

# THE CASERA PROJECT

“Creating Affordable and Supportive  
Elder Renter Accommodations”

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# Introduction

**W**e are living in an unusual time. Advocates for elderly housing and social services are so conditioned to receiving negative news from Washington that they celebrate continuation funding or even smaller than anticipated funding decreases. As an example, advocates for affordable, safe and secure housing were pleased to receive word of a program being funded at its previous year's level, even though it was \$120 million less than three years earlier. This happened in response to the appropriation of \$660 million for the Department of Housing and Urban Development (HUD) Section 202 program for fiscal year 1999.

By any standards this rent-subsidized program—now our primary project-based approach to providing new apartments for low-income elders seeking a more supportive setting—has been successful. Why then be satisfied with this inadequate response? The rejoicing was called for because in fiscal year 1996 the Administration had unsuccessfully tried to eliminate 202 as a separate program and in the past year, both HUD and the Clinton Administration had requested a 75% **decrease** in the earlier year's appro-

priation of \$660 million, but then lost to the wishes of Congress. Yet it is hard to feel victorious when there are long waiting lists of elder tenants for this program, when the number of low-income and frail age 75 and over population is getting larger, and when the costs of constructing and staffing a building are higher. We are losing the battle.

The attempt by HUD and the Administration to reduce the size of the 202 program is symptomatic of old ideas out of sync with new realities. It is no longer meaningful to conceive of housing for older persons as merely physical shelter. To satisfy the overwhelming preferences of older Americans to age in place in comfortable, familiar, noninstitutional settings; to help housing sponsors, owners, and administrators of rent-subsidized housing deal with the increased management burdens presented by their much older tenants; and to reduce the flow of low-income elders into our federally- and state-subsidized nursing homes, we must increase, not just maintain at earlier levels, the availability of supportive resources. While increases in the number of rental units subsidized with certificates or vouchers are to be applauded, these units are unlikely to be in buildings containing sufficient numbers of elders to financially or administratively justify many of the supportive service programs needed by the less independent 75 and 80 year old tenants.

This dismal federal response is not for lack of knowledge. Along with the success of the Section 202 program, HUD's Congregate Housing Services and Service Coordinator Programs have both



*By any standards this rent-subsidized program — now our primary project-based approach to providing new apartments for low-income elders seeking a more supportive setting — has been successful.*



been assessed as very successful in helping more frail elders live more independently in their rent-assisted apartments. Funding for both, however, has been both erratic (new funding is not available for the former and contract renewals for the latter are in doubt) and grossly inadequate given their latent demand. It is also sadly the case that little in the way of formal program linkages exist between HUD and the Department of Health and Human Services. It is noteworthy that this artificial separation of shelter and service is primarily a policy for the poor. For elders with higher incomes, the private sector has long recognized the desirability and profitability of linking housing and services. One has only to acknowledge the longstanding demand for continuing care retirement communities and the recent rapid growth of the for-profit assisted living industry in this country.

The solution perhaps is to pay heed to a 1998 comment by former HUD Assistant Secretary Nic Retsinas — “Don’t look to Washington for answers anymore. Look to the local level.” However constructive such a shift in outlook might be, translating it into policy might be a daunting task. It assumes most fundamentally that state governments, such as Florida, will be able to deal budgetarily with the escalating demands of its seniors. The reasonableness of this assumption, however, is far from obvious. As noted by experts like Dr. Larry Polivka, Director of the Florida Policy Exchange Center on Aging at the University of South Florida in Tampa, the image of Florida as the home of wealthy and healthy retiree populations making few demands on

the resources of state government is increasingly inaccurate. Between now and the year 2010, the fastest growing group of older persons will be in the age 75 and 85 plus age brackets, where the likelihood of frailty is the highest. The age 85 and over group alone is expected to increase over 71% between 1997 and 2010. Yet at the same time, human service programs available under the Older Americans Act are grossly under-funded and Medicaid funding, lagging far behind the growth trajectory of the low-income old, is still disproportionately allocated to nursing homes. The reduced role of federal housing programs and the increasing demands on Florida’s aging programs make it imperative that the state target carefully older persons in need of assistance to live independently.

The purpose of this report is to call attention to one of this state’s largest single concentrations of low-income elders — over 80,000 — that now occupy its rent-subsidized apartment buildings. This group is top-heavy with persons who are over the age of 75, women, living alone, and African-Americans. They are less likely to be well educated and less able to rely on family assistance. If they cannot maintain their independent living arrangements, they are prime candidates for nursing homes paid by Medicaid or state-subsidized board and care facilities. Whether or not they can delay this outcome often depends on the unwritten policies of their rent-subsidized facility. In many effective and not necessarily costly ways, some assisted housing managers are able to arrange a set of supportive services that clearly make it easier



*“Don’t look to Washington for answers anymore. Look to the local level.”  
— former HUD Assistant Secretary Nic Retsinas*

and more feasible for elder occupants to age in place. In others, where the managers have a bricks and mortar philosophy, the onset of frailty is the basis for elder tenants having to relocate to more supportive shelter elsewhere. In most instances, the reality is somewhere in between these extremes. Most managers are favorably disposed to their older tenants aging in place, but do not have the money, time, know-how, or motivation to translate their attitudes into action. Making the problem worse are community-based service providers who either underestimate the needs of these elder tenants, have identified them as a lower-priority group, or are simply too overcommitted to reach this group in need.

This report offers evidence of the now unmet needs for supportive services by Florida’s rent-subsidized elder population and how housing owners or administrators present very different opportunities for them to age in place successfully. Interviews completed by on-site administrators, public housing directors, and on-site service coordinators, along with older tenants themselves,

provide compelling evidence of our need for new and better approaches to facilitate the aging in place of low-income seniors. Building on these findings, this report presents a set of alternative programmatic strategies, a blueprint for actions, that are designed to create stronger, better, and more implementable linkages between older tenants and the supportive services that can help them. To this end, five prototype shelter-service models are described in this report. Their design is based in part on lessons learned from an extensive review of programs throughout the United States and in part on the ideas and recommendations elicited in focus groups from knowledgeable housing, service, health care, planners, and advocates throughout Florida.

The report first describes the rent-subsidized programs available in Florida and presents a statistical profile of their elder tenants. It then examines the differences in the aging-in-place policies and resources found in these facilities and identifies the unmet needs of their elder tenants. The final section of the report offers a set of programmatic strategies by which to better match these seniors with the supportive services they need to help them to remain independent in their current apartments.





## The Availability of Rent-Subsidized Housing and HUD's Supportive Service Programs in Florida

**A**s in other states, a diverse array of federal and state subsidized rental housing and supportive service programs now operate in Florida (Appendix I offers a brief overview). Senior households (as of mid-1997) were found in two major federal rent-subsidized housing programs —conventional public housing facilities (14,981) and Section 202 (14,504) — each accounting for about 21% of the subsidized rental units occupied by elder tenants. Section 8 Certificates and Vouchers used by elders (12,754) and administered by Public Housing Agencies constitute the next largest program — about 18% — followed by Section 236 units (9,240), representing about 13% of all elder units. About 7% (4,398) of elders are in the other HUD-subsidized housing programs; 5% (3,566) are in Section 8, moderate rehabilitated units (administered by Public Housing Agencies), and another 7% (4,822) are in rural housing. In Florida, a large number of rent-subsidized units (just under 54,000) are administered by its Housing Finance Corporation (FHFC). In the past, however, age data on its occupants were not collected. If it is conservatively estimated that 10% of these units are elder-occupied, then these 5,400 units would constitute about 8% of the elder rent-assisted units in the state. In total, about 69,600 senior households are in all these programs. If we assume (based on other HUD estimates) that one elderly person occupies 85% of these households, while two elderly persons occupy 15% of them, then over 80,000 older persons live in Florida's rent-subsidized housing.

Most rent-assisted housing programs now operating in the state

generate few new apartments for seniors. These are primarily produced by the Section 202 program, the Section 8 Certificate and Voucher program, the Rural Housing 515 program, and units produced under programs administered by the state's Housing Finance Corporation. The certificate/voucher program, however, serves a relatively small percentage of elders (about 22%). Moreover, these subsidized units are available primarily in scattered facilities and thus elder occupants do not benefit from the social, psychological, and administrative advantages of elder-designated buildings. As for the Section 202 program, between 1990 and 1996 an average of only 439 new elder-occupied units were built, ranging from a high of 738 units to a low of 65 units. In contrast, if we assume conservatively that elders vacate their existing apartment units at a 10% annual rate (and that new elder tenants replace leaving elders), a total of about 6,900 existing units will be occupied by incoming elder tenants each year. There can be no doubt that our aging in place policies not only affect the living arrangements of the existing elder tenant population, but also the opportunities available to low-income elders in conventional housing arrangements, who require more affordable and supportive rental alternatives.

As of early 1998, Florida's HUD and public housing facilities had been awarded five Congregate Housing Service Program grants and just under 35 Service Coordinator grants. This federal commitment, however, understates the presence of



service coordinators throughout the state. Based on survey data and word of mouth (no other data are available), about 75 service coordinators are currently working at either HUD or PHA facilities in Florida.

The varied program and funding characteristics of Florida's rent-assisted facilities result in their elder tenants occupying rental facilities that often have very different ownership characteristics, building amenities, and operating budgets. Representing a blend of older and newer facilities, their buildings also differ with respect to physical condition, architectural design, accessibility for the disabled, and level of technology (e.g., air conditioning, sprinkler and fire safety systems). Even facilities funded by the same government program may differ from each other, because

of historical shifts in its funding commitments and regulations. The Section 202 program is a good example of how the size, design, and fiscal condition of facilities depend on when they were built. Moreover, the federal regulatory environment, even with its volumes of rules, has often been flexible enough to allow for considerable variability in how the sponsor or owner responds to its aging tenants. In the main, however, traditional management practices combined with the lack of significant and permanent funding of supportive services by HUD have made it difficult for owners and sponsors—even those positively disposed towards the aging in place of their residents—to insure that more frail elder tenants will not have to vacate their units and move into family households or long-term care facilities.



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## A Statistical Profile of Elder Tenants in Florida's Rent-Subsidized Housing

**T**he CASERA project focused on the age 62 and over tenant population living in Florida's conventional Public Housing Authority (PHA) facilities and its Privately-Owned Multifamily Subsidized Rental facilities (HUD), including the Section 202 (including 202/236), Section 221, Section 8 noninsured, and Section 236 programs. Florida's seniors are not represented equally in these programs. They are found in about 38% of the units of PHA facilities, but in 52% of the apartments funded under the multifamily HUD programs (Appendix II).

### **The Location and Administrative Auspices of HUD's Elder-Occupied Rent-Assisted Facilities in Florida**

Overall state totals of rent-assisted housing can be misleading because they fail to reveal the unequal presence of affordable rental accommodations in different facilities and locations throughout the state and the extent they are under different administrative auspices. Such patterns are important for several reasons. First, they are indicators of the extent that certain locations are without their equal share (relative to the size of their at-risk low-income population) of affordable elder rental opportunities. Second, the extent to which facilities are found in a relatively few locations and administered by a relatively few sponsors or owners increases the chances that economies of scale might be realized in the delivery of supportive services. Thus, when a relatively small number of low-income elders are found in multiple and dispersed facilities and locations, the service costs to access

them are likely to be higher. In turn, services are likely to be delivered less frequently. On the other hand, when elders are concentrated in fewer facilities and locations, providers are more able to deliver their services less expensively, more frequently, and possibly to co-locate their offices or clinics on or near the project sites. The following indicators describe the unequal size and availability of both HUD and PHA elder-occupied rental units and the extent to which different organizations own or manage them.

### **HUD Facilities**

#### The Presence of Elders at HUD

##### Sites:

- About 19% of the HUD facilities are each occupied by 100 or more elder-occupied apartments; and about 39% of the HUD facilities are each occupied by 50 or more elder-occupied apartments.
- Over 75% of the elder-occupied apartments found in HUD facilities are located in less than a third of all HUD sites.

##### Elder Concentrations in HUD Sites:

- On average, about 52% of the apartments in a HUD facility are occupied by elder tenants.
- Elder-occupied apartments comprise 80% or more of their building's rental units in 44% of HUD facilities. Over 84% of all the elder tenants found in Florida's HUD facilities are located in these building sites.



### County Locations of Elders in HUD Facilities

- The vast majority (over 91%) of the elder-occupied units found in HUD facilities are located in just 17 (or about one-quarter) of Florida's 67 counties. Pointing to the skewed county distribution of these low-income assisted elder renters, these same 17 counties are occupied by only 69% of Florida's total low-income elderly population (below the 150% poverty level and not in federally-subsidized rental facilities).

### Organizational Concentrations of HUD's Elderly Units

- Only 16 sponsors or management agents own or administer the HUD facilities that represent over 51% of all of HUD's elder-occupied units.
- Only 45 sponsors or management agents administer the HUD facilities that represent 75% of all of HUD's elder-occupied units.
- Conversely, 123 sponsors or management agents are administering the HUD facilities con-

taining about 25% of all of HUD's elder-occupied units.

### **Public Housing Facilities**

#### The Presence of Elders in Public Housing Facilities

- Just under 10% of Florida's 419 public housing developments are each occupied by 100 or more elder-occupied apartments; while 24% of the state's public housing developments are each occupied by 50 or more elder-occupied apartments.
- Over 75% of the elder-occupied apartments found in Florida's public housing developments are located in only about one-quarter of the state's 419 public housing developments.

#### Elder Concentrations in Public Housing Facilities

- On average, about 38% of the apartments in a public housing development are occupied by elder tenants.
- Elder-occupied apartments comprise 80% or more of their building's rental units in 20% of Florida's 419 public housing developments. Over 56% of the elder tenants found in Florida's public housing developments are located in these developments.
- Elder-occupied apartments comprise 50% or more of their building's rental units in 30% of Florida's 419 public housing developments. Over 70% of the elder tenants found in Florida's public housing developments are located in these developments.



*In total, 29,012 elder households or 33,364 elders are estimated to be currently waiting for affordable rental housing in Florida.*



### County Locations of Elders in Public Housing Facilities

- The vast majority (over 91%) of the elder-occupied units found in Florida’s public housing facilities are located in just 17 (or about one-quarter) of Florida’s 67 counties. Pointing to the skewed county distribution of these low-income elder renters, these same 17 counties are occupied by only 69% of Florida’s total low-income elderly population (below the 150% poverty level and not in federally-subsidized rental facilities).

### Organizational Concentrations of Elders in Public Housing Facilities

- Only 80 of the 117 Public Housing Authorities in Florida own or operate developments that are occupied by elders (the other agencies only administer Section 8 Certificates or Vouchers). In 17 of these 80 Authorities (found in just 13 counties) are located just under 75% of all of Florida’s elder-occupied public housing units.

### **Gap Between Availability and Demand**

A representative sample of on-site HUD administrators and Public Housing Authority directors were asked to estimate the current size of their waiting lists for elder applicants. The average number (per facility) of “waiting” elders reported for each of the four HUD programs and the public housing (facility) program were computed for this sample and then each was multiplied by the actual number of projects (having at least one elder-occupied

unit) found in the respective funding category. The resulting waiting list estimates are as follows:

Section 202 (including 202/236) .....	12,186
Section 221 .....	1,352
Section 236 .....	3,286
Section 8 Noninsured .....	2,544
<b>All four HUD Programs ....</b>	<b>19,368</b>
<b>Public Housing Facilities .....</b>	<b>9,644</b>

In total, 29,012 elder households or 33,364 elders are estimated to be currently waiting for affordable rental housing in Florida. These estimates do not include the waiting lists for rural housing, vouchers/certificates, or for any of the state’s (FHFC) rent-assistance programs.

### **Diverse Characteristics of HUD’s Privately-Owned Multifamily Subsidized Rental Units and Public Housing Facilities**

The four HUD programs and the public housing facilities differed as to their building and tenant characteristics, a function in turn of their different sponsorship affiliations, program orientations, and funding characteristics. These differences can be summarized under the following six categories.

#### Year of Construction

In Florida, Section 221 facilities were built as early as the 1960s, though most units originated during the 1970s and 1980s. Almost all of the Section 236 housing was built during the early 1970s. Over 45% of the rental units of the Section 8 noninsured program were produced in the 1970s with most produced during the early 1980s. In contrast, the Section 202 program dates from



the 1960s and 1970s, and although over 40% of the program's units in Florida were built during the 1980s, almost 20% of the units were constructed during the 1990s. Public housing is the oldest program in the state, dating from 1939. A significant number of new units were produced through the 1980s, but there was relatively little new construction thereafter.

#### Building Size

The largest buildings (total apartment units) are in the Section 236 program (about 43% of facilities have over 150 units). The smallest buildings are found in the Section 8 noninsured program with over half of its facilities having fewer than 50 units. Dispelling images of the past, most public housing facilities are relatively small with about 34% having fewer than 50 apartment units and most (71%) having fewer than 100 units. Section 221 buildings are typically bigger than Section 8 noninsured or public housing, but still 57% of them have fewer than 100 units. While just under 25% of Section 202 buildings have fewer than 50 units (and over 60% fewer than 100 units), still 18% of its buildings contain 150 or more apartments.

#### Elder-Occupied Developments

The buildings funded under the Section 202 program contain the largest number of elder-occupied units. Over a third of their buildings contain over 100 elder-occupied apartments. Almost all the other programs, including public housing, are dominated by buildings with relatively small numbers of elder tenants (75%-80% of facilities having under 50 units). While almost 75% of Section 236 buildings have fewer

than 50 elder tenants, over 14% of the buildings are occupied by over 150 elder tenants.

#### Largest Elder Concentrations

The largest building concentrations of older persons (percent of building units occupied by elder households) are predictably found in the Section 202 program. Almost three-quarters are over 90% elder-occupied. The remaining buildings in this program contain various proportions of non-elder disabled tenants. Over 40% of Section 8 noninsured buildings and 24% of Section 236 buildings are predominantly elder-occupied (over 80% of the apartments occupied by elders). The smallest concentrations of predominantly elder-occupied units are found in the Section 221 program (11%) and public housing facilities (18%).

#### Average Monthly Unit Rent

The units in the Section 8 noninsured, Section 236, and Section 221 facilities have the lowest average monthly rents with over half their units under \$150 per month. Section 202 and public housing projects have higher average rents (respectively 25% and 37% of their units under \$150 a month).

#### African-American Tenants

The largest concentrations of African-American tenants (of all ages) are found in Section 221 developments and public housing facilities followed by Section 236 facilities with somewhat lower black tenant proportions. The lowest concentrations are found in Section 202 and Section 8 noninsured projects.



*The onset of physical or cognitive impairments obviously threatens the ability of low-income elder tenants to retain their independent life-styles.*



## Aging in Place: The Role of HUD's Facilities and Their Management

**T**he onset of physical or cognitive impairments obviously threatens the ability of low-income elder tenants to retain their independent life-styles. How they cope with their limitations will depend on many factors. Of central importance is obviously the seriousness of their functional disabilities and the extent that family members can be relied on to assist. Crucial also, however, especially when family members are absent, is whether the rental facility and its sponsor or owner present a residential environment that both allows and encourages elder tenants to achieve their essential everyday needs and to maintain adequately their apartments even with their weakened abilities. To assess this potential, we interviewed a sample of on-site administrators of 205 HUD facilities funded under the Section 221, Section 202 (including 202/236), Section 8 noninsured, and Section 236 federal rent-assisted housing programs. On average, older tenants in these facilities had the following characteristics:

- Just under 47% were aged 62-74, 42% were aged 75-84, and 11% were over the age of 85.
  - Almost 39% were African-American and 13% were Hispanic.
  - Over 91% were living alone and of those living alone, 78% were women.
  - 28% of elders had lived in their facilities 2 years or less, 61% for 3 to 10 years, and 11% for 11 years or more.
  - 67% received Medicaid benefits.
  - Over 83% had annual incomes under \$10,000.
- Almost 89% had incomes of under 50% of the area median income.

### Administrator's Attitudes About Aging-in-Place

#### Aging in Place Philosophy

Whether expressed in written documents or simply reflected in everyday policies and actions, HUD administrators hold an overall philosophy or value orientation about the desirability of helping their older and more frail tenants to remain in their current apartments. In both blatant and subtle ways this mindset will influence how they manage their facilities. To assess the views of administrators, they were asked how strongly they agreed with the following five positions (the percent of administrators strongly agreeing follows question):

- Frail elders do not have to move if they can arrange for their own help (86%).
- When elderly tenants are having difficulty taking care of themselves, we will arrange for them to receive supportive services (23%).
- If affordable supportive services were more readily available, we would be more open to keeping elderly as tenants (48%).
- Our philosophy is to assist frail elderly residents to remain in their current apartments as long as possible (56%).
- When elderly tenants are having difficulty taking care of themselves in their apartments, they would not be better off in some type of group home for the aged (31%).



*Aging in Place is the opportunity for older persons to remain in their current housing and receive supportive services to compensate for increasing frailty.*

### Frail Elder Admission Policy

The likelihood that low-income elder tenants will eventually need help to live independently is influenced at least in part by the level of frailty of elder tenants admitted to the rental development. Managers must refrain from discriminating against potential applicants because of their disabilities. Nonetheless, their varying aging in place dispositions are reflected by their responses to the question of whether they would admit otherwise eligible elder tenants who obviously needed some supportive services to take care of themselves or their apartments. Over 22% of administrators unequivocally answered no, while 61% would admit such tenants if they themselves could arrange to receive needed services. Only 16% of HUD administrators responded they would both admit these tenants and help them arrange for the necessary assistance.

### **Facility Resources to Accommodate the Needs of Elders Seeking to Age-in-Place**

HUD facilities offer very different opportunities for their less independent elder residents to age in place. The physical design of their apartments and common areas, the



closeness of their facilities to everyday needs, and the availability of on-site and off-site services will variously help accommodate the dependency needs of their elder tenants.

### Physical Plant — Apartments

The apartment units of elders are not universally equipped with special design features such as handrails or grab-bars in bathrooms, one- or two-way emergency signals in apartments, door-cards or other check-up mechanisms, and design modifications to accommodate disabled persons. Twenty-six percent of facilities have none of these features, 14% have one feature, 21% have two features, and only 40% have three or more of them.

### Physical Plant — Common Areas

Facilities differ as to whether they have the following common area features or adaptations (percent of facilities having feature in parentheses): a central dining room where tenants can eat (23%); a room or converted apartment where a nurse can check a resident (15%); grab rails in the public hallways (41%); any entrance to the facility that is wheelchair accessible (78%); a building sprinkler system (42%); a senior center located on or near project (14%); an adult day care center located on or near the project (3%); and a congregate or assisted living facility near the project (5%).

### Places Within Walking Distance of the Facility

Facilities differ as to whether they are close to establishments that serve everyday needs. The percent of

managers identifying the following places as being within walking distance included: bus stop (78%), supermarket (44%), health care clinic or hospital (17%), senior center (15%), and restaurant (52%).

#### Services to Less Independent Elders

Facilities differ as to who assumes the primary responsibility for arranging to have supportive services delivered to more vulnerable elder tenants. Over 29% of the responding facilities relied on a family member; 8% on friends; 4% on other residents; 6% on the housing sponsor; 14% on the onsite management; 15% on the facility's service coordinator; 15% on staff from a local senior service agency; 11% on consulted medical professionals; and 35% on the elder residents themselves (percentages will not add to 100% because multiple responses permitted).

#### Services by the Facility's Own Staff

Facilities differ as to whether their own employed staff are used to directly provide supportive services. Employed staff in 64% of facilities offered assistance in getting information about home or community services. However, only a very small group (9%) offered at least one of the following services that are either very labor-intensive or require specialized expertise: help with personal care, home health care, mental health counseling, and alcohol abuse treatment.

On-site staff assistance with at least two of the following "lighter" services (provide hot meals, special transportation van, apartment housekeeping, health screening, and self-care assessment, help completing

medical/insurance forms), was provided by 24% of the facilities, while 19% offered one, and 58% offered none of them.

#### Assistance From On-Site Service Coordinators

About 16% of HUD facilities have at least a part-time service coordinator on staff; 40% of these staff persons worked less than a 40-hour week. At least twice a week the following percentages of service coordinators report that they offer the following assistance to the elder residents in their facilities: provide emotional support (91%); find or arrange services (82%); help them keep their current benefits (e.g., food stamps, Medicaid) (61%); help them in some way with their medications (29%); and develop educational programs, such as health seminars (21%). In the course of seeking assistance for elder residents, service coordinators deal with an average of over 6 human service agencies. Almost two-thirds of the service coordinators believe that as a result of their position, community-based service providers are more responsive to the needs of their elder tenants.

#### Other Management Practices to Cope With Less Independent Elder Tenants

Facilities variously have in place a host of management practices that can improve the chances of their elder tenants remaining independent:

- About 86% of the facilities have a staff person on call at all times to assist elder tenants if they had some problem.



*About 16% of HUD facilities have at least a part-time service coordinator on staff; 40% of these staff persons worked less than a 40-hour week.*

- About 6% of facilities make special arrangements with a health care professional to provide on-call emergency services to elder tenants in need.
- About 16% of facilities have contracts or special arrangements with a senior citizen organization, nurses, social workers or volunteer groups to provide services to their elder tenants.
- About 52% of facilities provide their elder tenants with a written list of social agencies or services to call in the event they are having trouble caring for themselves or their apartments.
- About 36% of the on-site managers have received training regarding the needs of elder tenants who become physically frail or who have mental disorders.
- About 39% of facilities have a tenant or resident organization.
- About 24% employ resident volunteers to work at the facility.
- About 96% of administrators physically inspect their apartments for cleanliness and maintenance needs at least once a year; 55% conduct inspections at least every six months. Only 13% report that these inspections do not reveal new information about elderly tenants who might need special assistance taking care of themselves or their apartments.
- About 23% of administrators regularly assess at least once a year (50% of this group, every 6 months) if their elderly tenants need assistance to take care of themselves.

### **Housing Programs Respond Differently to the Aging in Place Needs of its Elder Tenants**

An analysis of how the responses of facilities differed by their federal program sponsorship reveals that the Section 202 program offers by far the most supportive physical plant, service, and organizational environment. A far second are facilities funded under the Section 236 program. Facilities funded under the Section 8 noninsured and Section 221 programs have the least supportive physical, service, and organizational infrastructure.

### **Most Serious Management Problems of Administrators**

The on-site administrators at HUD facilities were asked about the most serious management problems that resulted from their having seniors as tenants. There was strong consensus that the elder residents' poor apartment housekeeping was the most serious management problem. Other demanding management problems included: tenants with self-care problems; doing building repairs; tenants who feel very alone; mentally confused tenants; getting transportation for tenants; arranging for home care; tenants with drinking problems; and, tenants who are abusive. Three general categories of management problems emerged: (a) dealing with older tenants having demanding and difficult lifestyles; (b) dealing with elder frailty; and (c) dealing with service providers. It was also established that facilities having the most serious problems were more likely to have a predominantly elder tenant population, to have tenants over the age of 85, and to have tenants with higher levels of impairment.



# The Unmet Needs of Elderly Tenants

## The Perspective of Facility Management

Even the most responsive facility management will experience difficulties satisfying the varied and often complex demands made by its aging tenant population. The gap between what is needed and what is provided will be even greater in facilities where management is either less sympathetic or less resourceful. Surveys distributed to HUD administrators, Public Housing Authority directors, and on-site service coordinator staff asked each of these groups to identify the most serious unmet needs of their elderly tenants. There was general agreement that the most critical unmet needs included the following: getting help to temporarily ill tenants; getting help with apartment's housekeeping; getting affordable self-care help; and getting a family member to help. Two of the three groups identified getting specially arranged transportation on their list of priority unmet needs. A second tier of frequently identified unmet needs included the following: getting help managing medications; getting a friend to help; and getting mental health counseling.

## Barriers Making It Difficult for Facilities to Respond to Elder Tenant Needs

Each of the three groups identified obstacles that they felt made it difficult for them to help their elderly tenants deal with their inability to live independently. The groups, however, were not in total agreement about which of these presented the greatest obstacles. Both HUD administrators and PHA directors agreed that managers not having enough time to assist their

elder tenants, not having a service coordinator, not having a nearby senior center or adult day care center, and the unavailability of service providers when needed were serious administrative obstacles. They also agreed that residents' fear of going into a nursing home and their not admitting to their problems were serious barriers. Service coordinators, while also identifying residents' fears as problems, emphasized the difficulties of getting service providers, the unavailability of unskilled home aides, and the difficulties of getting transportation on demand.

## Relocation Patterns of Elder Tenants

If frail elder tenants' needs go unmet, the chances are greater that they will have to leave the facility to seek supportive shelter and services elsewhere. The following elder relocation behavior reported by HUD administrators suggests the benefits that might be realized by more effective supportive service intervention strategies. *A caveat: It is difficult to attribute causation from a study conducted at a single point in time.*

- On average, about 11% of elder residents vacated their apartments in the past year.
- Less than 1% of seniors were evicted from their units.
- Senior apartments were vacated for the following reasons: 36% died, 14% moved into another HUD facility, 2% left mainly because of noncompliance with building rules, 15% moved into their family home, 30% entered a nursing home, and 3% entered



a group retirement home. The last three reported reasons particularly suggest that at least 48% of moves were motivated by the need to obtain a more supportive shelter situation.

- Managers estimated that an apartment unit's average turn-over costs following a vacancy amounted to just over \$500.

### **Management's Estimate of their Elderly Tenants' Frailty**

On-site HUD facility administrators, directors of Public Housing Authorities, and service coordinators at a sample of HUD facilities were asked to estimate what percentage of their elder tenants were having trouble performing specific activities, remaining responsible for themselves, or taking care of their apartments. All three groups identified apartment housekeeping, walking, and getting to places outside the housing site as activities that elders had the most difficulty performing. A smaller percentage of elders were identified who had difficulty with personal hygiene or preparing meals for themselves. Overall estimates of the percentage of elderly residents who were having trouble remaining responsible for themselves or taking care of their apartments ranged from 14% to 17%. Service coordinators presented the highest estimate of the number of frail residents in their facilities.

Each of the three groups was also asked about the mental health problems of their elder tenants. From 7% to 13% of the respondents reported that their tenants were depressed or anxious, while from 5% to 7% reported that their tenants appeared confused. In both instances, the estimates presented by service

coordinators were the highest.

The three groups also estimated that from 3% to 5% of their elder tenants had an alcohol problem.

### **Self-Estimates by Elder Tenants of their Dependency Status**

A sample of 573 elder tenants living in eight different HUD privately-owned multifamily subsidized facilities in Florida was surveyed. Thirty-nine percent were aged 62-74, 43% 75-84, and 18% were 85 and over. Most (84%) were women and 90% of the group was unmarried (widowed, divorced, separated, or never married).

The tenants were asked about their difficulties in conducting two categories of everyday activities that are frequently used to measure the functional health of an elder population. These included their Instrumental Activities of Daily Living or IADLs (housekeeping, taking medication, getting to places out of walking distance, shopping, meal preparation, handling money, and using the telephone) and their Activities of Daily Living or ADLs (personal care, walking, getting in and out of bed, bathing, eating, and dressing). For each activity, they were asked whether they could do the activity without help, with some help, or were completely unable to do the activity.

The results indicated that 68% of elders could perform their IADLs and ADLs without help; 26% of elders required some help to perform at least one of their IADLs and ADLs; and 6% of the elder tenant group were completely unable to perform at least one ADL or IADL. These findings suggest that in order to remain in their independent living arrangements, 32% of the



*There was general agreement that the most critical unmet needs included the following: getting help to temporarily ill tenants; getting help with apartment's housekeeping; getting affordable self-care help; and getting a family member to help.*

elders would benefit from supportive services.

### **Services Needed**

When asked which services they now needed often, the following percentages of elders identified the following as most important: handrails or grab-bars in their bathroom (26%); transportation to and from a doctor's appointment (15%); transportation to and from a store (14%); help with their housekeeping chores (11%); emergency button to push or string to pull in their apartment (4%); and hot meals delivered to their apartment (4%).

When asked if they had a problem getting affordable transportation to places (not within walking distance) when they needed it, over 25% of the elders had a problem always or most of the time, 15% some of the time, 51% seldom or never, and 8% responded they didn't need to go to places.

### **Who to Turn to for Help?**

Over 8% of the elders reported they were so sick during the previous six months that were unable to carry on their usual activities for at least a month, and another 12% reported such incapacity for more than a week (but less than a month). Elder tenants were asked whom they could rely on in the event they were sick or disabled. Only 37% felt they could rely on someone as long as needed. About 6% could rely on someone for a few weeks or months; 7% for a week or less; 16% only now and then; and over 34% felt no person was available. Of those identifying a helpful person, 73% named a son or daughter (or other family member); over 7% would rely on a neighbor or friends in the building; 9% on a

friend outside the building; 5% on the building's service coordinator; 2% on someone they would hire; and 1% on the building manager.

When asked who they could turn to in the event they needed to arrange for services that would help them take of themselves (e.g., bathing, nail care, getting meals, getting around), the largest percentage, 63%, would again rely on family, 12% on the building's service coordinator, 14% on neighbors and friends, and 4% would rely on the building manager.

### **Relocating in Response to Dependency**

Elder tenants were asked where they would relocate if they could no longer live on their own in their apartment because of a health or disability problem. About 27% said they would move into the residence of a family member, 19% to a group home for the aged, 16% to a nursing home, 1% to a friend, 4% to a variety of other choices, and 34% said they didn't know. Two obvious observations: it is unclear whether family members would accommodate those elders seeking assistance, and it is rather frightening that over a third of these residents have no idea how they will cope with the onset of serious frailty.

### **Mental Well-Being**

Almost 47% of elder tenants reported that they hardly ever worried about things, but 18% reported that they worry about things very often and 36%, fairly often. Over 70% thought life was pretty routine as opposed to exciting (22%) or dull (8%).



## Blueprint for Action: Linking Supportive Services to the Senior Occupants of Rent-Subsidized Housing

**A** second and equally important mission of the CASERA Project was to identify a set of alternative programmatic strategies that would help elder tenants in Florida's rent-subsidized facilities better avail themselves of the supportive services they required to maintain their independent living arrangements. The strategies were designed to produce various outcomes:

1) Make it more feasible for older tenants to deal with their vulnerabilities without having to relocate and thus delay a premature and inappropriate move to a nursing or other group home.

2) Make it more realistic for housing owners and administrators who have demonstrated less interest in aging in place responses to offer more assistance to their frail elder tenants.

3) Offer much needed financial and administrative relief to those managements already committed to providing supportive services to their older tenants.

4) Offer all housing sponsors and managements the ability to deal more effectively with the bricks and mortar aspects of their administrative roles even as they confront higher

percentages of more frail tenants with more complex needs.

5) Increase both tenant and management well-being by helping them achieve their mutual goals.

6) Offer community- and home-based service providers the opportunities to deliver their assistance more timely, efficiently, and less expensively.

7) Increase families' peace of mind about the quality of the housing experienced by their kin and potentially reduce their caregiving burden.

8) Reduce the low-income elder demand for state-subsidized nursing and board and care facilities, thereby reducing fiscal demands on Florida's state government.

Two sources of information were utilized to develop these shelter-service linkage strategies. First, relevant studies and literature were reviewed that offered insights about how to better link shelter with supportive services. Second, a group of Florida leaders—housing administrators, social service and health care providers, and state government agency administrators engaged in day-long focus groups that elicited their ideas and recommendations. The participants, while encouraged to be as innovative as possible, were also counseled to make proposals that were economically and politically feasible to implement.

In the next section we outline the lessons learned from the exemplary efforts of others and those consistently identified by our panel of focus group participants. Based on this information, we identified a set of common elements and service components considered essential in the formulation and implementation of our proposed prototype shelter-service models.



*Expressed simply, the overarching goal of aging-in-place solutions is to assist elder tenants in maintaining their independent living arrangements in their current apartment settings as long as it is economically, administratively, and legally feasible.*



### **The Common Ingredients of Successful Aging In Place Approaches Directed Towards Low-Income Elders in Rent-Assisted Housing**

A central theme underlies the successful efforts nationwide and the recommendations offered by our panel of experts. Expressed simply, the overarching goal of aging-in-place solutions is to assist elder tenants in maintaining their independent living arrangements in their current apartment settings as long as it is economically, administratively and legally feasible. Importantly, the solutions designed to achieve this goal require that our efforts must actively involve at the minimum three distinctive groups of actors. We must provide both elder tenants and the owners, sponsors, and/or on-site administrators of their rent-assisted facilities with the knowledge, incentives, and financial resources necessary to access those supportive services that will be instrumental in achieving their goal of independent living. And, we must find ways to help the community-based network of home care and service providers mobilize their resources in a manner that helps both elder tenants and their housing administrators to achieve this fundamental goal. The following strategies are used by successful programs across the nation:

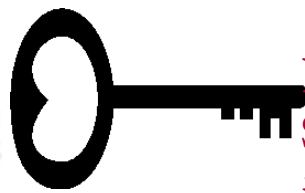
- The facility's sponsor or owner has a long-term commitment to managing the housing development and thus has a long-term perspective on allowing older tenants to age in place and addressing their service needs.
- The facility has a dedicated, full-time on-site manager (and support staff) who ensures that residents are living as independently as possible.
- The facility has one or more staff who can communicate with tenants who speak little or no English.
- The facility is occupied by a sufficiently large number of elder tenants allowing management to realize economies of scale when contracting, purchasing, and delivering supportive services.
- The facility has architectural/physical design features that minimize the tenants' likelihood of having accidents.
- The facility has a communication system that alerts management when elder tenants are incapacitated either because of an accident or medical emergency.
- The facility is located within walking distance of grocery stores, restaurants, bus transportation, and a variety store. Alternatively, the facility offers personalized transportation to these places.
- The facility is located in a community with a well-developed service infrastructure that provides a range of community-based (senior centers, congregate meal sites, adult day care, health screening clinics) and in-home services (homemaker, meals on wheels, personal assistance, door-to-door transportation).



*The elder residents in the facility are paying part of the cost of needed supportive services based on a sliding scale linked to their incomes.*

- The facility has an active and involved elder tenant group— often organized by facility staff — that advises management about tenants’ unmet needs and offers feedback about building activities.
- The facility makes extensive use of elderly volunteers who are often organized by facility staff. These volunteers counsel and assist elder tenants and physically help management deliver supportive services that the facility provides directly or that are supplied by community-based organizations (senior volunteer picks up hot meals and delivers them to the tenants).
- The facility has divided its management functions and in turn their staff assignments into at least two categories: staff who are primarily responsible for traditional bricks and mortar building administrative tasks and staff who monitor the needs of older tenants and the coordination, access, and securing of supportive services to this group.
- The facility has assigned its own staff resources to provide several of the supportive services needed by its more frail elder tenants.
- Elder residents pay a portion of the cost of needed services based on a sliding scale linked to their incomes.
- Management has secured federal funding from either the Congregate Housing Services Program or Service Coordinator Program.
- Management uses a percent of its rental revenues to hire a service coordinator.
- The facility has loaned or rented physical space (vacant apartment, office, common room, or a complete floor) to an outside vendor or community service provider.
- The facility is affiliated with a nonprofit or for profit organization that offers home- and community-based services to frail older adults living in the community at large. Thus, the facility’s tenants become identified as an “additional” targeted group.
- The management of two or more rent-assisted facilities has entered into cooperative arrangements to share information, staff or services (e.g., 50% sharing of a service coordinator staff position).
- The facility is actively engaged in grant-writing and other fund-raising activities to finance the delivery of services to its more frail senior tenants. Such funding will be variously offered by private businesses, foundations, and federal, state, county or municipal governments.
- The facility negotiates below-market prices from service vendors for goods or services (food and transportation). Usually, to accomplish this arrangement the facility will have a relatively large number of elder tenants.
- The facility relies extensively on community-based charitable and

- religious organizations, and on community volunteer groups to help assess and respond to the multiple supportive service needs of its elder tenant population.
- The facility subcontracts with community/human service agencies to offer supportive services required by its elder tenant population.
  - Facility management has enabled elder tenants to receive services subsidized through federal and state programs such as Medicaid Waiver, Social Health Maintenance Organizations (SHMOs), and community-based and in-home service programs.
  - The community-based aging network is organized around a lead agency that is alert to the supportive service needs of seniors living in rent-subsidized housing and works with facility management to coordinate and deliver services to frail residents.
  - The state unit on aging and the state's housing finance agency together play crucial roles to mobilize community resources to address both the supportive service needs of the elder tenants and management problems confronted by housing administrators seeking to maintain their independent living arrangements. Efforts vary but have included:
    - *Using state government revenues to subsidize the costs of services delivered to residents of rent-assisted facilities.*
    - *Implementing a needs-assessment study of tenants in rent-subsidized facilities.*
    - *Forming partnerships with human service and housing agencies (Health Care Association, Association of Senior Centers, Housing Finance Corporation, Elder Affairs, HUD, Public Housing Authorities, Department of Agriculture/Farmers Home).*
  - *Participating in the development of an area agency on aging's plan for providing supportive services to rent-subsidized facilities.*
  - *Offering seed money for housing providers seeking to develop supportive service programs in their facilities.*
  - *Funding demonstration projects offering supportive housing services in rent-subsidized facilities.*
  - *Training programs/technical assistance for housing professionals.*
  - *Training programs/technical assistance for service providers on rent-subsidized housing issues.*
  - *Providing technical assistance to relevant housing organizations.*
  - *Training/information programs for low-income seniors on rent-subsidized housing opportunities.*
  - *Convening public and private agencies involved in rent-subsidized housing regularly to discuss housing issues or to establish task forces on key issues.*
  - *Developing a resource guide directed to elders, their family members, and the professionals serving them that describes the availability and attributes of rent-subsidized opportunities.*
  - *Establishing a visible housing advocacy role focused on rent-subsidized housing legislation and ordinances.*
  - *Coordinating or helping to initiate lobbying efforts with private management or public agencies focused on rent-subsidized housing issues.*



# Models for Service Delivery in Subsidized Housing for Seniors in Florida

## Common Elements

Five models were proposed to link low-income elder tenants in rent-assisted housing accommodations to their needed supportive services. While differing in several respects they all shared the following common elements:

- Flexibility in service delivery coordination that can be achieved with different levels of resource commitment to meet local needs.
- Variety in the scope and intensity of services provided by each housing facility, depending on geographic location (e.g., urban versus rural), and local cultural diversity (race, ethnicity, language, and community).
- Maximizing resources available in the local infrastructure.
- Designating an individual or agency with lead responsibility for program and service accountability.
- Creating “focal point” congregating and socialization programs through senior centers, on- or off-site.
- Providing multiple levels of supports (from independent to

assisted living).

- Offering services that are available to residents in the broader community.

## Priority Services

Along with these common features, focus group participants agreed on an array of priority services required by seniors if they were to successfully remain in their homes even with diminished functional abilities.

### Health Services

The availability of a primary care clinic or wellness center. The health services included in a primary care clinic would include:

- Care management and medical services on site
- Geriatric assessment for individuals identified to be at highest risk
- Primary medical care
- Health screenings
- Early disease detection
- Nutrition and weight control
- Medication management
- Home safety; fall and injury prevention
- Immunizations
- Counseling services
- Exercises
- Podiatry
- Ophthalmology
- Wellness education

If offered off-site, the services in the center should be inexpensive and accessible with conventional transportation vehicles or special transportation vans. Alternatively, service delivery costs could be minimized by: co-locating the wellness clinic, pharmacy, home health agency at the housing site;

*Focus group participants indicated that many facility owners were not taking advantage of nutrition programs that are already in place.*



regularly delivering the services to the housing facility using a mobile health unit; or negotiating an arrangement with a hospital or clinic to supply nursing students to provide on-site primary care.

### Transportation

The recommendations for improving residents' access to transportation services involved the development of partnerships with other facilities, volunteers, and community providers.

- Collaborate with other facilities to provide a van for the use of their residents
- Solicit municipal and/or Department of Transportation funding
- Develop volunteer-based transportation/escort services through local civic and religious organizations
- Develop cooperative agreements with other providers who have access to vans and buses
- Negotiate agreements with retail cab drivers for services at special rates

### Meals

Focus group participants indicated that many facility owners were not taking advantage of nutrition programs that are already in place. Recommendations for maximizing the resources available included:

- Collaborate with local councils on aging to provide home-delivered meals, funded by the Older Americans Act
- Provide transportation for residents to participate in off-site congregate meal facilities, funded by the Older Americans Act
- Negotiate with retail restaurants or local food service providers to

provide on-site meals at reduced cost

### Case Management

A central feature of exemplary programs nationally, and a recommendation of the focus group participants, involved the more effective identification and management of the array of services required both by building administrators and their elder tenants. In some cases this is achieved by an on-site case manager who coordinates service access.

Other programs utilize a multi-disciplinary team to coordinate service delivery. In Florida this integration can be accomplished by the following programs and services:

- Community Care for the Elderly Program
- Medicaid Waiver management
- Geriatric case management
- Social work student interns supervised through various agencies/organizations
- Mental Health case management

### Homemaker and Personal Care

Recommendations for the provision of homemaker and personal care centered around identifying sources of funding or alternative strategies for providing assistance with the activities of daily living. These include:

- Funding from the Community Care for the Elderly Program
- Funding services through Medicaid Waivers
- Drawing on Medicaid and Medicare home health – personal care provisions
- Negotiating agreements with private service providers for



homemaker services

- Drawing on existing volunteers programs to provide homemaker services

#### Social-Educational Group Activities


While programs designed to help older persons function more effectively are crucial, it is also necessary to maintain their overall quality of life. To this end, focus group participants recommended improved access to social and recreational activities including:

- Facilitating access and transportation to adult education programs at local schools, community colleges, or colleges and universities
- Facilitating access to educational and recreational programs at senior centers
- Providing on-site activities and classes for a fee and opening them to the community
- Collaborating with intergenerational groups like the Girl Scouts/Boy Scouts
- Developing collaborative agreements with local providers, such as music schools, art schools, and public libraries
- Developing sponsorship of activities by local churches and synagogues

#### **Service Delivery Models**

A illustrative case: Mrs. C. is a 79 year old white female living in subsidized housing. Her total income is \$660 per month. She is diabetic, has high blood pressure, congestive heart failure and broke her hip this past year. When she is able, she eats in the dining room where meals are served at noon by the local aging service provider. At other times, she receives meals delivered from the aging service provider to her apartment. She has homemaker services provided weekly to do her laundry, change her bed, clean her bathroom and vacuum. She does her dusting and tries to maintain her apartment between homemaker visits. She also has someone to assist her in bathing. A volunteer buys her groceries and takes her to the doctor as needed. She has a son in town who travels extensively and she only sees him once a month. Recently, Mrs. C. was in the hospital where they discovered she also has chronic kidney disease. Her apartment was held for her although she was in the hospital and rehabilitation center for nearly six weeks. Without supportive services, Mrs. C. would have immediately been forced to relocate to a nursing home.

According to the Florida surveys, 32% of elders residing in multifamily facilities reported that they are in need of some assistance with their activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in order to remain as independent as possible. Facility administrators, directors of Public Housing Authorities, and service coordinators estimated that the percentage of elderly residents who are at risk of losing their independence ranged from 14% to 17%. More compelling is the report that 48% of seniors vacate their



*Facility administrators, directors of Public Housing Authorities, and service coordinators estimated that the percentage of elderly residents who are at risk of losing their independence ranged from 14% to 17%. Thirty-two percent of elders reported they are in need of some assistance to remain independent.*



apartments due to an inability to care for themselves or their place of residence. The largest group, an estimated 30%, enter nursing homes, a more costly residential alternative. This number may be underestimated because elders often conceal their need for supportive services due to fear of eviction and possible placement in a nursing home. Without preventative and supportive services, these residents risk premature and unnecessary institutionalization.

There is general consensus among housing, health care and service providers that the most critical component of any service delivery approach is service coordination for residents, which would ensure access to available programs and service accountability in the facility. To be effective, the service coordination, whether accomplished by one individual (a service coordinator) or by a case management team, must have knowledge of and access to the range of social services available; health, aging, and rehabilitative issues; and marketing, communications, and fundraising skills. Each of the models presented below point to service coordination as an essential component.

Five service delivery approaches are presented for consideration. Four are defined primarily by specific organizational structures, and one is primarily characterized by innovative funding mechanisms. The models are intended to provide each HUD and PHA housing facility with flexibility in the design of their social and supportive service delivery system, taking into account the local infrastructure and levels of resources.

## Model 1: The Basic Service Coordination Model



### Key Components:

- Skilled and competent service coordinator
  - Focus on empowering consumers
- Collaboration with home- and community-based service providers

The underlying goal of service coordination is to enable residents to age in place by assisting them to obtain needed services, avoiding unnecessary or premature institutionalization and improving their quality of life. Although there has been a rapid growth of the elder population, resources for health and social services programs have dwindled and eligibility criteria for nursing home admission have tightened. Elder residents in rent-subsidized housing who prefer the independence of aging in place can benefit from the economies of scale realized by service coordination, thus purchasing services at a reduced cost.

The major component of this model is the role of the service coordinator, a full- or part-time position in each housing facility, to coordinate the work of case managers and volunteer coordinators, and to create partnerships with other local entities to facilitate the residents' access to a broad base of community services. The function of the service coordinator is to identify the resident's needs and support them to age in place; to identify and secure funds to benefit the resident; and to coordinate the delivery of



*There is a general consensus among housing, health care and service providers that the most critical component of any service delivery approach is service coordination for residents, which would ensure access to available programs and service accountability in the facility.*

services. The following “Key Values for Service Coordinators” were outlined by Holland et al.:

- Treat residents with dignity and respect (respecting cultural differences and maintaining confidentiality)
- Promote resident autonomy (right to self-determination, right to refuse services)
- Set appropriate goals (identify resident’s strengths, competency, promote maximum functioning, least-restrictive environment, and aging in place)
- Embrace a systems perspective
- Do good
- Avoid harm
- Act fairly

The service coordinator will serve in the following roles as described by Holland and Lanspery: investigator, educator, community builder, advocate liaison, and service facilitator. As an investigator, the service coordinator analyzes the types, frequency, and other characteristics of services; study available community services; research residents’ participation and satisfaction with recreational and social programs; assess residents’ and commu-

nity resources; and observe residents. In the educator’s role, the service coordinator organizes programs of interest; distributes consumer materials; organizes meetings to “teach” residents; helps managers and residents recognize and solve safety and accessibility issues; and connects residents with educational and recreational programs. As a community builder, the service coordinator assists in organizing resident groups and their activities and community issues; mediates disputes among residents; helps residents build informal support networks; facilitates support groups; and helps residents get involved with neighborhood improvement efforts. As an advocate, the service coordinator acts as a liaison with the facility management, community agencies, and advocates on behalf of residents. The service coordinator locates additional services, seeks solutions, educates service providers about residents’ needs and lack of resources, and encourages providers to take advantage of economies of scale. As a service facilitator, the service coordinator establishes links to community agencies and service providers, develops resource directories, provides basic case management and referral services, and monitors the provision of ongoing provision of services by community agencies. In working with volunteer coordinators, the service coordinator must assure that resources available within families are identified; that residents of the facility are provided the opportunity to assist other, more frail residents; and that community volunteers are called upon to help provide services.

One challenge to implementing



this model is the financing of the full-time service coordinator position. The National Affordable Housing Act of 1990 includes a provision that specifies the service coordinator position as an allowable administrative expense, but considers it an optional component of the service delivery system. Thus, it is not a requirement in all HUD and PHA low-income housing facilities. In addition, there is a question whether there will be enough skilled applicants to fill the role of service coordinator. These models depend on competent and qualified service coordinators.

For facilities whose funding base is insufficient for creating such a position, the models below offer alternatives for reaching the goal of coordination of services for their residents.

## Model 2: The Partnership Model



### Key Components

- **Interagency collaboration for effective service delivery**
- **Written agreements among participating partners**
- **Maximizes resources through partnerships**

The goal of the Partnership Model is to establish interagency collaboration that results in the effective coordination of services. A key to forming good partnerships is to identify the mutual benefits to be gained by working together. It is also important to clarify roles which will allow reasonable limits to be set for all concerned and will ensure continuity if personnel changes. Written agreements are preferable and should address the following:

- Who is involved and who are the primary contacts
- What activities the participants

are committing to

- When the agreement will begin, reevaluated, or end
- Where the activity will take place
- What are the expected cost and benefits to the participants.

Examples of partnership agreements include Confidential Disclosure Agreement, Teaming Agreements, Agreements, and Letters of Agreement. There are two types of Confidential Disclosure Agreements: one in which the partner owns the information to be disclosed and another in which the agency owns and discloses the information to the partner. The agreement specifies the qualified personnel and organizations to receive the information, when the agreement begins and ends, and the required written permission and notification prior to release of the information. The differences lie in the party originating the agreement.

In the Teaming Agreement, all the partners are identified, the names of responsible agents are listed, and the activities to be undertaken are specified. The agreement also includes the activation date, documentation required of respective parties, anticipated products from the agreement, criteria for subcontracting the array of services, disposition of proprietary information, beginning and ending dates for the agreement, compliance requirements with federal and state regulations, assignability and termination clauses.

An Agreement specifies the following terms and conditions: statement of work, period of performance, personnel assigned to the program, criteria for changing the specifications of the agreement,



required compliance with federal and state regulations, criteria for termination of the agreement and a liability clause. Similarly, a Letter of Agreement specifies the description of the proposed work, fees and reimbursement procedures, a statement regarding the period of time for the agreement or the projected completion date.

The partnership model also provides for maximizing existing resources through the development of “geographic partnerships.” For example, several agencies could share vans or buses similar to those in Orlando; or mobile health service teams could visit multiple facilities similar to a program that is operational in Sarasota. Adult day care could be offered on site for residents and elders in the neighborhood. Adult education classes could be consolidated at one site or rotated among several. Similar partnerships may be formed with private sector and not-for-profit providers. For example, several housing facilities could pool their buying power to enter into mutually beneficial arrangements with home health

providers, pharmacies, malls, or grocery stores. In addition, retail services could be contracted on-site, given sufficient capacity. Partners may form a Community Ethics Council, with meetings at the senior housing facility to consider difficult ethical cases. This approach would heighten community awareness of the needs of the elders in rent-subsidized housing and of volunteer/partnership opportunities.

The organizational structure of the Partnership Model includes an advisory committee comprised of all collaborative partners (e.g., area agency on aging, local hospitals, senior centers, private providers). Similar to the Service Coordination Model, there is a full- or part-time service coordinator position, but the position is funded through pooled resources from the participating agencies. Case managers and volunteer coordinators work closely with the service coordinator, acting as the point person for the coordination of services.

The financing structure for this partnership model depends on the scope and intensity of services identified for the facility, willingness of potential partners to collaborate in a formal way, and available resources. One barrier to this model is the issue of “turf” brought about by the fragmented reimbursement system for in-home services. It is important to recognize and address the concerns raised by the participating agencies. Sponsoring meetings between housing and service providers within the project geographic area can help alleviate future problems. Another barrier may be concern about the liability associated with providing services such as transportation and the delivery of services by volunteers.



*The goal of the Partnership Model is to establish interagency collaboration that results in the effective coordination of services.*



### Model 3: The Congregate Housing and Capitation Model



#### Key Components

- One stop shopping for services
- Services provided on site
- Cost of services determined through a capitated system

The goal of the Congregate Housing and Capitation Model is to foster residents' independence through a "one-stop shopping" service package. In this model, all services are provided on-site, including congregate dining, health services, transportation, homemaker/personal care, and an array of group activities, such as adult day care. This model targets low-income frail elders at-risk who meet nursing home eligibility criteria as established under the Medicaid Waiver.

One outcome of this model is the extension of Florida's Community Care for the Elderly (CCE) Program, the Medicaid Waiver Diversion Program, and the Older Americans Act Program funds to HUD and PHA facilities through service capitation, similar to the current structure of private HMOs. The capitation model requires that a per capita rate be negotiated between the HUD or PHA facility and the Community Care for the Elderly Program for the services to be provided. The model is based on an average cost of the Assisted Living Facility Waiver Program which allows for provision of needed services to residents in the facility as a cost-effective alternative to nursing home care. The criteria to be used for this model include that the participants must be Medicaid eligible or qualify for the Medicaid Institutional Care Program. As

required under the CCE Program, some residents will have a patient responsibility (sliding fee scale) to the facility for the services if their monthly income exceeds the income criteria as specified under CCE. Under this model, there will be a daily payment rate per client (case management will be a capitated rate) to be provided by staff at the facility who meet the standards set in the approved Medicaid Waiver program.

The organizational structure of this model includes a full-time service coordinator who assigns and manages specific service providers on-site. A portion of the cost of the salary and compensation for the service coordinator would be subsidized by the HUD or PHA facility. The remaining portion of the salary would be covered through Medicaid Waiver funding. Case management is provided by the service coordinator who brokers services for residents.

Each facility would determine the array of services to be provided. This ambitious model requires that the facility have sufficient space to house a broad array of services. Other considerations include: eligibility for the Institutional Care Program level which would base targeting on service needs and frailty level and base capitated rates on different levels of needs. It also includes the ability to combine community resources with local, state and federal funding. In addition, staff must be versed in several areas of social services. On the other hand, the funding mechanism for such facilities may be more flexible, as funds from agencies beyond HUD or the PHA could be used to staff the facility.



#### Model 4: The Two-Tiered Assisted Living Program Model



##### Key Components

- Two levels of services within a facility
- Defined set of services to be provided for each level
- Service coordination with home- and community-based services

The goal of the Two-Tiered Assisted Living Program Model is to provide two levels of social and supportive services within the same HUD or PHA facility, providing a continuum of care for residents. Specifically, there would be designated areas or apartments within each facility for each level of care with a differentiated menu of services.

Currently, a similar model operating in New York consists of two levels of services: an Enriched Housing Program and Senior Independence Program. The Enriched Housing Program offers services to residents who are in need of minimal services and enjoy considerable independence. Among the supportive services provided are personal care, meal preparation, shopping,

housekeeping, and 24-hour on-call emergency services. In this program level, research suggests that success depends on the “networking” among human service agencies (state and local, private and non-profit). The Senior Independence Program targets residents who are more frail to prevent their premature institutionalization. An on-site service coordinator provides case management to residents and coordinates services on-site through existing local providers (private and non-profit). Among the array of services provided to residents are housekeeping, personal care, transportation, congregate meals, and adult day services.

Funding approaches to the Two-Tiered Assisted Living Program Model depend on the scope of services and include among others, a Congregate Housing Services Program grant, with matching community funds. However, a vast array of services to be provided under each level of services can also be subsidized through other existing state and local funding streams, a fee-for-service approach, or provided by volunteers.

Among the barriers to implementation of this model is the problem of different eligibility requirements to qualify for low-income housing versus community services. Thus, some residents may not be able to benefit from the menu of services provided in the facility, nor will the facility receive reimbursements if services are provided to ineligible residents.



*Specifically, there would be designated areas or apartments within each facility for each level of care with a differentiated menu of services.*



## Model 5: The Home Modification Program Model

### Key Components

- Emphasizes leadership and coalition building
- Assesses needs and identifies strategies of effective home modifications
- Educates providers, health care professions, policymakers, and consumers

In 1993, the Center for Universal Design convened the First National Conference on Home Modification Policy to address the growing gap between the need for and availability of assistance for home accessibility. A second national conference, A Blueprint for Action: The Second National Working Conference on Home Modification Policy was held in 1996 to develop home modification agendas at community, state, and national levels. The model as presented here is the action plan developed in 1996 “to promote home modification through coalition building and sustained and coordinated activities.”

The goal of the Home Modification Program Model is to act as a catalyst for “organizations to make a long-term commitment to home modifications as a priority issue at the national, state and community levels; and to promote effective public and private collaborations between national, state, and community stakeholders.” These will ensure adequate funding and broad targeting of efforts to meet the needs of households of all income levels. The home modification model includes several components: leadership and coalition building, research, education, funding, and service delivery.

The critical first step to implementing the model is leadership and coalition building through a “pres-

ence of an organization(s) willing to lead a coalition whose priority is increasing the availability of home modifications.” A small working group should first be formed to work out the issues of leadership and cost distinction, to conduct research, draft a report of needs and barriers to home modification in the geographic area, and to develop a 5 to 10 year action plan and short term objectives.

The coalitions “assess needs, determine the status of services and resources, and demonstrate effectiveness of home modification.” Results of the research are brought to policymakers and program developers to shape future legislation, regulations, and certification rules. Research should identify consumer characteristics and needs; resource gaps; levels of consumer knowledge; remodeler, health, or social service worker expertise; awareness on the part of elected officials; and level of inter-agency coordination. Research should also indicate the best methods of service delivery.

The educational component includes establishing information and referral centers as central places for consumers, service providers, and policymakers to get timely research and home modification information. It will provide a resource directory, establish a toll-free information and referral service, establish housing design awards programs, and develop internet websites to disseminate information. In addition, training programs and materials should be developed to cross-train social service, health care, and building professionals, as well as consumers.



Funding and financing efforts focus on developing new resources and reshaping and fully accessing existing resources. Representatives of funding and financing agencies should be part of the coalition that advocates with others for private insurance to allow medical insurance payments or reimbursements for home modifications. State housing agencies should include accessibility as an incentive feature to the application criteria for competitive funding programs. These efforts also include the creation of Community Housing Development Organizations (CHDO) with a home modification/home repair focus that can seek funding from a variety of federal sources.

Service delivery efforts should “concentrate on developing practitioner expertise by promoting uniform and accurate assessments and producing successful home modification

projects that demonstrate quality and efficacy.” Services to be offered include the following:

- Structural modifications (stairs, elevators, ramps, doorways, cabinets, rooms)
- Plumbing fixtures
- Addition of assistive devices (grab bars, lifts, alarms, toileting aids)
- Safety (lighting, flooring, smoke alarms, emergency egress)
- Security systems (response system, home security, locks, lighting)

Funding for the Home Modification Program Model will depend on the specific composition and membership of the state or local coalitions and the scope of services to be offered.



*The goal of the Home Modification Program Model is to act as a catalyst for “organizations to make a long-term commitment to home modifications as a priority issue at the national, state and community levels...”*





## A Call to Action

### **I. FUND ADDITIONAL SERVICE COORDINATORS WITHIN RENT-SUBSIDIZED FACILITIES**

- (a) Create a state-subsidized service coordinator program that funds quarter- to full-time service coordinator positions in HUD Private Multifamily, Rural Housing (Department of Agriculture), Public Housing Authority facilities, and Florida's Housing Finance Corporation (FHFC). Give preference to facilities that are now not currently funded by the federal Service Coordinator or Congregate Housing Services Programs.
- (b) Develop educational campaign/public relations packages for directors of Public Housing Authorities, nonprofit sponsors, on-site administrators, and private rental management firms that outline the administrative and economic advantages of hiring service coordinators who can advocate and link elder tenants with appropriate community-based services.
- (c) Obtain public, private, or foundation funding to provide managerial assistance to service coordinators statewide to assist them in creating a professional organization representing their members. This organization would: (1) publicize the benefits of their services to the housing community; (2) provide a formal networking forum for sharing information and common issues; and (3) offer continuing professional education.

### **II. CREATE INCENTIVES FOR RENT-SUBSIDIZED FACILITIES TO PROVIDE SERVICES TO ASSIST OLDER TENANTS TO AGE IN PLACE**

- (a) Provide economic and/or administrative incentives for HUD Private Multifamily, Rural Housing, Public Housing Authority and FHFC facilities (especially small and more isolated facilities), to realize greater economies of scale for capital and operating expenses associated with supportive services for seniors.
- (b) Design a service support program (by expanding the fiscal and administrative reach of currently operated programs) that is subsidized by a combination of state revenues, federal aid, and tenant contributions, to be administered by the Department of Elder Affairs. Target the program specifically to support the needs of the more frail rent-subsidized elder tenants occupying HUD Private Multifamily, Rural Housing, Public Housing Authority and FHFC facilities.
- (c) Specifically target, through service capitation and other approaches, the more frail rent-subsidized elder population living in HUD-sponsored, Rural Housing, Public Housing Authority and FHFC facilities with funding from current service programs, e.g., Community Care for the Elderly and Medi-caid Waiver programs.
- (d) Assess the potential of defining the elder populations occupying HUD-sponsored, Rural Hous-



*Increase the recruitment of volunteers to include high school and college students through community service programs.*

ing, Public Housing Authority and FHFC facilities as a defined insurance group. One benefit is that residents could then be enrolled in state-subsidized managed care programs, and state administered home- and community-based service programs.

- (e) Recommend to Florida's Housing Finance Corporation that certain existing state-funded programs serving older adults (such as the State Apartment Loan Program) offer point incentives in the application process for facilities that offer age-appropriate amenities and tenant programs that facilitate the aging in place of older tenants.
- (f) Florida's Housing Finance Corporation should set aside additional Low Income Housing Tax Credits for elderly-dedicated projects and/or award a higher number of "points" in the application process to developers proposing elder-designated housing projects.



### **III. STRENGTHEN THE LINK BETWEEN THE DEPARTMENT OF ELDER AFFAIRS' SERVICE PROVIDERS AND RENT-SUBSIDIZED FACILITIES**

- (a) Formalize collaborations among organizations to facilitate the assessment of the needs of elder tenants and to provide support services to them.
- (b) Fund, through the Department of Elder Affairs, a program that subsidizes and offers management guidance for the development of facility-on-site primary care and service support clinics directed towards rent-subsidized elder tenant populations. These would be sited either at large HUD-sponsored facilities and public housing sites or at senior centers.
- (c) Develop and fund "innovation zones" within each service and planning area of the Department of Elder Affairs to allow for the design and development of service delivery approaches tailored to the needs of each particular rent-subsidized facility. Allow for funding, service, and administrative flexibility for participating agencies in order to implement their proposed service design.

### **IV. DEVELOP PARTNERSHIPS TO EXPAND SUPPORTIVE SERVICES TO ELDER RESIDENTS IN RENT-SUBSIDIZED FACILITIES**

- (a) Explore the potential for both informal and formal alliances between rent-subsidized facilities and providers to facilitate the purchase and delivery of on-site services for frail elder residents.

(b) Establish a program to link teaching programs focused on the diagnosis and treatment of mental health problems with the administrators of HUD-sponsored, Rural Housing, Public Housing Authority and FHFC facilities.

(c) Encourage service provider agencies to take advantage of the economies of scale presented by large concentrations of elders in rent-assisted facilities by adapting a “clustering” service coordination approach.

(d) Explore the use of Senior Companions in supportive housing by providing additional stipends for those participating in the delivery of services.

(e) Increase the recruitment of volunteers to include high school and college students through community service programs.

(f) Explore strategies to formally involve churches and synagogues in caring for seniors in rent-subsidized housing (e.g., adopt a facility program).

**V. PROVIDE MANAGERS OF RENT-SUBSIDIZED HOUSING WITH THE NECESSARY TOOLS TO MEET THE NEEDS OF LESS INDEPENDENT ELDER TENANTS**

(a) Prepare a comprehensive training resource manual in combination with regional-based training seminars directed to on-site managers, administrators, and sponsors. The manual would:

(i) Help managers better understand the problems confronted by their older tenants

(ii) Improve their ability to access community-based services

(iii) Increase their knowledge of federal, state, and local grant opportunities

(iv) Improve their grantsmanship skills to secure funding to help finance their support services

(b) Educate management on how to detect and respond to the mental health problems of their elder tenants and locate mental health services on-site to provide clinical services.

(c) Organize community service awareness seminars directed to HUD, Rural Housing, Public Housing Authority and FHFC administrators and elderly tenants, where social service agency representatives, hospital discharge planners, health care professionals, insurance counselors, educational and other community leaders describe resources to facilitate aging in place.

(d) Florida’s Housing Finance Corporation must undertake a census of units under its administration to identify the size of its elder tenant population as a first step to conducting a needs assessment of this group.

**VI. INCREASE THE LOBBYING EFFORTS OF HOUSING PROFESSIONALS TO EFFECT CHANGES IN FEDERAL PROGRAMS INFLUENCING THE STATE’S AGING IN PLACE PROGRAMS**

(a) Encourage aggressive lobbying efforts by the Florida Association of Homes for the Aging and its national affiliate, the Ameri-



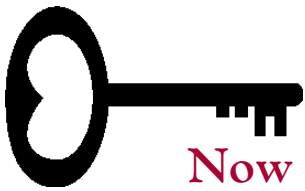
*Cost effective supportive services would also delay premature institutionalization.*

can Association of Homes and Services for the Aging (AASHA), along with other elder advocates to change the funding formula for allocating new Section 202 rental units to the state. The formula has two weaknesses: (1) it does not take into account the relatively high proportion of low income elderly renters in the state; and (2) its measure of housing problems is limited to the presence of poor physical conditions, a bricks and mortar indicator, that fails to assess the supportive housing needs of poor, less independent elders in the state.

- (b) Encourage aggressive lobbying efforts by the Florida Association of Homes for the Aging and its national affiliate, the American Association of Homes and Services for the Aging (AASHA), along with other elder advocates to increase the federal funding of the Service Coordinator Program and to ensure the continuation of existing contracts.
- (c) Change the Internal Revenue Service Code definition such that assisted living facilities (ALFs) legislatively defined by the State of Florida and targeted to primarily higher income functionally or cognitively impaired elders would be eligible for funding under the Low Income Housing Tax Credit Program and thus offer affordable units to low-income elders who are frail.
- (d) Change the Medicare Program reimbursement regulations developed by the Health Care Financing Agency to remove the barriers that discourage home health agencies from co-locating their facilities on the sites of HUD and public housing facilities.

## **VII. CONTINUE RESEARCH TO EXPAND THE KNOWLEDGE AND RESOURCES TO FUND AND PROVIDE SERVICES**

- (a) Evaluate the potential of managed care models to assist housing providers to meet the service needs of their more frail tenants.
- (b) Evaluate the impact of organizational barriers (e.g., the manner in which service provider contracts are awarded and funded) that inhibit the effective delivery of services.
- (c) Assess the strengths and weaknesses of alternative funding approaches to aging in place efforts.
- (d) Assess the desirability and feasibility of introducing standardized service need and functional health assessment procedures into rent-subsidized facilities.
- (e) Assess the social and economic implications of the current turnover rate of elder tenants in rent-subsidized housing facilities and its impact on the supply of low-rent subsidized apartments available to prospective low-income elders in the community.



## Now is the Time to Act

**I**t is fitting to quote from a report jointly produced by HUD and the U.S. Administration on Aging—one of the rare instances of collaboration between these two government entities:

*“Housing and services for the elderly.” This phrase once represented two separate thoughts — one pertaining to specially designated living arrangements for older people and the other to a set of social services designed for this group’s particular needs. Today, this phrase is taking on a new meaning because housing and services can no longer be so easily separated and, in fact, might be considered one and the same. As the number of elderly people in the U.S. population grows, the need for housing linked with supportive services increases as well. Numerous studies confirm that the elderly prefer to remain in their own home and communities for as long as possible...”*

With Florida’s aging demographics leading the rest of the nation, and with an estimated 80,000 elderly tenants in rent-subsidized housing, it is critical to establish service delivery approaches that successfully address the needs of older tenants to age in place. Seniors in rent-assisted housing clearly prefer to remain in their current accommodations as long as possible and delay the prospects of institutionalization. As important, today, housing sponsors and managers who seek to help their elder tenants remain independent as long as possible are experiencing many barriers in their efforts to link them with affordable supportive services. Other managers who currently offer few supportive services are open to the possibilities

of facilitating the aging-in-place of their tenants but are hesitant about doing something very different than their past practices, have serious reservations about getting involved in service delivery issues, or are discouraged by the absence or difficulties of accessing options linking their shelter with needed services.

Cost effective supportive services are crucial in a state whose population will demand ever larger increases in Medicaid spending. Currently, an estimated 30 percent of elderly tenants who leave rent-subsidized housing enter nursing homes. It is estimated that the cost of nursing home care in Florida will grow to more than \$2 billion by the beginning of the next millennium. The choice is to “pay now or pay later” in terms of the public cost of subsidizing long-term care needs for the elderly residents in more costly institutional care versus providing them with prevention and early intervention services to prolong their independence.

To prepare for the demand for services in the decades ahead, we must develop new service delivery approaches that forge new partnerships and innovative service collaboration among the agencies and community groups who serve these citizens. With dwindling resources available for social and human services, priority should be given to funding home- and community-based services that support the independent life-styles of elder tenants. Not considering the elder-occupied rent-subsidized facility as a major service delivery target is a badly missed opportunity.

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## APPENDIX I

### Federal and State Rent-Subsidized Housing and HUD's Supportive Service Programs Operating in Florida

A diverse array of federal and state rent-subsidized housing and supportive service programs now operate in Florida. A brief summary of the relevant programs is offered below.

#### Conventional Public Housing

This is the oldest federal program providing affordable rental units to the elderly. It is operated by state-chartered local Public Housing Authorities (PHAs), each of which usually owns its projects. Since the Housing and Community Development Act of 1992, an official distinction is made between elderly (age 62 and over) and nonelderly disabled persons in the public housing program. Under the program HUD gives grants to PHAs to finance the capital cost of the construction, rehabilitation, or acquisition of facilities. To cover the shortfall between tenant rents and operating expenses, HUD pays operating subsidies to most PHAs.

Eligible families and individuals must have low-incomes (no higher than 80% of the area median income) and rent payments are set at about thirty percent of a participant's adjusted income. Legislation effective on October 1<sup>st</sup>, 1999 will change substantially many of the operating features of this program. In particular, it will permit higher income families to enter rental facilities and will formally eliminate federal admission preferences (suspended through 1997).

Under the National Affordable Housing Act of 1990, Congress established service coordinators as an acceptable cost for operating subsidies. In addition, up to fifteen percent of the cost of providing services to elder tenants in public housing is an allowable operating expense. Services may include meals, housekeeping, transportation and personal assistance services. However, the service coordinator and the supportive services, although an allowable expense, are not mandated and, therefore, not usually available in most public housing programs.

#### Section 8 Rental Voucher and Certificate Programs

These are the federal government's major programs

for providing subsidized rental apartments to very low-income families, the elderly, and the disabled, allowing them to occupy decent, safe and sanitary housing in the private market. Referred to as tenant-based subsidy programs, rental assistance is attached to persons (rather than facilities) who seek affordable privately-owned housing, which can include apartments, townhouses and single-family homes. Section 8 rental vouchers and certificates are administered by local public housing agencies that receive their federal funding through HUD. Eligibility for a rental voucher or certificate is based on both a household's total annual gross income and family size. Eligible families must have low-incomes (no higher than 80% of the area median), but a large majority of families have incomes that do not exceed fifty percent of the median income for the area. Rental units must be within the jurisdiction of a given PHA and meet an acceptable level of health and safety standards before rental payments are approved. Under the Voucher program, the PHA typically pays the landlord the difference between 30% of a tenant's household income and the PHA-determined pay standard which is about 80 to 100 percent of the fair market rent (FMR). The household may choose a unit with a higher rent and pay the landlord the difference or choose a lower cost unit and keep the difference. Under the Certificate program this latter FMR rent-level flexibility is not available. As a result of 1998 legislation (see above), the Certificate and Voucher programs will be merged.

Section 8 housing assistance payment subsidies are also attached to facilities (that is, project-based) that have had previously substandard units upgraded under the Moderate Rehabilitation Program. This program is not currently being funded except in conjunction with single-room occupancy units for the homeless (SROs).

### **Section 221(d)(3) and Section 221(d)(4)**

The Federal Housing Administration (FHA) insures mortgages made by private lending institutions to help finance the construction or substantial rehabilitation of multifamily rental or cooperative housing projects with five or more units. Projects may be designed wholly or partially for low- to moderate-income residents who are elderly (age 62 or older) or have disabilities. The principal difference between the (d)(3) and (d)(4) programs is the amount of insured mortgage available to nonprofit and profit-motivated sponsors. These programs are available as alternatives to the Section 231 program, now largely inactive (only one facility in Florida). Legislation establishing the Section 221(d)(3) program was enacted in 1954; for the Section 221(d)(4) program, 1959. While there are no income limits for these programs, Section 221 insured properties often are linked with Section 8 rental-assistance to make them more affordable to low-income tenants.

### **Section 236**

Enacted in 1968, Section 236 provides monthly subsidies to private sponsors, reducing the interest rate

to as low as 1% on 40-year insured mortgages for new multifamily rental projects wholly or partially occupied by elder tenants, with 10% of the units usually designated for persons with mobility impairments. Section 236 projects can include self-contained apartments, congregate facilities, or a combination of the two. They can also contain dining halls, community rooms, and health care services. To insure that very low-income tenants (at or below 50% of area median income) do not pay more than 30% of their incomes on their rent, Section 236 projects have been eligible for rental assistance payments, which have now mostly converted to Section 8 housing assistance payments. No new subsidy commitments have been made under this program since 1973. The smaller rent revenues of Section 236 projects—even with Section 8 subsidies—severely restrict the operating budgets of these facilities and in turn the resources that can be allocated to staffing and services relevant to the needs of their frail tenants.

### **Section 8 Noninsured Facilities**

This program, originally established by the Housing and Community Development Act of 1974, is managed by HUD's Office of Housing (as opposed to Section 8 Certificates and Vouchers managed by the Office of Public and Indian Housing). HUD contracts directly with and provides rental subsidies to privately-owned apartment housing. These subsidies (for up to 20 to 40 years, depending on financing) are tied to specific property units (project-based assistance) and are paid to private owners/sponsors (profit and nonprofit) on behalf of their eligible tenants. Under the program, very low-income (at or below 50% of area median income) residents in subsidized units generally pay 30 percent of their income for rent and HUD pays the balance. These were designed both to assist tenants with incomes too low to obtain decent rental housing in the private market and to encourage new construction and properties requiring substantial rehabilitation. The program was largely eliminated in 1983 because of its high cost.

### **Section 202, Supportive Housing for the Elderly Program**

Since 1959 this program has persisted as the primary financing vehicle for constructing subsidized rental housing facilities for low-income elderly. Sponsors are private nonprofit organizations, and occupancy is now open to very low-income (under 50% of area's median income) elderly persons aged 62 or older. While now targeted to seniors, its occupants include nonelderly disabled tenants who before 1990 were eligible tenants. Annual housing construction of this program has declined from its earlier highs, even as advocates and experts have recognized its record of sound management, long waiting lists, and its benefits enjoyed by its less independent elder tenants.

The funding mechanisms for this program have changed since its inception. Currently, it provides capital

advances to finance the construction and rehabilitation of buildings that will serve as supportive housing for very low-income elderly persons and it provides rental assistance payments to help make their units affordable. Many, but not all, of the buildings have several congregate common areas (e.g., central dining room, community rooms, library). Along with expanding the supply of affordable housing, this program is designed to allow sponsors to provide supportive services for elderly participants, such as personal care, meals, health services, housekeeping and transportation. These are largely funded, however, by non-HUD or public sources including the housing sponsor, area or state agencies on aging, county or state health departments (Title XIX-Medicaid), county or state welfare departments (Title XX-Community Services Block Grants of the Social Security Act), city, county, state or other third party grants, (e.g. foundations), and/or user fees. A recent HUD Notice offers a description of how facilities under this program can accommodate an even higher level of “assisted housing” supportive services.

### **Section 515 Rural Rental Program**

This program was originally authorized in 1962 to provide rental housing units (and since 1977, congregate housing) for the elderly population living in rural communities with a population of up to 20,000 people and expanded in 1966 to serve all low- and moderate-income families. The Farmers Home Administration—now the Rural Housing Service, Department of Agriculture—offers insured low-interest loans for the construction, purchase, and rehabilitation of rural rental and cooperative housing. Eligible applicants include individuals, trusts, associations, general and limited partnerships, state or local public agencies, profit, and nonprofit corporations. It is often coupled with Section 8 subsidies or the Rural Rental Assistance Program to make its units affordable to very low-income and low-income families and elderly persons.

### **State Administered/Sponsored Rent-Assisted Programs**

A variety of low-rent housing programs are either funded or administered through Florida’s Housing Finance Corporation (FHFC). A major share of units administered by FHFC are funded through the Low Income Housing Tax Credit program (now known as Housing Credit Program), created by the Tax Reform Act of 1986, which provides tax credits to investors who build or rehabilitate rental housing in which at least 20% of the apartments are set aside for low income tenants—elderly or nonelderly. Another large program category includes units funded with tax exempt bonds (Multifamily Revenue Bond program) allowing below market loan interest rates. Other significant production of low-rent multifamily housing are generated by its low-interest mortgage loan program to developers who build or substantially rehabilitate rental properties (State Apartment Incentive Loan—SAIL) and a state-funded revenue

program (State Housing Initiatives Partnership—SHIP) directed to county and city governments that can be used to support both the development and rehabilitation of affordable rental housing. Unfortunately, with the exception of the SAIL program and recently completed projects, the number of elderly tenants in these programs is unavailable.

### **Service Coordinator Program**

This federal program now provides funding for the employment and support of service coordinators in public and assisted housing developments (including Conventional Public Housing, Section 8 subsidized moderate rehabilitation developments, Rural Housing Service— Section 515/8, Section 8 existing project-based, Section 202 and 202/8, 221(d)(3) and 236 developments) designated for the elderly and persons with disabilities.

A service coordinator is a social service staff person hired or contracted by a facility’s owner/management company or by a Public Housing Authority. The coordinator is responsible for assuring that elderly residents, especially those who are frail or at risk of needing institutionalization (along with non-elderly residents with disabilities) are linked to the supportive services they need to continue living independently in that development. The service coordinator, however, may not require any elderly or disabled family to accept the supportive services. Service Coordinator Program grant funds may be used to pay for the salary, fringe benefits, and related administrative costs for employing a service coordinator. Administrative costs may include, but are not limited to, the purchase of furniture, office equipment and supplies, training, quality assurance, travel, and utilities.

To be eligible, a development must have frail or at-risk elderly residents and/or non-elderly residents with disabilities who together total at least 25 percent of the building’s residents (not applicable to expiring fiscal year 1995 Elderly Service Coordinator Grants). Two or more owners and/or PHAs may join together to share a service coordinator and submit joint applications. Importantly, many rent-subsidized facilities not funded under this program may have social coordinators on staff, funded by the facilities’ operating (residual receipts) funds.

### **Congregate Housing Service Program (CHSP)**

This small federally-funded, project-based program (first authorized as a demonstration program in 1978) is designed to help the more frail elderly (age 62 and over) tenants in various federally-supported rent assisted programs age in place in their current accommodations rather than having to relocate prematurely to a long-term care institutional setting. A revised version of the program was authorized under the 1990 Cranston-Gonzalez National Affordable Housing Act and subsequently amended in 1992. The two programs differed in significant ways, most notably in the eligible targeted elderly population, the services provided, and program funding. Eligible programs include the public housing

program, Section 202, Section 8 project-based assistance, Section 221 (d), Section 236, and Section 515 of the Rural Housing Service.

Under the more recent program, HUD and the Rural Housing Service of the U.S. Department of Agriculture (formerly Farmers Home Administration) make 5-year renewable grants to local housing sponsors or Public Housing Authorities to help them fund an on-site service coordinator staff position, meals (at least one daily hot meal per day in a group setting), and nonmedical supportive services, such as transportation, personal assistance, housekeeping, and group and socialization activities. Services are intended for elderly residents with three or more activities of daily living (ADL) impairments (and the nonelderly disabled).

An independent professional assessment committee works with a service coordinator appointed by the grantee to determine individual eligibility for services and to recommend a service package to the housing management. Under CHSP, HUD provides funds of up to 40 percent of the cost of supportive services, grantees pay at least 50 percent of the costs, and program participants pay fees amounting to at least 10 percent of the program costs. Fees may be up to 20 percent of a participant's adjusted income. HUD has neither solicited nor funded applications for new grants under CHSP since 1994. Congress, however, has provided funds to extend expiring grants of both the older and new programs (just over 100 facilities).

## APPENDIX II

### Goals and Methods of the CASERA Project

#### MAJOR RESEARCH QUESTIONS

- How large is the physically and mentally vulnerable older (age 62 and over) population living in Florida's rent-subsidized housing?
- To what extent are these older tenants having trouble living independently because of physical or mental impairments?
- To what extent are public housing authorities, privately-owned multifamily subsidized housing facility administrators, service coordinators, and service providers helping tenants deal with their frailties?
- What are the unmet needs of these older tenants?
- Are there housing facilities exemplary in their ability to link frail tenants with supportive services?
- What programmatic strategies would improve the ability of older tenants to deal with their vulnerabilities without having to move?

#### RESEARCH APPROACHES

- Compile a database of all government-subsidized rental housing in Florida describing their demographics and housing features

- Assess the unequal availability of rent-assisted housing in counties throughout Florida
- Conduct mail survey of a sample of directors of public housing authorities and a sample of on-site housing administrators of privately-owned multifamily subsidized rental projects
- Conduct a mail survey of a sample of service coordinators found in privately-owned multifamily subsidized and public housing rental projects
- Conduct a mail survey of a sample of elderly tenants in privately-owned multifamily subsidized rental projects
- Identify exemplary projects that successfully link services with shelter
- Host a meeting of key housing providers, service providers, and agency heads to reach consensus as to a set of human service and housing strategies to address the support service needs of older tenants

#### PRODUCTS

- A comprehensive assessment of the unmet needs of the less independent elder tenants living in rent-assisted housing and the current responses by housing sponsors and managers
- A prototype plan detailing the components and implementation strategies of a supportive housing service program that can respond to the needs of frail elderly tenants in Florida's rent-subsidized housing projects

#### DATA SOURCES

##### Databases Describing Florida's Subsidized Housing and County Locations

To compile a database of all government-subsidized rental housing in Florida describing their demographics and housing features and their associated county characteristics, several primary data sets were used. These included:

- U.S. Department of Housing and Urban Development Multifamily Tenant Characteristics Support System—Office of Public Housing, Jacksonville HUD Office
- Low Income Public Housing Projects Inventory—Office of Public Housing, Jacksonville HUD Office
- Privately-Owned Subsidized Housing Projects in Florida database—Multifamily Housing Division, Jacksonville HUD Office
- 1997 Picture of Subsidized Households—U.S. Department of Housing and Urban Development, Office of Policy Development and Research, Washington (<http://www.huduser.org/data/picture.html>)
- 1990 Census of Population and Housing, Special Tabulation (STP) 14, Special Tabulation on Aging on CD-ROM
- United States Department of Agriculture, Rural Development, Multifamily Housing Management/Project Identification database based on Farmers

Gainesville office

- Florida Housing Finance Corporation Combined Programs Compliance Project Information Summary database—Tallahassee office

### **Mail Surveys of Administrators, Service Coordinators, and Elder Tenants of Rent-Assisted Facilities in Florida**

Each of the survey instruments was designed to assess the needs of older tenants in Florida's rent-subsidized housing and the challenges confronted by management and staff attempting to serve this group. While all surveys shared some common questions (assessments of elder tenant frailty), each was specifically designed to elicit answers from the targeted group. The mail surveys were administered to the following four groups.

#### On-Site Administrators of HUD Privately-Owned Multifamily Subsidized Rental Facilities

A representative sample of 205 HUD facilities funded under four different federal programs (Section 221, Section 202 (including 202/236), Section 8 noninsured, and Section 236) completed a 14-page mail survey. This sample represented about 46% of the 450 HUD facilities in Florida defined as the statistical population for the survey. On about 15 different social, economic, and demographic indicators, the interviewed sample and the statistical population displayed no significant differences.

#### Directors of Public Housing Authorities

A representative sample of 39 Public Housing Authority directors completed a 12-page mail survey. This sample represented 49% of the 80 Public Housing Authorities with at least one elder tenant in their public housing developments.

#### Service Coordinators

A sample of 33 service coordinators completed a 12-page mail survey. This sample represented 45% of the known service coordinators working at either HUD or public housing facilities throughout Florida.

#### Elder Tenants

A sample of 573 elder tenants (out of a possible 1,400 seniors) living in eight different HUD Privately-Owned Multifamily subsidized facilities throughout Florida were asked to complete a 14-page survey instrument. This sample occupied five Section 202 buildings, two Section 236 buildings, and one Section 221 (d) 4 building. Interview response rate was 41%. Researchers had service coordinators, on-site managers, or elder members of facility tenant association distribute the surveys to the elder residents in each facility. Same person collected surveys and mailed them back to CASERA PROJECT headquarters. Results are biased because they are over-representing the status and needs of the more active and well elder tenants.

### **Telephone Survey of State Government and Lead Service Agencies**

Just under 100 telephone surveys were conducted with specified staff from all of Florida's state agencies and the directors of all the state's leading aging services organizations who were likely to have policy or programmatic impact on supportive services available to elder rent-assisted housing population. Surveys elicited information about any state-based programs that were linking services up with the managements and elder tenants of rent-subsidized facilities in Florida. More generally, it sought information about the informal and formal relationships that existed among government agencies in Florida involving shelter-service links impacting rent-assisted housing facilities.

### **Site Visits**

Site visits were conducted at ten different rent-subsidized facilities throughout Florida that were identified by various professionals as doing a better than average job in linking their elder tenants with supportive services. The CASERA Project Director or senior staff taped open-ended interviews with on-site administrators, toured the facility, and photographed site.

### **Literature Review**

Studies and reports from throughout the United States were reviewed for their insights on linking services up with tenants in rent-subsidized housing.

### **Focus Groups**

Approximately 100 housing, service, and health care providers and administrators knowledgeable about Florida's housing, health, and social programs were invited (an average of 50 per day) to all-day "information gathering and decision-making" sessions. The purpose was to seek consensus as to what would constitute an economically, administratively, and politically feasible set of state-based housing support and human service strategies to address the aging-in-place needs of older tenants.

The responses of these groups were solicited through the application of the Nominal Group Technique (NGT), a problem-solving and idea gathering strategy appropriate for small groups of decision-makers. This approach was used to elicit majority beliefs regarding how best to address the service needs of elderly tenants in Florida's rent-subsidized housing.

NGT sessions were conducted over a two-day period. Each day, approximately four groups of 7-9 participants were asked privately to consider several sets of issues related to the provision of services for frail elderly tenants. For each issue, positions of participants were publicly recorded in group session. Discussion followed on grouping and on synthesis. The group decision was the mathematically pooled outcome of the votes of all participants.

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