriched services and service coordination" (Harahan et al., 2006). For this type of service delivery, potential clients are assessed prior to entering the housing complex to determine individual needs. This helps the agency determine the type of support that will be the most effective to keep the client independent, safe and cared for after they move in. In these programs, in-house service coordinators do the bulk of the assessment and referrals, adjusting to resident changes as necessary.

Due to the fact that the vast majority of older adults (95%) in public housing live alone, the need for a support system within the subsidized housing is immense (Black et al., 1999).
For older adults who have limited funds and declining health, services they receive through housing programs may be essential for well-being and autonomy. In addition, most public housing for elders is located in urban areas, generally in the central part of the city (Gibler, 2003). This may present added barriers for frail elders; independently navigating an urban environment in order to access resources could be overwhelming.

By offering comprehensive service planning, programs that provide affordable housing plus services are responding to the growing number of low-income elders that may find themselves losing independent capabilities due to lack of assistance combined with housing and financial insecurity (Harahan et al, 2006). Programs such as congregate housing services have also been proven to dramatically reduce costs associated with community-based long-term care for at-risk elders (Stone, Sanders & Coffey, 2009).

**Program Recipients**

Older adults who reside in public housing are often lacking natural supports such as family or friends who are able to assist them with their care needs. The majority of these residents are women in their 70’s or 80’s that have physical or cognitive limitations that require on-going attention (Golant, 2003). Isolation and long-term avoidance of tending to health concerns may present added barriers to the well-being of the older public housing population. In 2008, the median age within Section 202 housing was 76 years old and demographic information from 2006 reveals that nearly 20% of incoming public housing residents were over 80 years old (Stone et al., 2009).

Self-rated health has been found to be lower in the population of older adult public housing residents, as has the amount of positive social contact that they experience (Black et al., 1999). 80% of older adults in the general population are affected by chronic conditions; isolated community-dwelling elders may face higher likelihood of impaired functioning due to lacking supports (Harahan et al., 2006). Older residents of public housing, often considered at increased health risk, are affected by a variety of chronic health conditions.
The most common health-compromising issues for these residents include diabetes, arthritis, Parkinson's disease, cancer, cardiovascular problems and incontinence (Gibler, 2003). Due to these concerns, this population is at increased risk of health complications that can result in emergency room visits and premature nursing home placement, especially if they are not connected to services in a timely manner (Fischer, 2003). In addition to physical health concerns, rates of mental health problems including depression, anxiety, delusions and dementia-related issues are also higher in the populations of older subsidized housing residents (Rabins et al., 1996).

On top of chronic physical and mental health concerns, life-long disparities in income levels also play a role in the lives of many of these residents. Because these residents are primarily older women or minorities, traditional or sufficient retirement benefits are not likely to be in place during late-life (Gibler, 2003). Residents of public housing are also unlikely to have the ability to pay privately for in-home care. For those who faced problems accessing healthcare in their younger years, limitations in knowledge about medical systems may also present problems.

Many older adult renters are living on very limited means; Social Security may be the only income that they receive. Some residents receive retirement or pension payments, but few have other resources available to cover the costs of care. Medicaid clients comprise a large number of the residents in subsidized housing (V. Kennedy-Scott, personal communication, May 26, 2010). Subsidized older adult residents of public housing pay between 30-50% of their adjusted gross income for rent; the federal government covers the remaining costs (Hooyman & Kiyak, 2008). In 2006, the median annual income of Section 202 renters was $10,000, which is well under the financial eligibility requirements for subsidized rent (Haley & Grey, 2008).

Program Access, Quality and Financing

Affordable housing plus services are often co-located with other services provided through the Older Americans Act. Centers that provide health and wellness services,
congregate meal sites and other senior programs can often be found either on or nearby the premises of government-subsidized housing facilities (Stone et al., 2009). Intentionally locating housing plus initiatives near community service locations assists in linking frail elders with care in an effective manner, especially for those with mobility issues. In-house service coordination is particularly helpful in identifying needs that residents face; this is illustrated by the congregate housing model of directly connecting residents to services. Strategic location also makes it easier to access and serve large groups of those eligible for Older Americans Act provisions within a particular geographic area.

It is common for Medicaid or other case managers to refer clients to alternative housing that has added support services when service needs increase and housing becomes unaffordable (V. Kennedy-Scott, personal communication, May 26, 2010). Congregate care residents access housing plus services through a referral that begins with an initial screening to determine their fit for the program; care plans are subsequently tailored to individual needs. This generally provides more streamlined care and appropriate interventions for vulnerable community dwelling elders. In the case of Mr. J, who had previously resided in public housing without added supports, individualized attention and referral to an appropriate combination of services was an essential connection to care that will keep him off of the streets and living safely.

Subsidized housing for elders is often physically appropriate, yet with a lack of health and social support the possibility for aging in place throughout a trajectory of decline is dramatically reduced (Black et al., 2003). Section 202 grants are allocated to housing programs that aim to construct, renovate or adjust multi-unit complexes in order to better suit the needs of frail elders. While Section 202 does not specifically pay for the added supports, it sponsors the bulk of the initial costs for creating appropriate housing for frail elders, housing that is conducive to aging and in place and anticipated physical decline (Haley & Grey, 2008). Environmental adaptations include the appropriate placement of ramps, grab bars, and the inclusion of
wheelchair accessible units in post-1990 buildings (IFAS website, accessed 6/1/10). Waiting lists for Section 202 housing tend to be long due to the high numbers of older adults that are in need of physically appropriate and affordably priced housing options (HUD website, accessed 6/1/10).

Residents of affordable housing programs pay rent based on income guidelines; services that are offered within public housing may be paid for through Medicaid home and community based service waivers. In some cases, the cost of providing added supports may be written into the budget of the agency running the housing complex (Harahan et al., 2006). It has shown to be very cost-effective long-term to provide services, especially health and wellness related, within public housing. In particular, preventative health services impact the future spending on emergency medical care visits and premature nursing home placements (Fischer, 2003).

**Policy relevance and future directions**

As the aging population continues to boom and the needs of at-risk elders becomes a major issue, programs will need to continue to develop and improve services within public housing. With older adults living longer with more chronic conditions, the strain on the Medicare and Medicaid system will increase substantially in the years to come (Stone et al., 2009). Responding to the needs of at-risk older adults in the community will be essential to reducing government and private costs of care and avoiding unnecessary movement to restrictive levels of care (Golant, 2003).

Decreased institutionalization is an essential goal for policy makers that seek to reduce government expenditures on nursing facilities; with the older adult population expected to double in the next 20 years, anticipatory measures will become even more important (Gibler, 2003). Increasing and improving services in public housing has also been proven to reduce negative health outcomes, promote independence and dignity, and help many residents age in place successfully (HUD website, 6/1/10).
Useful data and evaluation of current models within Section 202 and related housing will help to guide the direction of services for years to come. Demographic trends reflecting changes in entry age, functionality and needs of older public housing residents provide essential information about how to best design and deliver services to an at-risk community-dwelling population.

As part of a focused initiative to expand affordable housing plus services, the Institute for the Future of Aging Services recently released a report on several innovative models of delivery currently in the U.S. (Stone et al., 2009). Within this report, the common theme among successful health support services in public housing was that of bringing the care directly to the people. It was determined that on-site clinics and regular visitation from nurse practitioners, occupational and physical therapists improved health outcomes for residents living in locations that offered such services (Stone et al., 2009).

Additional recommendations included partnerships between health professional schools and public housing locations. Several programs have developed clinical sites for health student rotations that are located in buildings; this has been very successful in motivating residents to keep appointments and comply with health-related recommendations. This also helps to expose health professionals to geriatric medicine, hopefully attracting more aging specialists to the field as the older adult population grows. Within these delivery models, service coordinators within housing program maintain regular communication with the health care professionals, alerting them to changes in the status of the residents (Stone et al., 2009).

Preventative services are especially promoted as important components in the future development of housing plus services. Community outreach and health promotion programs that encourage older adults to increase exercise or improve health behaviors (medication compliance, for example) hold promise for reducing decline in populations of at-risk elders (Stone et al., 2009). Many education programs are based on models of peer support, where a resident is trained to lead groups of other tenants in learning about health related topics.
Helping residents develop leadership and peer support within buildings also assists in creating healthy and socially connected aging communities (Harahan et al., 2006).

Though innovations in supportive services for public housing residents have been rapidly developing, advocates for at-risk elders insist that the political response to this issue is not adequate (Golant, 2003). The social, health and cost benefits of promoting and implementing supports in affordable housing have been recognized by many organizations that research best practices for helping frail elders retain independence. With increased advocacy and awareness, the issues that low-income elders face can be brought to the public and political eye. Organizations such as the Institute for the Future of Aging Services advocate for the increased speed in developing and implementing effective programs for older public housing residents (IFAS website, accessed 6/1/10).

Affordable housing plus initiatives are focused on promoting some of the highest cultural values in our society. With optimism, I look forward to observing future development and working within aging service systems to promote these very values: dignity, autonomy and the right to live in a healthy and safe environment, even for those who may face declining health and increased disability.
References


Websites:
