



IDEA: Increase resident stability, choice, and health while reducing medical and related care expenses by merging community based long term care and supportive services with affordable senior housing

The Challenge and Opportunity

The U.S. is experiencing unprecedented changes in its elderly population. The senior population is expected to double by 2030, when one in five citizens will be over the age of 65. While those ages 85 and older made up 12 percent of the senior population in 2000, they are projected to account for almost 25 percent by 2050. Research shows a strong correlation between old age, chronic conditions, disability and the use of long-term care services. This convergence of trends places an enormous strain on the United States' long-term care system while exponentially increasing costs to Medicaid and Medicare.¹

Affordable senior housing properties, such as Section 202, low income housing tax credit or public housing communities, provide a cost-effective answer by providing affordable housing with supportive services. For seniors, housing and healthcare are no longer tangentially related, but intricately enmeshed: over two million lower-income seniors across the country live in affordable housing with supportive services. This number is certain to increase in the upcoming years because many residents have aged in place—the average age of residents in Section 202 properties is 84—and are experiencing declining health and increasing frailty and disability levels. Many residents are eligible for nursing home level of care, and thus, the typical resident services associated with senior housing do not suffice. Proactive housing providers have tried to cobble together various public and private resources to provide needed supports for elderly residents, but despite their efforts, many needs still go unmet. Developing a sustainable, cost-effective solution that addresses these issues requires transcending many of the barriers that have long separated executive departments to create models that harness multiple departmental programs. President Obama has seized upon this idea through the promulgation of a number of “historic interagency partnerships,” with housing playing a key role in many cross-department collaborations. Implementing a collaborative approach will help dampen the costly Medicare expenses associated with seniors cycling in and out of emergency rooms/hospitals and diminish

¹ In 2005, national spending for long-term care amounted to \$206.6 billion. Medicaid paid nearly half (49%) of this amount, while Medicare paid 20%. The primary source of long-term care services, Medicare and Medicaid, are already stressed under the current demands placed on them. Although the elderly and persons with disabilities comprise only one-fourth of Medicaid enrollees, they account for two-thirds of Medicaid spending, largely due to the high cost of nursing home services.

high Medicaid costs for seniors who unnecessarily or prematurely transfer to nursing homes because they need more care than is available at their housing site.

Although many states are redirecting their Medicaid systems to provide more home and community based services, Medicaid funding retains an institutional bias. In 2006, 75% of Medicaid long-term care spending for older persons and adults with physical disabilities went towards institutional care. Medicaid spending in 2004 for home and community based services provided through a waiver program for the aged and disabled averaged \$8,440 per beneficiary compared to \$25,585 for nursing home services. On average, Medicaid can support three persons with home and community based services for every person in a nursing home.

The economy of scale created by affordable congregate settings provides an efficient platform for the delivery of home and community based services to help residents meet their needs as they age and avoid recurring hospitalizations and unnecessary transfers to nursing homes. The potential also exists for these congregate properties to become a hub for service delivery, extending their reach into the surrounding neighborhoods to help even more seniors. Devising a cross-department, intergovernmental solution involving HUD, HHS and DOT will create a coherent, efficient result that can provide exponentially more services through resources sharing than each department operating in its respective capacity could. This document builds upon such ideas, reflecting President Obama's interagency mandate, and outlines a new framework that offers a normative, sustainable system for providing affordable housing with services. The authors encourage housing providers, service providers, the federal government, states, and local communities to play an active role in developing these creative strategies.

Guiding Principles

This proposed framework would enable current and future housing providers, States and localities to replicate successful models at scale seamlessly to meet local needs cost-effectively. The goal is to create an environment where providers can meet the evolving needs of most seniors in residential settings. Based on learning from the existing successful State and practitioner developed approaches, the following principles must guide the development and implementation of any new framework:

- Support residents so that they safely age in place as their health and functional needs change, thus preventing unnecessary or premature transfers to higher levels of care at higher costs to Medicare and Medicaid,
- Enable the tools and approaches for housing finance, including both operating and capital support, to work effectively with the tools provided for supportive services,
- Dedicate services funding to the housing property and/or housing residents,
- Allow for the provision of health related and other supportive services on site, increasing resident access,
- Permit delivery by the housing property and/or through partnerships with community service providers,
- Capitalize on the economy of scale created by congregate settings to provide for the efficient and cost-effective delivery of services.

Recommendations

The framework would have two essential components: (1) a housing platform with supportive services provided by participating housing providers and/or through partnerships or contracts with community service organizations, and (2) reliable, coordinated revenue streams to provide health and related supportive services for those who choose to receive them in a housing setting. *To be sustainable, this framework must make the funding streams, both housing and services capital, predictable, available and integrated from the outset.*

As the goal of this model would be to support a resident's ability to safely age in place, a range of services would be provided to meet a resident's evolving needs. A resident may initially be independent and benefit from wellness and prevention programs. As their health or frailty level begins to change, however, they benefit from congregate meals or help with keeping up their home to ultimately needing assistance with managing their personal care. The model would require a minimum level or package of supports, and available services might include:

- Care/case management
- Transportation
- Meals
- Wellness and prevention programs (fitness, education, wellness nurse, etc.)
- Homemaker services (shopping, running errands, housekeeping, laundry, etc.)
- Personal care (assistance with dressing, bathing, grooming, etc.)
- Medication management
- Nursing
- 24/7 protective oversight

The service delivery mechanism might vary—the housing provider might deliver services directly, it might contract for services from a community provider, or services might be made available through a combination of direct delivery and contracting. The key to the service model is flexibility. The objective would be to complement the array of services currently available in the community by improving resident access to existing services, facilitating a more efficient delivery of services to residents, and filling in gaps where resident needs may be going unmet.

The coordination and integration of housing and services and the creation of a sustainable funding source for the services would be accomplished through the following strategies executed in tandem to insure predictable and adequate resources for development and operation of the housing coupled with supportive service monies for the services appropriate for the resident community over time:

Housing Platform with Supportive Services

- **Expand the Low Income Housing Tax Credit (LIHTC) Program.**
Low income housing tax credits currently account for the lion's share of newly constructed and rehabilitated affordable housing projects for low- and moderate-income persons. Competition for tax credits is stiff, and only a few states have elected to

prioritize supportive senior housing projects in their allocation plans. A new supply of tax credits for service enriched senior housing would be created that would not force states to reallocate tax credits from other important uses. Housing sponsors would agree to use a portion of the equity raised by the new credits for the provision of support services. In addition, States would agree to provide a basis boost for senior service enriched supportive housing.

- **Expand the Section 202 Senior Housing Grant and Rental Assistance Contract.** To build additional housing with support services for very low income seniors, the Section 202 senior housing grant and rental assistance program would be expanded to require and pay for a portion of supportive services within the current 202 program. The Capital Advance would include funding for the capital costs associated with the delivery of services. The Project Rental Assistance Contract would include funding for a portion of the ongoing costs of the supportive services. Project selection would be delegated to the State Housing Finance Agencies and would allow mixed financing with tax credits. The program would authorize providers to set selection criteria for residents to achieve a particular mix of service needs that could be accommodated by supportive services funding.

Revenue Streams for Supportive Services

- **Establish a dedicated and predictable funding stream for the delivery of services in affordable congregate senior housing settings.** Currently, supportive and health-related services delivered in the community are funded through multiple mechanisms such as Older American's Act (OAA) programs, various State and local programs, and Medicaid waivers. Opportunities would be examined to retool or expand any of these current funding mechanisms in a way that could provide a predictable revenue stream for the provision of supportive services in senior housing properties. This could include a program that directs Medicaid home and community based services funding to senior housing settings or combines Medicaid funds with OAA funds to create a congregate services package. Food stamp funding on behalf of eligible seniors could be assigned to the housing provider to cover certain costs of a meals program.

A mechanism combining Medicaid and Medicare funding streams might also be considered to provide a more integrated and extensive package of health and medical related services and supports. Although most housing providers would not choose this option, a housing provider could provide the medical care itself or through an affiliate, assuming it was properly licensed, or it could contract with one or more other care providers. The goal of the funding mechanism would be to allow senior housing providers to respond to the range of resident needs in their properties and support residents' ability to remain safely in their own home as their needs change.

Existing, successful State models provide guidance and insight into how to craft a larger federal initiative. Attachment A includes examples of existing programs that fund services in affordable

senior housing settings and incorporate many of the principles described in this proposed framework.

Strategic Value

This approach offers a new framework for long term care service delivery that is more efficient and cost-effective and may help to preserve the financial viability of Medicaid and Medicare. At the same time, it honors seniors' choices and desires to remain in their own homes for as long as possible. This approach offers a model that can be implemented widely and in a way that is commensurate with the dramatic growth in the senior population and with the varying needs of the senior housing population. It builds on existing programs rather than reinventing the wheel. Finally, this new approach breaks down the existing silos and overturns a stale assumption – that housing and supportive services cannot be treated as one – as we address the demands of the future in long term care for seniors.

Illustrations of Successful Current Programs

The following are descriptions of three service models that have been successfully combined with either existing housing or newly built affordable housing. None of them, however, is perfect; nor does any one of them make the funding streams, both housing and services capital, predictable, available and integrated from the outset. Each, however, has aspects that can be adapted for the new framework and has elements that are a part of the new framework.

Mission Creek Senior Community Services Plan-Mercy Housing California

Mercy Housing California (MHC) is the owner, developer and manager of Mission Creek Senior Community (MCSC), an affordable housing community for seniors (elders 62 years and older), located in the Mission Bay Neighborhood of San Francisco. This affordable senior housing development offers 139 apartments which includes 51 apartments for very low-income disabled elderly households who are homeless or at risk of homelessness, 88 apartments for very low income elderly households, and one manager's apartment. All residents have incomes that fall below 50 percent of area median income (AMI) and are subsidized by Section 8 rent subsidies from either HUD through the SF Housing Authority or the San Francisco Department of Public Health.

A unique and critical component to MCSC is the existence of a 7,820 square feet adult day health center in the complex, operated by North and South of Market Adult Day Health, where a variety of health and social services are available for frail senior residents as well as other frail elders in the community at-large. Other non-residential uses in the complex include a branch of the San Francisco Public Library (7,535 sq ft.), community-serving retail (3,660 sq ft, housing a neighborhood coffee shop and "green" laundry); and a multi-purpose community space with warming kitchen and dining room (6,000 sq ft). Various lounges, laundry facilities, outdoor gardens and other appropriate residential amenities are built into the facility.

The program at Mission Creek Senior Community integrates on-site service staff and programs with linkages to community-based providers who have the capacity to provide a spectrum of

services for independent to frail seniors thereby offering a level of service not unlike assisted living. What follows is an overview of the services provided and the community-based agencies that provide them.

SERVICES	PROVIDER	FUNDING SOURCE
Property Management	Mercy Services Corp.	Property Budget/HUD subsidies
Resident Services Coordinator (RSC)	Mercy Services Corp.	Property Budget/HUD subsidies
Resident Services Coordinator (RSC)	Mercy Services/ ADHC	DPH subsidies
Resident Services Activity Director	Mercy Services	Property Budget/HUD subsidies
Adult Day Health Services	NSM-ADHC	Medi-Cal, DPH; VA, Private Funding
IHSS	DHS/DAAS	Primarily Medi-Cal
Case Management	Multiple Providers	Multiple sources, incl. DAAS – AoA funds, general fund and IHSS.
Meals – ADHC Clients	Project Open Hand	Medi-Cal, DAAS, Dept. of Education
Groceries	Food Bank	Private funding
Home-Delivered Meals	Multiple Providers, Coordinated by Clearinghouse	DAAS – AoA and General fund Private funding
Third-Party Rent Payment and Money Management	Lutheran Social Service currently providers for DAH clients	DPH
Transportation - Other	Para-transit Services, MUNI Accessible Srvs.	Transportation Authority
LGBTQ groups	MSC and Open House	
Health Services	Multiple Providers	DPH
Other specialized services, like Hospice, Home Health, DME, etc.	Multiple Providers	Medicare, Insurance, Medi-Cal, DPH
Substance Abuse Support Groups	AA, NA, DPH	Self-funded, volunteer run organizations
Social and Recreational Activities	Mercy Services Corp.	HUD
Wellness Promotion and Preventive Services	IOA and other well elder programs	Multiple

Illinois Supportive Living Model

Illinois' Supportive Living Program combines housing and supportive services offering the same care as traditional assisted living facilities, but in affordable settings. The Illinois supportive living model is administered through the Illinois Department of Healthcare and Family Service and the services are paid for under a federal Medicaid 1915c waiver specifically targeted to residents of Supportive Living Facilities (SLFs). SLFs offer apartment homes ranging from studios to two-bedroom apartments that residents can furnish themselves financed by a variety of housing finance tools, including low income housing tax credits, state financing programs, conventional financing or Section 202. Residents have access to services including three meals a day, housekeeping, social, education and wellness activities, help with bathing, dressing and medication management and scheduled transportation. In some cases, meal programs are paid for by the federal food stamp program. Food stamp eligible residents assign their food stamps to the provider in return for receiving all meals, snacks, and beverages. Residents who are not food stamp eligible have other optional meal plans. All Supportive Living residents must be able to take care of themselves and do not have health needs that require skilled, 24-hour nursing care.

The 1915c waiver designated the number of Medicaid-supported individuals that can be served under the model each year. Funding for the SLF services comes from the Medicaid waiver, food stamps, if available, and from a portion of the residents' SSI checks (on average, \$537.00 covers room and board and leaves each resident approximately \$100.00 for monthly pocket expenses). Currently there are 101 operating buildings with 8,000 apartments. The 1915c waiver allows up to 12,000 units, and 47 additional buildings are currently under development to achieve that level. The properties are developed by both for- and non-profit entities. There are two Section 202, one Section 232 and several LIHTC properties.

Seniors Aging Safely At Home (SASH) – The Vermont Initiative

Vermont's SASH system is based on the premise that high concentrations of seniors – whether in a senior housing community or a residential neighborhood – will create the opportunity to deliver health and wellness services in a far more coordinated and integrated manner with better health outcomes at a lower cost.

SASH will be funded by reforming traditional housing and health care funding programs. Housing resources such as the Low Income Housing Tax Credit Program and the HUD Section 202 program would be enhanced to allow more flexible use of these resources to accommodate the need for housing to serve as a setting for care. Similarly the Medicaid and Medicare programs will be bundled and made more flexible to align reimbursement incentives with the imperative to control chronic conditions and provide services in the least costly setting.

Inadequate care coordination has been identified nationally as a major issue for older adults in assuring quality of care, particularly for frail elders and person with multiple health problems being served by multiple providers in multiple settings. SASH is an organizational framework for care coordination at the community level.

How the SASH system works:

- (1) All residents in a residential setting are invited to participate in SASH regardless of whether they are “well” or extremely frail.
- (2) SASH is staffed by Coordinators and Wellness Nurses.
- (3) Participants’ current providers are invited to participate in the SASH as team members.
- (4) Participants are assessed cognitively, physically, functionally.
- (5) Individualized plans are developed for each participant.
- (6) If the participant has an existing provider, the care plan is led by that provider to avoid duplication of services.
- (7) SASH staff develop a Community Care Plan (CCP) by aggregating the needs identified in the individual plans such as needs across the community for medication management, falls prevention, homemaker services, or personal care services.
- (8) Community Care Plan is tailored to each SASH community; however, SASH sites have two menus to draw upon in designing their programs: an inventory of over 50 Evidenced Based Practices; and an inventory of Promising or Untested Practices.
- (9) SASH staff are sources of information; the contact person for the discharge planner at the hospital or nursing home; and the referral source to existing programs.

At the community level, SAHS creates a system that invests in early intervention and prevention at a lower cost; improve quality and timeliness of information; integrate primary, acute, chronic and long term care services; and reward efficiency.

Seniors Aging Safely At Home is intended to offer a system of Home & Community Based Services. SASH is a systems approach to better utilizing existing assets in a more efficient and humane fashion so that limited resources will be sufficient to meet future needs.