



# Public Housing and Supportive Services for the Frail Elderly: A Guide for Housing Authorities and Their Collaborators

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The Council of Large Public Housing Authorities is a national nonprofit organization that works to preserve and improve public and affordable housing through advocacy, research, policy analysis, and public education.

Printed in the United States of America.

ISBN 978-1-887748-66-7

*Design and Typography:*  
The Boland Design Company

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## FOREWORD

This report translates into practical advice the experience of public housing authorities in creating housing with supportive health and social services for elders. It summarizes the experience of employees of these authorities and their collaborators in state and local public and nonprofit service agencies.

The Council of Large Public Housing Authorities (CLPHA) and the Milbank Memorial Fund collaborated to write and publish the report. CLPHA is a national nonprofit organization that works to preserve and improve public and affordable housing through advocacy, research, policy analysis, and public education. The Fund is an endowed operating foundation that has worked since 1905 to improve health by helping decision makers in the public and private sectors acquire and use the best available evidence to inform policy for health care and population health.

Public housing is the ideal laboratory in which to find ways to allow seniors to age in place. Elderly households represent 31 percent of the nation's approximately 1.1 million public housing households. Of the seniors in public housing, 16 percent are over the age of eighty-two.

This report will be of benefit to people both inside and outside of public housing. According to persuasive research, approximately half the population born between 1946 and 1964 is at risk of having incomes that will not meet their needs as they grow older. These Americans will have difficulty paying out-of-pocket costs for health and long-term care as well as meeting their minimum need for food, housing, and essential transportation. Moreover, most American seniors, like those in public housing, prefer to live in their own homes as long as possible, even as they become progressively, though intermittently, frailer as a result of the convergence of biological aging and chronic disease. Creating and maintaining more housing with supportive services will be needed to meet these demands. It will require more public funds, but at the same time will reduce demand for Medicaid financing for health and long-term care.

Work on the report began in 2000, after Daniel J. Wuenschel, then Executive Director of the Cambridge Housing Authority, participated in a meeting of decision makers about affordable assisted living convened by the American Association of Homes and Services for the Aging and the Fund. At his invitation, Dan Fox, the President of the Fund, visited housing that had been renovated for seniors by the Authority. The housing also provides residents with health and social services through collaboration with public and nonprofit agencies.

Wuenschel suggested to his colleagues in CLPHA that they join the Fund in preparing a guide to developing and managing senior public housing with supportive services. CLPHA and the Fund organized work groups on housing renovation, licensing requirements and issues of choice and safety, and planning and programs of health and human services. Msgr. Charles Fahey and Charles Palmer, program officers of the Fund, wrote several drafts of the guide and revised them following review by members of the work groups and the steering committee.

Members of the steering committee and the work groups are listed in the Acknowledgments along with staff of CLPHA and the Institute for Social and Economic Development who assisted in

the project. Because the guide is grounded in their first-hand experience, we recommend it to anyone interested in providing housing and supportive services for low-income seniors.

Daniel M. Fox  
President  
Milbank Memorial Fund

Sunia Zatterman  
Executive Director  
Council of Large Public Housing Authorities

## ACKNOWLEDGMENTS

The following persons participated in meetings and work groups and/or reviewed this report in draft. They are listed in the positions they held at the time of their participation.

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Public Housing Authorities, Washington, D.C.; Sara Lindholm, Project Manager, Illinois Affordable Assisted Living Initiative; Bobbi Marsells, Assistant Secretary, Housing Authority of the City of Milwaukee, Milwaukee, Wis.; Larry McNickle, Director, Housing Policy, American Association of Homes and Services for the Aging, Washington, D.C.; Elisa Minoff, Research Fellow, Council of Large Public Housing Authorities; Frederick Murphy, Executive Director, Syracuse Housing Authority, Syracuse, N.Y.; David Nolan, Managing Director, NCB Development Corporation, Oakland, Calif.; Stephen Norman, Executive Director, King County Housing Authority, Tukwila, Wash.; Tara O'Neill, Research Associate, Council of Large Public Housing Authorities; Dean Painter Jr., President/Chief Executive Officer, the Eaton Terrace Group, Lakewood, Colo.; Tony Perez, Executive Director, Housing Authority of the City of Milwaukee, Wis.; Steven D. Pierce, Executive Director, Massachusetts Housing Finance Agency; Don Redfoot, Senior Policy Advisor, AARP, Billings, Mont.; Susan Reinhard, Executive Director, Center for Medicare Education, American Association of Homes and Services for the Aging, Washington, D.C.; Debra Roane, Director, Programs and Services, AAHSA Development Corporation, Washington, D.C.; Rene Rodriguez, Department Director, Miami-Dade Housing Agency, Miami, Fla.; Lyle Schumann, Deputy Executive Director, Housing Authority of Baltimore City, Baltimore, Md.; Michael Siewert, Research Director, Housing Research Foundation, Washington, D.C.; Rod Solomon, Deputy Assistant Secretary for Policy, Program and Legislative Initiatives, Office of Public and Indian Housing, Washington, D.C.; Virginia Spencer, Executive Director, Housing Research Foundation, Washington, D.C.; James Steiner, Director, Assisted Living, National Equity Fund, Inc., St. Paul, Minn.; Robyn I. Stone, Executive Director, Institute for Policy Research, American Association of Homes and Services for the Aging, Washington, D.C.; Peter Sybinsky, Director of Provider Relations, TennCare, Tennessee Department of Finance and Administration; Harry Thomas, Executive Director, Seattle Housing Authority, Seattle, Wash.; Arturo Tigera, Director, Housing Development Division, Miami-Dade Housing Agency, Miami, Fla.; Julio Urbina, Senior Program Officer, the Fan Fox and Leslie R. Samuels Foundation, New York; Joan Wagnon, Mayor of Topeka, Mayor's Office, Topeka, Kans; and Daniel J. Wuenschel, Executive Director, Cambridge Housing Authority, Cambridge, Mass.

## GLOSSARY

**Activities of Daily Living (ADLs):** ADLs refer to the basic tasks of everyday life, such as eating, bathing, dressing, toileting, taking medications, and moving.

**Acute Care:** Care for illness or injury that has developed rapidly, has pronounced symptoms, and is finite in length.

**Adult Day Care:** A weekday, daytime community-based program of activities designed to promote well-being through social and health-related services in a safe, supportive, cheerful environment. A social adult day care setting differs from adult day health care (ADHC), which usually requires a health assessment by a physician before someone is admitted into the program. ADHCs often provide physical, occupational, and speech therapy, and are usually staffed with an RN and other health professionals.

**Aging in Place:** The concept of allowing older persons to remain in the same place as their care needs change, rather than requiring a move to another type of facility.

**Area Agencies on Aging (AAAs):** Local organizations in communities across the country that plan, coordinate, and support a wide range of home- and community-based services, including information and referral, home-delivered and congregate meals, transportation, employment services, senior centers, adult day care, and long-term-care ombudsman programs.

**Assisted Living Facility:** A facility for people needing assistance with activities of daily living (ADLs) but wishing to live as independently as possible for as long as possible. Assisted living exists to bridge the gap between independent living and nursing homes. Residents in assisted living centers are not able to live by themselves but do not require constant care either. Assisted living facilities offer help with ADLs, and many also have centers for medical care; however, the care offered may not be as intensive or available to residents as the care offered at a nursing home. Assisted living is not an alternative to a nursing home, but an intermediate level of long-term care appropriate for many seniors.

Most assisted living facilities create a service plan for each individual resident upon admission that details the personalized services required by the resident and guaranteed by the facility. The plan is updated regularly to assure that the resident receives the appropriate care as his or her condition changes.

The term used for assisted living facilities differs across the country. Other common terms for these facilities include: adult congregate living care, adult foster care, adult homes, adult living facilities, board and care, community-based retirement facilities, domiciliary care, enhanced care, personal care, residential care, retirement residences, sheltered housing, and supported care.

**Care/Case Management:** Assessment and coordination of the overall care needs of a person, including both medical and social needs.

**Caregiver:** A person, either paid or voluntary, who helps an older person with the activities of daily living, health care, and financial matters and provides guidance and social interaction.

**Community-Based Services:** A variety of supportive services delivered in community settings designed to help older persons live as independently as possible. Services may include case management, meals, companionship, adult day care, and senior centers.

**Congregate Meals:** Program providing older persons with free or low-cost nutritionally sound meals in easily accessible locations.

**Home Health Care:** Care provided to individuals and families in their place of residence for promoting, maintaining, or restoring health or for minimizing the effects of disability and illness including terminal illness.

**Home Modification:** Adaptation and/or renovation to the living environment intended to increase ease of use, safety, security, and independence. Modifications that would make a home or facility more accessible include widening doorways, adding wheelchair ramps, and adding hand rails in bathrooms.

**Home-Based Services:** A variety of supportive services delivered in an older person's home designed to help him or her live as independently as possible. Services may include case management, meals, companionship, and housekeeping.

**Hospice:** A program of palliative and supportive care services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones. Hospice services are available in home and inpatient settings.

**Instrumental Activities of Daily Living (IADLs):** IADLs refer to activities related to independent living and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

**Lease-up Reserve:** An amount, either paid in capital or funded through a loan, that anticipates an initial occupancy vacancy.

**Long-Term Care:** A general term that describes a range of medical, nursing, custodial, social, and community services designed to help persons with chronic health impairments or forms of dementia.

**Long-Term-Care Ombudsmen:** People who work cooperatively with nursing homes and board and care facilities to improve the quality of life for residents. They serve as residents' rights advocates,

investigating and negotiating resolutions to concerns voiced by residents in matters of resident services and care.

**Medicaid:** A joint state-federal health benefit program administered by states for persons with low incomes. Program eligibility, services offered, and financing vary widely from state to state.

**Medicare:** A national health insurance program for eligible people sixty-five and older and some disabled persons.

**Moving to Work:** An experimental program that provides funding and regulatory flexibility to select public housing authorities to allow them to better address local needs.

**Nursing Home:** A state-licensed health care facility that is staffed with nurses around the clock and a physician on call and that has approved procedures for maintaining medical records and administering medications.

**Out-of-Pocket Cost:** The amount of a medical bill that is not covered by Medicare, Medicaid, insurance, or other third-party payers.

**Personal Care:** A level of care addressing deficits in the activities of daily living and instrumental activities of daily living. Such care is intended to maintain and support an existing level of health, rather than to cure or rehabilitate.

**Public Housing:** Federal program offering housing assistance to low-income households.

**Public Housing Authorities (PHAs):** Independent agencies established by localities to develop, own, and manage housing for low-income populations.

**Public Housing Developments:** Affordable housing units owned and operated by public housing authorities.

**Skilled Care:** A level of care that is prescribed by a doctor and requires the training, skills, and twenty-four-hour-a-day supervision of a registered nurse.

## EXECUTIVE SUMMARY

Public housing is the largest federal program offering housing assistance to low-income elders. For many, it offers a form of security every bit as indispensable as their retirement income. It can be their only bulwark against fear of homelessness, institutionalization, and isolation.

But the elderly resident population is changing radically, bringing new challenges to public housing providers. These residents are not only poorer than the general senior population, they are also older, disproportionately minority and female, and more likely to be alone.

At the same time this population is increasing, the ability of housing authorities to provide appropriate facilities is decreasing. Public housing did not originally target older Americans at all. The situation began to shift in 1956 when Congress for the first time gave preference to seniors in public housing. Throughout the 1960s and 1970s, a large number of developments were built specifically for low-income seniors. With very few exceptions, these were traditional apartments. While adequate for the majority of low-income older residents, this housing does not provide the flexibility to allow residents to age in place, nor does it necessarily provide the range of housing options needed to serve the increasing share of frail seniors.

A significant portion of public housing for the elderly is rapidly becoming physically and functionally obsolete. Most developments are simply not equipped to meet the residential and supportive service needs of their increasingly frail and diverse residents. Without these services, the only alternative can be moving people into costly, isolated institutions. People can be devastated by unnecessary institutionalization, and services provided in nursing homes are also far more costly than those offered in other settings.

Public housing authorities (PHAs) across the country are, however, finding innovative ways to serve these tenants. PHAs are building partnerships with nonprofit organizations and with state and local service providers. They are finding new ways to raise capital for modernization and development, creating models that can guide other housing authorities grappling with similar situations.

This report offers an overview of supportive housing for housing authorities who are adopting new approaches in order to meet the needs of their elderly tenants.

The first section of the report describes three case studies of successful developments planned by housing authorities to address the needs of their rapidly aging populations. In Miami, Cambridge, and Milwaukee, public housing authorities designed programs that were place-specific: they responded directly to the characteristics of their local elderly populations; they worked with local and state organizations to leverage money for the developments; and they partnered with service providers to fill in the gaps in local senior services and offer a full spectrum of care to the elderly.

The second section, “Developing Supportive Services in Public Housing: Getting Started,” offers advice on gauging local need and designing and evaluating projects. This section outlines in detail the benefits and disadvantages of different program designs, such as working with service providers or offering services internally; concentrating supportive services in one development or dispersing them over several sites; offering “a la carte” services or service packages; and making meal programs mandatory or optional.

The third section, “Service Delivery,” summarizes the different types of supportive services that may be provided at a public housing site. Services can range from the relatively less-intensive care management model, which typically includes counseling and service referrals to residents, to the very intensive Program of All Inclusive Care for the Elderly (PACE), which typically offers an adult day care center supplemented by in-home and referral services.

The fourth section, “Regulatory Requirements,” helps housing authorities navigate state and federal regulations for assisted living facilities.

The final section, “Funding Assisted Living,” lists different funding sources available for public housing assisted living developments. PHAs may receive funding through the U.S. Department of Housing and Urban Development (HUD), as well as through other federal departments. Leveraging public housing assets may also serve as a source of funding, either by donating land for a tax write-off or by creating mixed-income developments. The section also describes how Medicaid funding can be used to pay for services.

Appendix A includes a checklist of specific issues to be addressed during project design, which might help PHAs in the first stage of planning a development for seniors. Appendix B lists a variety of information sources, including project models, websites, and suggested reading.

## CASE STUDIES

### HELEN SAWYER PLAZA

In 1999, the Miami-Dade Housing Agency (MDHA) opened the nation's first licensed assisted living facility in public housing, the Helen Sawyer Plaza Assisted Living Facility. Combining services and public housing allowed MDHA to transform an underperforming property to a very successful development that provides its low-income elderly residents with much needed services.

As early as 1976, MDHA provided meals to residents of Helen Sawyer Plaza; however, in 1995 the congregate meal service was discontinued. The lack of meal service and other services meant that many residents had to be transferred to nursing homes when it became impossible for them to continue living independently. Because of these circumstances and declines in the surrounding neighborhood, Helen Sawyer had an occupancy rate of just 30 percent in the mid-1990s.

MDHA's goal was to meet the physical and emotional needs of elderly public housing residents and allow them to age in place. The housing authority also wanted to find a way to improve its use of Helen Sawyer. With the help of a consultant, the MIA Consulting Group, Inc., MDHA created a plan to convert the building to an assisted living facility.

Because the physical structure was sound, modernization needs were relatively modest: approximately \$4,800 per unit was spent in rehabilitation. Securing all of the licenses required to operate an assisted living facility in public housing was more complicated. MDHA had to work with officials from the state of Florida to receive an assisted living facility license. Next, MDHA had to work with the state to get a waiver making Helen Sawyer's assisted living services eligible for Medicaid funding reimbursement.

Helen Sawyer Plaza is located within walking distance of three hospitals and 180 community and government agencies. The eight-story building has 104 units—83 efficiency units and 21 one-bedroom units—with air conditioning and balconies.

All residents are low-income. Units are affordable at 50 percent of area median income, and all units receive rental subsidy through MDHA's Public Housing Operating Subsidy fund. Residents must be eligible for Medicaid and at risk of being placed in a nursing home. Medicaid waivers cover the costs of services for 63 percent of residents. Additional funding is provided by the Optional State Supplement to Supplemental Security Income (SSI). Approximately 6 percent of funding annually is in the form of private payments made by the residents.

Helen Sawyer Plaza provides a variety of services to residents, including bathing, grooming, feeding, physical therapy, transportation services, and medication assistance. Three meals are provided per day, and thirty hours of activities are available each week. There is twenty-four-hour supervision on-site.

The costs of operating Helen Sawyer Plaza are covered by the following funding sources:

- Optional State Supplement to SSI (41 percent)
- State Sponsored Medicaid Waivers for Services (29 percent)
- HUD Operating Subsidy (18 percent)
- HUD Utility Subsidy (6 percent)
- Private-Pay (6 percent)

MDHA partnered with various organizations to bring Helen Sawyer Plaza to fruition, including:

- State of Florida Department of Elderly Affairs
- MIA Consulting Group, Inc.
- Miami-Dade County (which renovated abandoned buildings in the area and improved transportation access to the site)

#### **NEVILLE PLACE**

In the mid-1990s the Cambridge Housing Authority (CHA) was facing a potential crisis: an aging and increasingly frail low-income elderly population with little affordable supportive housing to serve these residents. While elderly populations were aging rapidly across the country and many cities were facing similar shortages, Cambridge's problem was particularly acute. Because residents of CHA elderly housing had moved in when the developments were built, they were aging together as a group. As of 1998 the authority housed eighteen hundred elderly households, with an unusual proportion of very old residents: 29 percent were aged seventy-five to eighty-four, and 10 percent were eighty-five or older.

As the elderly population aged, many residents were finding basic activities of daily life difficult and needed to leave CHA housing for nursing homes. Between 1996 and 1998, more than 40 percent of the residents over the age of sixty-two who moved out of elderly housing left because they had difficulty living independently. These low-income residents had very few places to go. As of August 1999, there were 246 assisted living or supportive housing units for frail elderly in operation in Cambridge. Of these, only 37 units were designated for low-income residents.

To address the significant shortage of affordable supportive housing, CHA planned developments that would create a citywide continuum of care for the frail low-income elderly. CHA began employing service coordinators in some of its elderly housing developments and offering meal programs and more comprehensive services in others. CHA's plans culminated in Neville Place, a mixed-income assisted living facility that is part of a senior living campus developed around Fresh Pond, an area originally landscaped by Frederick Law Olmsted. The state-of-the-art facility opened its doors to seventy-one residents in 2001 and offers daily meals; twenty-four-hour on-site personal care and assistance; a full program of social, educational, cultural, and wellness activities; and extensive amenities including walking paths, common spaces, outside patios, and a beauty parlor. Neville Place serves a wide range of needs and has a specialized residential program catering to individuals with memory loss and early-stage Alzheimer's. Residents also have access to the skilled nursing center next door, which was also built by CHA and offers short-term rehabilitation and long-term care. Neville Place's seventy-one units include:

- Thirty-four efficiencies, twenty-four one-bedroom units, and thirteen Alzheimer's units
- Thirty-nine low-income units, eighteen moderate-income units, and fourteen market-rate units

Low-income residents pay their monthly fees through a combination of HUD Section 8 vouchers, SSI, and the Massachusetts Medicaid Group Adult Foster Care Program. Low-income residents with Medicaid pay approximately between \$200 and \$300 in rent. Those without Medicaid pay between \$1,200 and \$1,300. Market-rate units range from \$2,700 to \$3,200.

Neville Place is managed by Senior Living Residences, an experienced assisted living service provider. A director, social worker, activities director, and a part-time nurse as well as twenty-four-hour caregiver staff, office staff, maintenance staff, and food service staff work on-site.

CHA was able to develop the facility by using Moving to Work (MTW) flexibility to leverage over \$13 million through its partnerships with local, state, and national organizations. Financing for CHA's Neville Place comes from:

- Low-income housing and historic tax credit equity
- Project-based Section 8 of HUD rental voucher system
- HOME funds
- Community Development Block Grants (CDBG) funds
- Local Initiatives Support Corporation (LISC) funds
- The East Cambridge Savings Bank
- The City of Cambridge
- Cambridge Health Alliance
- Housing Innovation Funds
- Massachusetts Department of Housing and Community Development
- Community Economic Development Assistance Corporation
- Federal Home Loan Bank

#### **LAPHAM PARK VENTURE**

A guiding tenet of the Venture is that no elderly resident would ever need to struggle to access services or to plead for essential services. Since 1996, the Venture has kept this promise to every resident. Ninety-six percent of Lapham residents now age in place.

—Susan J. July, Milwaukee Housing Authority

Located in the city of Milwaukee, Lapham Park was built in 1964; many of today's residents were among the first to move into the two-hundred-unit public housing building. Over the years, as the residents aged, it became clear that the building and services were not keeping pace with the residents' needs. By the late 1990s, Lapham Park residents were among the frailest elderly and most at risk for nursing home placement. The typical resident had five major health conditions, all of which could be directly traced back to a lifetime of poverty. The residents were overwhelmingly African American with very low incomes. And while some tenants were receiving services on-site, there was no coordination among providers. As a result, as many as twenty-six social workers were visiting the building each day.

Faced with a building that did not meet its residents' growing needs, stakeholders invested in the well-being of poor, frail older adults created the Lapham Park Venture. This venture brought together a partnership of practitioners in gerontology, housing, medical arts, planning, architecture, and social services to provide on-site, integrated, consumer-centered care to these residents.

The primary goal for the partners was to deliver effective and cost-efficient services that would support residents' desire to age in place. (A number of surveys had found that the vast majority of the elderly wanted to remain in their homes.) In bi-weekly focus groups, Lapham residents identified the lack of clinical services on-site as their primary concern. They pointed out that they were too frail to take public transportation to medical appointments located predominantly in suburban locations or to wait for extended periods of time for routine medical care. They also felt isolated from one another, citing a lack of community space and social activities.

The partners developed an on-site clinic to provide routine medical assistance during regular weekday hours and other around-the-clock services, seven days a week. Services include home health care, dental care, physical therapy, podiatry, and hospice care.

Tenant feedback also spurred renovations to enhance the sense of community: the building now includes a billiards room, crafts room, barber and beauty shop, gym, movie theater, and therapeutic whirlpool. In talking with tenants, planners discovered that they had fond memories of Walnut Street, which was near the facility. As a result, the renovated space includes floor-to-ceiling sepia-toned photographs from the Walnut Street of the 1930s. The community space is compliant with the Americans with Disabilities Act and includes unique senior-friendly features, such as non-glare lighting fixtures, handrails in the hallways, sitting areas on the way to common areas, cognitive cues for finding one's way, and accessible knobs, keys, tubs, and showers.

The success to date of Lapham Park has also met the planners' secondary goal of determining whether the model of a continuing care retirement community could be superimposed on a publicly funded housing development to facilitate true aging in place for low-income seniors.

All units in Lapham Park are subsidized by the Housing Authority of the City of Milwaukee's (HACM) public housing operating fund. The cost of services for most residents is covered by Medicaid. Residents who do not qualify for Medicaid can access limited services through other funding and/or pay a small share of the costs out-of-pocket. The property is managed by Friends of Housing, which handles leasing, maintenance, and rent collection.

#### Demographics and Site Characteristics

- 200 units (190 one-bedroom and 10 two-bedroom)
- 18 percent of residents are eighty years or older
- 96 percent of residents are African American; 56 percent are female; 74 percent are very low-income
- Median annual income of residents of \$7,553
- Services including congregate meals, transportation, recreational activities, case management, long-term care, on-site primary medical care, physical therapy, and prescription management

#### Partners in the Lapham Park Venture

- Housing Authority of the City of Milwaukee
- Milwaukee County Department on Aging
- Lapham Park Residents' Organization
- SET Ministry
- St. Mary's Family Practice Residency Program
- Community Care Organization
- Children's Outing Association
- Social Development Commission
- Marquette University
- Milwaukee Area Technical College
- Alzheimer's Association of Southeastern Wisconsin
- YWCA
- St. Mary's Family Practice and Community Education Center Student Program

#### Sources of Funding for Development and Daily Operation

- Medicare and Medicaid
- Public Housing Operating and Capital Funds
- HUD funds for Service Coordinator Program
- Funds from the Milwaukee County Department on Aging under the Older Americans Act
- Funds from the Wisconsin Housing and Economic Development Agency
- Community Development Block Grants
- Private donations from foundations and nonprofit organizations

## DEVELOPING SUPPORTIVE SERVICES IN PUBLIC HOUSING: GETTING STARTED

### ASSESSING RESIDENTS' NEEDS AND INFRASTRUCTURE

The first step for any housing authority is to assess the health and functional status of its tenants. Among the organizations that may be able to help gather that information are local service providers, advocacy groups, research organizations, and government agencies, such as the Area Agency on Aging.

Resident assessments can provide detailed information about individual tenants' health needs, cognitive functioning, family relationships, language and cultural needs, major risk factors and frailty, and literacy levels. The quality of the elder's home environment—which experts say is the best place to assess individual needs and capacities—is an important predictor of functional limitations, social isolation, substance abuse, and physical and mental disabilities.

A survey can also determine which tenants qualify for service subsidies, such as Medicaid funding for home- and community-based care. (Because Medicaid is a federal- and state-funded resource, qualifications based on frailty, income, and assets vary from state to state.)

The next step is for authorities to determine the difference between existing services and buildings and their tenants' needs. For example, much of the nation's public housing stock was built decades ago. Older buildings frequently lack the features and facilities needed to accommodate residents' physical limitations. The neighborhoods where existing public housing is located should also be considered. The majority of public housing seniors (59 percent) live in central cities. Seniors living in these neighborhoods may have increased access to community resources, such as hospitals and churches. However, these locations can also have drawbacks as many developments are in impoverished areas where safety concerns are high and access to basic amenities can be limited.

During this phase, a housing authority may wish to contact a service provider in the area to assist with assessment of existing facilities. A service provider that specializes in working with seniors will be able to help identify specific features that will be needed based on the level of service that will be provided.

Another source of information about the services available in a given neighborhood is the database of Medically Underserved Areas, which is maintained by the U.S. Department of Health and Human Services. This database shows areas that scored low on the Index of Medical Underservice, which measures poverty rate, percent of population over sixty-five, and the number of full-time physicians, among other things. The database is available on the Health Resources and Services Administration's website at <http://bphc.hrsa.gov/databases/newmua> (accessed June 23, 2006).

#### *Market Environment*

The third step is for housing authorities to learn what services are currently being provided in the community, identifying the community organizations that are already working with low-income elderly. Housing authorities can investigate what other organizations are doing and how these services can complement the housing authority's potential project. Also, possible competitors should be identified. For example, if a state's Medicaid waiver program affords an opportunity for private

developers to construct affordable new assisted living facilities, PHAs that choose to rehabilitate their buildings to create assisted living may have difficulty recruiting tenants who are not already in public housing.

### *Project Design*

Project design has two phases. The first is developing a mission statement that provides a framework for establishing the goals and purpose of what the PHA wants to provide its elder public housing tenants.

The second phase addresses the actual details of the project, such as the target population; current physical environment and services; regulatory environment; changing the physical environment; changing the services; staffing; agency partners; financing the project; and the elderly as consumers.

### *Project Evaluation*

It is important that evaluation be built into the project from the very beginning to learn how services are affecting tenants, to identify changes that need to be made, and to document effectiveness.

Evaluation can range from a simple consumer satisfaction survey to an in-depth evaluation by an outside company.

## **ADVANTAGES AND DISADVANTAGES OF ALTERNATIVE PROJECT DESIGNS**

### *Collaborating versus Providing Services Internally*

One of the first questions that a PHA will have to answer is whether to collaborate with another organization or to be the principal service provider. Some of the benefits of collaborating or contracting with another organization include:

- Relative ease of start-up—the housing provider can offer services without significantly increasing overhead costs or the number of staff. The housing provider uses the service delivery skills already available in the community, rather than having to develop them.
- Fewer regulatory barriers—regulatory policies and procedures related to services, especially with public funding, may be daunting, making it difficult for housing authorities to provide services directly. Licensing and regulatory requirements may be less burdensome for the PHA if they are borne by outside service providers. PHAs in some states may not qualify to be service providers, or the regulatory barriers may be too inflexible to let PHAs serve tenants well.
- Fewer risks to the housing authority—the housing provider may incur fewer liability risks by sharing the responsibilities of providing services.
- Increased number and type of services—collaborating with existing service providers may allow the PHA to offer more complex services than it could otherwise.
- Increased consistency with the housing authority’s mission—housing authorities have been created to develop, own, and operate affordable rental units, in this case housing for elders.

Providing supportive services to frail seniors is a substantially different operation for which few PHAs have experienced staff. By collaborating with service providers, PHAs can avoid distraction from their traditional mission of providing affordable shelter.

By contrast, the principal benefit to a PHA of providing services itself is increased control of appropriateness, cost, and quality of services.

A third option is for the housing authority to partner with an experienced service provider long enough to learn the service business and then assume the provider's role over three to four years. This strategy may strengthen loan applications, since a lender is likely to see a proven service provider as essential to a project's success.

#### *One Location versus Scattered Sites*

People who need services and a suitable environment may be concentrated in one section of a building or dispersed throughout a building. They may be located at one site or many. They may live in a building designed or renovated for seniors regardless of frailty, or in a purpose built structure.

An advantage of grouping people in need of assisted living services in one location will be cost savings from economics of scale and reduced staff time, particularly if the housing structure is large. A disadvantage is that some tenants will have to move to a new unit in order to receive services. Moreover, some tenants may prefer a scattered site approach because they feel stigmatized by being readily identifiable as having higher needs and view a move to a particular section of the building as a step closer to death.

State policy may also determine the decision of using one location or several sites. For example, tenants in New Jersey cannot be required to move to a certain section of a building to receive services.

The physical layout of the building may also influence the final decision. Efficiency units may be well-suited to assisted living services. If these units are already concentrated within a building, it may be appropriate and efficient to concentrate services there as well. In order to provide assisted living services more space may be needed, requiring renovating the existing structure or building a new addition for service delivery, tenants' socialization, and staff needs. When services are in one location, it may be difficult to increase or decrease program size as demand changes, which may lead to vacant units or people not receiving services.

In some states, scattered units or one section of a building cannot be licensed separately. Instead, the entire building must be licensed. Such a regulation can raise staffing costs for the project, based on the staffing ratio.

#### *"A la Carte" Services versus Package Services*

Another decision is whether to allow tenants to select certain services or require them to accept or reject an entire package of services. Allowing tenants to choose their services strengthens their independence by letting them make decisions about their care. When tenants are involved in decision

making, particularly if fees are charged for services, they may choose truly necessary ones rather than becoming dependent on all of the available services.

A market study can determine if enough tenants are likely to use the services offered under either model. Issues to consider when conducting the market study include how providing a la carte or package services will affect the PHA's ability to:

- Maintain sufficient occupancy in the facility
- Maintain a diverse occupancy in the facility (i.e., whether offering a service package will allow the PHA to attract tenants with a variety of conditions and service needs, if this is desired)
- Meet the needs of tenants for a longer period of time (i.e., as they become progressively frailer)
- Attract enough tenants to cover the cost of providing services

#### *Mandatory versus Voluntary Meal Programs*

Meal programs may be mandatory or voluntary. The frailer the population is, the greater the need is for a meal program, since frailer tenants have more difficulty accessing offsite meals and services. A PHA can prepare meals on-site or contract with an external provider to prepare and deliver meals.

A stable, critical mass of participants is necessary to sustain a satisfactory kitchen facility and staff. This may be difficult to achieve if meals are voluntary. On the other hand, tenants could resent mandatory participation in a meals program. To help resolve these issues, a PHA may choose to develop an alternative meals program. For example, it can arrange with an Area Agency on Aging to provide meals for tenants and members of the community through individual deliveries or at a congregate meal site. Another alternative is to make the meal program voluntary and to arrange to have "meals on wheels" delivered to tenants who are interested.

#### **COLLABORATION BETWEEN HOUSING AUTHORITIES AND SERVICE PROVIDERS**

Because their backgrounds and perspectives are different, housing and services staff will need to take time to educate one another and to clearly define their roles. In order to operate an assisted living program within public housing, many staff members may need to assume new roles. Successful assisted living programs spend considerable time on initial and continuing staff training. For example, in an assisted living program, everyone—including housekeepers and maintenance staff—should be involved in checking on and supporting tenants and reporting changes in their needs.

Although all of the partners are important, a central entity must lead the collaboration and be accountable for service delivery. This entity is responsible for overseeing the service system and ensuring quality. The entity may be the PHA itself or an outside individual or firm.

## SERVICE DELIVERY

The primary purpose of offering health and social services in public housing is to help participants remain independent as long as possible in the least restrictive setting. It is equally important to promote residents' physical and mental health. Services can be provided at three levels: basic, moderately intensive, and most intensive.

Basic level services might include:

- Food
- Health promotion and disease prevention
- Recreation
- Transportation
- Information about, and referral to, desired services
- Medication assistance
- Cognitive assistance

Moderately intensive services might include:

- Care management for individual seniors and coordination of services from all of the partners
- Assistance with activities of daily living (e.g., transfer from place to place in the residence, toileting, eating, bathing)
- Assistance with instrumental activities of daily living (e.g., shopping, paying bills, arranging and getting to appointments)
- Medication assistance
- Cognitive assistance
- Adult day care

The most intensive service level might include:

- Physician services
- Home health services
- Rehabilitation services (outpatient and inpatient)
- Assisted living environments and services (including twenty-four-hour staff)
- Nursing home environments (intermediate and skilled) and services (including twenty-four-hour staff)
- Medication administration (as allowed by state regulation)
- Cognitive assistance

An array of models for delivering these services has been developed to respond to varying needs as tenants age. Several models, ranging from basic to intensive, are discussed in the following section.

## **CARE MANAGEMENT**

One of the least intensive models of service provision is care management. Care management is interdisciplinary and acknowledges the consumer as the focal point. It allows tenants to live more independently by providing access to specifically tailored services in their homes. It may be most effective when staff provide linkages among the various community services as part of a holistic approach to care and empowerment.

Care management includes advocacy, tenant outreach, socialization, service planning and brokering, resource coordination, problem solving, community building, evaluation, record keeping, and referrals. It does not include direct personal care, though it includes oversight of a personal care program or provider agency. In some states, management or oversight of personal or health care services requires licensing. The degree to which a care manager may oversee services is subject to state regulations. Care managers in public housing are often nonprofessionals; those who are professionals are typically on-site social workers or visiting nurses.

## **HOUSING WITH SERVICES/CONGREGATE CARE**

A PHA may wish to provide a more intensive level of care by providing services to tenants in congregate housing, which offers independent living in apartments with shared recreational areas. In New Hampshire, for example, a grant under HUD's Congregate Housing Services Program (CHSP) was used to enhance statewide services within the public housing system. The CHSP is no longer funded. However, the New Hampshire project was recently named a promising practice by the Centers for Medicare and Medicaid Services and may be an instructive example for PHAs looking into congregate care. More information about the program can be found at <http://www.hud.gov/offices/hsg/mfh/progdsc/chsp.cfm> (accessed June 23, 2006).

It may be possible for housing authorities to provide personal care and supportive services without being licensed or registered as an assisted living facility. A housing authority that wants to offer an intensive care package could include some or all of the following: housekeeping and laundry, scheduled personal care, meals, monitoring by nurses, and emergency response, such as the Lifeline Program.

One example of how services can be offered within public housing is a program created by Massachusetts, which has a separate state-funded public housing program. The Massachusetts Executive Office of Elder Affairs and the Massachusetts Department of Housing and Community Development collaborated in a pilot program to create the Supportive Housing Program. This initiative brings intensive services to tenants of state-subsidized housing. It helps seniors remain independent by providing them with case management, twenty-four-hour on-site personal care, housekeeping, daily meals, medication reminders, transportation assistance, and shopping and laundry services.

The Executive Office of Elder Affairs provides grants to hire staff to oversee the service program, and the Department of Housing and Community Development contributes limited grants for renovating community spaces. To handle case management, the Office of Elder Affairs contracts with Aging Services Access Points (ASAP). The case managers assess an individual's needs, develop a plan to meet those needs, and monitor the plan. Other agencies already under contract with ASAP coordinate and provide the services. Seniors who meet the income and needs criteria of the Office of Elder Affairs receive these services at no cost. Others may purchase the services on a sliding scale.

Services provided to all tenants without charge include case management to determine individual needs; twenty-four-hour staff availability for emergencies; scheduled services for qualifying households; one or two meals per day, using the federal Title III meal program; medication reminders; and regular, programmed social activities. Additional services—personal care, house cleaning, laundry, grocery shopping, and transportation assistance—are free to qualified seniors and can also be purchased by other tenants on a sliding scale.

#### **ASSISTED LIVING**

On the more intensive end of service delivery, housing providers can offer assisted living services. While there is no one widely accepted description of assisted living, the Assisted Living Workgroup in a report (2003) to the U.S. Senate Special Committee on Aging suggested that assisted living should be considered as a state-regulated, long-term care option that provides or coordinates oversight of services to meet residents' needs. It recommends that assisted living units be private occupancy, shared only with the permission and choice of residents.

Assisted living can serve persons with physical disabilities, medical needs, and cognitive impairments. An estimated 50 percent of assisted living residents have some form of cognitive impairment. Dementia care is widely integrated into assisted living programs; because the progression of the underlying disease is slow, special care units are not the best setting for all persons with dementia. In addition, special care units are rarely available to low-income people.

An assisted living program that provides twenty-four-hour staff and nursing oversight is beneficial to tenants for many reasons. Elderly tenants are often frail or have cognitive impairments that necessitate protective oversight. They may routinely need certain services at odd hours and in small increments, like "as needed" medications, cueing and reminders, and assistance with transfers and walking. They may also need occasional assistance in incontinence management; behavioral interventions (such as training or using other means to interrupt actions that can harm a patient or others); or skin and wound care, which cannot easily be given by care providers who make scheduled visits.

Assisted living services could include:

- Twenty-four-hour staff
- Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities)

- Health-related services (e.g., medication management)
- Social services
- Recreational activities
- Meals
- Housekeeping and laundry
- Transportation

**PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)**

The Program of All Inclusive Care for the Elderly (PACE) is a managed care approach that provides a full range of services to the population on the plan. A federal program financed by both Medicare and Medicaid, PACE focuses on frail seniors who meet the criteria for nursing home care. Although clinical eligibility requirements for PACE vary from program to program, they are generally higher than Medicaid waiver eligibility due to greater service needs. PACE typically uses an adult day care center supplemented by in-home and referral services, based on individual needs. PACE is a risk bearing program with payment for services made directly to the PACE provider at a fixed monthly rate. The provider is responsible for all medical services and acute and long-term care needed by enrollees.

Although it may not be practical for PHAs to create a PACE program, they may arrange for seniors in public housing to use an existing one. For example, the PHA could be one of the housing providers in a PACE environment. PHAs interested in learning more about PACE or finding out if there are PACE programs in their state may obtain more information at <http://www.medicare.gov/Nursing/Alternatives/Pace.asp> (accessed June 23, 2006).

## REGULATORY REQUIREMENTS

Housing authorities that become involved in supportive housing will find that they must work with a new group of local, state, and federal regulators. A PHA's decision about whether to serve its tenants by providing services directly or by collaborating with other organizations will affect the complexity of regulatory requirements. Even housing providers who make arrangements with service providers for personal or health care may need to obtain some kind of license, registration, or certification.

Regulations can cause conflicts. Regulations are intended to reduce risk, but the goals and objectives of different regulatory agencies may not be complementary. In addition, some regulations will conflict with the goals of a facility's administration or the desires of the tenant or the tenant's family. As a senior's physical or mental abilities decline, there is likely to be increased tension among the tenant, the family, other tenants, program staff and administrators, the regulator, and the public.

### REGULATIONS FOR ASSISTED LIVING

In many states, health care regulations now permit, and often encourage, greater provision of services within residential settings. *Assisted Living State Regulatory Review 2003*, a report published by the National Center for Assisted Living, provides helpful information about assisted living policies in each state, including information about Medicaid reimbursement policies.

State regulations for assisted living vary considerably. Some may require apartments as opposed to bedroom units or high visual contrasts between floors, walls, and walkways. Other state regulations may include little beyond a general philosophy of assisted living.

Medicaid criteria also need to be considered. In most states, seniors can be served in an assisted living facility regardless of whether they qualify for nursing home care. And Medicaid state plans can pay for assisted living services for individuals who do not need nursing home care. However, only people eligible for nursing home care can be covered under Medicaid home- and community-based services waivers.

Housing authorities should also consider the long-term impacts of regulations. One problem that might occur is that tenants could be forced to move from public housing into a nursing home rather than be able to age in place. This situation is likely to occur in states where adding an assisted living program to public housing means that the whole building must be licensed for assisted living. If the entire building becomes a licensed setting, the state may require tenants to move out of their apartments and into nursing homes if they exceed the discharge criteria established for the assisted living regulatory category. In some states, the assisted living provider can work with the state to provide exceptions to the discharge criteria when the program can meet a tenant's needs.

### CONFLICTS BETWEEN TENANTS' PREFERENCES AND REGULATIONS

Service providers must bridge the expectations of clients and regulators. Allowing tenants to choose whether to receive services has some risk. The challenge for the program administrator is to

understand and balance the desire of the tenants for autonomy with the safety concerns of the regulators, the families, and other parties. When doing so, the administrator should recognize that frail elderly people often have difficulty making decisions, communicating their preferences, or advocating on their own behalf. In contrast, more independent seniors often minimize or misrepresent their needs and do not comply with service plans.

Tenants may not want services even though the service providers believe they are needed. Tenants have the right to refuse services. However, some tenants may not understand the services that are available or the risks of not using them. Tenants may have misgivings about using a service because they are unwilling to ask for help or reluctant to give up their privacy. These feelings may lessen over time if the service providers are able to gain the tenants' trust.

## FUNDING ASSISTED LIVING

Financing an assisted living facility in public housing often requires combining public and private capital and operating subsidies for shelter and care. Public funding sources may include HUD grants and Medicaid waivers. Some states, such as Massachusetts, New Hampshire, and New Jersey, have funding for assisted living services to subsidized housing tenants. In such states, the PHAs typically work actively with state legislatures and state executive offices to develop assisted living services.

Accessing private capital often involves creating a partnership with a for-profit investor, similar to the mixed-finance models used in the HUD's HOPE VI developments. For example, a partnership is required for any housing authority that wants to use the Low Income Housing Tax Credit Program. However, PHAs lose some control when this type of partnership is created, and in some states the authorizing legislation creating the PHA may not permit such a partnership. PHAs can also secure financing directly from a private lender, but only if they propose to own and operate the project as a mixed-income development or use project-based Section 8 funding instead of a PHA operating subsidy.

Although some lenders and investors may have reservations about supporting assisted living projects—such as concerns about profitability or unstable income sources—these concerns diminish somewhat when assisted living facilities are created within public housing. Assisted living within public housing can be less risky because it has the political and financial stability of the PHA behind it. In the case of conversions, many real estate development and construction risks are avoided or significantly reduced because the building already exists. In addition, there may be less concern about marketability because the seniors already under the PHA's management need services. Finally, because of cost savings associated with assisted living conversions, larger lease-up and operating reserves can be capitalized in the development budget to alleviate lender and investor concerns about project performance.

### MEDICAID FUNDING

Medicaid is a joint state-federal program, giving states some flexibility in determining which services will be covered by Medicaid waivers, income-eligibility formulas, and payment mechanisms.

#### *Waivers*

The Medicaid waiver most relevant to seniors is the home- and community-based services waiver. These waivers permit states to offer services to people who qualify for nursing home care provided the services cost the same as or less than nursing home services. (They are typically designed to cost less than nursing home care.) Depending on the state, the number of people who can be served under the waiver may be limited if the waiver is budgeted for a certain number of "slots."

The home- and community-based services waiver has been available since 1981. Initially, most states used it only to pay for services in residential care settings for people with mental retardation or other developmental disabilities. By 2002, however, thirty-six states had Medicaid waiver programs that also allowed payment for services for elders in residential care settings.

If no existing waivers cover assisted living, the PHA may be able to work with the state Medicaid agency, which would apply to the federal government for a waiver. State matching funds must be available. States complete a preprinted application that allows them to check off various aspects of its waiver proposal. Assisted living is one of the options included on the form, and states may provide their own definition of services, which is subject to approval. Waiver services can be provided statewide or limited to specific geographic areas.

In some cases, Medicaid waivers are project-based, meaning that the waiver attaches funding only to a specific project. For example, the first demonstration Medicaid waiver for assisted living in Rhode Island attached the funding to two selected projects. If the Medicaid waiver is not project-based, the PHA will need to determine which tenants are likely to be eligible for the waiver. The following issues will affect a PHA's ability to serve its target population:

- Whether the Medicaid payment will cover the cost of services and administration of the program
- How long eligibility determinations take
- How long waiting lists are
- Whether Medicaid reimbursement is provided before or after services have been delivered. (In the latter case, projects need enough operating capital—in addition to operating reserves, lease-up reserves, replacement reserves, and, in some cases, transition reserves—sufficient to weather thirty-to-sixty-day delays in payments.)

Some states also have a Medicaid Assisted Living for the Elderly waiver, which pays for certain services to eligible recipients who reside in assisted living facilities.

#### *Other Medicaid Funds*

The Medicaid state plan may cover certain services provided in assisted living facilities, such as personal care. State plan services are an entitlement, which means that all beneficiaries who meet the criteria must be served. Twenty-four states funded personal care in their state plans in 2004 (Kassner 2005).

In rare instances, Medicaid funds can be used for debt payments on a housing structure. This could be the case if the state pays a lump sum service payment. In this situation, if a service provider can provide services for less than the reimbursement amount, the excess from the service payment can be used to pay debt service. In some states, the Medicaid program requires cost accounting, which takes back any profit that providers make on Medicaid-reimbursed services and lenders.

Medicaid rules and regulations can be a challenge to a PHA working on an assisted living project. Lenders may have reservations about projects if it is unclear whether they will generate sufficient income. Funding sources that are not adjusted for the cost of living may also create difficulties. For example, in Massachusetts the Medicaid-funded Group Adult Foster Care supportive services subsidy does not have a cost-of-living adjustment. Lenders and tax credit investors may be reluctant to underwrite an assisted living facility for fifteen to forty years when its operations depend on Medicaid assisted living waivers that are renewable in three to five years. This is true even though every Medicaid

waiver for assisted living has been regularly and routinely renewed. Some communities have long waiting lists for Medicaid waiver reimbursement. Medicaid waiver funding may also be problematic because many states do not provide a “bed hold” allowance. This means that when the tenant is out of the unit (e.g., in the hospital or visiting family), the Medicaid waiver program does not pay for services.

#### **MIXED-INCOME ASSISTED LIVING**

Another way to help cover the cost of assisted living is to open the facility to private-pay tenants as well as to public housing tenants. Then, if revenues for the public housing tenants are insufficient, revenues from the private-pay tenants may help make up the difference. Services for low-income tenants can be supplemented by the higher service payments from market-rate tenants.

#### **ADDITIONAL CAPITAL FUNDING SOURCES**

- **HOPE VI** grants, funded by HUD, can be used by PHAs to modernize and renovate public housing for seniors. Fifteen percent of the total grant can be used for supportive services.
- **The HOME Investment Partnerships Program (HOME)**, enacted as part of the National Affordable Housing Act, encourages partnerships between public and private sector organizations. To receive funds, states and localities must develop a comprehensive plan describing housing goals. HOME could be a resource for seniors because it is administered locally and could be used to finance housing that is part of supportive housing. However, HOME funding is not available to PHAs if they are combining the HOME funds with any of their own capital funds (Section 9 funds), except HOPE VI dollars.
- **The Low Income Housing Tax Credit (LIHTC) Program**, which is funded by the U.S. Treasury Department and administered by a government entity in each state, can be used to create affordable housing for seniors by providing a tax credit of 9 percent to those who invest in the housing. This is a substantial potential equity resource, but there is great competition for the credits.
- **Community Development Block Grants** are provided annually by HUD on a formula basis to entitled cities and urban counties that meet eligibility criteria. Each state can also administer these community development grant funds for non-entitlement areas. These grants could be used to link housing and services for seniors.
- **The Federal Home Loan Bank** offers grants and other low-cost, long-term funds to member lenders to help finance housing projects through two of its Community Investment Cash Advance programs. The Community Investment Program is a discounted-rate lending program. The Affordable Housing Program provides grants and interest-rate subsidies for loans. Some Federal Home Loan Banks may offer additional funds for affordable housing.
- **HUD’s Section 232** program provides mortgage insurance to facilitate the construction and rehabilitation of assisted living and other health care facilities.

- **The Community Facility Loan and Grant Program**, funded by the U.S. Department of Agriculture (USDA), provides grants and loans to construct or renovate community facilities that offer services in rural areas. Assisted living facilities may qualify.
- **The Assisted Living Conversion Program**, which is funded by HUD and administered by local HUD offices, is available to private, nonprofit owners of certain housing developments (including Section 202 and Section 8 project-based developments). It provides a grant to convert some or all of the dwelling units in the project into an assisted living facility for the frail elderly. Funding typically covers basic physical conversion of existing units and space for services.
- **Tax-exempt bond financing** provides a lower effective interest rate than private financing for facility debt financing. Tax-exempt bonds can be issued by state housing finance agencies and industrial or economic development agencies, either as private activity bonds or as 501(c)(3) nonprofit bonds if the PHA has, or creates, a nonprofit subsidiary.
- **Section 9 Capital Funds**, which PHAs receive from HUD annually on the basis of a formula related to the number of units they own and operate, may be a resource. These funds can be used to retrofit public housing or for simple alterations to make the units accessible (e.g., installing grab bars). In addition, PHAs can pledge a certain portion of the projected future income stream of these funds to retire debt.
- **HUD's Project-Based Section 8 Vouchers** may provide funding for affordable housing in the form of rent subsidies. Each PHA determines whether Section 8 Housing Choice Vouchers (HCVs) will be available for project-based assistance. ("Project-based" means that the assistance stays with the unit rather than following the tenant when he or she moves.) If project-based Section 8 vouchers are made available, they may be used in private assisted living facilities to cover the cost of housing only. The HCV assistance cannot be used for the cost of meals or supportive services.
- **Supplemental Security Income (SSI)** programs and food stamp programs may also provide income to affordable housing projects. SSI programs may provide income if tenants meet eligibility guidelines. In a few states, such as Illinois and Wisconsin, arrangements have been made for assisted living facilities that meet USDA criteria to accept tenants' food stamps as payment toward meal costs (Mollica 2002).

Housing authorities may be able to use local funding sources. Some state housing finance agencies have funding available under state programs. City governments may also have their own programs. Cities may be willing to provide tax increment financing for some projects. Under tax increment financing, all increases in property taxes in a designated area are earmarked for improvements in that area.

When considering potential funding, housing authorities should also determine how much of the money will have to be placed in reserves. For example, there may be a requirement that one-third of tax-credit proceeds be placed in reserves. This will limit the funds available for development costs. When planning a facility, the PHA should also find out what design features underwriters and

investors will require as part of a workout strategy (a strategy for the lender to handle the property if the loan gets into serious trouble). For example, if an underwriter requires that all units meet independent senior housing standards to provide a workout option if the services fail, the building's size and budget will grow considerably.

## **OBSTACLES**

While any developer of an assisted living facility will face funding challenges, PHAs may find that they face additional difficulties. Two obstacles that are particularly complicated for PHAs to overcome are obtaining predevelopment financing and managing Medicaid financing.

Obtaining the funding to cover the upfront cost of the project may be difficult because PHAs do not have access to the same financing options that a private developer might. Upfront costs might include a feasibility study, tenant needs assessment, preliminary architectural plans, environmental assessments, surveys, and market studies. While covering upfront costs can be challenging, there may be funding sources that can help. PHAs may be able to cover many predevelopment costs through their annual capital fund allocation as long as the activities are described in their annual and five-year plans. Also, some PHAs that have operated their own programs have generated enough revenue to cover the start-up costs before the end of the project's first year. State housing agencies sometimes have loan programs for predevelopment costs, as does the NCB Development Corporation (NCBDC). The NCBDC provides predevelopment funds in the states involved in its Coming Home Project: Alaska, Arkansas, Florida, Iowa, Maine, Massachusetts, Vermont, Washington, and Wisconsin.

**APPENDIX A: SPECIFIC ISSUES TO BE  
ADDRESSED DURING PROJECT DESIGN**

This appendix presents some specific aspects of project design that housing authorities will need to consider. These lists are not meant to be comprehensive; rather, they are designed to provide a starting point for housing authorities who have never been involved in supportive housing.

#### Target Population

When making decisions about the target population, consider:

- Which population to serve
- What types of services the population wants and needs now
- What types of services the population is likely to need as it becomes frailer
- How to address the conflict between risk and consumer choice
- What linguistic and cultural diversity the population has and how this diversity affects the services provided

#### Current Physical Environment and Services

When analyzing the current physical environment and services, consider:

- Safety of the interior and exterior physical environment
- Suitability of the environment for the physically frail and cognitively impaired
- Suitability of the physical environment for service provision
- Services already available to tenants
- Accessibility of the services
- Use of existing services
- Obstacles that prevent tenants from accessing services
- Gaps in services
- Current coordination of the various services

#### Regulatory Environment

Consider the federal, state, and local regulatory environment, including:

- Populations that can be served under the regulations
- Regulations that affect the housing renovation or new construction being considered
- Regulations that affect the services being considered
- Complexity of the regulations and the PHA's capacity to comply with them
- Licensing required to provide the services
- Impact of regulations related to new services on current tenants

#### Changing the Physical Environment

When planning changes in the physical environment, consider:

- Modifications needed to make the physical environment safe for physically frail and cognitively impaired tenants

- Adequacy of the physical infrastructure, such as plumbing and electrical systems
- Changes needed to modernize the physical environment, for example, adding amenities such as a gym
- Alterations needed to make the physical environment suitable for delivering the services that the PHA wishes to provide
- Alternative ways to change the physical environment, for example, new construction versus retrofitting
- Cost-effectiveness of each option for altering the physical environment
- Length of time the housing will be usable after alterations or new construction
- Neighborhood setting of the housing
- Efficiency of upkeep of the structure
- Ease of making future modifications as tenants' needs change
- Changes necessary to allow cognitively impaired tenants to receive services and live among unimpaired tenants
- Alterations that can be made to help tenants remain independent, such as handrails in the hallways, sitting areas on the way to common areas, cognitive cues for finding one's way, and accessible knobs, keys, tubs, and showers

#### Planning the Services

Issues to consider when planning the services include:

- Services already being offered
- Level of services the PHA wants to provide and the level of risk it is willing to take
- Various service models available and the goals and methods of each
- Expected service outcomes
- Plans for program permanency and continued funding
- Licensing and regulations associated with the service models
- How to deliver emergency services
- How to tailor services to tenants' needs
- How the facility will handle tenants who experience progressive dementia
- Whether twenty-four-hour staffing can be provided
- How to link tenants to services
- Changing the PHA's policies that can hinder access to services, such as restrictive admissions, transfers, and evictions
- How and where to refer tenants if the physical environment and services no longer meet their needs
- How to disseminate information about new services

## Staffing

Key staffing issues include:

- How to obtain PHA staff commitment to the change in mission required to alter the physical environment or add services
- Adding or redeploying staff to match the changed mission

## Agency Partners

When identifying service providers, consider:

- Quality of the services they provide
- Their commitment to serving the frail elderly
- Agency missions and philosophies
- Type and amount of each agency's experience
- Evidence about each agency's collaborative work in the past and at present
- Whether the service providers are appropriately licensed to provide the services
- Each agency's organizational resources and ability to draw on additional resources

Many PHAs are familiar with providers in the community and the quality of their services. If the PHA is not familiar with them, the following tips may be helpful:

- The Area Agency on Aging can broker connections with service providers and private developers.
- The gerontology research program at the local university or college can usually identify potential service providers.
- The state Medicaid program and the state health department can advise the PHA on the reputation of the service providers being considered.
- PHAs should ask potential partners for copies of their licenses, recent financial audits, and last three years of state survey reports, and for information about any claims against them that are pending or have been settled in the last three years.
- Recent sale of an agency or changes in its top management can affect its performance.
- Consumer input about service providers is often available from local long-term-care ombudsmen and advocacy groups.

Before awarding a contract to potential service providers, a PHA should solicit proposals and become familiar with any state requirements regarding the selection process. There are separate procurements for an initial feasibility study and for project development, which are likely to add costs. PHAs should also consider a number of management styles. Some PHAs may choose a top-down approach, in which they do the bulk of the planning and decision making about the project and establish contractual relationships with service providers. Other PHAs may choose a team approach, in which the service providers have decision-making authority in all stages of project planning and implementation. The management style that will be used should be explained in any request for proposals.

After community providers have been chosen, the next step is to move toward formal relationships with these agencies. The housing provider may want to obtain a guarantee from the service providers that they will not withdraw services from frail seniors without sufficient notice.

### Financing the Project

Financial considerations include:

- Availability of funding for services, renovations, or new construction
- Eligibility for funding sources' subsidies and services
- Stability and continuity of potential funding
- Cost-effectiveness of the proposed program design
- Determination of whether waivers of laws and regulations are needed and, if so, who can apply for them
- Whether the funding will be project-based or person-based

Project-based funding and person-based funding are quite different. PHAs receive project-based funding for their basic housing mission, while most human service providers are funded by reimbursement for specific services rendered to clients. It is advantageous for PHAs to advocate that funding for services be project-based because this funding is more flexible. To facilitate this type of arrangement, the PHA should identify core services that tenants need. A flexible plan could be created to let tenants select some services and not others. PHAs should be cautious about agreeing to provide service to people who may require a higher level of care than the facility can accommodate.

Although human services funding is typically person-based, some Medicaid waiver funding for assisted living is project-based, as long as individual tenants meet eligibility criteria. Project-based funding makes financing a new or retrofitted facility much more feasible if there is enough demand.

Public housing tenants often use services from community agencies, such as Area Agencies on Aging, family service agencies, the Salvation Army, or Catholic Charities. These agencies receive public or private support. At times they may accept "donations" from clients or charge according to their ability to pay. Individuals may receive meals and have home attendants in their residences, or they may attend clinics and daycare programs or eat meals in group settings.

### The Elderly as Consumers

Consider these issues:

- Consumer expectations about services
- Involving consumers in the planning and implementation of services
- Presenting the changes to the consumers
- Level of acceptance by elderly tenants of proposed changes in their physical environment or services
- Willingness of tenants to participate in programs that could help pay for the services but may affect their income
- Community expectations

## APPENDIX B: INFORMATION SOURCES

### ORGANIZATION PROJECT MODELS

**The CenterPoint Foundation** is a nonprofit organization committed to expanding the availability of affordable assisted living and has focused much of its energy and resources on public housing for the elderly. Contact: Stephen Gardiner, President, (617) 786-9074, [sgardiner@centerpointfoundation.org](mailto:sgardiner@centerpointfoundation.org).

**The Massachusetts Executive Office of Elder Affairs and the Massachusetts Department of Housing and Community Development** created the Supportive Housing Program to bring intensive services to tenants of state-subsidized housing for the elderly. Contact: Maggie Dionne, Director of Housing and Supportive Services, (617) 222-7465, [maggie.dionne@state.ma.us](mailto:maggie.dionne@state.ma.us).

**NCB Development Corporation (NCBDC)** is a national nonprofit organization dedicated to empowering underserved communities through a combination of policy, program, development, and finance initiatives. NCBDC works with federal and state agencies as well as with community organizations to create and implement innovative models of affordable housing and services (including nursing home alternatives such as affordable assisted living and the Green House Project), economic development, and education. The Coming Home Program provides policy consulting to state governments as well as predevelopment loans and technical assistance to organizations interested in creating affordable assisted living demonstration projects in nine states: Alaska, Arkansas, Florida, Iowa, Maine, Massachusetts, Vermont, Washington, and Wisconsin. The Green House Project works nationally to help organizations replace long-term care institutions with small homes licensed as skilled nursing homes. Both programs are funded by the Robert Wood Johnson Foundation. NCBDC's website ([www.ncbdc.org](http://www.ncbdc.org), accessed July 7, 2006) provides the Assisted Living Operating Proforma and Financial Feasibility Analysis Model, a free tool to assess the viability of assisted living projects. The website also provides policy and Medicaid information, case studies, Green House Project information, and an electronic newsletter. Contact: Marilyn Ellis, (202) 336-7761, [mellis@ncbdc.org](mailto:mellis@ncbdc.org).

**The National Equity Fund (NEF), Inc.**, ([www.nefinc.org](http://www.nefinc.org), accessed June 20, 2006), created by the Local Initiatives Support Corporation (LISC) works with local organizations to finance neighborhood-led housing initiatives and support community revitalization. LISC's website ([www.lisc.org](http://www.lisc.org), accessed June 20, 2006) has information about special needs housing and the Illinois Affordable Assisted Living Initiative, which it created. Contact: Deborah Burkart, Vice President, Supportive Housing and Assisted Living Acquisitions, (213) 240-3133, [debbieb@nefinc.org](mailto:debbieb@nefinc.org). For more information about the Illinois Affordable Assisted Living Initiative go to [www.nefinc.org/Developers/IAALI%20Fact%20Sheet.pdf](http://www.nefinc.org/Developers/IAALI%20Fact%20Sheet.pdf) (accessed June 20, 2006).

## **WEBSITES**

**www.aahsa.org** (accessed June 20, 2006): The American Association of Homes and Services for the Aging (AAHSA) is committed to advancing the vision of healthy, affordable, ethical aging services for Americans. AAHSA publishes Medicaid fact sheets to help the organization's members—many of whom provide HUD-assisted housing for the elderly—to understand the potential and limitations of Medicaid HCBS coverage, particularly for assisted living, and their variations from state to state.

**www.aoa.dhhs.gov** (accessed June 20, 2006): The website of the Department of Health and Human Services' Administration on Aging is designed to provide a comprehensive overview of a wide variety of topics, programs, and services related to aging.

**www.elderweb.com** (accessed June 20, 2006): ElderWeb publishes a newsletter, feature articles on aging, news about upcoming events, and more.

**www.giaging.org** (accessed June 20, 2006): Grantmakers in Aging is dedicated to promoting and strengthening grant making for an aging society.

**www.hud.gov** (accessed June 20, 2006): The U.S. Department of Housing and Urban Development's mission is to increase homeownership, support community development, and increase access to affordable housing free from discrimination. This site includes information about the many HUD programs and funding mentioned in this report.

**www.jchs.harvard.edu** (accessed June 20, 2006): The Joint Center for Housing Studies is Harvard University's center for information and research on housing in the United States.

**www.medicare.gov/Nursing/Alternatives/Pace.asp** (accessed June 20, 2006): This website provides information about the Program of All Inclusive Care for the Elderly (PACE).

**www.miaconsulting.com** (accessed June 20, 2006): MIA Consulting Group, Inc., is involved in creating assisted living in public housing. It collaborated with the Miami-Dade Housing Agency to create the Helen Sawyer Plaza Assisted Living Facility.

**www.servicecoordinator.org** (accessed June 20, 2006): This is the website for the American Association of Service Coordinators (AASC), a national nonprofit organization representing service coordinators serving families, the elderly, and persons with disabilities, and others who are involved in creating and maintaining service-enhanced housing environments.

## **SUGGESTED READING**

For complete bibliographic information, see the References.

*Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes* examines the potential demand for assisted living services in subsidized housing and the capacity to provide these services, offers case studies of subsidized housing projects that provide assisted living services, and describes typical issues that arise in these projects (Wilden and Redfoot 2002).

*Affordable Assisted Living: Surveying the Possibilities* explores the demand for affordable assisted living and discusses lessons learned from the private-pay market, the challenges of developing a financial package to make assisted living affordable, and policy options and strategies. (It is not specific to assisted living in public housing.) (Schuetz 2003.)

*Aging in Place: The Demographics and Service Needs of Elders in Urban Public Housing* paints a portrait of public housing for the elderly. Although it is based on a survey conducted in 1986–87, it still offers important insights into the way public housing serves seniors. The results from its survey of about one hundred PHAs reveal not only the physical condition of the properties and the demographic characteristics of their elderly tenants but also information on tenants' assistance needs, service provision responsibilities and practices, and project management issues (Holshouser 1988).

*The CASERA Project: Creating Affordable and Supportive Elder Renter Accommodations* analyzes affordable housing and services for low-income frail elders in Florida, where housing authorities are already confronting the demographic pressures that other areas will experience in the coming decades, particularly due to strong demand among the “oldest old.” Although the analysis often lumps public housing together with Section 202 and other privately owned, HUD-assisted properties, it explores a variety of financing and delivery strategies that are increasingly relevant to PHAs in today's more flexible, deregulated environment (Golant 1999).

*Creating Community: Integrating Elderly and Severely Mentally Ill Persons in Public Housing* provides a clear introduction to the issue of integrating younger, disabled people in public housing for the elderly although it does not include the current “designation” process (National Resource Center on Homelessness and Mental Illness 1993).

*Elderly: Public Housing and Assisted Living, a Timely Collaboration for Aging Seniors* explores the conversion of public housing to assisted living facilities in several cities and argues for expanding assisted living programs in public and private housing to offer seniors more choices (Gardiner 2004).

*Evaluation of the HOPE for Elderly Independence Demonstration: Final Report* assesses one federal attempt to make the vouchers work better with home- and community-based services in the mid-1990s. It tested the use of service coordination for low-income, frail, elderly voucher recipients in scattered private apartments (Ficke and Berkowitz 1999).

*A Golden Opportunity: Managing the Risks of Service to Seniors* offers helpful information on training paid and volunteer staff in risk management strategies (Nonprofit Risk Management Center and Housing Authority Insurance Group 2003).

*Helping Elders in Public Housing and in HUD's Assisted Housing Stock to Age in Place Successfully via On-Site and Near-Site Housing-Based Healthcare Programs* provides some of the only multi-city data and analysis focused specifically on the health care needs of public housing's low-income seniors. The report includes some loosely described but striking observations about mobility impairments, the incidence of falls, social isolation, and other vulnerabilities among this population (Schwartz 2000).

*Housing America's Seniors* offers a concise overview of housing options, as well as data on economic and health disparities among the elderly and other factors that are shaping the demand for supportive housing today and in the future (Schafer 2000).

*Housing Our Elders* is the most coherent statement of recent federal strategies to expand affordable housing for seniors and to improve the range and coordination of housing and service combinations; it also provides basic information on the structures and tenants of various forms of HUD-assisted housing, including elder-occupied public housing (U.S. Department of Housing and Urban Development 1999).

*Linking Housing and Services: Six Case Studies* describes an initiative in two St. Paul high-rises through HUD's Congregate Housing Services Program, which has made no new grants for several years (Pynoos, Lanspery, and Hardwick 1994).

*Miami Housing Agency Brings Assisted Living to Frail Elderly* sketches Miami's first and most notable effort to convert a conventional high-rise into a fully licensed assisted living facility (FieldWorks 2001).

"Predictors of Nursing Home Placement among Elderly Public Housing Residents" and "Need and Unmet Need for Mental Health Care among Elderly Public Housing Residents": these two articles from *The Gerontologist* summarize research conducted at several Baltimore public housing projects by a team of Johns Hopkins medical and mental health researchers. They describe the high incidence of psychological and cognitive problems among seniors in public housing, as well as the forces that drive tenants toward institutionalization in nursing homes (Black, Rabins, and German 1999; Black et al. 1997).

“Public Housing: A Pioneer in Housing Low-Income Older Adults” places public housing for the elderly in its historical context, tracing major legislation and policy developments that explain its sudden rise and enduring constraints (Nenno 1994).

*Public Housing for Seniors: Past, Present, and Future* is the best source for basic facts on the housing stock and tenants’ demographics (Housing Research Foundation 2002).

*A Quiet Crisis in America* offers more than fifty policy recommendations, including ways to use the HOPE VI program and public housing in general to address the critical lack of appropriate housing and services for low-income seniors (Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century 2002).

*Report to Congress: Assessment of the Loss of Housing for Non-Elderly People with Disabilities: Final Report*, while concerned primarily with factors affecting the availability, affordability, and appropriateness of privately owned, HUD-assisted housing, this report also looks at the role of public housing in several large- and medium-sized metropolitan housing markets (Locke et al. 2000).

*State Assisted Living Policy 2002* provides helpful information about assisted living policies in each state, including information about Medicaid reimbursement policies (Mollica 2002).

*State-Funded Home and Community-based Service Programs* describes some home- and community-based services’ policies and programs (Braunstein 2001).

“The Transition to Section 8 Housing: Will the Elderly Be Left Behind?” This article appearing in the *Yale Law and Policy Review* reflects on problems in the design and utilization of Section 8 vouchers that may limit their usefulness for frail seniors (Cremin 2000).

*Understanding Medicaid Home and Community Services: A Primer*, prepared by the Health Care Finance Administration (now the Centers for Medicare & Medicaid Services), offers a detailed and systematic view of Medicaid; it includes a useful illustration of Medicaid’s potential applicability to assisted living facilities (U.S. Department of Health and Human Services 2000).

*Use of Housing Choice Vouchers in Assisted Living Facilities, Notice PIH 2000-41 (HA)*, an HUD notice (U.S. Department of Housing and Urban Development 2000).

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