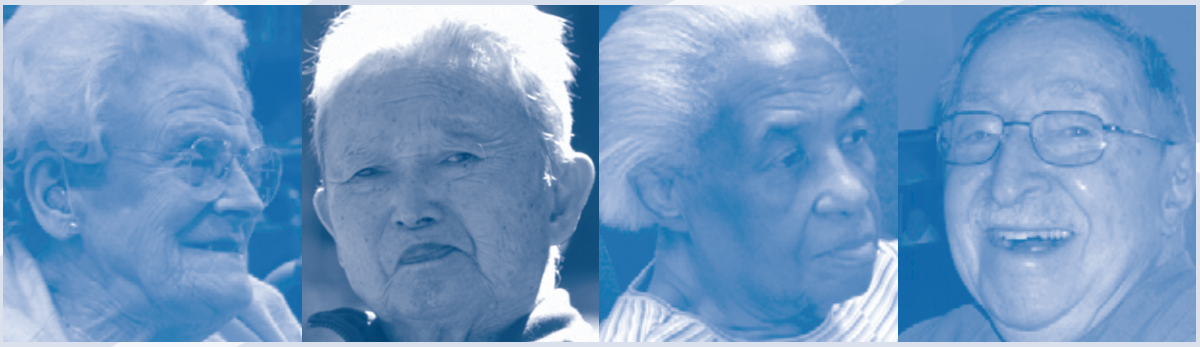

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A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages

Mary F. Harahan • Alisha Sanders • Robyn Stone, Dr. P.H.

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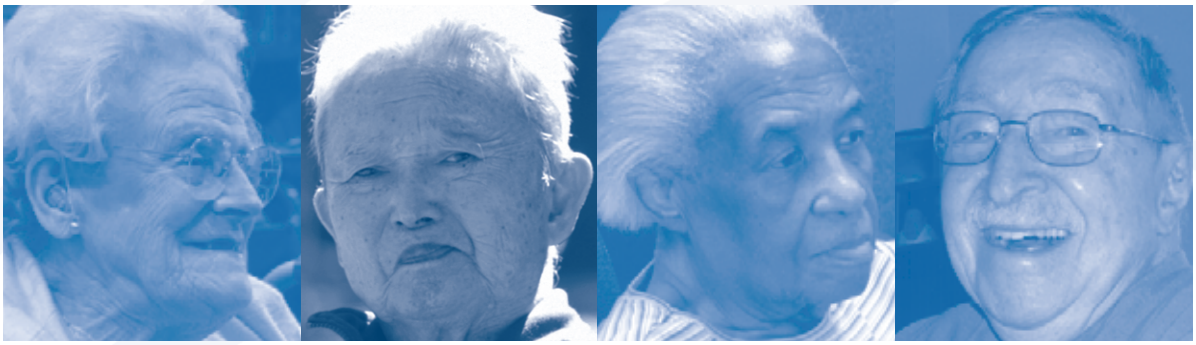

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Creating New Long-Term Care Choices for Older Adults: A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages

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The Institute for the Future of Aging Services is a policy research institute whose mission is to create a bridge between the practice, policy and research communities to advance the development of high-quality health, housing and supportive services for America's aging population. IFAS is the applied research arm of the American Association of Homes and Services for the Aging (AAHSA). AAHSA members serve two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. AAHSA's commitment is to create the future of aging services through quality people can trust.

Creating New Long-Term Care Choices for Older Adults

A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages

Introduction

The aging of the baby boomers will profoundly influence the delivery of health and long-term care services in this country. By 2030, older adults will comprise 20 percent of the population—doubling from 35 to 70 million people. As they age and face chronic illness and disability, the boomers will demand greater and more innovative long-term care choices. Of particular concern to lower-income seniors and their families will be finding affordable long-term care solutions.

Over the past several decades consumer advocates, policy makers and service providers have supported the development of new models of organizing and delivering health and supportive services to meet these new demands. In recent years, for example, substantial attention has been paid to developing licensed assisted living as a potentially less expensive and more attractive alternative to nursing homes.

The purpose of this study is to examine long-term care strategies that integrate affordable independent housing with health and supportive services so that low- and modest-income older adults who are frail and/or disabled are able to remain in the community. In this report, these strategies are called Affordable Housing Plus Services (AHPS).

Definition

The Institute for the Future of Aging Services (IFAS) the applied research arm of the American Association of Homes and Services for the Aging (AAHSA), defines AHPS as having three elements:

- Independent, unlicensed, largely subsidized multi-unit housing where large numbers of low- and modest-income older adults live in close proximity.
- Health-related and supportive services, funded separately from the housing, and available to at least some older residents (e.g., personal care, housekeeping, meals, transportation, health and wellness services, etc.).
- A purposeful linkage connecting residents to these services supporting their ability to “age in place” despite declining health and increasing disability.

About 1.8 million older adults—mostly poor, single women in their mid 70s to early 80s—live in federally subsidized housing—more than the number who live in nursing homes.

Methods

Findings from this study were generated through several methods:

1. A review of the research and evaluation literature.
2. Two informal workgroups held with AAHSA members and staff and other experts to develop definitions and identify policy and practice issues to be addressed in invitational workshops.
3. Telephone and in-person discussions with AAHSA members, other housing providers and aging and housing experts to identify exemplary programs.
4. Four invitational workshops attended by housing and aging services stakeholders to discuss the merits of, challenges to and opportunities for AHPS.

Findings from the Literature

About 1.8 million older adults—mostly poor, single women in their mid 70s to early 80s—live in federally subsidized housing—more than the number who live in nursing homes (Wilden and Redfoot, 2002). The majority live in public housing, Section 202 Supportive Housing for the Elderly, Low Income Housing Tax Credit (LIHTC) and Section 515 Rural Rental Housing properties. Unknown numbers of low-income seniors also live in rental properties subsidized through state and municipal programs and in privately financed unsubsidized housing rented or sold at market rates without regard to income.

Research shows that many of these older residents need assistance with routine activities. The 2002 American Community Survey found that subsidized older renters were twice as likely to be disabled as were older homeowners (Redfoot and Kochera, 2004). Over half reported limitations in activities like walking and climbing stairs, compared to one quarter of older homeowners. A third reported difficulty with shopping or going to the doctor, twice that of older homeowners. Likewise, surveys of Section 202 property managers indicate the proportion of residents having difficulty preparing meals or performing personal care tasks increased almost fourfold between 1988 and 1999. Managers in the 1999 survey also reported that 30 percent of vacancies are due to residents transferring to nursing homes (Heuman, Winter-Nelson and Anderson, 2001).

Connecting residents to needed assistance is not straightforward. Discontinuities between housing and long-term care agencies are well documented (Pynoos, Liebig, Alley and Nishita, 2004; Golant, 2003; Wilden and Redfoot, 2002; Redfoot and Kochera, 2004; Lawler, 2001). For example, housing policy is largely about “bricks and mortar” and, with few exceptions, housing funds cannot pay for services. Conversely, health and supportive services financing cannot be used to pay rent unless an individual is willing to enter a nursing home or, in some states, an assisted living facility (ALF). Diverting a resident’s transfer to a nursing home is rarely the goal of housing policy. Nor is the availability of AHPS typically considered in developing long-term care policy.

Older residents themselves face barriers to getting the support they need (Pynoos, Liebig, Alley and Nishita, 2004; Golant, 2003; Wilden and Redfoot, 2002; Lawler, 2001). They are less likely than older homeowners to have family members to rely on. Community providers may incorrectly believe the housing provider is responsible for providing services. Other tenants may pressure management to evict residents who look too old and frail. Families may face difficulty in locating service providers. Housing managers may worry about their liability if confused residents leave the stove on or disturb other residents. Most often, housing providers and community services agencies simply view their missions through different lenses and lack experience working together.

The impact of AHPS is largely untested. In the 1990s, the U.S. Department of Housing and Urban Development (HUD) evaluated two of its programs designed to help seniors age in place through case management and supportive services—the Congregate Housing Services Program (CHSP) and the Hope for Elderly Independence Demonstration Program (HOPE IV). Researchers found participants were satisfied with both programs, but observed no significant impact on their nursing home use or length of residence in independent housing. These findings are not surprising given participants were found to be less disabled than those eligible for nursing homes (Ficke and Berkowitz, 2000).

The lack of research leaves policy makers and providers with little guidance on whether and which AHPS strategies are wise investments. Fortunately, however, a variety of existing programs can serve as natural laboratories in conducting impact evaluations.

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Inventory of Affordable Housing Plus Services Strategies

IFAS has developed an inventory of AHPS programs across the country. These programs have been largely pieced together through the initiative and persistence of individual housing providers, community services agencies and, in a few cases, committed state leaders. Although not formally evaluated, they provide a rich set of examples for others.

The inventory could have been categorized in several ways. However, given the fact that a third of AAHSA's members sponsor housing that is largely publicly subsidized, we chose to divide our examples by how the housing is financed. We created further subcategories to help organize the examples. Unfortunately, it is difficult to neatly define the varying strategies and we acknowledge that some of the programs could fall under several subcategories. Also note that the examples identified here and the details included about them are not exhaustive, but are merely used for illustrative purposes.

A more detailed inventory can be found at www.futureofaging.org.

A. **Privately Financed Housing** refers to multi-unit owner and rental housing that receives no public subsidies, but is still affordable to low- and moderate-income older adults. It may include neighborhoods of single-family homes with large concentrations of senior households. Strategies include:

   1. **Housing Cooperatives** allow residents to own and control their apartments through a cooperative arrangement in which they own stock and are involved in management and programming of the property. Maintaining affordability is difficult and is typically achieved by capping the resale price (limited-equity cooperatives). Services can be informal or formal, involving joint purchasing and/or scheduling or a coordinated program staffed by community agencies or the cooperative itself. **Penn South Cooperative, New York, NY**, is a limited-equity cooperative built in 1961 with 6,200 residents. As residents began to age, the co-op established a collaborative program with community agencies to provide supportive services. Now a separate nonprofit agency, the program offers cultural and educational activities, case management, day care, home care services, primary health care, wellness services, personal care and a variety of other supportive services to residents of the cooperative. **7500 York Cooperative, Edina, MN**, is a limited-equity cooperative with 330 units developed in 1978. As residents aged, the co-op offered office space to a home health agency, through which residents can arrange for services. With an onsite office, the agency can offer services in 15-minute intervals rather than the customary two-hour blocks—allowing residents to better target services to their needs. The agency also may serve seniors in surrounding apartment buildings out of this office.

2. **Shared Housing** involves two or more unrelated individuals living together in a private single-family home. Some programs match elderly homeowners with individuals willing to help with household chores in return for reduced rent. Others involve small numbers of older people living together and providing mutual support. Accessory housing is another type of shared housing where a trailer or portable manufactured home is placed next to a main home, enabling a frail senior to maintain independence and still be close to a family member or caregiver. **HomeShare Vermont, Burlington, VT**, helps seniors and persons with disabilities live independently by linking them with individuals seeking affordable housing or caregiving opportunities. Typically, a student or working-age adult is matched with an elderly homeowner for whom they carry out household chores in exchange for free or reduced rent.

3. **Mobile Home Parks/Manufactured Home Communities** provide homeownership opportunities to some lower-income seniors. Usually the housing unit is owned, the lot is leased and upkeep and maintenance are included in the lot fee. Social and recreational amenities are often shared. While many mobile home parks have been disappearing as land values increase, some are being converted to cooperative ownership to maintain their existence and affordability. Formal programs to link residents to services are hard to find, although aging in place is an issue. **Millennium Housing, Newport Beach, CA**, operates several senior parks in California. Residents receive a monthly magazine with information on where to get help with meals, bills, etc. A partnership with a community program provides homebound residents with home repairs and emergency response systems.

4. **Single Room Occupancy Hotels (SROs)** rent small private rooms, usually in depressed downtown areas, to low-income individuals on a weekly or monthly basis. Some space—like bathrooms, living rooms and kitchens—is typically shared. Urban renewal has eliminated many SROs; however, several cities have converted run-down hotels into SROs with supportive services. **Project Hotel Alert, Los Angeles, CA**, is funded by the city aging department to provide older adults living in SROs a wide range of services, including case management, information and referral, transportation, meals and medical screening. One SRO has been retrofitted with wheelchair-accessible bathrooms to accommodate disabled elderly residents.

B. **Publicly Subsidized Housing** refers to multi-unit rental housing owned or subsidized by federal, state or municipal governments. Strategies for integrating services include:

   1. **Co-Location and Volunteerism** is a low-cost approach in which the housing manager encourages local providers to locate health and/or supportive services programs on or near the property and recruits volunteers to fill service gaps. Commonly co-located services include a Title III meals site, senior center or health and wellness programs. **Golden West Senior Residence, Boulder, CO**, a 255-unit refinanced Section 202 property, provides space to Medically Based Fitness (MBF) for operation of a wellness center. MBF staffs the center with a physical therapist and an exercise physiologist. Golden West also partners with several other programs or individuals who provide services at the property on a regular basis, such as footcare, massage, reflexology, hearing aid maintenance and banking services.

   2. **Service Coordination** entails a full- or part-time staff person employed by the housing property to help residents identify and arrange for needed services, advocate on their behalf and provide

educational programs. About 37 percent of Section 202 housing properties have onsite service coordinators (Heuman, Winter-Nelson and Anderson, 2001). **National Church Residences (NCR)**, headquartered in Columbus, OH, employs 154 service coordinators serving 194 of its senior housing properties. Service coordinators typically conduct an intake evaluation of residents requesting assistance; assess behavior, functioning and needs; develop a case management plan; and refer residents to community agencies. **Schwenkfeld Manor, Lansdale, PA**, employs nurses as service coordinators. In addition to traditional information and referral and case management, they informally observe changes in residents' status, provide health education and advise residents when they should call their doctor.

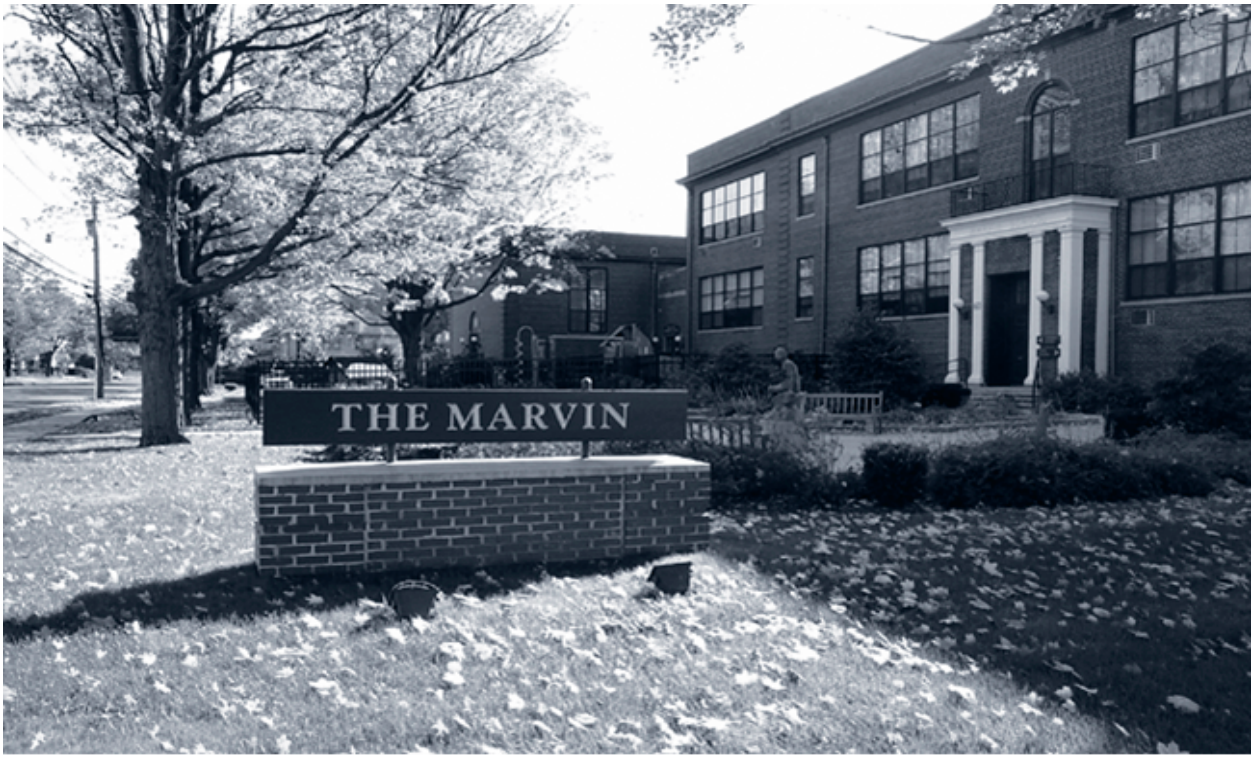
3. **Enriched Services and Formal Service Coordination** are strategies offering residents formal assessment, case management and a range of personal care and supportive services provided by onsite staff and/or a service agency owned by or under contract to the housing provider. Although the amount and intensity of services varies, 24-hour oversight, personal care, medication management, homemaking and transportation are likely to be available. With HUD approval, **Peter Sanborn Place, Reading, MA**, gives priority to prospective residents with high levels of need. Frail residents receive a comprehensive assessment and detailed care plan, and their status is monitored. A Section 202 loan refinance freed up resources that were reinvested in building renovations and resident services. The property operates its own home care agency, which provides case management, personal care, medication monitoring, homemaker services and transportation to eligible residents and the surrounding community. The local Visiting

Peter Sanborn Place, Reading, MA

Nurses Association provides care and rehabilitation services under contract.

4. **NORC Service Programs** target naturally occurring retirement communities (NORCs), defined as a geographic area, neighborhood or building originally populated by people of all ages that has evolved to contain a high proportion of older adults. In some NORCs, property managers, residents and service providers have collaborated to develop programs to address elderly residents' changing needs. Services are available to all NORC residents, regardless of income, health or functional status. **Vladeck Cares/NORC Supportive Services Program, New York, NY**, serves seniors living in Vladeck House, a public housing project with 27 buildings and 3,000 residents, 860 of whom are elderly. Funded by the city, the state aging departments and private sources, it provides preventative health and social services, medical and health services, case management, mental health counseling and educational and cultural opportunities.

5. **State Supportive Housing Partnerships** are generally aimed at reducing Medicaid costs by delaying institutionalization. Partnerships among state housing agencies, subsidized housing properties and state aging and health agencies expand services to state-subsidized housing residents. State-designated providers are licensed to deliver personal care and supportive services to residents. **The Marvin, Norwalk, CT**, is a senior congregate housing community funded through LIHTC and low-interest loans from the state. All residents have access to supportive services through Connecticut's Congregate Housing for the Frail Elderly program, including a daily meal, weekly housekeeping and access to a service coordinator. Onsite, 24-hour oversight, an on-call nurse, health and wellness servic-



The Marvin, Norwalk, CT

Eaton Terrace Residence, Eaton Senior Programs, Lakewood, CO

es and emergency transportation also are subsidized. Residents pay a monthly congregate services fee based on their income. Those eligible for assisted living services under the state's Medicaid waiver receive nursing and personal care assistance.

6. **Assisted Living as a Service Program** is a state strategy to provide licensed assisted living as a package of services rather than as facility-based care. In **Minnesota**, most assisted living services are provided in facilities registered with the state health department as "housing with services establishments." These facilities offer, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services. If the property provides the services directly, it must have the appropriate license from the health department. Otherwise, it must contract with a licensed home care provider.

7. **A Campus Network Strategy** takes advantage of independent senior housing and licensed assisted living on the same campus to provide low- and modest-income residents some of the benefits of a continuing care retirement community. There is no entrance fee, and residents pay separately for different levels of care. **Eaton Senior Programs (ESP), Lakewood, CO**, operates Eaton Terrace Residence (ETR), a 162-unit subsidized senior housing property and Eaton Terrace II (ET II), an adjacent assisted living facility. ESP is able to leverage resources across both residential properties. ET II has an assisted living and home care license, which allows staff to provide services anywhere in the community. ETR residents may purchase personal care, housekeeping and medication monitoring services at whatever level they need. Residents pay out-of-pocket, unless Medicaid covers their costs. ESP also has created a "care consultation team" to support resident needs, which includes a nurse, social workers, activities coordinators, pastoral counselors, resident assistants and other staff.

Although each property has staff that focuses specifically on their residents, they are able to leverage expertise and resources across the team. Staff from the assisted living property are also able to provide after hours emergency response to ETR.

8. **Integrated Housing, Health Care and Supportive Services** enable residents to age in place by offering access to medical, health and long-term care services. They involve a formal collaboration between one or more affordable housing providers, neighborhood health care providers and aging services agencies. **Lifelong Medical Care, Oakland, CA**, anchors a collaboration between a housing developer, a federally qualified health center and a PACE (Programs of All-Inclusive Care for the Elderly) program to provide an assisted living level of care without special licensing or funding. The health center serves healthy and moderately disabled seniors, providing primary care, mental health services, adult day care, podiatry, dental care and other services. PACE serves residents eligible for skilled nursing facilities with a full spectrum of primary, acute and long-term care services. **The Sixty Plus Program**, Atlanta, GA, run by Piedmont Hospital, partners with four affordable housing properties to send a nurse to each weekly. Residents can schedule appointments, and the nurse follows up with patients discharged from the hospital. Piedmont physicians can also ask the nurse to check on their patients.

9. **Housing/Health Partnerships** are collaborations between one or more health providers and low-income housing sponsors to increase the supply of affordable housing. The potential exists for the two partners to create programs providing residents access to medical and health-related services. **Mercy Housing's** Strategic Health Partnerships is an initiative between Mercy Housing and seven Catholic health care systems to increase the supply of affordable housing for low-income seniors and poor families by leveraging health system resources.

The Ravine at Central College, National Church Residences, Westerville, OH

Lessons from the Regional Workshops

In 2005, IFAS held four invitational workshops, bringing together 230 stakeholders from 14 states to examine the merits of, challenges to and opportunities for the development of AHPS strategies. Participants represented housing, health care and aging services providers; federal and state policy makers; architects; investment bankers; insurers; and consumer advocates. The first workshop, targeting the Cleveland area, was hosted by the A.M. McGregor Home. The other three, hosted by AAHSA state affiliates in California, Rhode Island and Georgia, facilitated statewide and regional participation. The following summarizes lessons learned.

A complete workshop report can be found a www.futureofaging.org.

Do AHPS strategies work? Although most participants understood that the benefits of linkages between independent affordable housing and services had not been carefully evaluated, several apparent strengths were noted:

- The product is attractive. Vast majorities of seniors want to stay in their home, even as their health declines.
- Co-location of services such as adult day care and health services, particularly in larger housing communities, helps seniors with significant disabilities, including dementia, stay in their apartments.
- AHPS programs allow health professionals and aging service providers to more efficiently target services because potential consumers are clustered.
- Exploiting economies of scale through bulk purchasing of services and supplies and/or coordinated scheduling saves money.
- Since many communities already have a rich array of services, purposefully linking residents to these services helps meet residents' needs at very low marginal costs.

Several apparent strengths of affordable housing plus services strategies were noted

. . .meets resident desire to remain in their own home.

. . .capitalizes on existing community resources and strengths.

. . .exploits economies of scale in purchasing and scheduling.

- Much of the burden of caring for aging residents is transferred from the housing provider to community services agencies, which typically have greater capacity.

However, there was some disagreement about whether AHPS can or should support all residents regardless of their health condition and/or level of disability. Several housing providers believed all residents should be able to live out their lives in the property, maintaining that services comparable to a nursing home can be provided effectively. Others said keeping residents with significant disabilities who may need access to services 24/7—especially those with severe cognitive and/or mental health problems—is not possible or even appropriate. There was widespread agreement on the importance of evaluating and comparing the outcomes of alternative AHPS approaches for different populations.

What does an effective strategy look like? No one strategy was endorsed as appropriate for all environments. Some participants said caregiving staff should be employees of the property. Others thought housing providers should not deliver services directly, except for service coordination. Most agreed that a wide range of models could work, as long as they are anchored by a case management mechanism. Attendees felt that a particular AHPS approach should emerge from the state regulatory environment, the housing providers' capacity and service availability in the community. AHPS models also should be responsive to the changing characteristics of residents, such as the growing prevalence of new residents with cognitive impairments, mental health conditions or pre-existing disabilities. Some participants also said attention should be paid to the differences in the demand for and the availability of services in rural areas.

Which services are critical? Discussants emphasized the need for AHPS strategies to provide residents access to a full range of health-related and supportive services. Transportation ranked highly although questions were raised about the capacity of some housing communities to organize access to transportation services. Much less agreement was expressed about the desirability of incorporating primary health care and chronic care management. Some thought these services were too complex and risky for many housing providers and were only feasible as part of a PACE program. Others noted the growing experience with "house call" programs, where physicians and nurses offer primary care, preventative services and chronic care management to residents in their own apartments by using technology and a team approach. These programs seem ideally suited to affordable housing arrangements with large numbers of seniors.

What are the prerequisites of a successful strategy? Participants identified three fundamentals for AHPS strategies:

- **Informed housing providers who understand the need for services**—Housing providers must see themselves as more than property managers who collect rent and maintain the physical plant. They must understand residents' need for

No one affordable housing plus services strategy was endorsed as appropriate for all environments. Attendees felt that a particular approach should emerge from the state regulatory environment, the housing providers' capacity and services availability in the community.

Participants identified three fundamentals for successful affordable housing plus services strategies:

- *Informed housing providers who understand the need for services.*
- *Persistence and creativity.*
- *A person of a group to act as a catalyst.*

services, accept at least some of the responsibility for meeting these needs and ensure that service coordinators and onsite managers share this understanding. In addition to employing a service coordinator, they must be prepared to make financial and human resource investments to fill gaps in community services and be flexible enough to allow residents to refuse services and make some bad choices. Learning how to support aging residents to take risks was perceived to be part of maintaining an independent living environment.

- **Persistence and creativity**—Successful organizations are proactive—seeking out community partners, networking with policy and practice stakeholders, staying on top of new funding opportunities and working around policy and regulatory barriers. Knowing how to "work the system" was deemed essential.
- **A catalyst**—Some individual or organization must take ownership of the goal, identify and convene stakeholders, facilitate information gathering, mobilize resources and coordinate ongoing activities.

What are the obstacles? A number of barriers were acknowledged:

- **Licensing/regulation**—Licensing and regulation was identified as an impediment to the ability of independent housing providers to support residents' aging in place. For example, Internal Revenue Service rulings appear to limit the level of health and medical services that can be provided in properties financed through low-income housing tax credits (LIHTC). LIHTC properties also may not pay for health services with rent proceeds. Some states prohibit independent housing providers from providing direct services. In most states, assisted living services can only be provided to eligible residents in a licensed facility. Many housing providers expressed strong opposition to becoming licensed caregiving facilities to obtain services for residents. Providers said licensing requirements often result in increased costs, forcing them to rely on Medicaid, for which all residents may not be eligible. Participants pointed to assisted living regulations as an example of what they wished to avoid. Publicly reimbursed assisted living services were judged too rigid, serving only a narrowly defined population. A number of participants urged HUD and the Department of Health and Human Services to review federal and state regulations governing Section 202 and LIHTC properties, the assisted living conversion program, service coordinators and fair housing to identify and remove regulatory barriers to AHPS programs
- **Liability**—Housing providers expressed concerns about how to balance resident choice, including freedom to reject services, with their perception that they would be liable for poor choices that compromised resident health or safety.

- **Fair housing laws**—These laws were regarded as confusing. They prohibit housing providers from giving preference to frail and disabled residents unless a special waiver is obtained. Many participants also believed the unattended consequences of these laws discourage providers from determining a prospective resident's physical and mental health needs, even though such information is crucial to their ability to meet new residents' needs. Fair housing rules also seem unclear about when a tenant can be evicted when decision making is impaired. Several attendees suggested HUD needs to clearly spell out the implications of fair housing rules for AHPS.
- **Difficulty of bridging housing and aging services**—There was widespread agreement that housing and aging services providers know little about each other's programs or policies. Several said the workshop was the first time they had even been together in the same room. Housing providers rarely participate in long-term care policy forums and vice versa. According to several workshop attendees, both the housing and aging services communities need to be educated about their mutual interests.
- **Resources**—Finding funding was regarded as the major challenge facing AHPS program development. Relying on a single funding source, such as the Section 202 program or Medicaid, is shortsighted, several participants said. In their view, future needs cannot be accommodated without putting together a mix of funding. Several pointed out that AHPS strategies also must be designed around resident needs rather than allowing a funding source to determine who is served and how.
- **Limited understanding/capacity of certain housing providers to meet resident service needs**—Housing representatives were more likely than others to observe that a number of their colleagues saw their roles in traditional terms—leasing, collecting rents and maintaining the physical plant—rather than as architects of a housing environment that must adapt to changing needs of increasingly frail residents. They said it's not unusual for housing managers to interpret "independent housing" literally—if a resident needs help, she must move or find it herself. Housing providers also may lack sufficient knowledge about community resources and have limited skills in developing partnerships.
- **Resident opposition**—Several housing providers said residents themselves often oppose aging-in-place strategies. Many don't want to be reminded that they may lose independence as they age. To overcome this challenge, residents must be educated about and have sustained involvement in planning AHPS programs.
- **Affordability**—Participants said AHPS programs must minimize costs to residents, the housing sponsor and public entities. One suggested approach was to work with a home health agency or other community provider to break down the amount of services that can be purchased into short increments. Residents do not always need, nor can they afford, the two- or four-hours blocks of time typically available.

The workshops demonstrated that linking affordable senior housing and services is doable, and is widely perceived to be beneficial. Participants also identified a variety of obstacles to achieving wider implementation of promising strategies.

- **Nursing home influence**—Attendees had differing perspectives on the role of nursing home providers. Some thought nursing homes would oppose AHPS strategies. Others thought they could be valuable partners, given their interest in managing beds to keep acuity levels high for reimbursement.

What are funding opportunities? The workshops clearly demonstrated that funding is a primary challenge in developing new AHPS programs. Having concluded that neither Medicaid nor the Section 202 program are likely to be reliable funding sources on their own, participants identified other potential ideas that include:

- **New public initiatives**
  - Creating a state tax credit or bond program to fund resident services as well as affordable housing.
  - Developing health-related and supportive services "savings accounts" where pretax contributions of housing providers and residents could accumulate over time.
- **Housing provider strategies**
  - Developing mixed-income properties where the costs of services for lower-income residents are cross subsidized by wealthier ones, as in nursing homes.
  - Developing "win-win" partnerships between housing communities and health care entities. These partnerships can enhance resident access to primary care and chronic care management and increase referrals to providers and improve their ability to monitor and manage the resident's care.
- **Changes to HUD programs**
  - Increasing the limit on the proportion of savings from refinancing HUD loans (currently 15 percent) that can be spent on services.
  - Allowing federally subsidized housing providers to add the costs of some services, in addition to service coordination, to their operating budgets.
  - Capitalizing the cost of services in publicly subsidized housing up front in the debt service.
  - Charging higher-income residents extra fees for service coordination.
- **Expanding existing opportunities**
  - Documenting and disseminating to affordable housing providers the probable "return on investment" if they contribute their own resources to resident services.
  - Educating service coordinators on how to reduce service costs (e.g., capitalizing on economies of scale, working with community providers to deliver services in smaller increments, etc.).
  - Documenting the benefits of renting out commercial space for resident services to housing communities .
  - Encouraging wider participation in the HUD-funded service coordinator program.
  - Educating Section 202 providers about the potential of refinancing old loans to invest in services.

Next Steps

The workshops brought together a variety of stakeholders to identify common interests and seek common ground. For that alone, most participants judged them a success. Several additional initiatives were proposed to move an AHPS agenda forward:

- **Resident and Family Education Programs**—Residents and their families often aren't aware of the services available in their community. As one participant put it, many residents see services as a light switch—either "on" or "off." This participant thought the concept of a "dimmer switch" was more appropriate with residents and families learning how to seek services as needed, rather than waiting for a crisis. Service coordinators, AAHSA state affiliates, area agencies on aging, AARP chapters, the Red Cross and Alzheimer's Association chapters could develop and disseminate educational materials describing a community's resources and how to use them.

- **Provider Education and Technical Assistance**—Participants stressed the value of educating affordable housing providers about aging residents' service needs, available community resources and how to access them, promising AHPS strategies and how to overcome regulatory barriers. Some participants suggested AAHSA develop and operate a clearinghouse for members to provide technical assistance.

- **National Awareness Campaign**—There was significant support for raising the visibility of AHPS as a potential vehicle for meeting the long-term care needs of at least some low- and modest-income seniors. Participants spoke of subsidized elderly housing residents being "off the radar screen" of advocates and policy officials seeking long-term care solutions. Some observed that while funding has significantly grown for home and community-based services over the past several decades, little is known about the extent to which seniors in subsidized housing have benefited. One suggestion was to move AHPS onto the agenda of the Conference of Mayors since municipalities are now dealing with the problem of poor seniors who are unable to remain independent. It was also noted that advocates for the homeless have been effective in educating government about the importance of linking housing options with services to sustain independent living. Affordable housing providers might develop a similar platform for aging seniors in affordable housing.

- **Replication of Workshops in Rural Areas**—All workshops were held in urban areas, primarily for an urban or suburban audience. AHPS strategies that work in rural communities may be different. Holding one or more workshops in rural areas was suggested, possibly in partnership with the U.S. Department of Agriculture.

- **Developing AHPS in Market-Rate Housing**—The experience of subsidized housing providers dominated the workshops. IFAS was unable to identify more than a handful of AHPS programs in privately financed housing arrangements that are affordable to modest-income seniors. Future work should be directed at identifying and supporting housing cooperatives, mobile home parks, neighborhood-based NORCs, SROs and other market-rate housing arrangements to develop AHPS programs.

Applied Research and Evaluation Agenda

The information base on AHPS is extremely weak. The functional and cognitive characteristics of seniors in affordable housing, the services they receive and what difference they make and where these seniors go when they leave independent housing are simply not known. There is almost no evidence regarding the impact of AHPS programs on residents, families, housing providers, the larger community and funding sources such as Medicaid. IFAS has developed a policy, applied research and evaluation agenda to address these questions. It includes:

- Studies of the supply and demand for AHPS.
- A comparative evaluation of the outcomes of AHPS strategies.
- A comparison of the outcomes of AHPS programs and licensed ALFs.
- A review of state and federal regulations that impede AHPS development and implementation.
- The costs and benefits of options for organizing service coordination within AHPS programs.
- Practice-oriented studies investigating effective approaches within AHPS programs to organize after-hours care and unscheduled services, support cognitively/mentally impaired seniors, improve risk management and increase insurability and integrate primary care and chronic care management.

IFAS has developed an applied research and evaluation agenda to build the evidence base on the impact and cost effectiveness off affordable housing plus services strategies.

Conclusion

This was the first time such wide-ranging groups of stakeholders came together to examine the potential of replicating AHPS models. Across all workshops, a great deal of interest and enthusiasm was evident. Anecdotally, these providers believed linking affordable housing properties with supportive and health-related services could support lower-income seniors' desire to age in place despite declining health and increasing frailty—all while using public resources cost-efficiently. Current models can serve as natural laboratories to evaluate the efficacy of meeting these goals. They also offer a shared learning opportunity for other communities and housing and service providers to ignite or expand their own housing with services programs. Stakeholders at all levels should look at the lessons learned from these workshops to see what they can do to ease the challenges to expanding affordable housing with services options.

Participants at the workshop in Decatur, GA, one of four held across the country.

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