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**Adding Assisted Living Services To  
Subsidized Housing:  
Serving Frail Older Persons With Low Incomes**

by  
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and  
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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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## FOREWORD

This report coincides with a sea change in policy discussions regarding federal housing programs for older persons. Once the bastion of a “bricks and mortar” approach that narrowly defined the role of housing programs as providing a place to live, the Department of Housing and Urban Development (HUD) has begun to chart a new focus of providing supportive services to enable frail older residents to “age in place” longer. As a recent HUD report noted (HUD, 1999):

Public, private, and nonprofit owners of HUD-assisted elderly housing have worked hard to bring supportive services into their conventional multifamily housing models through the use of service coordinators, for example. Nonetheless, there is mounting evidence that many of their increasingly frail residents have more comprehensive assistance needs which demand supportive environments such as assisted living. Without extending such options to lower income seniors, the number of households forced prematurely into institutional living will certainly increase.

Congress has also focused on adding the supportive services that are typically available in assisted living facilities to traditional subsidized housing projects for older persons. The past two HUD appropriations from Congress (FY 2000 and 2001) have included funds to retrofit subsidized elderly housing projects for use as assisted living. In addition, Congress has authorized and funded a “Commission on Affordable Housing and Health Care Facility Needs in the 21<sup>st</sup> Century.” The Commission is charged with conducting a study that:

Identifies and analyzes methods of promoting a more comprehensive approach to dealing with housing and supportive service issues involved in aging and the multiple governmental agencies involved in such issues....

To explore some promising new models of service delivery, Robert Wilden, past national director of elderly housing at the HUD, and I have examined the current state of assisted living services in federally subsidized housing. The report that follows is but a first step in identifying residents’ needs and examining issues that arise when assisted living services are added to subsidized housing for older persons. Further research is especially needed on the long-term quality outcomes of such services and programs.

This report can be useful to policy decisionmakers, practitioners, housing providers, and consumer advocates as they search for ways to promote the independence and dignity of frail older persons with modest means. We believe the report will be especially timely in light of the work of the National Commission and recent Congressional efforts to make federal housing programs a major setting for such efforts in the future.

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## **EXECUTIVE SUMMARY**

### **I. INTRODUCTION**

Assisted living has grown rapidly as a supportive housing arrangement for many frail individuals who need help with activities of daily living but do not need constant skilled nursing. Because costs are high and public reimbursements are scarce, older persons with modest means have had limited access to assisted living. Policy decisionmakers have looked with increasing interest to the possibility of offering assisted living services in federally subsidized housing because of the concentration of frail older persons with low incomes who live in those settings.

### **II. PURPOSES**

This study has two main purposes:

- (1) To examine research on the potential demand for assisted living services in subsidized housing and on the current capacity to provide such services; and
- (2) To report on case studies of subsidized housing projects that have developed assisted living services and on the issues that frequently arise with such programs.

### **III. METHODOLOGY**

The study was conducted using two different approaches to the issues related to assisted living services in subsidized housing. The first approach examines the existing research on the potential demand for assisted living services among older residents in federally subsidized housing and the capacity to deliver such services. Because the policy goals of providing such services are to promote independence and prevent unnecessary institutionalization, this section compares risk factors for receiving nursing home services with the characteristics of the older residents in subsidized housing. In particular, similarities and differences in age, gender, income, disability, and informal family supports are described. Finally, the section examines the sparse research on the supportive services provided in subsidized housing, specifically, the service coordinator program and the federal Congregate Housing Services Program (CHSP). Although these programs generally do not provide a full regimen of assisted living services, they have played important roles in laying the groundwork for expanding to assisted living. A summary of this existing research appears in the Findings section below and in Section IV of the full report.

The second approach uses a case study method to explore important policy and management issues raised by providing assisted living services in subsidized housing. Seventeen sponsors of subsidized housing for older persons located in nine states participated in this research. The sponsors included in this study were those suggested by various housing experts or other sponsors. Efforts were made to include sponsors from states that provide substantial Medicaid funding for such services (e.g., New Jersey and North Carolina) as well as states that provide no Medicaid funding for assisted living in subsidized housing (e.g., Connecticut). Some sponsors were also selected because of their substantial experience with state (e.g., Maryland) or federal (e.g., New Hampshire) Congregate Housing Services Programs. Finally, the selection criteria

included both public housing and private not-for-profit sponsors. Because of the nonrandom method of selection, these results should be viewed as exploratory rather than representative of the limited universe of subsidized housing projects offering assisted living services.

Between October 1999 and January 2000, the lead author visited eleven sponsors located in seven states (CN, KY, MD, NJ, NH, NC, and VA). Interviews with six other sponsors were conducted by telephone or by mail. A Project Interview Schedule (Appendix A) was mailed to sponsors to obtain relevant data before the interviews. Major findings of that empirical research are summarized below and in Section V of the full report. Details from each of the case studies are reported in Section VI of the full report.

## **IV. FINDINGS**

### **A. THE POTENTIAL DEMAND FOR ASSISTED LIVING SERVICES IN SUBSIDIZED HOUSING: A RESEARCH REVIEW**

Almost no research directly addresses the issue of providing assisted living services in federally subsidized housing. Research does, however, indicate that federally subsidized housing has efficiently, if inadvertently, targeted older persons at risk of receiving nursing home services — especially those at risk of receiving Medicaid assistance for such services. Information from federal surveys and other studies shows that current residents of subsidized housing for older persons are similar in many respects to individuals living in nursing homes or to those deemed at high risk of entering nursing homes. Subsidized housing residents are overwhelming female; report more disabilities than older persons who do not live in subsidized housing; have very low incomes; and tend to have no one to turn to if they become sick or disabled.

The research review also indicates that capacity to provide assisted living services in subsidized housing depends on three factors: (1) characteristics of the physical plant; (2) the presence of services coordinators; and (3) previous experience with service provision. The federal CHSP, enacted in 1978, has been a major source of funding for both service coordinators and some supportive services. The federal CHSP has also been used as a model for a number of state programs that have, in some cases, provided the basis for expanding services to include assisted living in subsidized housing.

### **B. FINDINGS FROM CASE STUDIES**

While each project was unique, the following findings describe the important issues confronted by sponsors of subsidized housing for older persons who are offering assisted living services.

#### **1. FINANCIAL ISSUES**

- Finding funding sources for assisted living services is one of the most difficult issues faced by sponsors. Limited funding often requires developing multiple funding sources and can result in low staff pay and high turnover.

- On the plus side, assisted living services can sometimes help troubled housing projects and may result in overall cost savings compared to costs in a nursing home or a market-rate assisted living facility.

## **2. SERVICE DELIVERY ISSUES**

- Projects offering assisted living have retained a residential environment, and most provide services to residents throughout the building rather than grouping those who need services into one location.
- Most sponsors provide services à la carte and contract out at least some of their assisted living services.
- Smaller sponsors and those without mandatory meals programs may have more difficulty developing meal programs for assisted living residents.

## **3. LEVEL OF EFFORT AND TYPE OF HOUSING**

- States can greatly facilitate the expansion of assisted living programs in subsidized housing by developing statewide strategies and funding mechanisms.
- Public housing authorities and private nonprofit sponsors bring different strengths and resources to assisted living programs.

## **4. MANAGEMENT ISSUES**

- An effective assisted living program requires housing and services professionals to think and operate differently from how they might in a more traditional environment. Effective coordination, both within the building and with external service providers, can eliminate overlapping services, confusion, and potential conflicts.
- The assisted living programs have enhanced access to services by residents, whether or not they needed full assisted living services, with no evidence that providing such services has increased liability or insurance costs for the sponsors interviewed.

## **5. OTHER ISSUES**

- States vary widely as to how they regulate assisted living programs.
- Many facilities would benefit from modifications to accommodate assisted living programs and residents.

### **C. CONCLUSIONS FROM CASE STUDIES**

- The case studies in this report demonstrate that assisted living services can be successfully integrated into subsidized housing projects for older persons.
- The major obstacles to implementing assisted living services in subsidized housing are funding for services and training and coordination of housing and services staff.
- States that funded such programs have greatly facilitated the development of assisted living services in subsidized housing.
- State efforts to develop regulations and monitoring efforts specific to assisted living services in subsidized housing are in their nascent stages. If such services become more common, states will have to develop more effective ways to monitor and enforce quality.
- Research is needed to develop models and strategies for expanding assisted living services in subsidized housing nationwide and improving their quality.

# **Adding Assisted Living Services To Subsidized Housing: Serving Frail Older Persons With Low Incomes**

## **I. INTRODUCTION**

Assisted living has grown rapidly as a supportive housing arrangement for many frail individuals who need help with activities of daily living but do not need constant skilled nursing. Because costs are high and public reimbursements are scarce, older persons with modest means have had limited access to assisted living. Policy decisionmakers have looked with increasing interest to the possibility of offering assisted living services in federally subsidized housing because of the concentration of frail older persons with low incomes who live in those settings.

Although few subsidized housing projects offer assisted living,<sup>1</sup> both federal and state governments have taken steps to promote affordable assisted living in these environments. The past two appropriations (fiscal years 2000 and 2001) for the Department of Housing and Urban Development (HUD) have included \$50 million for converting elderly housing facilities to assisted living. The FY 2001 bill also included an additional \$50 million under the Section 202 program (the major federal program still producing housing for older persons) to develop new subsidized assisted living facilities.

Offering assisted living services in subsidized housing addresses issues related both to future directions for long-term care and to future missions for subsidized housing. Substantial numbers of frail older residents live in subsidized housing, the result of program targeting and resident aging-in-place. Most of these residents would prefer to stay in the familiar setting of their current homes with supports that enable them to remain independent. Many housing managers feel ill-equipped to handle the range of management responsibilities that have come about from having large numbers of frail tenants in their buildings (Stewart, 2000; American Association of Homes and Services for the Aging, 1997).

From the perspective of long-term care policy, substantial cost increases for skilled nursing care have created pressure to explore a wider range of options for older persons who need public support. In particular, pressure has mounted to provide assisted living services that are affordable to older persons with low incomes when such services can prevent or delay more costly nursing home care (Mollica, 2000).<sup>2</sup>

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<sup>1</sup> Only 5.1 percent of Section 202 facilities reported offering assisted living services in a 1999 survey (Heumann, Winter-Nelson, and Anderson, 2001). One out of four (24.6 percent) reported offering full or partial congregate services.

<sup>2</sup> Mollica (2000) contains a very useful discussion on increasing state efforts to provide Medicaid funding for assisted living.

The aging and frailty of the residents of federally subsidized housing, which many housing sponsors experience as management problems, may represent an opportunity for expanding long-term care options for older persons with modest means. Targeting supportive services to residents in subsidized housing for older persons could be an efficient way to save Medicaid dollars that now go to nursing home care while promoting the independence of frail older persons (Crystal, Kurland, and Rosenthal, 1996).

## **II. PURPOSES**

This report has two main purposes:

- (1) To examine research on the potential demand for assisted living services in subsidized housing and on the current capacity to provide such services; and
- (2) To report on case studies of subsidized housing projects that have developed assisted living services and on the issues that frequently arise with such programs.

## **III. METHODOLOGY**

The study was conducted using two different approaches to the issues related to assisted living services in subsidized housing. The first approach examined the existing research on the potential demand for assisted living services among older residents in federally subsidized housing and the capacity to deliver such services. Because the policy goals of providing such services are to promote independence and prevent unnecessary institutionalization, this section compares risk factors for receiving nursing home services with the characteristics of the older residents in subsidized housing. In particular, similarities and differences in age, gender, income, disability, and informal family supports are described.

The research review examined the sparse research on the supportive services provided in subsidized housing, specifically, the service coordinator program and the federal Congregate Housing Services Program (CHSP). Although these programs generally do not provide a full regimen of assisted living services, they have often laid the groundwork for expanding to assisted living. A summary of this existing research appears in the Findings section below and in Section IV of the full report.

The second approach used a case study method to explore important policy and management issues raised by providing assisted living services in subsidized housing. Seventeen sponsors located in nine states participated in this research. The sponsors included in this study were those suggested by various housing experts or other sponsors. Efforts were made to include sponsors from states that provide substantial Medicaid funding for such services (e.g., New Jersey and North Carolina) as well as states that provide none (e.g., Connecticut). Some sponsors were also selected because of their substantial experience with state (e.g., Maryland and New Jersey) or federal (e.g., New Hampshire) Congregate Housing Services Programs.

Finally, the selection criteria included both public housing and private not-for-profit sponsors. Public housing authorities used public housing, Section 8, and Low Income Housing Tax Credits to finance the housing. The nonprofit corporations used Section 236 and Section 202 funds. (See Table 1 below for a summary of funding sources used by participating projects in this study and the glossary in Appendix C for descriptions of these federal programs.)

Between October 1999 and January 2000, the lead author visited eleven sponsors located in seven states (CN, KY, MD, NJ, NH, NC, and VA). Logistical problems made site visits impossible for two sponsors in New Jersey, one in North Carolina, one in Washington State, and two in Minnesota. In most cases where site visits were not possible, a contact person for the sponsor filled out the Project Interview Schedule. In a couple of cases, the lead author interviewed contact persons by telephone to obtain this information. A Project Interview Schedule (see Appendix A) was sent in advance of an in-person or telephone interview in order to allow sponsors to prepare for the interview and to find requested data. Major findings of that empirical research are summarized in Section V below. Details from each of the case studies are reported in Section VI.

Due to the open-ended nature of the interviews and the different ways project owners or managers collect, retain, and retrieve data, the available information varied considerably among the projects described in this report. (See Appendix B for a list of the contact persons providing information.) Because of the nonrandom method of selection, these results should be viewed as exploratory rather than representative of the limited universe of subsidized housing projects offering assisted living services.

**Table 1: Housing Funding Sources for Sponsors**

	<b>Public Housing</b>	<b>Section 236</b>	<b>Section 202</b>	<b>Section 202/8</b>	<b>Section 202/PRAC</b>	<b>Section 8</b>	<b>Tax Credit</b>
Immanuel House (CT)		X					
Tower One/ Tower East (CT)			X	X			
Christian Church Homes (KY)		X		X			
Springvale Terrace (MD)			X				
Cedar Lane Apts. (MD)		X		X			
Homecrest House (MD)				X			
Minneapolis PHA (MN)	X						
St. Paul PHA (MN)	X						
Stafford House (NH)						X	X
Asbury Tower (NJ)		X					
Bernard Dubin House (NJ)				X			
VNA Central Jersey (NJ)						X	
Koinonia Apts. (NC)				X			
Preiss-Steele Place (NC)							X
Astor Dowdy Place (NC)	X						
Culpepper Garden (VA)		X		X	X		
Housing Authority Vancouver (WA)	X					X	
<b>TOTAL*</b>	<b>4</b>	<b>5</b>	<b>2</b>	<b>7</b>	<b>1</b>	<b>3</b>	<b>2</b>

\* Several sponsors have projects funded under more than one federal program, so the total project number is more than 17.

“Assisted living” lacks the precise definition that other terms such as “skilled nursing care” have. As used in this report, “assisted living” describes supports for activities of daily living (ADLs) *and* instrumental activities of daily living (IADLs). ADL assistance includes such services as bathing, dressing, toileting, transferring, and eating. IADL assistance includes such services as escort help for outside appointments, medication monitoring and cueing, bill paying, and health status monitoring. Most sponsors provide 24-hour supervision and medication management.

Not all of the projects in this report provide all of the services described in the above definition. Moreover, some projects use terms other than “assisted living” to describe the services provided. Indeed, some sponsors were reluctant to use the term “assisted living” to describe their services, in part because state laws vary significantly with regard to how they define and regulate assisted living. Nevertheless, all the projects described have one thing in common: they all focus on older people’s increasing need for assistance as they age, and they are all committed to making sure that supportive services are available to those who need them.

Although the case studies are exploratory in nature, they demonstrate a wide variety of approaches to providing assisted living to residents of subsidized housing. They include projects large and small; housing authorities with many projects in a given community; private, nonprofit owners of just one project; and sponsors who manage only housing as well as those who operate a whole spectrum of projects, including independent living, congregate, assisted living, and skilled nursing facilities.

The assisted living programs are as diverse as the sponsors and projects themselves; they include a variety of service packages with a mix of public and private financial support and use a diverse array of service provision models. Some sponsors have significant fundraising capacity and thus have been able to subsidize the services provided to residents. Others do not have such resources and have had to explore local and state agencies to find services that could be delivered at little or no cost to residents. Many programs have worked with state and local governments to improve regulatory oversight for assisted living, obtain Medicaid waivers, achieve better coordination among providers, and create new sources of funding for such services. The wide variety of projects, services packages, and financing illustrates how assisted living services can be successfully integrated into subsidized housing under a variety of circumstances.

The descriptions of the 17 sponsors were based on information from the Project Interview Schedule, telephone conversations, and, where possible, site visits. In each case, the contact person who was interviewed or who filled out the Project Interview Schedule was given the opportunity to review the information included in this report for accuracy. Some sponsors did not provide complete information. As a result, a few case studies omit information on some topics.

#### IV. THE POTENTIAL DEMAND FOR ASSISTED LIVING SERVICES IN SUBSIDIZED HOUSING: A RESEARCH REVIEW

Few housing sponsors offer assisted living, and almost no research directly addresses the issue of providing such services in federally subsidized housing. The following review focuses, therefore, on the potential demand for assisted living services and the capacity for meeting that demand. Because a major public policy goal of providing such services is to prevent premature institutionalization, the review focuses on the correspondence between risk factors for nursing home admission and characteristics of older residents in subsidized housing.

##### A. FEDERALLY SUBSIDIZED HOUSING FOR OLDER PERSONS

The federal government has made a substantial investment in a network of housing for older persons that reaches nearly every community in the country, providing a potentially efficient base for adding affordable assisted living services. As shown in Table 2, the nation's housing subsidy programs serve more than 1.7 million older households or roughly 1.9 million older residents,<sup>3</sup> which exceeds the 1.4 million older persons in the nation's nursing homes (National Center for Health Statistics, 2000).

	<b>Total</b>	<b>Age 62+</b>
<b>HUD Programs</b>		
Public Housing	1,120,000	358,400
Section 202	319,502	319,502
Section 221(d)(3)	109,861	21,437
Section 236	429,567	146,053
Section 8 new/rehab	744,889	343,673
Tenant Based Section 8	1,420,000	213,000
<b>Rural Housing Service</b>		
Section 515	453,275	190,829
<b>Federal Incentives via State Agencies</b>		
Low Income Housing Tax Credit	433,427	108,357
HOME	125,100	20,016
<b>Total</b>	<b>5,155,621</b>	<b>1,721,266</b>

<sup>3</sup> The number of individuals is derived by multiplying the number of households by 1.1, a standard multiplier used by HUD to estimate individuals living in housing for older persons.

<sup>4</sup> Data in this table come from Kochera 2001.

## **B. TARGETING TO THOSE IN NEED**

Housing programs serving older persons have efficiently, if inadvertently, targeted those at risk of receiving nursing home services. A 1989 Urban Institute study estimated that one-third of older residents in federally subsidized housing had some degree of frailty and that seven percent were at substantial risk of needing institutional care (Struyk, et al., 1989). Those numbers have almost certainly risen since that report was written, given the aging-in-place of many residents with increased levels of frailty. The past decade has also seen some increase in the availability of supportive services.

The risk of needing nursing home care is linked to a number of factors: age, disability level, income, gender, and availability of informal support from family and friends. For each of these factors, tenants in federally subsidized housing for older persons are at much higher risk than the general older population. Moreover, because of the income-eligibility criteria for subsidized housing, most residents are either currently eligible for Medicaid assistance or would soon become eligible if they had costly health problems.

### **1. AGE**

Because of the greater risk of severe disability and greater use of institutional care for older persons with disabilities, the risk of nursing home use goes up dramatically with advancing age. The likelihood of severe disability increases from 1 in 30 for those aged 65 to 74 to 1 in 10 for those aged 75 to 84 to 1 in 3 for those aged 85 and older (Stucki and Mulvey, 2000). According to the 1997 National Nursing Home Survey, there were 10.8 nursing home residents per thousand population aged 65 to 74, 45.5 per thousand aged 75 to 84, and 192.0 per thousand aged 85 and older (National Center for Health Statistics, 2000). Among persons aged 95 and older, 43.1 percent are receiving institutional care (Spector, et al., 2000).

The relationship between nursing home risk and age takes on added significance in the context of federally subsidized housing for older people where the average resident age has been steadily rising. In three waves of national surveys of the Section 202 Elderly Housing Program, the average age of residents rose from 72.0 years in 1983 to 73.6 years in 1988 to 75.0 years in 1999. The oldest projects also had the oldest residents. Among projects built before 1974, the average age of residents was 78.1 years, with 38.6 percent of residents older than 80 years (Heumann, Winter-Nelson, and Anderson, 2001).

Section 202 housing managers were asked in the 1999 survey to name the primary reasons applicants seek their housing. As Table 3 indicates, support with frailties was cited much more frequently as the primary reason for seeking elderly housing among applicants 80 years and older.

**Table 3: Needs Influencing the Decision to Move to Section 202 Housing by Age of the Applicant<sup>5</sup>**

<b>Age of the applicant</b>	<b>Financial assistance</b>	<b>Support with frailties</b>	<b>Increased social contacts</b>	<b>Improved housing quality</b>	<b>Improved security</b>
Under 62	64.8%	9.4%	2.7%	20.0%	3.1%
62-69	64.0%	2.7%	9.1%	16.0%	8.3%
70-79	51.7%	7.7%	11.6%	13.8%	15.2%
Over 80	48.1%	20.3%	4.3%	10.4%	16.9%

## **2. GENDER**

Older women are more at risk of entering a nursing home than older men, partly because women have higher disability rates and because they tend to live longer than their husbands and, therefore, have less support when they need it. Among persons aged 85 and older, 24.2 percent of men have severe disabilities compared to 38.2 percent of women (Stucki and Mulvey, 2000). Women are consequently much more likely than men to enter a nursing home – 52 percent vs. 33 percent (Kemper and Murtaugh, 1991). Nursing home stays are also much longer for women. The average length of stay for women is 319 days compared to 201 days for men, and women are twice as likely as men to stay for five years or longer. As a result, women outnumber men in nursing homes by roughly three to one (74.6 percent to 25.4 percent) (National Center for Health Statistics, 2000).

The predominance of older women in subsidized housing for older persons is strikingly similar to that in nursing homes, even given the gender imbalance among the general population of older persons. The 1999 Section 202 survey found that women outnumbered men by a ratio of more than three to one – 77.6 percent to 22.4 percent (Heumann, Winter-Nelson, and Anderson, 2001). Similar gender ratios are also to be found in other types of subsidized housing for older persons.

## **3. INCOME**

Eligibility for housing assistance varies somewhat, depending upon the funding program and the location of the housing. In general, housing assistance is limited to those who have incomes below 50 percent of the local median income. In 1997, the median income for older households in public housing was \$7,451; for project-based Section 8, it was \$8,227; and for other programs, it was \$10,669 (Department of Housing and Urban Development, 1999).

Average incomes at these levels mean that many subsidized housing residents are currently eligible for Medicaid assistance and others would soon be eligible if they needed care. Medicaid eligibility is generally tied to eligibility for the Supplemental

<sup>5</sup> Heumann, Winter-Nelson, and Anderson 2001.

Security Income (SSI) program, which was set at under \$6,000 in income and under \$2,000 in assets in 1999. If an individual is not eligible for SSI, in many states he or she may use incurred medial expenses to “spend down” income to the state’s Medicaid income cut-off. Some states do not let a person spend down. Instead, his or her income must be under 300 percent of the SSI federal benefit level (Kassner and Shirley, 2000).

#### 4. DISABILITY

The most obvious risk factor contributing to institutionalization of frail older persons is level of disability. According to data from the both the Survey of Income and Program Participation (SIPP) and the American Housing Survey (AHS), older tenants in subsidized housing report much higher levels of disability than other older renters or homeowners. Although the two surveys used somewhat different lists of ADLs and IADLs to measure disability and worded questions somewhat differently, the pattern from each survey was very similar, as shown in Table 4.

**Table 4: Percent of Older Persons Reporting Disabilities by Housing Tenure<sup>6</sup>**

	<b>Older Homeowners</b>	<b>Older Unsubsidized Renters</b>	<b>Older Subsidized Renters</b>
Some difficulty with an ADL or IADL (1994-1995 SIPP)	18.8	28.1	40.2
Need help with an ADL or IADL (1995 AHS)	16.2	18.8	31.5

IADL limitations have been shown to be directly related to increased risk of nursing home placement among public housing residents (Black, Rabins, and German, 1999). The relatively high level of self-reported disability among older subsidized renters is in line with managers' estimates of disabilities as reported in the 1999 survey of Section 202 housing. In that survey, managers estimated that 22.3 percent of their residents were frail, compared to the 13 percent estimated in the 1988 survey. Much more dramatic were the increases in specific disabilities reported by these managers. (See Table 5.)

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<sup>6</sup> Survey of Income and Program Participation, 1994-1995 (U.S. Census Bureau, 1995), and the American Housing Survey, (Department of Housing and Urban Development, 1995); Analysis by AARP Public Policy Institute. These data are the most recent collected that allow for analysis of disability levels for older persons with differing housing tenure (i.e., owner or renter).

**Table 5: Percent of Residents Having Difficulty Performing Various Activities, as Reported by Manager<sup>7</sup>**

	<b>1988 All Projects</b>	<b>1999 All Projects</b>
Getting out of chairs	11.0	30.5
Getting to and from places	11.4	34.0
Performing personal care	4.9	18.5
Taking Prescribed Medications	NA	18.9
Preparing Meals	5.4	18.7
Finding way into apartment	0.8	1.9
Remembering to do things	4.0	11.2
Doing Laundry	6.5	21.3
Doing Housekeeping	9.4	26.6
Average of all activities	NA	20.2

## 5. FAMILY SUPPORT

Family support is a very strong predictor of nursing home placement. According to the National Academy on Aging, only seven percent of older persons with long-term care needs who have family supports are living in nursing homes compared to 50 percent of those who have no family supports (Stone, 2000). Having a spouse present is generally the first line of support, followed by adult children living in close proximity. Older renters in subsidized housing are far less likely to have a spouse present than older homeowners or other older renters, as indicated in Table 6.

**Table 6: Older Household Type (Aged 65 and Older) by Housing Tenure<sup>8</sup>**

	<b>Homeowners</b>	<b>Renters, No Subsidy</b>	<b>Renters, Subsidized</b>
Married, Spouse Present	66.2%	36.0%	15.3%
Living Alone	23.0%	48.2%	74.9%
Other	10.8%	15.8%	9.8%

<sup>7</sup> Heumann, Winter-Nelson, and Anderson, 2001.

<sup>8</sup> Survey of Income and Program Participation, 1994-1995 (U.S Census Bureau, 1995); Analysis by AARP Public Policy Institute.

Data have not been collected on the numbers of relatives or friends who are available to provide informal support to residents in subsidized housing, though some studies suggest that such support is weak. An evaluation of participants in the federal Congregate Housing Services Program (CHSP), a program that provides supportive services to frail residents, found that one in three participants (32 percent) had no living children (U.S. House of Representatives, 1987). In a more recent survey of 573 older residents in subsidized housing in Florida, one-third of the respondents (34 percent) replied that they had no one to turn to for help in the event they were sick or disabled (Golant, 1999).

## **C. CAPACITY TO DELIVER SERVICES**

The capacity to provide assisted-living-level supportive services to frail older residents varies enormously, depending on: (1) characteristics of the physical plant, (2) the presence or absence of service coordinators on staff; and (3) previous experience with service provision.

### **1. CHARACTERISTICS OF THE PHYSICAL PLANTS**

Some housing facilities are more capable of providing assisted living than others by virtue of their physical plants. Larger facilities with commercial kitchens, dining areas, and other common spaces may be able to add assisted living services with relatively little retrofitting. Smaller facilities with limited common spaces may be ill equipped to provide such services without having to make major alterations to the physical plant.

As federal funding for housing to meet the needs of older persons has declined in recent years, smaller facilities with fewer amenities have been built. Moreover, cost-containment measures instituted in the mid-1980s severely limited common spaces for services. More than 60 percent of Section 202 facilities occupied before 1984 provided congregate dining compared to half that many projects (29 percent) occupied in the mid-1980s (Heumann, Winter-Nelson, and Anderson, 2001).

### **2. CONGREGATE SERVICES AND SERVICE COORDINATORS**

An important precursor to assisted living for residents of subsidized housing has been the federal CHSP. Enacted in 1978, the CHSP funds congregate services in approximately 100 subsidized housing projects. Most funds go toward service coordination and meals; however, the CHSP has been effective in leveraging other supportive services such as housekeeping, transportation, and personal care (U.S. House of Representatives, 1987).

Although the CHSP is small, its impact has been significant. Until the housing acts of 1990 (42 U.S.C. 8012)<sup>9</sup> and 1992 (12 U.S.C. 1701(q)(g)),<sup>10</sup> housing sponsors were forbidden to include any social services staff in their budget requests except for the few projects participating in the CHSP. Since the authorization and subsequent funding of

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<sup>9</sup> 42 USC 8012 amended the National Housing Act of 1959 to allow service coordinators in Section 202 housing.

<sup>10</sup> 12 USC 1701(q)(g) added authority for service coordinators in other public and assisted housing serving older persons or persons with disabilities.

service coordinators that began in fiscal year 1993, the number of service coordinators has grown dramatically. The 1999 National Survey of Section 202 found that 37.4 percent of elderly housing projects now have service coordinators on staff (Heumann, Winter-Nelson, and Anderson, 2001). Although comparable survey data do not exist on other housing programs, a 1998 report estimated that 3,700 resident service coordinators were employed in federally subsidized housing nationwide (Mokkler and Monks, 1998).

Few service coordinators are able to offer full assisted living programs, but they are able to connect frail residents with many services that are frequently included in assisted living programs. The 1998 report on service coordinators found that the services most frequently used by their clients were housekeeping (85.0 percent), home healthcare (83.7 percent), and personal care assistance (79.0 percent) (Mokkler and Monks, 1998). In a HUD evaluation, coordinators agreed that the program was effective in “improving the quality of life for the residents, linking residents with the services they need to continue living independently, and assessing and monitoring residents’ needs for and use of services” (Department of Housing and Urban Development, 1996).

### **3. SERVICES EXPERIENCE**

Subsidized housing projects vary enormously in the services they offer. Reflecting the greater need as well as the larger size and greater physical capacity of the older projects, the 1999 survey of Section 202 housing found that older projects were far more likely to offer supportive services than newer projects. Fifty-nine percent of projects occupied before 1974 offered meals or housekeeping services compared to less than 20 percent for the periods since the mid-80s (Heumann, Winter-Nelson, and Anderson, 2001).

In addition to laying the foundation for the service coordinator program, the federal CHSP has also served as a model for a number of state programs. The state and federal CHSP programs have provided the basis in some states for expanding services still further to include assisted living in subsidized housing. For example, New Hampshire expanded its federally funded CHSP program to housing authorities throughout the state, using Medicaid waivers to provide health-related services beyond the basic CHSP model in subsidized housing projects (Martin and Salloway, 1997). Maryland has a similar state-funded CHSP that provides assisted living services in several projects.

New Jersey has the most extensive program for using its statewide CHSP as a base for expanding to assisted living services in subsidized projects. The state developed a new licensing category specifically to encourage assisted living programs in subsidized housing projects (Crystal, Kurland, and Rosenthal, 1996). Fourteen services providers are currently licensed in the state to provide assisted living programs in 37 different subsidized housing projects throughout the state. New Jersey uses Medicaid waivers to provide support for both the CHSP and assisted living programs and is seeking state funding for residents who are not eligible for Medicaid.

Similarly, Maine now includes its CHSP as one of three “assisted living” licensure categories – along with adult family care homes and residential care facilities. The state’s Bureau of Elder and Adult Services characterizes congregate housing services as “Maine’s preferred type of assisted living” because the regulations require private apartments with individual bathroom and food preparation areas. More than 300 individuals are served by congregate “assisted living” (State of Maine, 2001).

#### **D. CONCLUSIONS FROM THE RESEARCH REVIEW**

The network of federally subsidized housing has enormous potential to promote the independence of frail older persons with low incomes by providing assisted living services. Characteristics of older residents in subsidized housing mirror the risk characteristics of those needing nursing home care in terms of age, gender, income, disability level, and informal supports. Many sponsors have the capacity to provide assisted living because of building facilities, service coordination staffing, and experience providing limited supportive services. Although limited in size, the federal CHSP has spawned similar state programs that have become the basis for efforts to subsidize assisted living for residents with low incomes.

## E. REFERENCES FOR RESEARCH REVIEW

- AAHSA (American Association of Homes and Services for the Aging). 1997. **Affordable Assisted Living: Options for Converting or Expanding Housing to Assisted Living**. Washington, DC: American Association of Homes and Services for the Aging.
- Bishop, Christine E. 1999. "Where Are the Missing Elders? The Decline in Nursing Home Use, 1985 and 1995." **Health Affairs**, July/August, pp. 146-155.
- Black, Betty Smith, Peter V. Rabins, and Pearl S, German. 1999. "Predictors of Nursing Home Placement Among Elderly Public Housing Residents." **The Gerontologist**, vol. 39, no. 5, pp. 559-568.
- Crystal, Stephen, Carol H. Kurland, and Lila Rosenthal. 1996. **Expanded Services for Frail Elderly Tenants**. New Brunswick, NJ: Rutgers University, Institute for Health, Health Care Policy, and Aging Research.
- Department of Housing and Urban Development. 1999. **Housing Our Elders: A Report Card on the Housing Conditions and Needs of Older Americans**. Washington, DC: U.S. Department of Housing and Urban Development.
- Department of Housing and Urban Development). 1996. **Evaluation of the Service Coordinator Program**. HUD Report No. 1613-PDR. Washington, DC: U.S. Department of Housing and Urban Development.
- Department of Housing and Urban Development. 1995. **American Housing Survey**. 1995. Washington, DC: U.S. Department of Housing and Urban Development.
- Golant, Stephen M. 1999. **The CASERA Project: Creating Affordable and Supportive Elder Renter Accommodations**. Gainesville: University of Florida.
- Heumann, Leonard, Karen Winter-Nelson, and James Anderson. 2001. **The 1999 National Survey of Section 202 Housing for the Elderly**. AARP Public Policy Report #2001-02. Washington, DC: AARP.
- Kassner, Enid, and Lee Shirley. 2000. **Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community-Based Waiver and Nursing Home Services**. Washington, DC: AARP.
- Kemper, Peter, and Christopher M. Murtaugh. 1991. "Lifetime Use of Nursing Home Care." **New England Journal of Medicine**, February 28, pp. 595-600.
- Kochera, Andrew. 2001. "A Summary of Federal Rental Housing Programs." **Public Policy Institute Fact Sheet # 85**. Washington, DC: AARP.

Martin, Tamara A. and Jeffrey Salloway. 1997. **Evaluation, The Tavern Alternative Housing Program: Providing Alternative Housing for Low-Income Seniors.** Concord, NH: The New Hampshire Health Care Transition Program.

Mokkler, Pamela M., and Janice C. Monks. 1998. "National Resident Service Coordinators' Perceptions Study: The Role of Service Coordination in Independent Housing Communities." **Quality Aging Solutions Report.**

Mollica, Robert. 2000. **State Assisted Living Policy: 2000.** Portland, ME: National Academy for State Health Policy.

National Center for Health Statistics. 2000. **The National Nursing Home Survey: 1997 Summary.** Washington, DC: U.S. Department of Health and Human Resources, National Center for Health Statistics.

Rhodes, Jeffrey A., and Nancy Krauss. 1999. **Nursing Home Trends, 1987 and 1996,** Publication No. 99-0032. Rockville, MD: Agency for Healthcare Policy and Research.

Spector, William D., John A. Fleishman, Liliana E. Pezzin, and Brenda C. Spillman. 2000. **The Characteristics of Long-Term Care Users.** Publication No. 00-0049. Rockville, MD: Agency for Healthcare Policy and Research.

State of Maine, Bureau of Elder and Adult Services. 2001. "Overview of Maine's Assisted Living Programs." Presented at the "Coming Home" program sponsored by the Robert Wood Johnson Foundation and the National Cooperative Bank.

Stewart, Julie Masker. 2000. "Aging in Place: The Impact on Public and Affordable Housing," **Housing and Community Revitalization Strategies**, Summer, vol.# 2, issue 2.

Stone, Robyn. 2000. "Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century." **Milbank Memorial Fund.**

Struyk, Raymond J., Douglas B. Page, Sandra Newman, Marcia Carroll, Makiko Ueno, Barbara Cohen, and Paul Wright. 1989. **Providing Supportive Services to the Frail Elderly in Federally Assisted Housing**, Report 89-2. Washington, DC: The Urban Institute.

Stucki, Barbara, and Janemarie Mulvey. 2000. **Can Aging Baby Boomers Avoid the Nursing Home?** Washington, DC: American Council on Life Insurance.

U.S. Census Bureau. 1995. **Survey of Income and Program Participation 1994-1995.** Washington, DC: U.S. Census Bureau.

U.S. House of Representatives, Select Committee on Aging. 1987. **Dignity, Independence, and Cost-Effectiveness: The Success of the Congregate Housing Services Program.** Report No. 100-650.

**STATUTES CITED**

42 U.S.C. 8012

12 U.S.C. 1701(q)(g)

## **V. ADDING ASSISTED LIVING SERVICES TO SUBSIDIZED HOUSING: FINDINGS FROM CASE STUDIES**

The following section summarizes major issues that emerged from case studies of 17 projects that provide assisted living services to frail older residents. Section VI provides more detailed descriptions of the programs in these projects. Each project has confronted problems such as service availability, staffing, and building limitations. As a hybrid between housing and services, subsidized housing projects often have to deal with unique issues that are different from purpose-built assisted living. Limited resources and experience sometimes force compromises that restrict services. The problems these innovative projects have confronted and the solutions they have devised can be very instructive to policy decisionmakers, housing sponsors, and services providers.

### **A. FINANCIAL ISSUES**

#### **1. FUNDING**

*Finding funding sources for assisted living services is one of the most difficult issues faced by sponsors. They typically find it necessary to develop several funding sources.*

Given the expense of assisted living services and the limited resources of residents, sponsors have had to be creative in finding funding sources for services to frail residents. Typically, sponsors arrange services through an array of public and private sources. Seven sponsors reported three funding sources, five sponsors had four funding sources, and one sponsor reported five funding sources. Table 7 shows the services funding sources for the 17 sponsors.

**Table 7: Funding Sources for Services with 17 Subsidized Housing Sponsors**

	Resident	Medicaid	OAA Title IIB	Fed/ State CHSP	HUD Grant	State	County	Comm. Action Prog.	Private
Immanuel House (CT)	X				X				X
Tower One/ Tower East (CT)	X				X				X
Christian Church Homes (KY)	X	X				X			X
Springvale Terrace (MD)	X			X			X		X
Cedar Lanes Apts. (MD)	X				X				
Homecrest House (MD)	X					X	X		X
Minneapolis PHA (MN)						X	X		
St. Paul PHA (MN)	X	X							
Stafford House (NH)	X	X				X			
Asbury Tower (NJ)	X	X		X					
Bernard Dubin House (NJ)	X	X		X					
VNA Cent. Jersey (NJ)	X	X		X					
Koinonia Apts. (NC)	X		X				X	X	
Preiss-Steele House (NC)	X	X	X						
Astor Dowdy Pl. (NC)	X	X	X	X	X				
Culpepper Garden (VA)	X					X	X		X
Housing Authority Vancouver (WA)	X	X							
<b>TOTALS</b>	16	9	3	5	4	5	5	1	6

Sponsors vary in the degree to which services are funded from private contributions or from publicly subsidized sources. Sixteen sponsors require at least some resident payments for services. Residents pay virtually the full cost at Cedar Lane Apartments (MD). Because public subsidies are lacking, several owners also have developed substantial fundraising capacity and fund their programs primarily from resident payments and private fundraising. Immanuel House and Tower One/Tower East (CN),<sup>11</sup> Christian Church Homes (KY), and Homecrest House (MD) fall into this category.

Nine sponsors have residents who benefit from Medicaid home and community-based waivers but they use a variety of approaches. For example, Stafford House (NH) received its initial funding from a special state account set aside from Medicaid funds. The housing authority worked with the state to develop a Medicaid waiver proposal to provide more stable funding.

CHSP programs are also significant sources of public funding for a limited number of projects. Five sponsors receive federal or state CHSP funding. Local public resources are also often tapped to provide services. For example, Preiss-Steele Place (NC) convinced the county to provide one of its social workers on-site each week to do case management at no cost to either the project or the residents. In the Minneapolis Public Housing Authority, all services are paid for by state or county programs.

## **2. CONTROLLING COSTS VS. REASONABLE PAY FOR WORKERS**

*Funding limitations result in relatively low staff pay that can result in high staff turnover.*

Owners are strongly motivated to keep assisted living costs as low as possible in order to make services affordable. In cases like Cedar Lane Apartments (MD), where the residents pay the full cost of services, the cost issue is particularly acute. Nurses aides or assistants are the core staff for providing personal care. Many of these people are paid at or near minimum wage. Paying at this level may keep costs down but makes it difficult to develop a loyal and committed staff, which often results in high staff turnover.

## **3. IMPACT OF ASSISTED LIVING ON TROUBLED PROJECTS**

*Assisted living services can help troubled housing projects financially by making otherwise hard-to-rent efficiency units marketable to assisted living residents.*

Assisted living can benefit a project economically and contribute to the well-being of residents. Efficiency apartments are often in less demand because consumers want a separate bedroom. Projects with such units can sometimes benefit from converting efficiency apartments to assisted living units.

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<sup>11</sup> Because Connecticut does not make extensive use of Medicaid waivers, both Tower One/Tower East in New Haven and Immanuel House in Hartford have created nonprofit fundraising bodies, have brought services available within their communities into their facilities at no cost to the facility, and have provided some services to residents on a fee-for-service basis.

Springvale Terrace (MD) had a cluster of efficiency apartments that were very difficult to rent because of their location, which required a trip on two separate elevators to reach the central dining room. By adding a nursing station and a small dining room as well as upgrading the units, it became possible to rent them to persons requiring enhanced personal care. Cedar Lane Apartments (MD) includes 22 efficiency units without kitchens. After the facility was licensed for assisted living, these units were marketed to applicants requiring enhanced personal care for whom kitchens were less important.

An assisted living program may not have as dramatic an impact on the economics of other projects as in the two described above. However, of the eleven sponsors visited by the lead author, none showed adverse economic impacts as a result of providing assisted living services, and most showed at least a modest positive impact. Immanuel House (CN) is in a highly competitive market and has no waiting list but has only seven vacancies out of 201 units. The administrator believes that vacancies would be higher if the project did not provide the rich menu of resident services that it does. Tower One/Tower East (CN) is also in a competitive market with no waiting list, and only five out of its 365 units are vacant. The administrator believes that safety features, as well as the extensive services available, have been essential to keeping the buildings full.

In projects with long waiting lists, such as Culpepper Garden (VA) and Bernard Dubin House (NJ), it is more difficult to assess the impact of the assisted living program on the economics of the projects. It may be that their waiting lists are long because they offer desirable services and their turnover rates are low because residents stay who without supportive services would otherwise have to move.

#### **4. COST DATA FOR ASSISTED LIVING PROGRAMS**

*The limited data available suggest that providing assisted living services in subsidized housing may result in overall cost savings compared to costs in a nursing home or a market-rate assisted living facility.*

Cost data were insufficient to make conclusive comparisons among assisted living programs or between assisted living in subsidized housing versus private assisted living projects or nursing homes. Projects vary in the services that they offer (as do private assisted living projects) and the information that they gather. Among projects that kept relatively complete cost data, the cost of assisted living services in subsidized housing was substantially less than most market-rate assisted living or skilled nursing facilities. Table 8 shows the average monthly cost of services in those projects for which data were available.

**Table 8: Selected Characteristics of 17 Assisted Living Services Sponsors**

	<b>Average Monthly Cost (Exclusive of Rent)</b>	<b>Scattered Units (Yes/No)</b>	<b>Services Provided: Directly (D) Contracted (C) Mixed (M)</b>	<b>Average Age: All Residents</b>	<b>Average Age: Assisted Living Residents</b>
Immanuel Tower (CT)	NA	Y	C	78	NA
Tower One/ Tower East (CT)	NA	Y	M	86	NA
Christian Church Homes (KY)	\$1,414	N	D	82	NA
Springvale Terrace (MD)	\$1,109 (1)	Y & N	D	85	85
Cedar Lane Apts. (MD)	\$1,225 (2)	Y	D	83	86
Homecrest House (MD)	\$886 (3)	N	M	83	88
Minneapolis PHA (MN)	\$800	Y & N	C	NA	NA
St. Paul PHA (MN)	\$1,117	Y	C	NA	NA
Stafford House (NH)	\$588	Y	M	76	NA
Asbury Tower (NJ)	\$407 (4)	Y	M	77	81
Bernard Dubin House (NJ)	NA	Y	M	84	NA
VNA Central Jersey (NJ)	NA	Y	C	NA	NA
Koinonia Apts. (NC)	NA	Y	C	79	NA
Preiss-Steele Place (NC)	NA	Y	C	68	NA
Astor Dowdy Place (NC)	\$424	Y	M	68	74
Culpepper Garden (VA)	\$1,100 (5)	N	D	80	NA
Housing Authority Vancouver (WA)	\$1,500- \$1,800 (6)	Y	C	NA	NA

- (1) Monthly charge to enhanced personal care residents; may not reflect total cost of services
- (2) Monthly charge to resident receiving intensive services
- (3) Monthly charge to resident; may not reflect the total cost of services
- (4) Includes cost of both CHSP and Expanded Services Program (ESP) funded by Medicaid
- (5) Projected charge to resident (facility not yet open at time of interview)
- (6) Covers both rent and services; \$1,500 is for the lowest level of care and \$1,800 is for the highest

Among those projects that keep relatively complete cost information is Christian Church Homes (KY). The total monthly services cost per assisted living resident is \$1,414, which includes \$329 for meals (three meals, seven days a week), \$38 for housekeeping, and \$1,047 for personal care. In addition, the rent for an efficiency apartment is \$570 per month for a total cost of \$1,984. Few, if any, residents pay this amount, because HUD provides housing subsidies, and the sponsor provides service subsidies. Furthermore, most residents are Medicaid-eligible and benefit from state supplemental funds.

A private assisted living provider manages the program for the Housing Authority of Vancouver (WA). The assisted living provider receives tenants' contributions as well as a reimbursement (primarily Medicaid) of \$1,500 to \$1,800 per resident per month, depending on the level of care required. The provider pays the housing authority for the rent and contracts for services under an arrangement worked out between the state Medicaid program and the assisted living provider.

Most sponsors did not include rent as part of their cost reports. The Amherst H. Wilder Foundation, which funds assisted living services in several housing projects in St. Paul, Minnesota, reports an average monthly cost per resident of \$1,117, which includes food and services but not rent. In New Jersey, the Asbury Park project was a pilot project for assisted living in subsidized housing and was closely monitored and evaluated by Rutgers University. The average cost for a Medicaid-eligible participant was \$6,548 per year excluding rent. The market rent for an efficiency apartment was \$530 per month or \$6,360 per year. The total of \$12,908 fell well below the average Medicaid cost for skilled nursing care of \$36,000 in 1996 in New Jersey. The average monthly cost shown in Table 9 for Asbury Park is significantly lower than \$6,548 per year because most residents did not require the full array of assisted living services.

## **B. SERVICE DELIVERY ISSUES**

### **1. SCATTERED VS. CONCENTRATED ASSISTED LIVING UNITS**

*Assisted living residents in most projects are scattered throughout the building rather than grouped in one location.*

Although some projects have located all residents receiving assisted living services in one area, most provide the services to persons throughout the building (See Table 9 above). Sponsors who have located all service recipients in one area argue that such an approach creates cost savings due to economies of scale and the savings of staff time. On the other hand, sponsors who have assisted living residents scattered throughout the building argue that this arrangement ensures that these residents are not set apart or stigmatized in relation to other residents of the project, and it also allows residents to obtain assisted living services without having to move.

State policy and a project's physical configuration can dictate choices. New Jersey regulations prohibit requiring residents to move to a special section in the building to receive services. Dealing with a peculiar physical plant, Springvale Terrace (MD) had a cluster of efficiency units that were very difficult to rent because of their location and size. However, such units lend themselves to providing assisted living services. The location of the unit dictated a solution of offering assisted living services in a segregated section of the building. On the other hand, the 22 efficiency units without kitchens in the Cedar Lane Apartments (MD) were scattered throughout the project. Under that configuration, scattered unit services were necessary.

Twelve of the 17 sponsors described have assisted living residents scattered throughout their buildings. Three sponsors have clustered the residents receiving assisted living services into one area or one building. Culpepper Garden (VA) has a Section 202 PRAC (Project Rental Assistance Contract) project licensed as an Adult Care Residence. Residents requiring assisted living services must relocate into this recently built assisted living wing. Christian Church Homes (KY) has received licensing to operate 61 efficiency units on three floors as a personal care facility. Homecrest House (MD) had its third project, Homecrest III, certified as a state CHSP provider and places residents needing assisted living services in this building.

Two sponsors have both concentrated and scattered assisted living residents. Springvale Terrace (MD) has 40 residents receiving personal care scattered throughout the building and another 36 residents receiving personal care in a designated section of the building. The Minneapolis Public Housing Authority has three projects with assisted living residents scattered throughout the buildings and one project of 42 units in which all residents receive assisted living services.

## **2. RESIDENTIAL VS. INSTITUTIONAL ENVIRONMENT**

*All of the sponsors visited by the lead author have retained a residential environment while implementing an assisted living program.*

A number of architectural and staffing factors determine the environment in a project. None of the sponsors visited by the lead author appeared institutional in the sense that a nursing home is institutional (no locks on doors, open nursing stations, wide corridors, semi-private rooms, uniformed nurses, medication carts), although some of the projects had more institution-like features than others. For example, the Christian Church Homes (KY) Section 202/8 project was built with ten-foot-wide corridors and four-foot-wide apartment front doors. Springvale Terrace (MD) has an open nursing station in the area providing enhanced personal care. These features are not typical for most housing projects.

On the other hand, all of the visited sponsors had taken steps to reduce the institutional appearance and enhance the residential nature of the environment. For example, service providers wear street clothes rather than uniforms. In Asbury Tower (NJ), service providers carry medications in briefcases rather than on traditional medicine carts. In most projects, nursing services were run out of offices rather than nursing stations in the corridors. In all cases, the assisted living residents had private apartments with full baths and, in most cases, kitchens or kitchenettes.

## **3. PROVIDING SERVICES DIRECTLY VS. CONTRACTING**

*Most sponsors contract out at least some of their assisted living services.*

Owners who provide most services directly argue that this approach can save money and provide the owner with control over the assisted living program. Those who contract the services to outside agencies argue that many owners lack the skills necessary to administer an assisted living program. They also note that contracting out, particularly for personal care services, may provide some liability protection to the owner in the event of a mistake made by the assisted living staff.

Four sponsors provide all assisted living services through their own staff. In Cedar Lane Apartments (MD), all service-providing staff members are project employees. The administrator believes that this arrangement is less costly to residents, who pay the full cost of all services. Six sponsors provide some services through their own staff and contract out other services. For example, Stafford House (NH) employs housekeepers but contracts out personal care to a local Visiting Nurses Association.

Seven sponsors provide all assisted living services through outside providers. Two sponsors in North Carolina—Preiss-Steele Place and Koinonia Apartments—provide residents with a list of agencies through which services can be obtained. For the most part, these two sponsors neither provide services nor contract for services but instead assist residents in contracting with appropriate local providers.

#### **4. A LA CARTE VS. BUNDLED SERVICE PROGRAMS**

*Most sponsors in this study provide à la carte services; those providing bundled services tend to be the larger projects that provide services directly through project staff.*

Owners who provide or arrange for à la carte services argue that doing so supports resident independence and responsibility by keeping the locus of decision-making with the resident. They claim that when the resident has decision-making power, particularly when fees are involved, residents stay focused on what they need and are discouraged from becoming overly dependent. A la carte services are provided in a number of projects, including Immanuel House and Tower One/Tower East, both in Connecticut. Culpepper Garden (VA) offers housekeeping services to any resident for a fee, and a private home health care agency subsidized by the county offers personal care for a fee.

Owners providing packaged services (whether directly or by an outside contractor) point out that it is much easier to structure such a program and to maintain a simple billing system. When services for individual residents can be billed in increments of as little as five minutes, accounting can quickly become complex and unwieldy. Thus, a number of sponsors have opted to bundle service programs and charge the resident a flat rate. Among them are Christian Church Homes (KY) and the three sponsors in Maryland.

#### **5. MANDATORY VS. VOLUNTARY MEALS PROGRAMS**

*Smaller sponsors and those without mandatory meals programs may have more difficulty developing meal programs for assisted living residents.*

Some older Section 202 and Section 236 projects have mandatory meals programs, requiring residents to take one meal per day as a condition of occupancy. This policy was permitted in the early days of Section 202 as a way of creating the “critical mass” necessary to provide a cost-effective meals program. For these projects, providing two or three meals per day to assisted living residents has generally been easy to do, because they already have the capacity to provide meals. Newer Section 202 projects have not been permitted to make meals mandatory because of a change of policy by Congress in the 1980s. In addition, newer projects tend to be smaller and may not have the space for a commercial kitchen or a central dining room.

Six sponsors have mandatory meals programs for all residents. In the Tower One/Tower East project (CN), Tower One has a mandatory meals program, but Tower East, which is a newer Section 202 project, does not. All three of the sponsors in Maryland have mandatory meals programs in their projects. Other sponsors have succeeded in making optional meals programs available to all residents, regardless of whether they are in the assisted living program. Immanuel House (CN) has a memorandum of understanding with a local hospital that provides an optional onsite meals program.

Public housing projects do not have mandatory meals programs and frequently provide meals for assisted living residents through outside contractors. The Minneapolis Public Housing Authority has a contract with Volunteers of America to provide meals for assisted living residents in four projects. The St. Paul Housing Authority provides meals for assisted living residents through a contract with the Wilder Foundation, which also provides other assisted living services. Participants receive breakfast in their apartments and the other two meals in the central dining room.

## **6. COORDINATION WITH LOCAL SERVICE PROVIDERS**

*Effective coordination eliminates overlapping services, confusion, and potential conflicts.*

Some participants in assisted living programs may already be receiving in-home services from hospitals and other local agencies. Because these services may overlap with assisted living services provided by the project, coordination with such groups is essential in order to prevent resident and staff confusion. Coordination can also mitigate potential opposition to the project's assisted living program by agencies that may perceive themselves as competitors.

HUD funding for service coordinators often provides a critical link between frail residents and needed services. For example, in Tower One/Tower East (CN) the service coordinators maintain contact with a wide range of public and private service providers. They also coordinate the provision of assisted living services by their contractor as well as by a number of home health care agencies that provide services to one or more residents.

The Laconia Housing Authority (NH), which developed Stafford House, uses its Professional Assessment Committee (PAC) not only for resident assessment but also as a way to coordinate services between local agencies and build local support for its program. The PAC consists of a social worker from a county nursing home, representatives from the state Department of Health and Human Services and its Elderly and Adult Services Division, and representatives from three county agencies, including the agency for the mentally disabled, the mental health agency, and the county long-term care coordinator.

## **C. LEVEL OF EFFORT AND TYPE OF HOUSING**

### **1. STATEWIDE EFFORTS VS. INDIVIDUAL PROJECT APPROACH**

*States can greatly facilitate the expansion of assisted living programs in subsidized housing by developing statewide strategies and funding mechanisms.*

Sponsors in this study from two states have benefited from statewide efforts to provide assisted living in subsidized projects. The availability of Medicaid funds in a special demonstration account allowed New Hampshire to develop a pilot program based on the state's experience with the federal CHSP. The Laconia Housing Authority received funding for a pilot assisted living program in Stafford House, which it manages. The

housing authority and its consultant worked with the state in developing its Medicaid waiver to cover assisted living in subsidized projects. Now, the pilot is receiving funds through the Medicaid waiver, and other subsidized projects are also eligible to set up assisted living programs and receive funding through the Medicaid waiver.

New Jersey provides assisted living programs in 37 public housing and privately owned subsidized projects, based on its experience with a state CHSP. In 1994, the state received a grant from the federal Administration on Aging and used the funds to operate a two-year pilot assisted living program at Asbury Tower. Rutgers University conducted a study of the pilot program. Based on the pilot's success, the state developed licensing procedures and regulations for assisted living programs in subsidized housing. New Jersey received a Medicaid waiver that permits Medicaid reimbursement for assisted living services to Medicaid-eligible residents of subsidized housing. The state is also attempting to develop state funding for assisted living residents with low incomes who are not eligible for Medicaid.

In contrast to the statewide efforts of New Jersey and New Hampshire, projects operating in states without strong statewide efforts must typically put together service packages from multiple funding sources. Such projects vary widely in the services they provide because no state agency defines the program.

## **2. PUBLIC HOUSING VS. PRIVATE NONPROFIT HOUSING**

*Public housing authorities and private nonprofit sponsors bring different strengths and resources to assisted living programs.*

With an inventory of projects throughout a city, public housing offers an opportunity to develop a community-wide approach to assisted living for frail older persons with low incomes. For example, the St. Paul Public Housing Authority has contracted with the Wilder Foundation to provide assisted living in four projects. The four projects contain 750 units and house approximately 170 residents receiving assisted living services. The Minneapolis Public Housing Authority also provides assisted living in four projects but does so through three separate assisted living service providers. The four Minneapolis projects contain a total of 665 units and serve 109 residents through its assisted living program. The Housing Authority of Vancouver (WA) provides assisted living in two projects with 252 units. These two projects serve 60 assisted living residents.

Although private nonprofit owners generally do not have multiple housing projects in any one city, they sometimes have greater experience in providing services because they operate care facilities such as nursing homes or assisted living in other locations. For example, Christian Church Homes (KY) draws on nursing staff from its adjacent nursing home to work in its assisted living program in a Section 202 project. Presbyterian Homes of New Jersey has developed a number of projects providing a wide range of services. They were able to draw on experiences and staff from other parts of their organization when developing an assisted living program for Asbury Tower.

## **D. MANAGEMENT ISSUES**

### **1. COMPATABILITY OF HOUSING AND SERVICES STAFF**

*Cooperation between housing and services staff must be developed and cannot be taken for granted.*

An important issue for any owner contemplating offering assisted living services is the relationship between the staff who manage and operate the project and the staff who will be providing assisted living services. In one case included in this report, the project manager was dismissed after a very difficult period during which there was little coordination between the two staffs. In this instance, the housing staff was perceived to be suspicious and hostile toward the service staff.

Sponsors of CHSP programs have found the addition of assisted living services less of a problem, because many issues were resolved when the CHSP was instituted. Service coordinators can be critical in developing links between housing managers and service providers. However, it is necessary to obtain clear agreement on the purposes of assisted living and the roles of all staff in order to make an effective transition into providing assisted living services.

### **2. INTEGRATING STAFF FROM DIFFERENT DISCIPLINES**

*An effective assisted living program requires professionals to think and operate differently from how they might in a more traditional environment.*

Providing assisted living services in a subsidized project tends to put a variety of professionals in a new and unaccustomed environment. Nurses and their aides, social workers, and housing managers have different training and experience that affects how they relate to their customers. An effective assisted living program requires professionals from all disciplines to adjust to the unique hybrid environment of assisted living in subsidized housing. For example, housing staff, from managers to maintenance workers, need training in how to recognize potential problems and service needs as they interact with residents and how to report them to appropriate services staff.

All staff should function as a team focused on the well-being of the residents. Although this sounds simple, projects with successful assisted living programs have invariably spent considerable time and effort in initial and ongoing staff training. In Tower One/Tower East (CN), even the maintenance staff and the housekeepers are involved in checking and reporting on changes in resident needs. All staff members are trained to be sensitive to resident needs, regardless of their specific job.

### **3. IMPACT OF ASSISTED LIVING ON THE CHARACTER OF THE PROJECT AND ON POTENTIAL RESIDENTS**

*The short-range impact of assisted living services on the residential character of the projects has been minimal.*

One concern of owners and residents in projects about to embark on an assisted living program is how the program will affect the character of the project. For example, residents of Asbury Towers (NJ) were concerned at the inception of the pilot assisted living program that their housing would become more like a nursing home. After the program became operational, these concerns dissipated, and residents not participating in the assisted living program found comfort in the fact that assisted living services would be available to them in their homes should they ever need them. With 30 assisted living residents scattered throughout a 350-unit high-rise building and service providers dressed in street clothes and carrying medications in briefcases, the assisted living program had very little impact on the overall character of the project as a residential facility.

Some sponsors have been concerned that having older and frailer residents will discourage younger applicants with few or no frailties from moving in. It is sometimes difficult to sort out cause and effect in evaluating this concern. In Tower One/Tower East (CN), the tendency over the last several years has been for new applicants to be older and frailer. The assisted living program was initiated in response to that change, but having a program in place may also attract older and frailer applicants.

Most sponsors decided to provide assisted living because of the aging and frailty of their residents, especially in older projects such as Immanuel House (CN) and Springvale Terrace (MD). Because the assisted living programs are fairly recent developments, it is not yet clear what the long-term impact will be on characteristics of the resident population or the residential character of the projects.

### **4. IMPACT OF ASSISTED LIVING PROGRAM ON RESIDENT ACCESS TO SERVICES**

*The assisted living programs have enhanced access to services by residents, whether or not they needed full assisted living services.*

Sponsors were generally committed to enabling all residents, including those not yet requiring assisted living services, to remain as independent and autonomous as possible. In many cases, the assisted living program provided benefits to residents not receiving assisted living services by offering optional services such as meals and housekeeping or the opportunity to consult with a nurse. Service coordinators often take the lead in providing help to residents who are in need of services as well as making sure wellness programs are available to all residents. For example, Tower One/Tower East (CN) has two service coordinators who are available to all residents.

Persons entering assisted living programs are typically evaluated on admission and periodically thereafter to make sure they are receiving the services they need. In the Minneapolis Public Housing Authority, a county nurse performs the initial assessment on each applicant and determines both eligibility and level of need, because funding comes from the county-administered Medical Assistance Program. In Preiss-Steele Place (NC), residents are responsible for obtaining the services they need, but they receive assistance in doing so from a county caseworker who spends several hours each week on site.

## **5. PROJECT LIABILITY**

*This study found no evidence that providing assisted living services increased liability or insurance costs for the sponsors interviewed.*

Several project administrators reported that one reason for contracting out the personal care and administration of medications is to avoid potential liability in the event of an accident or mistake. It is not clear whether and to what extent contracting out results in reduced liability, but none of the sponsors mentioned cases in which this was an issue. When sponsors were asked about insurance liability issues and additional charges for coverage because of the provision of assisted living services, they reported that the problems were minimal.

### **E. OTHER ISSUES**

#### **1. STATE LICENSING**

*States vary widely as to how they regulate assisted living programs.*

States vary considerably in approaches to licensing assisted living programs. Kentucky and New Hampshire did not have assisted living licensure at the time this research was conducted, although they were working on licensing requirements. Other states have more than one program that could cover assisted living. For example, Maryland certifies CHSPs and licenses assisted living facilities. Two Maryland sponsors have very similar programs, yet one is certified for CHSP and the other is licensed for assisted living.

New Jersey has added a new type of licensure. The state developed regulations to license assisted living programs as well as assisted living facilities. A licensed assisted living program can be brought into a subsidized housing project for older persons without the necessity of licensing the facility. Washington and Minnesota also followed this pattern of licensing the providers of assisted living services rather than the facility.

The exploratory nature of this research did not allow for the complex data gathering required to measure quality outcomes. It is clear, however, that similarly frail older persons are receiving a variety of assisted living services in a variety of settings under a wide range of state regulations and oversight.

## **2. DESIGN APPROPRIATENESS AND RETROFITTING NEEDS**

*Many facilities would benefit from modifications to accommodate assisted living programs and residents.*

Certain design features of older projects such as long, narrow corridors with apartments lining each side, often make serving frail older persons difficult. Residents who are easily confused can lose their way in such settings. Narrow corridors also represent challenges for wheelchair users, because they may not provide sufficient room to pass. In one project, an altercation developed when two persons in electric wheelchairs moving in opposite directions refused to grant each other the right-of-way. In another project, the user of an electric wheelchair nearly ran over the administrator while traveling in a narrow corridor.

A frequent problem is the lack of space for offices, lounges, and meals programs. Several projects have converted efficiency or one-bedroom units to meet such needs. For example, much of the first floor of Immanuel House (CN) was converted to a medical clinic, day care center, computer learning center, and offices for staff. Opening a unit in the midst of a long corridor can provide an area for socializing, a landmark to help those who are confused, or a pull-off space for passing wheelchairs.

### **F. CONCLUSIONS FROM CASE STUDIES**

*(1) These case studies demonstrate that assisted living services can be successfully integrated into subsidized housing projects for older persons.*

The case studies in this report demonstrate that assisted living services can be successfully integrated into subsidized housing projects for older persons. They also demonstrate that there is no one “right” way to initiate and deliver such services. Indeed, sponsors must tailor their programs around the physical plant, staffing, services availability, and resident needs that are unique to any given project.

*(2) The major obstacles to implementing assisted living services in subsidized housing are funding for services and training and coordination of housing and services staff.*

The case studies highlight a number of issues that any owner must address before initiating assisted living services. The two most important issues appear to be funding for services and the planning, training, and coordination necessary to ensure that housing management staff and assisted living staff work as a unit in serving the needs of the project residents. All of the case examples have had to come to some resolution on these two issues, though no two projects resolved them in precisely the same way.

*(3) States that funded such programs have greatly facilitated the development of assisted living services in subsidized housing.*

States can play a crucial role in enhancing the development of assisted living services for residents of subsidized housing. The case studies illustrate the importance of state funding mechanisms for providing assisted living services to residents of subsidized housing. States that have such funding mechanisms, such as New Hampshire and New Jersey, had the active involvement of housing authorities and nonprofit owners in working with state legislatures and state executive offices.

*(4) State efforts to develop regulations and monitoring efforts specific to assisted living services in subsidized housing are in their nascent stages. If such services become more common, states will have to develop more effective ways to monitor and enforce quality.*

New Jersey is the only state to develop regulations specific to assisted living in subsidized housing. Other states, such as Minnesota and Connecticut, have developed more generic regulations for assisted-living-type services provided in residential settings. These regulations tend to treat such “assisted living” services in a manner similar to home care services. Other states, such as Maine and Maryland, regulate “assisted living” in subsidized housing as “congregate housing services.” Many states simply have no regulations at present that apply adequately to assisted living services in subsidized housing.

*(5) Significant research is needed to develop models and strategies for expanding assisted living services in subsidized housing nationwide.*

Further research on assisted living in subsidized housing is greatly needed as interest in this service option grows. Despite the more extensive use of service coordinators, few project owners routinely assess resident needs for assisted living services. Furthermore, information from individual assessments is not aggregated in a way that allows the development of area-wide and statewide strategies for the delivery of services. Little work has been done in analyzing the cost-effectiveness of providing assisted living services to residents of subsidized housing. Research is also needed on design and retrofitting options, building code issues, and funding mechanisms both for retrofitting buildings and for services.

Critical to the expansion of assisted living in subsidized housing will be evaluations of the quality of services that are provided to the residents. Such research is especially critical given the variety of facilities, staffing and services offered. Surveys of resident satisfaction would also determine whether services are meeting expectations and enhancing resident quality of life.

## **VI. CASE STUDIES IN PROVIDING ASSISTED LIVING IN SUBSIDIZED HOUSING**

### **Connecticut**

#### *Immanuel House*

Immanuel House is sponsored by Immanuel Congregational Church in Hartford. The 220-unit apartment complex for older persons contains 145 efficiency apartments; the rest are one-bedroom units. The project has no waiting list.

#### **RESIDENTS**

The resident population reflects the aging-in-place common in older projects. The average age of the residents is 78 to 79, and average occupancy is eight years. Sixty percent of the residents are women, and roughly equal numbers are blacks and whites.

#### **PROJECT INFORMATION**

Financed under the Federal Housing Administration (FHA) Section 236 program, the project was first occupied in November 1971. The interest rate on the mortgage was effectively reduced to one percent, making it possible to offer reduced rents to low-income tenants. Rents range from \$485 to \$503 per month for efficiency units and \$568 to \$580 for one-bedroom apartments. A Section 8 Loan Management Set-Aside contract covers 122 units, and six residents have Section 8 vouchers or certificates.

#### **ASSISTED LIVING PROGRAM INFORMATION**

Connecticut does not license assisted living facilities, but recognizes the project as a Managed Residential Community (MRC). The HUD-paid service coordinator brings services into the building for both residents and persons in the neighborhood. Hartford Hospital provides an onsite lunch program. Approximately 50 residents, as well as 100 persons from the community, participate regularly in the lunch program. Approximately 20 residents receive meals-on-wheels. Ninety residents receive housekeeping services, and 35 receive personal care. Residents choose their service providers and the amount of services. Approximately 100 residents receive no-cost companion services.

Through arrangements with community agencies, the project offers a wide range of services, which are available both to residents and the community. St. Francis Hospital operates a medical center. The City of Hartford operates a mini-library. The Hebrew Home and Hospital runs a geriatric day care center, and about half of the participants are project residents. Under an arrangement with a child care facility operated by a local Baptist church, children visit with residents and residents visit the children. Public transportation picks up residents on a regular basis to go grocery shopping. The project also houses a computer learning center, which offers both use of computers and computer training to project and community residents. The Honor Society from a nearby high school provides volunteer services to residents, such as waiter services at mealtime.

The Immanuel Church Foundation receives bequests and donations on behalf of the project. Resident volunteers operate a small grocery store onsite and give the income, about \$8,000 to \$10,000 annually, to the foundation. The foundation currently realizes \$30,000 from investments, which it uses for programming and other activities such as the purchase of a 14-person van. The project negotiated a lease with an adjacent medical office condominium that needed extra parking. The lease generates approximately \$40,000 per year, which goes into a fund for capital improvements.

## ARCHITECTURAL AND DESIGN ISSUES

The ground floor includes a full commercial kitchen and a central dining room, an exercise/meeting room, a public library, a game room, and a storage area for residents' personal belongings. The main floor includes the grocery store, the medical clinic, the day care center, the computer learning center, and offices. Several apartments were converted to make room for these services.

## POLICY AND PROCEDURAL ISSUES

The service coordinator participates in interviews with potential residents and their families and provides them with information about assisted living service options. Residents meet monthly to plan activities, and staff and residents meet quarterly to discuss issues and problems. Residents also volunteer in activities to monitor the entrance to the building and lead activities.

### *Tower One and Tower East*

## PROJECT INFORMATION

Sponsored by the New Haven Jewish Federation, the Tower One and Tower East complex includes two high-rise buildings with a total of 359 units serving older persons in New Haven. Tower One, which opened in 1971, contains 215 apartments. Tower East, a Section 202/8 project that opened in 1982, consists of 144 one-bedroom units and six two-bedroom units. Residents receiving assisted living services are located throughout the projects.

## RESIDENTS

The resident population reflects the aging-in-place phenomenon common to older projects. The average age of residents is 86 to 87 years old, and the average term of tenancy is five years to six years. The complex does not have a waiting list. New residents tend to be older and frailer than residents of previous years, and they tend to require intense orientation. The overwhelming majority of residents are women, and many are in their 80s. Almost 75 percent of the residents are white.

## PROJECT INFORMATION

Tower One was financed under the original Section 202 program and has benefited from a three percent mortgage. Thirty-four units are one-bedroom apartments, and 181 are efficiencies. Efficiencies rent for \$440 to \$490 per month; one-bedrooms, for \$705 to \$742 per month. A Section 8 Loan Management Set-Aside contract covers 93 units in Tower One. The monthly contract rents for Tower East are \$1,173 for a one-bedroom unit and \$1,303 for a two-bedroom unit. All residents of Tower East benefit from Section 8 subsidies, paying only 30 percent of their income for rent.

## ASSISTED LIVING PROGRAM INFORMATION

The Board of Directors established Tower One, Inc. in 1991 to provide an organizational structure for delivering supportive services to residents and for conducting fundraising activities. In 1992, Tower One/Tower East formally organized assisted living services and entered into an agreement with a home health care agency to provide services to Medicare- and Medicaid-eligible residents.

Tower One/Tower East has partnered with a number of other organizations to provide a service-rich environment. The Hospital of St. Raphael Project ElderCare provides onsite primary and specialty health care. The Yale University School of Nursing provides geriatric assessment and health promotion through a special grant by the Tower One/Tower East Foundation. The University of New Haven Dental Hygiene Program offers dental examinations and oral health care education. A geriatric psychiatric group provides individual and group therapy. The complex has a full-service bank branch. Both the central dining room and the convenience store are operated onsite. An onsite SeniorNet Computer Learning Center is supported by Southern New England Telephone Co., IBM, the Hospital of St. Raphael, SAGE Services of Connecticut, and HUD.

Tower One has a mandatory evening meal program six days per week, and Tower East residents can elect to participate in the meals program. A coffee shop, operated by the residents, provides breakfast, lunch, and an evening snack.

## STAFFING

In 1992, a combination of fundraising and an Older Americans Act Title IIIB grant (which expired in 1997) allowed the projects to employ two Resident Emergency Monitors overnight on weekdays and around the clock on weekends and holidays. In addition, each project has a HUD-supported service coordinator who is a trained social worker. The Rose Room Program provides assistance and supervision for residents with cognitive impairments, including mealtime reminders and escort services. The staff can also provide housekeeping, chore services, home-delivered meals, and transportation arrangements on a fee-for-service basis. All project staff are trained to be alert to changes in residents' physical or mental condition. Every apartment is inspected twice each year by the service coordinator. Staff members also use these contacts to assess how residents are doing.

## ARCHITECTURAL AND DESIGN ISSUES

The building layout poses some problems for residents. For security reasons, the main entrance to the complex is in Tower East, so Tower One residents have a longer walk. Rails need to be installed in the hallways, and because corridors are narrow, some system is needed to facilitate wheelchairs. Many units need built-in shower seats and hand-held showerheads, and furniture resistant to incontinence is needed in common areas. Battery-operated smoke detectors need to be hard-wired, and the emergency response system needs to be upgraded so that staff can communicate with residents in their units.

Tower One has made several major upgrades to deal with resident aging and the aging of the building. For example, a sprinkler system was added with financing provided through the Connecticut housing tax credit program. The HUD has provided Flexible Subsidy loans and grants to replace windows, roofing, and elevators, among other repairs.

An additional Flexible Subsidy request is being prepared to modify bathrooms and the emergency call system to accommodate resident aging. Planned bathroom changes include seats in the tubs, grab bars, hand-held showers, and accessible toilets. The emergency call system, which is now operated by a pull cord, will be replaced with a system allowing direct communication between the resident and the front desk.

## POLICY AND PROCEDURAL ISSUES

In 1998, Connecticut promulgated two-part assisted living regulations. Both projects were approved as Managed Residential Communities (MRCs) by the Department of Health Services, and the home health agency developed is licensed as an Assisted Living Services Agency (ALSA). ALSA services include assistance with bathing, dressing, and medication management. Because no Medicaid or other state funds are currently available for ALSA services, residents are charged on a fee-for-service basis. Homemaking and live-in personnel are also available on a fee-for-service basis.

The Board of Directors establishes the admission policies. The family of each applicant is interviewed, and the service coordinator meets with the applicant and makes a home visit to determine needs. Residents are actively involved in the operation of the facility. Five residents serve on the 32-member Board of Directors and participate on all Board committees. They work with staff in program planning.

## Kentucky

### *Christian Church Homes of Kentucky*

Christian Church Homes operates three projects on one site in Louisville. Chapel House, a Section 236 project, opened in 1974; Friendship House, a Section 202/8 project, opened in January 1980; Christian Health Center, a nursing home, opened in 1984.

#### RESIDENTS

In 1999, the average age was 77 years for Chapel House residents and 82 years for Friendship Heights residents. Eighty percent of Chapel House residents were white and slightly more than 80 percent were women. Their average gross income was \$9,666 per year. In Friendship House, just under 85 percent were women and 89 percent were white. The average gross income in Friendship House was \$11,617.

#### PROJECT INFORMATION

Chapel House consists of 225 units, including 107 efficiencies and 118 one-bedroom units. The basic rent for an efficiency ranges from \$320 to \$345 per month; for a one-bedroom unit, the rent is \$412. A Section 8 Loan Management Set-Aside covers 100 units. At the time of this study, Chapel House had no waiting list. Friendship House consists of 191 units—164 efficiencies and 27 one-bedroom units. All units are covered by a Section 8 contract, and rents are \$570 for an efficiency and \$655 for a one-bedroom unit. Section 8 residents pay 30 percent of their monthly income for rent. Three floors, containing 61 efficiency units, were licensed as a personal care facility in April 1997. Friendship House has a waiting list.

#### ASSISTED LIVING PROGRAM INFORMATION

Friendship House has a mandatory daily lunch program, but breakfast and dinner are also available. Chapel House does not have a meals program, but residents can purchase meals à la carte at the dining room of Friendship House. Many of the Chapel House residents volunteer in Friendship House.

Kentucky does not have an assisted living category for licensure. Residents in a personal care facility must be 16 years of age or older and be ambulatory or mobile non-ambulatory and be able to manage most of the activities of daily living. Residents receive three meals per day, housekeeping, continuous supervision, basic health and health-related services, personal care services, residential care services, and social and recreational services. Each personal care resident must have a plan of care, and medical records must be kept at the facility. The plan of care is updated every six months. The resident is an active participant in developing the plan of care along with the family, a social worker, the dietitian, the doctor, and a nurse. Twenty-four-hour staff coverage must be provided on each of the personal care floors.

Residents in the personal care program must take all three meals and are charged \$329 per month. All personal care residents receive meals in the central dining room on the first floor, and they are served along with all other residents. Residents receiving personal care are charged \$38 per month for housekeeping and laundry and \$1,047 per month for personal care. The total cost per month for a personal care resident, including the contract rent of \$570 (assuming the resident is not eligible for Section 8 assistance), is \$1,980. Other project residents may purchase these services on an à la carte basis.

Eighty percent of the personal care residents are SSI-eligible, and Kentucky provides a supplement to bring resident incomes up to \$894 per month. Recipients retain \$40 per month to cover personal expenses, and the project receives \$854 each month to cover the residents' share of the contract rent, meals, and services. The project sponsorship provides roughly \$200,000 annually to subsidize the personal care program. The sponsor has considerable fundraising capacity and is able and willing to continue to assist the project financially.

## STAFFING

Staff providing service to the personal care residents are all project employees, but the nursing staff are employees of the adjacent nursing home. Project employees assigned to the personal care residents include an activities director, two housekeepers, a social worker, a dietary manager and 10 dietary workers. The nursing home provides three LPNs and 18 certified nursing assistants. The cost of the nursing staff is about \$300,000 per year, including fringe benefits.

## ARCHITECTURAL AND DESIGN ISSUES

Alterations costing about \$100,000 were made in order to comply with the licensing requirements for personal care. Changes included conversion of office space to a nursing station and an apartment to an activity area, separation of commercial and residential hot water due to different requirements for temperature, and creation of a roll-in shower facility. Changes to the units included adding a night light and relocating the call system from the reception area to the nursing station. A wander system was also installed. Christian Church Homes of Kentucky paid for the costs of these changes. The Section 202/8 project was built with 10-foot corridors and 4-foot doors into the apartments.

## POLICY AND PROCEDURAL ISSUES

Both the Section 236 and the Section 202/8 projects have resident councils. Policies covering admission and termination of residents in the Section 236 and the Section 202/8 projects are established by the Board of Directors in conformity with HUD requirements for each project. Admission to the personal care units is open both to nonresidents and residents of the Section 202/8 and Section 236 projects. Personal care residents may be transferred to the nursing home if they require more services than the personal care program can provide.

## Maryland

Maryland's extensive CHSP is administered by the Department of Aging. Assisted living, on the other hand, is administered and regulated by the Department of Health. The following projects illustrate how similar types of "assisted living" services can be provided under separate licensure and regulatory categories, even within the same state.

### *Springvale Terrace Home, Inc.*

Sponsored by the United Church of Christ, Springvale Terrace is a 156-unit apartment complex for older people in Silver Spring. The project was financed under Section 202 in two separate increments. The first phase opened in April 1965 and includes 124 units. The second phase opened in 1970 and includes 32 units. Both phases were funded under the original Section 202 program and benefit from 50-year below-market loans.

#### RESIDENTS

The resident population reflects the aging-in-place phenomenon common to many older projects. The average resident age is 85, and women outnumber men by four to one. Approximately 70 percent of residents are white. The average term of residency in the assisted living units is about three years; in other units, it is about five to ten years.

#### PROJECT INFORMATION

Springvale Terrace includes 139 efficiency units that rent for \$476 per month and 17 one-bedroom units that rent for \$631 per month. The earlier Section 202 project is not subject to income limits, but the later project that opened in 1970 has low-income restrictions. The project has no Section 8 subsidies but has a Rent Supplement Contract for approximately \$36,000 per year, which subsidizes rents for very low-income households.

In the early 1990s, the project was in serious financial difficulty due to competition from new subsidized projects, which offered larger units and deeper subsidies. Ground floor units were particularly difficult to rent. The sponsor hired an agency experienced in managing housing for older persons, including assisted living. The new management transferred residents with dementia and incontinence to other facilities that could better meet their needs. Reserve funds were tapped to renovate the ground floor units. Along with the provision of a nursing station, a dining room, and enhanced personal care, these renovations made the units marketable. The project now has a short waiting list.

#### ASSISTED LIVING PROGRAM INFORMATION

The project is not licensed for assisted living but is certified under the state's CHSP. In 1996, the certification was expanded from 40 to 76 residents, roughly half of the project residents. Forty residents receive personal care, and 36 receive enhanced personal care. Those receiving personal care are scattered throughout the building, and those receiving enhanced personal care are located in the renovated ground floor section.

Residents receiving personal care receive three meals per day. All residents can eat in either of the two dining rooms. The total annual income for the meals and services program (excluding rent) is approximately \$1,135,000, of which \$1,045,000 is paid by the residents. The Department of Aging and the Montgomery County Nutrition Program provide the remaining \$90,000. Residents can purchase housekeeping for \$38 per month, which includes cleaning and linen service. Housekeeping services are included in the fee for personal care. All residents can also purchase laundry services for \$40 per month.

The monthly fee, including the rent of \$476 for an efficiency apartment, totals \$1,178 per month for those receiving personal care. The monthly fee, including \$476 for rent, totals \$1,585 for those receiving enhanced personal care, which includes medication assistance as well as other personal care services. Residents must be able to dress themselves, get in and out of bed, and if incontinent, be able to take care of the problem themselves. Residents who do not meet these criteria can stay in the project if they have outside help.

Applicants for personal care units must have an assessment by a doctor along with a recommendation for admission. Follow-up assessments occur as necessary. The staff fill out "incident reports" covering things like injury due to falls, getting lost in the building, and emotional outbursts. Incident reports are one way of tracking whether residents' needs have changed and whether the services provided are adequate. The project has working agreements with Holy Cross Hospital to provide physical therapy and Adventist Choice to provide additional personal care.

## STAFFING

The project has a services coordinator, who serves all residents. The project is staffed around the clock, and substantial resources are devoted to nurses and nurses assistants (approximately \$180,000 per year). Although the administrator is hired and supervised by an outside management agent, the administrator and all staff are paid by the project and viewed as project employees.

## ARCHITECTURAL AND DESIGN ISSUES

The layout of the project has been an impediment to integrating the residents receiving enhanced personal care with the other residents. The main dining room is at the opposite end of the building from the enhanced personal care units. Residents must go up in one elevator, walk down a corridor and go down in another elevator to get from one place to the other. The project has applied for a Flexible Subsidy grant for a new elevator (to eliminate the need to ride two elevators), a sprinkler system, and replacement windows.

## POLICY AND PROCEDURAL ISSUES

Admission and termination policies are essentially set by HUD. Current residents, as well as nonresidents, are accepted for enhanced personal care. A medical assessment is required for admission to the personal care units. Residents who develop needs that cannot be met by the staff must move out of the project unless they hire outside help sufficient to meet their needs.

## *Cedar Lane Apartments*

Located in Leonardtown, Cedar Lane Apartments consists of 178 units for older persons. The project consists of two separate projects jointly sponsored by the Episcopal Diocese and the Roman Catholic Diocese — a Section 236 project, which opened in 1977, and a Section 202/8 project, although the two projects are operated as one.

### RESIDENTS

The average age of all Cedar Lane residents is 83, and women outnumber men by three or four to one. The 23 residents receiving intensive services average 85 to 87 years of age, and the ratio of women to men is six to one. Roughly 95 percent of the residents are white. Average residency for those receiving intensive services is two years compared to six years among the other residents.

### PROJECT INFORMATION

The Section 236 project has 128 units, of which 115 are efficiencies, 12 are one-bedroom units, and 1 is a two-bedroom unit. Twenty-two of the efficiency units have no kitchen. At its opening, the project had 23 units licensed under the Domiciliary Care Program. The project developed serious financial difficulty due to vacancies in the efficiency units, particularly the 22 units without kitchens. This problem was resolved when the project was issued a new license in 1996 as an assisted living facility with 128 units. The project has ample space for a nursing station and other offices as well as a large dining room. The Section 236 project has basic monthly rents of \$442 for an efficiency unit and \$533 for a one-bedroom unit. A Loan Management Set-Aside Contract covers 85 units.

The Section 202/8 project, consisting of 45 one-bedroom units and 5 two-bedroom units, opened in 1982. It is joined to the Section 236 project by an enclosed walkway. Current rents in the Section 202 project are \$852 for a one-bedroom unit and \$967 for a two-bedroom unit. All residents receive Section 8 assistance.

### ASSISTED LIVING PROGRAM INFORMATION

Residents of both projects participate in the mandatory meal program, which consists of one meal daily. The dining room is in the Section 236 project and is large enough to accommodate the residents of both projects in two sittings. Residents may choose to purchase other meals and are charged based on what they select. They are billed separately at the end of the month for the non-mandatory meals.

Since 1996, 23 residents have been receiving intensive services, including three meals per day, housekeeping, laundry, personal care, bathing assistance, help transferring to and from bed, and medication management. Most of these individuals reside in the units without kitchens. Residents pay a flat fee of \$1,225 per month, which includes everything except their rent. These residents are located throughout the Section 236 building. The nursing staff that serves these 23 residents is available to other residents of

both projects on a fee-for-service basis. Indeed, all services are available to all residents on an à la-carte fee-for-service basis, but no services are subsidized by outside sources.

Residents receiving intensive services receive an annual assessment by the Department of Health. Other residents use as many services as they wish or can afford. Although some residents select services based on convenience rather than need, their willingness to pay the full cost suggests that the services are important to them. The importance of services is underscored by the fact that most residents have incomes so low that they receive Section 8 assistance. The project charges a flat fee for some services, such as \$1 for meal delivery. Housekeeping and personal care are charged at the rate of \$13.50 per hour.

## STAFFING

All services are provided by the 65 facility staff members, of which approximately one-third are part-time. Despite the staff size and the wide range of services provided, the facility has the atmosphere and feeling of a housing project, not an assisted living facility. The administrator reports that staff turnover is relatively low, morale and commitment are high, and many of the staff could work in other facilities making significantly more than they do at Cedar Lane. According to the administrator, staff commitment is a large part of what keeps the costs at a modest level. A service coordinator serves both projects, and a grant from HUD has been approved to cover the coordinator's salary.

## ARCHITECTURAL AND DESIGN ISSUES

Cedar Lane Apartments has benefited from some unique features. First, the project has been able provide assisted living without facing major capital requirements because the necessary space for offices and nursing and community areas already existed. Second, the current project administrator has been an active participant with the state as assisted living licensure requirements have evolved. This involvement has given the state the benefit of the experience at Cedar Lane and the project the benefit of having its unique features considered during the development of the licensing requirements.

Changes to the building have been funded out of operating expenses or reserves. Automatic front doors were installed. The assisted living license requires separate spaces for soiled linens, for washing linens, and for storing clean linens. The project also has a store, a hair salon, and a barbershop.

## POLICY AND PROCEDURAL ISSUES

The Board of Directors is made up of community representatives as well as representatives of the two sponsoring dioceses. The president of the residents' association also serves on the Board of Directors.

Admission and termination policies are based on HUD requirements. Both project residents and nonresidents are on the waiting list for the intensive service units. Residents do not receive priority over nonresidents. Termination from the 23 intensive service units is based on an assessment of the appropriateness of the services offered to the needs of the individual resident. Cedar Lane Apartments has transfer agreements with two nursing homes and one hospital.

The project has liability insurance as an independent living facility. The insurance company views it as an independent living facility as long as not more than 50 percent of the residents are assisted living residents. Only 23 residents are viewed as assisted living residents, despite the fact that the facility is licensed for 128 assisted living units and residents beyond the 23 have opted for some of the assisted living services.

### *Homecrest House*

Homecrest House consists of three projects in Silver Spring with a total of 257 units. The projects are sponsored by the National Capital B'nai B'rith Assisted Housing Foundation.

#### RESIDENTS

Homecrest I has 139 residents, of whom 117 are women. Homecrest II has 104 residents, of whom 89 are women. The average age in the two projects is 82, and almost 80 percent of Homecrest II residents are older than 75. The great majority of residents in both projects are white, and the combined waiting list includes about 30 persons.

The 43 residents in the assisted living building, Homecrest III, average 88 years of age. Most are women, and all are white. Residents in Homecrest I and II are given priority over nonresidents for admission to Homecrest III. Homecrest III has a waiting list of about 30 persons who are not residents of the other projects.

#### PROJECT INFORMATION

Homecrest I and II are both Section 202/8 projects. Homecrest III was financed by four loans: (1) a Maryland Department of Housing and Community Development (MDHCD) bond fund loan; (2) a MDHCD rental housing production program loan, (3) a loan from Montgomery County Community Development Block Grant (CDBG) funds, and (4) a loan from the National Capital Foundation for Homecrest House.

Homecrest I reached initial occupancy in July 1979 and contains 135 units—20 efficiencies and 115 one-bedroom units. Homecrest II opened in April 1985 and contains 100 one-bedroom units. The two buildings are connected by an enclosed promenade. Contract rents in Homecrest I are \$573 per month for an efficiency and \$696 per month for a one-bedroom unit. The contract rent in Homecrest II is \$830. All units in both projects are covered by Section 8, so residents pay 30 percent of their income for rent.

Opened in March 1990, Homecrest III contains 42 one-bedroom units and is certified by the Department on Aging as a CHSP. The contract rent for a one-bedroom unit is \$790 per month. Most residents have Section 8 certificates or vouchers and, therefore, pay only 30 percent of their income for rent.

The sponsor established a foundation called the National Capital Foundation for Homecrest House for the purpose of raising charitable funds and accepting gifts in support of all three projects. In addition to a loan to support the development of Homecrest III, the foundation provided the funds to build the promenade connecting Homecrest I and II. It provides a variety of amenities to the projects, including artwork displayed in the lobby and the hallways. The foundation purchased and maintains a van that serves all three projects. It also provides the salary for the activities director, who serves all three projects, and funds a variety of social and educational programs.

#### ASSISTED LIVING PROGRAM INFORMATION

All residents of Homecrest III receive a service package consisting of a noon and evening meal daily, groceries to prepare breakfast in their apartments, one hour of housekeeping each week, plus one hour per month of heavy housekeeping and laundry service and help as needed for bathing. Each of the units in Homecrest III has an accessible shower with a seat. All units have wide doors and lower medicine cabinets to accommodate persons with disabilities. Homecrest III includes a commercial kitchen; central dining room; library; crafts room, including a kiln for making pottery; a lounge area; and shop space for a hairdresser, who serves all three projects. Homecrest III has 24-hour security.

The residents of Homecrest III may receive subsidies both for their rent and for the service package. Four residents are able to pay market rates, and the rest receive Section 8 assistance. The service package for very low-income residents (those eligible for Section 8) is \$886 per month for a single person.

Residents with very low incomes are eligible for three subsidies that can reduce their payment to an amount substantially below \$886. The Maryland Office of Aging provides a subsidy to residents based on their ability to pay. This subsidy comes to about \$130,000 per year for the project as a whole. The Montgomery County Senior Nutrition Program provides a subsidy of \$3.50 for each noon meal. For the project as a whole, this comes to about \$46,000 per year. The foundation contributes about \$88,000 per year to cover a portion of the cost of the security service as well as other services.

#### STAFFING

The service package for Homecrest III is provided by a combination of project staff and outside providers. An outside contractor provides the meal service for all three projects. Housekeeping services and security services for Homecrest III are performed by outside contractors. The project employs two full-time and four part-time staff who do laundry, serve meals during the week, and provide personal care (primarily help with bathing). The manager and the receptionist also are actively involved with the residents. Project

staff check on each resident three times each day. Each unit has three pull cords, which are connected to the reception desk, and the reception desk is staffed around the clock.

#### POLICY AND PROCEDURAL ISSUES

A resident council serves all three projects. The council sponsors social activities and works to improve resident life. It may represent residents collectively in dealing with management.

Admission standards for Homecrest I and II are set by the Board of Directors and conform to HUD regulations. Homecrest III has its own Board of Directors, which establishes admission policies. Applicants for Homecrest III are required to provide a physician's certification indicating that they need the services provided by the project. Residents who find it necessary to leave Homecrest III most often go to a nursing home.

## Minnesota

Minnesota has two levels of licensure for assisted living providers (ALPs). An “A” license allows the ALP to provide nursing services along with the typical assisted living services. An “E” license is less inclusive and does not permit the provider to administer medications. The Minnesota statutes define an assisted living facility, the medical eligibility of program participants, and the staffing and program requirements. Both state and county employees are responsible for monitoring the ALPs for program compliance.

### *Minneapolis Public Housing Authority*

The Minneapolis Public Housing Authority (MPHA) operates assisted living programs in four high-rise structures. Three outside contractors provide services, and each is licensed by the state as an ALP.

#### RESIDENTS

The MPHA has demographic data on the 4,743 households living in high-rises but not specifically on the approximately 100 assisted living residents. Residents are equally divided between men and women. One-third of residents (35 percent) are persons age 62 or older. Nonelderly residents with disabilities represent slightly more than a quarter of the resident population. The average tenure of a resident in MPHA housing is three-and-one-half years, but the perception of the MPHA is that the average tenure of assisted living residents is longer. ALP residents typically do not leave the project until they require more care, improve in their health condition (e.g., persons recovering from surgery are sometimes included in the ALP), or die. Most households have incomes below 30 percent of the median, which for a one-person household is \$13,350 per year. Just under half of the households are black.

#### ASSISTED LIVING PROGRAM INFORMATION

The four assisted living programs started at different times, the earliest in August 1992 and the most recent in January 1999. One program covers approximately 25 people in a 186-unit building designated for older persons. The other three programs are in buildings that include families as well as older persons. An 86-unit family project has 25 assisted living residents. Another project has about 17 assisted living residents in a complex of about 350 units serving families as well as older persons. This program is enhanced with a cultural component for older Koreans. A fourth program encompasses all 42 units in a high-rise building that serves both older persons and persons with disabilities.

Each ALP site has a congregate dining program providing lunch and dinner Monday through Friday. Volunteers of America (VOA) is the meals contractor. The ALP pays VOA for each meal and is reimbursed by the county. In addition to meals, the ALP provides housekeeping, personal care, medical management, case management, social activities, 24-hour emergency response, and transportation to medical appointments. The staff of an ALP typically includes a program director, home health aides and home care aides, an RN or an LPN, and staff to provide the meals program. Home care aides

provide personal care but may not have any involvement in administering medication and may not perform any medical procedures, such as blood pressure checks.

The MPHA provides space for the programs and staff but is not required to obtain state or local licensure. MPHA enters into a Space Use Agreement with the ALP to provide services to medically eligible frail older clients or clients with disabilities. Although administered by the counties, the program's primary funding source is the Minnesota Medical Assistance Program. The level of funding depends upon the number of clients and their level of need. Eligibility is determined through an assessment process administered by the county's nursing staff. Because of their very low incomes, public housing residents are generally not required to pay for ALP services. The average cost of the program, exclusive of rent, is \$800 per month per client.

## POLICY AND PROCEDURAL ISSUES

Admission to an assisted living program is open both to current residents of public housing and to applicants of combined public housing and assisted living. Assisted living residents are intermingled with other public housing residents who are not in the assisted living program. Applicants for both public housing and assisted living must meet the admission requirements of both programs and can be placed in any available unit in a building that has an assisted living program. Public housing residents who develop the need for assisted living are not required to relocate unless they live in a building that does not have an assisted living program.

### *St. Paul Public Housing Authority*

Beginning in 1986, the St. Paul Public Housing Authority has contracted with the Amherst H. Wilder Foundation to administer assisted living in four senior housing high-rise projects. In one building with 144 units, 35 residents receive assisted living services. The other three buildings range from 185 to 220 units, and each has up to 45 assisted living residents.

## ASSISTED LIVING PROGRAM INFORMATION

The housing authority provides the space for offices, activities, equipment, storage, and laundry at no cost. The Wilder Foundation provides around-the-clock onsite staffing, laundry, housekeeping, activities, personal care, social service, emergency assistance, medication administration, case management, and three meals per day. Participants receive breakfast in their apartments and the other two meals in the central dining room.

Residents must be Medicaid-eligible or pay the cost of the services in order to participate in the assisted living program. About 10 percent of the participants pay privately. The service package, excluding meals, is funded through a state Medicaid waiver. Medicaid and participant payments do not cover the full cost of the program. The foundation generally absorbs between \$20,000 and \$90,000 annually in unreimbursed costs. The average monthly cost per assisted living resident is \$1,117, which includes food and services but not rent.

## **New Hampshire**

Assisted living in New Hampshire's public housing projects began with a HUD-funded CHSP in the Manchester Housing Authority in the 1980s. The program has evolved to become an assisted living program in all respects except for 24-hour supervision. Staff was onsite 12 hours per day, seven days per week. Some participants have transferred into the program from nursing homes, and studies showed it to be cost-effective. The state legislature became interested in the program as an alternative to nursing home care and provided funding to match HUD funding for any new CHSP grants in the state. As a result, housing authorities received funding in the early 1990s for seven new CHSP sites.

### ***Stafford House***

In 1996, the Laconia Housing Authority purchased Stafford House along with an adjacent mini-mall. The building includes 50 one-bedroom units. The building's Section 8 contract, which covered all units, continued in place with the new ownership.

#### **RESIDENTS**

The average age of Stafford House residents is 76 years, all of whom are white. Of the 17 residents in the assisted living program, 13 are women and 10 are older than 80 years old.

#### **PROJECT INFORMATION**

The housing authority has converted the mini-mall to an adult day care and senior center. The housing authority installed a new elevator and fire doors in the apartment building and implemented an assisted living program. Both the apartment building enhancements and the conversion of the mini-mall were financed in a single mortgage along with federal low-income housing tax credits. Stafford House had a waiting list of 15 people.

#### **ASSISTED LIVING PROGRAM INFORMATION**

Since 1993, the housing authority has operated an assisted living program in the nearby Sunrise Towers, a 99-unit public housing project in which 30 residents receive assisted living services. The service coordinator in Sunrise Towers also serves as the service coordinator at Stafford House and is paid by the housing authority. The assisted living program at Sunrise Towers was funded using HUD and state CHSP funds.

The assisted living program in Stafford House was originally funded by the state as a pilot program under a grant from a special state Medicaid fund. New Hampshire discovered a provision in the Medicaid rules that allowed the state to collect and use Medicaid funds in ways not originally contemplated, a provision since eliminated. Subsequent to Stafford House's receiving the state grant, New Hampshire got a Medicaid waiver. The Medicaid waiver currently funds a portion of the assisted living program.

A unique feature of the pilot program is the state's requirement that at least half of the assisted living residents be relocated from nursing homes. This requirement has been met, demonstrating that an assisted living program can effectively serve the needs of many nursing home residents at a significantly lower cost. Assisted living residents are located throughout the building, and residents may transition into assisted living services.

Neither CHSP nor assisted living are licensed in New Hampshire. While assisted living will eventually be subject to state licensure, it is currently viewed as a pilot program. The assisted living program at Stafford House currently covers 17 residents who receive two meals daily. The meals program is contracted out to the local Community Action Program (CAP) agency during the week, with the housing authority providing evening and weekend meals from its commercial kitchen in Sunrise Towers. The 17 residents also receive approximately one hour of housekeeping per week as well as laundry services. The housing authority employs housekeepers who perform these services.

Personal care is contracted out to a local Visiting Nurses Association (VNA), and residents receive such services an average of three times per week. Residents benefit from a portable medical alert system, which is contracted out to New Hampshire Emergency Response. Extensive case management services are provided by the housing authority staff. All housing authority staff are trained to be sensitive to residents, and computerized files provide up-to-date information on each assisted living resident.

Although the housing authority does not provide transportation services directly, the service coordinator works with families and local transportation agencies. As a last resort, the housing authority has a local taxi company under contract to provide transportation. Neighbors are encouraged to help each other. Housing authority residents act as volunteers to accompany other residents to medical appointments and to help in other ways. Such arrangements are always made with the involvement of the resident and his or her family, so that the volunteer is protected against liability.

Other residents benefit from the presence of the assisted living program. The service coordinator serves all residents, not just those receiving assisted living services. A clinic is held two days a week at the project, when VNA nurses are available. The VNA provides this service free of charge because it offers a marketing opportunity for future clients. Residents who do not receive assisted living services can also participate in the meals program for a fee or purchase housekeeping services at a rate of \$10 per hour.

The total cost of the assisted living program at Stafford House is approximately \$120,000 per year. Assisted living residents are required to pay 20 percent of their adjusted incomes for the service package, including meals. The housing authority collects both rent (30 percent of income) and services (20 percent of income) in a single monthly payment. Participant contributions generate about \$20,000 per year for the program. Approximately \$100,000 comes from state and federal Medicaid funds.

The adult day care and senior centers in the building adjacent to the project are open to residents and older persons living in the community. Both the local CAP agency and the local hospital rent space, generating sufficient income to service the mortgage. The hospital runs the adult day care center, and the CAP agency operates a meals program.

Because assisted living residents pay a flat fee for all services, which in all cases is a small fraction of the cost, measures other than cost to the resident are used to assure that services are efficiently used. All residents are expected to help themselves as much as possible, and staff are trained to involve the resident in housekeeping activities. Unless they are sick, residents are required to come to the dining room for all meals. Residents may not be able wash laundry but may be able to fold it. Many residents participate in the Neighbor to Neighbor program, which does fundraising for program activities and provides direct services to other residents.

### ARCHITECTURAL AND DESIGN ISSUES

No major architectural issues affect the assisted living program. However, the authority hopes to obtain funds to enclose the walkway between Stafford House and the adult day care and senior center. The mortgage was insufficient to do the enclosure at the time the mini-mall was converted to its new uses.

### POLICY AND PROCEDURAL ISSUES

A Professional Assessment Committee (PAC), which serves both Stafford House and Sunrise Towers, meets monthly to review the record on each participant. Decisions regarding changes to the service plan for a participant are made by the service coordinator in consultation with the PAC. The PAC has several members: a social worker from the county nursing home; a representative from the New Hampshire Department of Health and Human Services and its Division of Adult and Elderly Services; a representative from the county agency for the mentally disabled; the pharmacist from the local hospital; a social worker; the county long-term care coordinator; and a representative from the county mental health agency. The PAC serves an educational function within the community and averts potential conflicts between different agencies. It is also effective in lobbying state and local officials on issues affecting assisted living.

The housing authority maintains separate waiting lists for residents who need assisted living and those who do not. Those requesting assisted living must have their admissions request reviewed and approved by a doctor. Residents who are not receiving assisted living services but need them are given priority over nonresidents applying for assisted living. There is currently a backlog of residents who have aged in place and now need assisted living services.

## **New Jersey**

New Jersey has developed a statewide strategy for providing assisted living services in subsidized housing. Much of the momentum for providing such services came from previous experience with a CHSP. About 50 state-funded CHSP sites are in operation; another 15 sites recently received initial state funding and are expected to open soon.

In 1994, the state Division on Aging (DOA) received a two-year grant from the federal Administration on Aging to develop an assisted living model for subsidized housing for older persons. The DOA awarded funds to the Presbyterian Homes of New Jersey Foundation to implement the demonstration in Asbury Tower, which had also served as the pilot site for the state CHSP program 17 years earlier. The demonstration program was entitled the Expanded Services Program (ESP). DOA also contracted with the Rutgers University Institute for Health, Health Care Policy and Aging Research to conduct an evaluation of the demonstration model and to research issues pertaining to its replicability and cost.

As a result of the demonstration program and follow-up study, the state amended its regulations to provide for the licensing of assisted living programs in subsidized projects for older persons. New Jersey licensure category for assisted living programs designed for subsidized housing is unique and makes it possible to provide assisted living services in HUD-subsidized projects for older persons without requiring expensive retrofitting to meet building standards generally required of newly built assisted living facilities.

Fourteen services providers are currently licensed in the state to provide assisted living programs in 37 different subsidized housing projects throughout the state. Unlike most states, New Jersey has a nurse delegation process, which permits Certified Medication Aides (CMAs) to administer medications under the supervision of an RN. CMAs are used extensively in the assisted living programs described below.

The state offers Medicaid waivers to pay for assisted living. A newly created Department of Health and Senior Services administers the waiver program. The state is attempting to procure funds to subsidize program participants who are not eligible for Medicaid.

### ***Asbury Tower***

Sponsored and managed by Presbyterian Homes and Services Inc., Asbury Tower is a 350-unit project for older persons located in Asbury Park.

#### **RESIDENTS**

In 1994, white women headed 70 percent of households in Asbury Tower. The average age was 77 years. The average ESP participant is 81 years of age. Of the 59 residents served during the demonstration, 53 were women. ESP participants live throughout the building and have never been required to move in order to participate in the program.

## PROJECT INFORMATION

The project was developed under the HUD Section 236 program and opened in 1973 with 100 efficiency and 250 one-bedroom units. Residents benefit from reduced rents based on a one percent interest rate mortgage. The basic rent is \$480 for an efficiency and \$581 for a one-bedroom unit. A Rent Supplement Contract covers 70 units, and 134 units are covered by a Section 8 contract. Three residents have Section 8 certificates/vouchers. In total, residents in 207 apartments receive subsidies.

## ASSISTED LIVING PROGRAM INFORMATION

Asbury Tower has a state-funded CHSP, which has been in place since 1977. Services include a daily hot lunch served in the congregate dining room and one to two hours of housekeeping per week. Other CHSP services include laundry and food and personal shopping. Residents pay for CHSP services on a sliding scale based on their incomes.

The ESP began in May 1994 and was built upon the core of services provided through the CHSP. At that time, the CHSP had 94 participants. Although personal care was not provided under the CHSP, a 1993 survey showed that 25 CHSP participants and 34 non-CHSP participants purchased personal care services.

In order to serve frailer residents, the ESP added bathing, dressing, and personal care services; toileting assistance; orientation assistance; socialization activities; assistance with meal preparation; assistance with ambulating and transferring; escort help for outside appointments; medication monitoring, cueing, and administration; health education and health status monitoring; and case management coordination of community services and medical appointments. ESP staff is available in the building daily from 7:30 a.m. through 8:00 p.m., with nurse on-call coverage 24 hours a day.

Extended hours and the ability to deliver services in small time units (5 to 15 minutes) promote flexibility in service provision. At the end of the second grant year, an average of 30 residents received ESP. The staff consisted of the ESP coordinator/RN, an LPN, and five resident assistants, who were certified home health aides or certified nurses aides. ESP participants receive an average of 4.8 hours of services weekly.

The average annual ESP cost per participant was \$3,347. The average annual cost for an ESP participant who was Medicaid nursing home-eligible was \$5,012 per year. Adding the cost of the CHSP (\$1,536 per year) and the rent (averaging \$6,000 per year), the total cost is \$12,548 per year for an ESP participant who was Medicaid nursing-home-eligible compared to at least \$36,000 per year for a nursing home.

## POLICY AND PROCEDURAL ISSUES

During the first year of the demonstration ESP, participants were not required to pay for ESP services. Asbury Tower has subsequently implemented a fee schedule based on the CHSP schedule, which varies based on the resident's income.

### *Bernard Dubin House*

Bernard Dubin House was developed under the Section 202/8 program and owned by the Jewish Federation Housing, Inc. The building opened in September 1978 with 144 units in Cherry Hill. Sixty-four units are efficiencies; and 80 units, one-bedroom. All residents receive Section 8 subsidies, and the project has a waiting list of 160 people.

#### RESIDENTS

The average tenure for assisted living residents is 15 years compared to 12 years for other residents. The great majority of the 169 residents are white women with an average age of 84. All 12 assisted living residents are white and older than 80 years and only one is male.

#### ASSISTED LIVING PROGRAM INFORMATION

The state funds a CHSP onsite with \$138,000 per year. A hot lunch is provided daily to 42 residents. Ninety residents receive four hours per month of housekeeping. Twelve residents receive three hours per month of personal care. Residents pay on a sliding scale for services, depending on their income. For example, residents pay \$6 to \$12 per hour of personal care. Resident contributions to the CHSP amount total \$79,000 per year.

The assisted living program began in January 2000 with 12 participating residents, including nine residents who are also in the CHSP. Assisted living residents have the option of one or two meals per day, as do CHSP residents. Housekeeping and laundry services are the same for assisted living and CHSP residents. The difference in the two programs is in the area of personal assistance. The assisted living administrator is also the activities director and is licensed as an Assisted Living Program (ALP) director.

Assisted living services are provided under contract by Kennedy Hospital, which provides \$25,000 to help cover the administrator's salary. The ALP administrator is a project employee; other assisted living staff are hospital employees. The hospital rents space for a health center for \$15,000 per year. Personal care, including administration of medicine, is provided by certified home health aides under the supervision of an RN. Both the project and the hospital are licensed to operate assisted living programs.

The assisted living residents are eligible for Medicaid under New Jersey's Medicaid waiver, and the hospital is responsible for billing for Medicaid. Any costs for the assisted living program that exceed the sum of the Medicaid reimbursement plus resident fees are covered by the hospital. Therefore, the assisted living program is cost-free to the project.

#### ARCHITECTURAL AND DESIGN ISSUES

Under state regulations, assisted living residents cannot be required to move for services. For those residents who need help with showers, bathrooms were modified to include shower seats and hoses. The nominal cost was covered out of project operating funds.

### *VNA Central Jersey Personal Care Inc.*

Licensed as an assisted living program provider, the Visiting Nurses Association (VNA) of Central Jersey Personal Care Inc. provides services to a number of housing facilities for older persons in Monmouth and Middlesex counties. One client is Peter Cooper Village, located in West Long Branch. This project was developed under the Section 8 New Construction program and was initially occupied in 1979. It contains 150 units consisting of 40 efficiencies, 100 one-bedroom units, and 10 two-bedroom units. At the time of the study, the project had a waiting list of approximately 100 people.

#### RESIDENTS

Of the twelve assisted living participants, ten are women and nine are older than 80. All are white. Assisted living residents are located throughout the building.

#### ASSISTED LIVING PROGRAM INFORMATION

Peter Cooper Village has a state CHSP with 15 participants. The program includes a daily noon meal, with the cost based upon the resident's income. Housekeeping costs \$12 per hour, and the 16 residents who participate receive about an hour per week. Medicaid reimbursement is available for those CHSP residents who are also in the assisted living program. The project has a service coordinator who is paid from project funds.

VNA began providing assisted living services in Peter Cooper Village in December 1997 under a program agreement. VNA provides a number of services: meal preparation in the resident's apartment, housekeeping, laundry, shopping, companion services to medical appointments, transportation, and personal care.

VNA is responsible for collecting the residents' share of the fee and for billing under the state Medicaid waiver. The project pays nothing for the program, and the state sets the fees based on the resident's income. Twelve persons are currently in the program, six of whom also participate in the CHSP. The assisted living program and the CHSP operate independently, and the service coordinator is the liaison between the two programs. Participants in the assisted living program are assessed regularly by an RN. Service plans are reviewed with the participants and their families as part of these assessments.

#### STAFFING

Services are provided by two full-time Certified Medication Aides (CMA) under the supervision of a part-time RN. The billing rate for the CMAs is \$8.25 per hour and \$22 per hour for the RN. Both the hours of service and the billing are monitored by the RN.

## **North Carolina**

North Carolina funds personal care in residential care facilities through its state Medicaid plan. Funding through the state plan means that all residents in such facilities who are Medicaid-eligible can receive personal care services under Medicaid. As a result, North Carolina provides more Medicaid-funded services in residential care facilities than any other state. More than 20,000 persons in North Carolina's residential care facilities are served by Medicaid. The ready availability of Medicaid-funded personal care has made it easier to provide assisted-living-type services in residential settings.

### ***Koinonia Apartments***

Koinonia Apartments, sponsored by the First Presbyterian Church of Lenoir, is an 84-unit apartment building for older persons. The project was developed under the Section 202/8 program and reached initial occupancy in August 1979. All units are one-bedroom, and all residents benefit from Section 8.

#### **RESIDENTS**

The average age of residents is 79 years old, and 20 percent of residents are older than 90. Nearly all residents are white. The average term of residency is 10 years. Women make up 95 percent of the resident population. No residents are younger than age 62.

#### **ASSISTED LIVING PROGRAM INFORMATION**

The project is staffed by a full-time administrator, a part-time activity director and van driver, and a full-time maintenance worker. The administrator functions as manager, service coordinator, and case manager. Because the project has no funds to pay for assisted living services, it has developed a strategy of finding agencies in the community that can provide services onsite at little or no cost to residents. The project serves as the site for a Title III nutrition program, which serves a noon meal five days per week. Residents may contribute, although payment is not required. Approximately 40 residents participate regularly in this program along with approximately ten people from the community.

Housekeeping services are provided to residents in two ways. Green Thumb, which operates a federally funded training program for older workers, provides housekeepers in training at no charge to residents. These workers do light housework such as laundry, making beds, and sweeping. The administrator also has a list of individuals in the community who provide reasonably priced housekeeping services.

Personal care is available from the Caldwell County Home Health Agency and from the local Community Action Program. Both agencies provide a limited amount of personal care at no charge to residents. Five to eight residents receive personal care services. The home health agency offers no-cost respite care, which includes up to eight hours per week of care to relieve the primary caregiver.

The project provides a variety of activities for its residents: exercise; blood pressure checks; craft activities; entertainment; and transportation to the library, picnics, and shopping. The building includes an exercise and lounge area; crafts room; library; beauty shop; and a small store, which sells cards, stamps, and crafts.

Fire drills and fire safety classes are held regularly. A central alarm system wired directly into the fire department provides immediate service. One resident, with the consent of her guardian, has had her stove disconnected. The project helped her locate a person to prepare and deliver her meals. The resident pays for this service.

## ARCHITECTURAL AND DESIGN ISSUES

The building includes eight apartments with walk-in showers, lower kitchen cabinets, and wider doors. These units are grouped in clusters of four at the end of the hall on each wing.

## POLICY AND PROCEDURAL ISSUES

Residents are active in a residents' council and help maintain the building and grounds. They also have gardens. Both residents and nonresidents help with services such as transportation to medical appointments or shopping and visiting and assistance with personal tasks such as reading or writing letters.

### *Preiss-Steele Place*

Preiss-Steele Place is a 102-unit project for older persons and persons with disabilities located in Durham. Initial occupancy was November 1993. All units are one-bedroom, and rents, excluding electricity, range from \$358 to \$395 per month. The income limit for one person is \$20,850 per year, and approximately two-thirds of the residents benefit from Section 8 certificates or vouchers.

## RESIDENTS

The average term of residency is four years, and the average age is 68. Approximately 85 percent of the residents are women, and 90 percent are black. Residents tend to stay in the facility until they need skilled nursing care.

## PROJECT INFORMATION

The project was developed by Development Ventures, Inc. (DVI), a nonprofit, tax-exempt housing development corporation created by the Durham Housing Authority to develop housing for low- and moderate-income families. The project was financed with federal low-income housing tax credits and a variety of loans and grants. The project ownership contracts with the Durham Housing Authority to manage the project.

The project is described as an assisted independent living facility, although it is not licensed as such. It was developed with more common space than most projects designed for independent older people as it features a fully equipped commercial kitchen and a very large common area/dining room. Although the commercial kitchen is currently used only to accommodate food that is brought in from outside, the sponsorship believed that it would be needed as residents age in place. Other common areas include an examination room for visiting nurses, sun rooms on each level, lobbies and lounges, a beauty parlor and barber shop, office space, and facilities for assisted bathing. The project has a 24-hour emergency response system. Each floor has a coin-operated laundry room. The project is located in a residential area and is near a major shopping center.

#### ASSISTED LIVING PROGRAM INFORMATION

Residents can expect to age in place and obtain services on an à la carte basis. The facility has a very small staff, consisting of a part-time manager, a part-time assistant manager, and a maintenance staff. Resident volunteers manage the entrance and phones. Residents are expected to help each other. A county social worker is available onsite for a half day each week. The social worker functions as a case manager. Services are provided by community service agencies and include meals, housekeeping, laundry, bill paying, grocery shopping, personal care, home health aide services, and transportation. Services are paid for by Medicaid, Title III of the Older Americans Act, other public subsidies, and resident payments. North Carolina's Medicaid plan allows eligible individuals to tap Medicaid funds to pay for personal care services.

The Meals-on-Wheels program provides one meal on weekdays. The meals program is paid for by the county, and participants make a modest contribution. A voluntary group called Friends of Preiss-Steele was formed to expand meal service into the community. The Friends also promote other activities, such as concerts and computers classes. An optician provides eyeglass repairs onsite at no charge to residents. The juvenile court refers young people to the project to do clerical work and help residents with their groceries. The local hospital participates in health fairs held at the site.

The resident council has its own bylaws and standing committees. It sponsors activities and programs for the residents, has its own choir, and has conducted food and clothing drives to benefit the North Carolinians who lost their homes in the last hurricane. The council charges a fee of \$2 per month.

#### POLICY AND PROCEDURAL ISSUES

Residents' income must fall within prescribed limits. The housing authority performs a landlord check and a criminal check on all applicants. The project manager personally interviews all applicants. An applicant must be able to live independently in order to be admitted. The county social worker may interview the applicant if further assessment of the ability to live independently is needed.

### *Astor Dowdy Project*

The Astor Dowdy project is a high-rise building for older people owned and operated by the Housing Authority of High Point. It contains 105 units, consisting of 28 efficiencies, 70 one-bedroom units, and seven two-bedroom units. It was initially occupied in 1968. Residents pay 30 percent of their income for rent. The project did not have a waiting list.

#### RESIDENTS

Over half of the residents of Astor Dowdy are women, and residents are overwhelmingly white. The average age is 68, and the average term of residency is 15 years. Reflecting the general resident population, 18 of 23 CHSP participants are women and 16 are white. The average age of the older CHSP participants is 74.

#### ASSISTED LIVING PROGRAM INFORMATION

The project has a voluntary meals program funded by the Older Americans Act and administered by United Services for Older Americans. Lunch is offered weekdays, and residents may make a small contribution. About 15 residents participate in this program.

The project also has a HUD-funded CHSP. This program has been in effect since 1981 and currently serves 23 people. Each CHSP participant is required to take one meal daily but has the option of a second meal each day. Fourteen people receive approximately one hour per week of housekeeping, and nine people receive personal care. The CHSP service coordinator is an LPN. The CHSP service coordinator supervises medication administration. The participants also benefit from transportation and wellness programs.

The total annual cost of the CHSP is \$117,000. HUD provides 40 percent of the budget, or approximately \$47,000. Participants pay 10 percent, or approximately \$12,000. The local match of 50 percent, or about \$53,000, is met through Medicaid and in-kind services by the housing authority. Seven of the participants are on Medicaid. The Medicaid participants receive personal care from an outside contractor. The client and the provider negotiate the service terms. Medicaid reimburses the provider directly.

The service coordinator is the only employee of the CHSP. She administers the meals program for the CHSP and is assisted by several resident aides, who are housing authority residents volunteering their time.

The housing authority received a three-year Economic Development and Supportive Services grant from HUD for \$372,000. Under this grant, 15 public housing residents have been trained as certified nursing assistants, and ten public housing residents have been hired to provide services such as housekeeping, shopping, and preparing meals for residents. The grant also provides money for direct services to residents.

## ARCHITECTURAL AND DESIGN ISSUES

The building required a few changes to accommodate the CHSP. The main dining room was converted to offices and meeting rooms. The multipurpose room now also serves as the dining room. Each floor is equipped with a coin-operated washer and dryer. Each apartment has an emergency light and a buzzer that sounds when activated by the resident, and each floor has a resident monitor.

## POLICY AND PROCEDURAL ISSUES

A Professional Assessment Committee (PAC) evaluates residents for participation and retention in the CHSP. The PAC has six members, including the service coordinator, an assistant to the service coordinator, the building manager, a mental health worker, a health department representative, and a hospital representative. CHSP participants are housed throughout the building.

## Virginia

### *Culpepper Garden*

Sponsored by the Unitarian Universalist Church of Arlington, Culpepper Garden is a 340-unit apartment complex for older persons. The complex includes three projects funded at different times by different federal programs. The third project is licensed as an "Adult Care Residence" to offer assisted living services. The decision to develop the assisted living project was made to address the increasing age and frailty of the residents of the earlier projects, which do not offer assisted living services.

#### RESIDENTS

The average resident age is 80. Most residents are women; the majority of residents are whites. The project has a waiting list, although turnover averages about 50 units per year. Incoming residents average about 75 years of age.

#### PROJECT INFORMATION

The Section 236 project opened in May 1975 and consists of 204 units, including 125 efficiencies, 72 one-bedroom units, and seven two-bedroom units. Rents are \$396, \$501, and \$641, respectively. The project receives Rental Assistance Payments of roughly \$72,000 per year, which subsidize rents for about 15 percent of the Section 236 residents. The Section 202/8 facility opened in October 1992 and consists of 63 one-bedroom units, for which the contract rent is \$938 per month. All residents benefit from Section 8, so they only pay 30 percent of their adjusted monthly income for rent.

A new Section 202/PRAC facility was opened in February 2000 to offer assisted living services. It has 73 one-bedroom units whose contract rents are \$485 per unit per month. Residents of Section 202/PRAC projects pay 30 percent of their income for rent.

#### ASSISTED LIVING PROGRAM INFORMATION

Both the Section 236 and Section 202/8 projects have mandatory evening meals. Brunch is offered daily from 9:30 a.m. to 1:00 p.m. as an optional meal. All meals are prepared in the central kitchen, and residents eat in the central dining room located in the Section 236 project. Two dining areas are included in the Section 202/PRAC project to serve the 73 assisted living residents, who may also eat in the central dining room.

A clinic is available to a general practitioner who visits weekly and a podiatrist who visits monthly. A nurse is available one morning per week at no charge to residents or the project. The Arlington Health Foundation provided a two-year \$300,000 grant to pay for a nurse's aide around the clock and to provide medication management for eight to 10 residents. The project offers housekeeping services at a charge of \$8 per hour. Personal care is available through a home health care agency subsidized by the county. The project also has a HUD-funded service coordinator. Arlington County rents space in the Section 236 project to provide an extensive recreation and activities program.

Participants are asked to pay a membership fee of \$5 per year. The Red Cross provides weekly transportation for grocery shopping.

Residents in the new project must meet assisted living admission requirements, which include the need for personal care. (Applicants with cognitive disabilities are not admitted, because the facility does not have secure entrances.) These residents are projected to need approximately 1.25 hours of personal care per day. The project will have a full-time RN director, a full-time LPN as deputy, a full-time activity coordinator, and 16 full-time certified nursing assistants to provide the personal care services.

In addition to rent, residents pay \$300 per month for three meals a day and snacks and \$800 per month for personal care. Auxiliary grants up to \$481 per month from Arlington County and the state are available to persons with very low incomes. Residents must spend down their assets to \$2,000 to become eligible for these grants. Once residents are eligible for auxiliary grants, they are automatically eligible for Medicaid. The auxiliary grants will provide an estimated \$64,000 per year of assistance. The Board of Directors hopes to raise \$50,000 per year to assist residents in covering their personal care costs.

Because the new Section 202/PRAC project was not open at the time of the interview, projections of resident incomes and subsidy needs are still tentative. Key staff have been hired, and the number of applications received substantially exceeds the number of units available. Current residents of Culpepper Garden in need of assisted living services will receive priority for admission, followed by residents of Arlington County.

## ARCHITECTURAL AND DESIGN ISSUES

The decision to develop a new assisted living facility, rather than bring assisted living into the existing projects, made it much easier to provide necessary physical features. The new facility differs from a typical project in that it has an extra elevator and includes significantly more public space as well as extra space for offices and dining.

In order to cover the extra costs involved in building the project, Culpepper Garden obtained \$1.3 million from Arlington County and raised \$250,000 in addition to the \$5.2 million capital advance from HUD. The new building is connected to the Section 236 project, so residents can move between the three projects without going outdoors. Both the new Section 202/PRAC project and the Section 202/8 project has a sprinkler system throughout, but the Section 236 project does not. All units in the new project are handicapped-adaptable, and 10 percent are handicapped-accessible with additional grab bars. All units in the new facility have bathrooms and showers that are wheelchair-accessible. The new building did not require a Medicaid waiver.

## POLICY AND PROCEDURAL ISSUES

Policies covering admission and termination of residents in all three projects are established by the Board of Directors in conformity with the HUD requirements. Residents of the assisted living facility, unlike residents in the other two projects, must need some personal care and must take three meals per day from the facility.

## Washington

### *The Housing Authority of Vancouver*

The Vancouver Housing Authority contracts with Columbia Pacific Management to provide assisted living services in two projects. A 100-unit public housing project opened in 1970 with 98 one-bedroom units and two two-bedroom units. A Section 8 New Construction project opened in 1979 with 152 units, of which 144 are one-bedroom units and eight are two-bedroom units. The projects are located within a mile of each other.

#### ASSISTED LIVING PROGRAM INFORMATION

Licensed as an assisted living provider, Columbia Pacific contracted with Emeritus Assisted Living to manage the assisted living program in both projects. These two projects accept Medicaid residents. The contract between the housing authority and Emeritus covers up to 100 persons who may receive assisted living services in either building. At present, 60 residents participate in the assisted living program.

Assisted living participants are located throughout both buildings, and public housing residents of either building are not required to move to receive assisted living services. Public housing residents receive preference on the waiting list. In order to be accepted, an applicant must be eligible under the Community Options Program Entry System (COPES), which is covered under the state's Medicaid waiver. A state caseworker determines eligibility and level of care need and reevaluates each participant quarterly.

Once an applicant is accepted into the assisted living program, the person's lease with the housing authority is terminated. Emeritus pays about \$250 per month per apartment to the housing authority for units occupied by assisted living residents in public housing and about \$500 per month per apartment in the Section 8 project. Assisted living participants sign over all but \$53 of their incomes to the contractor. Emeritus bills Medicaid for the balance over and above the resident's contribution based on three levels of care. In Clark County, where these two projects are located, the lowest level of care costs about \$1,500 per month; and the highest level of care costs about \$1,800 per month.

The service package includes three daily meals, which are prepared in a commercial kitchen located in the public housing project for participants in both buildings. Emeritus provides housekeeping, laundry service, management and disbursement of medications, and personal care. An administrator paid by Emeritus runs the assisted living program at both sites. The contractor also provides seven-day coverage with either an RN or an LPN. The contractor accepts housing authority residents as employees through a "moving to work" program. These residents receive training from the contractor and are employed in the food service program or as housekeepers or personal care services providers.

## ARCHITECTURAL AND DESIGN ISSUES

The two projects were required to meet certain physical standards regarding fire safety, laundry facilities, and kitchen facilities. The state granted the two projects waivers of the requirement that all assisted living residents be located on one floor of each building.

**APPENDIX A: Project Interview Schedule**

Project Name \_\_\_\_\_

Person Interviewed \_\_\_\_\_

Position \_\_\_\_\_

**Section 1: Project Information**

1. Under what program was the project developed (e.g., Section 236, 202, Public Housing, etc.)? \_\_\_\_\_
2. What was the date of initial occupancy? \_\_\_\_\_
3. How many units are in the project? \_\_\_\_\_
4. Breakdown of units by size: efficiencies \_\_\_\_\_ 1 BR \_\_\_\_\_ 2 BR \_\_\_\_\_
5. How many units benefit from Section 8? \_\_\_\_\_
6. How many units are vacant? \_\_\_\_\_
7. Is there a waiting list? Yes/No If so, how many are on it? \_\_\_\_\_
8. Does the project have a meals program? Yes/No If so, please describe (How many meals served? Cost per meal?) Is the meal program mandatory? Yes/No
9. Does the project have a state or federal Congregate Housing Services Program (CHSP)? Yes/No If so, please provide the following information:
  - a. Number of residents participating in CHSP \_\_\_\_\_
  - b. List services provided and number of persons receiving each service:

Meals	Yes/No _____	(meals per week)	_____	(# persons)
Housekeeping	Yes/No _____	(hrs/wk)	_____	(# persons)
Personal care	Yes/No _____	(hrs/wk)	_____	(# persons)
Other	Yes/No _____	(hrs/wk)	_____	(# persons)
  - c. Total yearly cost of program \_\_\_\_\_
  - d. Source of funds for program (if more than one source, please list below including amount from each source)
10. Does the project have a service coordinator? Yes/No
11. Is the service coordinator paid out of project income? Yes/No

12. If not paid from project income, what is the source of funding for the service coordinator? \_\_\_\_\_

***Section 2: Assisted Living Program Information***

1. What was the opening date for the assisted living program? \_\_\_\_\_
2. How many residents are in the program? \_\_\_\_\_
3. List services provided and number of persons receiving each service:  
Meals \_\_\_\_\_ (# week) \_\_\_\_\_ (# persons)  
Housekeeping \_\_\_\_\_ (# hrs/wk) \_\_\_\_\_ (# persons)  
Personal laundry \_\_\_\_\_ (Yes/No) \_\_\_\_\_ (# persons)  
Personal shopping \_\_\_\_\_ (Yes/No) \_\_\_\_\_ (# persons)  
Companion services to medical appointments (Yes/No)  
Transportation (Yes/No)  
Other (please specify)
4. If the project also has CHSP, how many CHSP residents participate in the assisted living program? \_\_\_\_\_
5. Does the assisted living program pick up all the service costs or only the incremental costs over and above the CHSP costs? \_\_\_\_\_
6. If the project has a services coordinator, how does the position relate to the assisted living program?
7. What controls are in place to assure that the services provided are necessary?
8. What controls are in place to assure that the services provided are cost effective?

***Section 3: Capital Costs***

1. What changes were made to the physical plant to facilitate assisted living? Please describe below:
2. What changes were made to the living units to accommodate assisted living? Please describe below:
3. What were the capital costs of the changes described in #1 & #2 above? \_\_\_\_\_
4. What was the source of these funds? \_\_\_\_\_

5. If financing was used to cover capital costs:
  - a. How was the financing secured? (e.g., residual receipts note, etc.)
  - b. What were the terms of the financing?
  - c. Where was the financing obtained?
  - d. What is the monthly debt service? \_\_\_\_\_
  - e. What is the source of funding for the debt service?

**Section 4: Assisted Living Service Costs (exclude CHSP costs)**

1. Please provide the total cost and the cost per resident for each of the services provided:

	Total mo. cost	Mo. cost per resident
Meals	_____	_____
Housekeeping	_____	_____
Personal care	_____	_____
Transportation	_____	_____
Other (please specify)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
Overhead costs	_____	_____
TOTAL COST OF PROGRAM	_____	_____

2. Please indicate the amount funding received from each of the sources below:
  - a. Resident funds \_\_\_\_\_
  - b. Medicaid \_\_\_\_\_
  - c. Built into budget \_\_\_\_\_
  - d. Capital reserves \_\_\_\_\_
  - e. HUD grant (not CHSP) \_\_\_\_\_
  - f. Older Americans Act \_\_\_\_\_
  - g. State/city \_\_\_\_\_
  - h. Other (specify) \_\_\_\_\_
3. Are residents required to contribute? Yes/No

4. Are residents asked voluntarily to contribute? Yes/No
5. If residents contribute, how is the amount of the contribution determined? If there is a sliding scale, please include it below.

**Section 5: Staffing**

1. Are the services provided directly by the facility or are they contracted out to an outside service provider? \_\_\_\_\_
2. If contracted out:
  - a. Who is the service provider? \_\_\_\_\_
  - b. What is the amount of the contract? \_\_\_\_\_
  - c. What is the relationship between the service provider and the project sponsor? (e.g., contract with nursing home, which is a separate corporation but has the same sponsor as the subject project)
  - d. What is the relationship of the service coordinator with the assisted living staff?
3. Provide a list of staff in the space below:

Position title	Salary	Hours per week
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Section 6: Residents**

1. What are the criteria for admission to the project?
  - a. For nonassisted living units?
  - b. For assisted living units?
2. Are nonresidents of the project eligible for assisted living units, or are such units reserved for residents in independent living units who require additional services as a result of aging in place?
3. Other than as recipients of services, what roles do residents have in the assisted living program? (e.g., advisory role, referrals, fund raising, etc)

4. What is the average term of residency?
  - a. In nonassisted living units? \_\_\_\_\_ years
  - b. In assisted living units? \_\_\_\_\_ years

5. Please provide the following information about current residents:

	Non-assisted living	Assisted living		Non-assisted living	Assisted living
a. Gender			c. Race		
(1) Male	_____	_____	(1) White	_____	_____
(2) Female	_____	_____	(2) Black	_____	_____
			(3) Hispanic	_____	_____
b. Age			(4) Asian	_____	_____
(1) Under 62	_____	_____	(5) Native Amer.	_____	_____
(2) 62-69	_____	_____	(6) Other	_____	_____
(3) 70-79	_____	_____			
(4) Over 80	_____	_____			

***Section 7: Regulatory Issues***

1. What, if any, state or local building code requirements had to be met in order to convert to assisted living?
2. What, if any, state or local licensing requirements had to be met in order to convert to assisted living?
3. What, if any, HUD approvals were required?
4. What were the costs involved in meeting the requirements of #1 – 3 above? (Include both direct and indirect costs, such as the staff time invested in the licensing process)
5. How long did it take to obtain necessary licenses? \_\_\_\_\_ months
6. What are the ongoing regulatory oversight requirements of the state or locality?
7. Was a Medicaid waiver required? Yes/No
8. How long did it take to get the waiver? \_\_\_\_\_ months
9. If HUD approval was required, how long did it take? \_\_\_\_\_ months
10. Is delegation of nursing activities permitted by state law, so that medications can be administered by aides under the general supervision of nurses? Please comment.

### ***Section 8: Architectural and Design Issues***

1. Are there modest design changes to the project that could enhance the ability of frail elderly to live independently (e.g., breaking up long corridors that confuse residents)? If so, please describe below.
2. Are there modest design changes to the units that could enhance the ability of frail elderly to live independently? (e.g., changing height of counters, electrical outlets, etc.) If so, please describe below.
3. Are there alterations that are required or desirable in order to enhance fire safety? If so, please describe below.
4. Are there special equipment needs, such as whirlpools, special bathrooms, facilities for handling soiled laundry, furniture resistant to incontinence? If so, please describe below.
5. What other design issues need to be addressed?

### ***Section 9: Policy and Procedural Issues***

1. Who establishes the admission policy?
  - a. For residents of independent living units
  - b. For residents of assisted living units
2. Who establishes the termination policy?
  - a. For residents of independent living units
  - b. For residents of assisted living units
3. What is the termination policy?
  - a. For residents of independent living units
  - b. For residents of assisted living units
4. Is there a Professional Assessment Committee (PAC)? Yes/No
5. Please describe the membership, qualifications, and responsibilities of the PAC

6. Are assisted living services provided to residents regardless of where they live in the project, or are persons who receive assisted living services required to relocate into a special section of assisted living units?
7. Does the assisted living provider serve other projects in the area? Yes/No
8. Does the assisted living provider serve other individuals in the area, such as those in single family homes? Yes/No
9. Describe the extent to which there is coordination with outside agencies:
  - a. In order to assure that there is no duplication of services?
  - b. In order to maximize governmental or other outside financial support?
  - c. In order to assure that necessary services are available in the community as well as in the project?
10. What procedures are in place to assure that assisted living residents receive the services that they need without encouraging residents to become overly dependent?

***Section 10: Liability Issues***

1. Describe the liability of the project under the appropriate category below:
  - a. Staff administering assisted living program are project employees
  - b. Staff administering assisted living program are employees of outside contractor
2. Describe any negotiated risk agreements executed by program recipients and the program provider to cover situations where the resident chooses risky behavior, such as failing to medicate, failure to follow diet, walking in areas where there is a high risk of falling, etc.
3. To what extent is insurance available to protect the project owner from the risks described above?
4. If insurance is available, what is the annual cost? \_\_\_\_\_
5. If insurance is available, what does it cover?

**APPENDIX B: Contact Persons**

<p><b><u>CONNECTICUT</u></b>                  Rev. Charles Gelbach, Executive Director                  Immanuel House                  15 Woodland Street                  Hartford, CT 06105</p>	<p>tel. (860) 525-4228                  fax (860) 522-6912                  e-mail: CGelbach@aol.com</p>
<p>Dorothy Giannini-Meyers, President /CEO                  Tower One/Tower East                  18 Tower Lane                  New Haven, CT 06519</p>	<p>tel. (203) 772-1816                  fax (203) 777-5921                  e-mail: towers.dgm@snet.net</p>
<p><b><u>KENTUCKY</u></b>                  Troy D. Burden, Residential Services Administrator                  Christian Church Homes of Kentucky – Louisville                  960 South Fourth Street                  Louisville, KY 40203</p>	<p>tel. (502) 589-5747                  fax (502) 560-5157</p>
<p><b><u>MARYLAND</u></b>                  Ron Griffin, Executive Director                  B'nai B'rith Homecrest House                  14508 Homecrest Road                  Silver Spring, MD 20906</p>	<p>tel. (301) 598-4000                  fax (301) 598-6485</p>
<p>Joseph H. Dobson, Jr., Administrator                  St. Mary's Home for the Elderly                  Cedar Lane Apartments                  22680 Cedar Lane Court                  Leonardtown, MD 20650</p>	<p>tel. (301) 475-8966                  fax (301) 475-1629                  e-mail: smhe@erols.com</p>
<p>Joseph J. Podson, Administrator                  Springvale Terrace                  8505 Springvale Road                  Silver Spring, MD 20910</p>	<p>tel. (301) 587-0190                  fax (301) 588-1126</p>
<p><b><u>MINNESOTA</u></b>                  Jan Liddick                  Family Self-Sufficiency Employment Service Counselor                  Minneapolis Housing Authority                  1001 Washington Avenue North                  Minneapolis, MN 55401</p>	<p>tel. (612) 342-1222                  fax (612) 335-4497</p>
<p>Joslyn Showalter                  Director of Assisted Living and Adult Day House                  Amherst H. Wilder Foundation                  919 Lafond Avenue                  St. Paul, MN 55104</p>	<p>tel. (651) 772-5231                  fax (651) 772-5227</p>

<b><u>NORTH CAROLINA</u></b>	
Rachel Brown, Services Coordinator Housing Authority of the City of High Point 500 East Russell Avenue High Point, NC 27260	tel. (910) 887-2661 fax (910) 887-2414
Gayle A. Taliaferro, Housing Manager The Housing Authority of the City of Durham 500 Pickwick Trail Durham, NC 27704	tel. (919) 479-5050 fax (919) 620-7739
Jack Preiss, President New Directions for Downtown, Inc. 500 McCallie Avenue Durham, NC 27704	tel. (919) 667-9200 fax (919) 667-9111
Patricia S. Hodge, Administrator Koinonia Inc. 318 Main Street Lenoir, NC 28645	tel./fax (828) 758-2617
<b><u>NEW HAMPSHIRE</u></b>	
Charlotte A. DuBois Supportive Services Director Laconia Housing and Redevelopment Authority 25 Union Avenue Laconia, NH 03246	tel. (603) 524-2112 fax (603) 524-2290
Jan Lane, President Jan Lane Associates 307 Addison Road Goffstown, NH 03045	tel./fax (603)623-2141 e-mail: KLASSCHSP@AOL.COM
<b><u>NEW JERSEY</u></b>	
Cindie Dawid, Administrator Asbury Towers 1701 Ocean Avenue Asbury Park, NJ 07712	tel. (732) 988-9090 fax (732) 988-0405
Barbara E. Finkleman, Executive Director Jewish Federation Housing, Inc. 3051 W. Chapel Avenue Cherry Hill, NJ 08002	tel. (856) 667-6826 fax (856) 667-6907
Marjorie Forgang, Dir. of Specialized Services Visiting Nurses Association of Central Jersey Personal Care Inc. 141 Bodman Place Red Bank, NJ 07701	tel. (732) 224-6819 fax (732) 530-5626

<p><b><u>VIRGINIA</u></b>  William P. Harris, Executive Director  Culpepper Garden  4435 N. Pershing Drive  Arlington, VA 22203</p>	<p>tel. (703) 528-0162  fax (703) 524-3671</p>
<p><b><u>WASHINGTON</u></b>  Alice Porter, Director of Housing  The Housing Authority of Vancouver  500 Omaha Way  Vancouver, WA 98661</p>	<p>tel. (360) 993-9525  fax (360) 993-9594</p>
<p>Kacy Kang, Regional Director  Emeritus Assisted Living  3131 Elliott Avenue, Suite 500  Seattle, WA 98121</p>	<p>tel. (206) 298-2909  fax (206) 301-4080</p>

## **APPENDIX C: GLOSSARY**

**AMERICANS WITH DISABILITIES ACT (ADA):** Legislation enacted by Congress in 1990 that prohibits discrimination against people with disabilities in the areas of employment, public services, public accommodations, transportation, and telecommunications.

**ASSISTED LIVING FACILITIES:** Group residential settings, other than licensed nursing homes, that provide protective oversight and personal care on a 24-hour basis for persons with impairments in the performance of activities of daily living (ADLs), and that have the capacity to meet expected unscheduled needs for assistance. Assisted living facilities are similar to board and care homes except that they are often only for private-pay residents and usually promote independence and dignity for residents.

**COMMUNITY DEVELOPMENT BLOCK GRANTS (CDBG):** Grants distributed on a formula basis by the U.S. Department of Housing and Urban Development (HUD) to state and local governments to be used for a variety of purposes related to community development and housing.

**CONGREGATE HOUSING SERVICES PROGRAM (CHSP):** The federal CHSP program was authorized in 1979 to provide nonmedical services to frail older residents in federally subsidized housing. Approximately 100 sites nationwide participate in the program. The majority of the funding goes to service coordination and meals with other services funded as possible. A few states, such as Maine, Maryland, and New Jersey, have similar state CHSP programs.

**CONTRACT RENT VS. TENANT RENT:** Contract rent in Section 8 projects is the amount of rent required to cover operating expenses, reserves, and debt service. Tenant rent is the portion of the contract rent paid by the resident, normally 30 percent of adjusted monthly income for residents receiving Section 8 subsidies. Section 8 subsidies cover the difference between the tenant rent and the contract rent.

**FAIR HOUSING AMENDMENTS ACT:** In 1988, the Fair Housing Act was amended to include protections against discrimination in housing based on disability or familial status. The act generally requires accessible public spaces and “reasonable accommodations” from providers in making individual units accessible.

**FLEXIBLE SUBSIDIES:** Grants or loans from the U.S. Department of Housing and Urban Development (HUD) made to private owners of older FHA-insured multifamily projects to upgrade or renovate older buildings.

**LOW-INCOME HOUSING TAX CREDITS:** Authority is granted by the federal government to states to issue tax credits up to a specified limit. Projects that receive tax credit allocations are required to serve a specified number of low-income persons. Tax credits are provided to investors to induce them to invest in projects serving low-income persons who benefit from below-market rents.

**MEDICAID:** Authorized under the Social Security Act to provide medical services to persons with low incomes and assets, the program is also used extensively to fund nursing home services for frail older persons. Waivers are used by all states to fund some home and community-based services, but the program is still heavily weighted toward institutional services for persons with disabilities.

**OLDER AMERICANS ACT:** The Older Americans Act funds a variety of services such as meals, transportation, and senior centers to promote the independence of older persons. Some states use Older Americans Act funds to augment their home and community-based services programs for older persons.

**PUBLIC HOUSING:** Housing owned and operated by public housing authorities (PHAs). Admission is restricted to persons having very low incomes, generally not exceeding 50 percent of the area median income. PHAs receive operating subsidies from the U.S. Department of Housing and Urban Development (HUD) to cover the difference between the rent received from residents and the cost of operating the projects. Residents are required to pay 30 percent of their adjusted monthly income for rent. PHAs also receive modernization funds from HUD to repair and renovate older projects.

**RENT SUPPLEMENTS:** Neither the original Section 202 program nor the Section 236 program (see below) had deep subsidies for persons with very low incomes. Many of these projects received rent supplement contracts that the projects allocate to persons needing rental assistance. Many of these contracts were superseded by subsequent Section 8 contracts, but some projects continue to operate with rent supplements.

**REPLACEMENT RESERVES:** A separate account required by the U.S. Department of Housing and Urban Development (HUD) for each FHA-insured and Section 202 project. The amount of rental income set aside for replacement reserves is determined by HUD. Funds from this account are used to cover capital expenses, such as replacement of windows, furnaces, and major appliances.

**SECTION 8 PROGRAM:** Many programs fall under the category of Section 8 of the United States Housing Act of 1974. Section 8 programs provide subsidies to low-income persons to cover the difference between resident payments (typically 30 percent of adjusted monthly income) toward rent and the full amount of the rent.

**SECTION 8 PROJECT-BASED PROGRAMS:** There are two major project-based Section 8 programs: the New Construction/Substantial Rehabilitation program (Section 8 NC/SR); and the Loan Management Set-Aside program (Section 8 LMSA). In the Section 8 NC/SR program, HUD provides a twenty-year Section 8 contract to the project owner covering between 20 percent and 100 percent of the units in the project. In the Section 8 LMSA program, HUD provides owners of existing FHA projects (most frequently, Section 236 projects) with a contract covering some or all of the units in the project. The initial term of the contract cannot exceed 15 years, and typically is for a much shorter period of time.

**SECTION 8 RENT CERTIFICATES/VOUCHERS:** The principal form of federal rent assistance in existing housing. The certificates represent the difference between the fair market rent set by HUD and 30 percent of the tenant's income.

**SECTION 202 PROGRAM:** Authorized by the Housing Act of 1959, the original target population was older persons (age 62 or older) whose incomes were too high for public housing but insufficient to afford housing in the private market. The program provided nonprofit sponsors with 50-year loans at below-market interest rates (typically 3 percent). Projects under the original program were developed from 1959 to 1968.

**SECTION 202/8 PROGRAM:** As amended in 1974, Section 202 loans were used in tandem with Section 8 project-based subsidies. Nonprofit owners received loans with a 40-year term and an interest rate pegged to the average government borrowing rate. At least 20 percent of the units were covered by a Section 8 contract, although most projects had contracts covering all units in the project. Section 8 contracts had a term of 20 years.

**SECTION 202/PRAC PROGRAM:** As amended in 1990, Section 202 now provides capital advances to nonprofit sponsors to develop projects for older persons, separating the program from Section 8. Section 202 provides additional subsidies in the form of Project Rental Assistance Contracts (PRAC). The PRAC covers the difference between the resident's share of rent (30 percent of adjusted monthly income) and the rent required to operate the project. Required rents are much lower in PRAC projects compared to Section 202/8 projects because no debt service is required on capital advances.

**SECTION 202 COST CONTAINMENT:** Due to rising costs in the Section 202 program, HUD initiated cost-containment policies beginning in 1982. Under these policies, two-bedroom units were prohibited, and at least 25 percent of the units in each project were required to be efficiencies. Size limitations on units were also imposed. Efficiency units were limited to 415 square feet; one-bedroom units were limited to 540 square feet. Limitations were also placed on the amount of common area to be provided. Balconies were prohibited. The cost-containment policies became less restrictive in 1989. They do not apply to the Section 202/PRAC program.

**SECTION 236 PROGRAM:** Section 236 of the National Housing Act of 1959 provides FHA mortgage insurance and interest reduction payments to owners for the purpose of developing rental or cooperative housing projects for lower-income residents. Projects were developed under this program from 1968 through 1972. Owners paid the mortgagee debt service based on a hypothetical 1 percent mortgage. HUD paid the mortgagee the difference between that amount and the debt service required on the market rate mortgage. **BASIC RENTS** reflect the rent required to operate the unit and service a 1 percent mortgage. **MARKET RENTS** reflect the rent required to operate the unit and service the market rate mortgage. Residents meeting the income requirements pay whichever is higher: the basic rent or 30 percent of their adjusted monthly income.