Indian Women & Elder Abuse

Mashkawaziiziibiikwe
Eileen Hudon
Anishinabe -- White Earth
Crane Clan

Respect of Native Women

Respect her ability to govern her own life & her personal authority to make decisions regarding all aspects of her life.

Respect the control and use of her own resources.

Respect her distinct identity, history & culture.

Respect her life history, including the impact of colonization, racism & sexism.

Respect and support her Healing Journey.

"Taking the message into the community."

Minimal Services

Racism

Multiple Victimization

Jurisdictional Maze

Dehumanized

Relocation

Boarding School

Colonization

Papal Bulls

Cultural Genocide

"1 in 3"

Community Silence

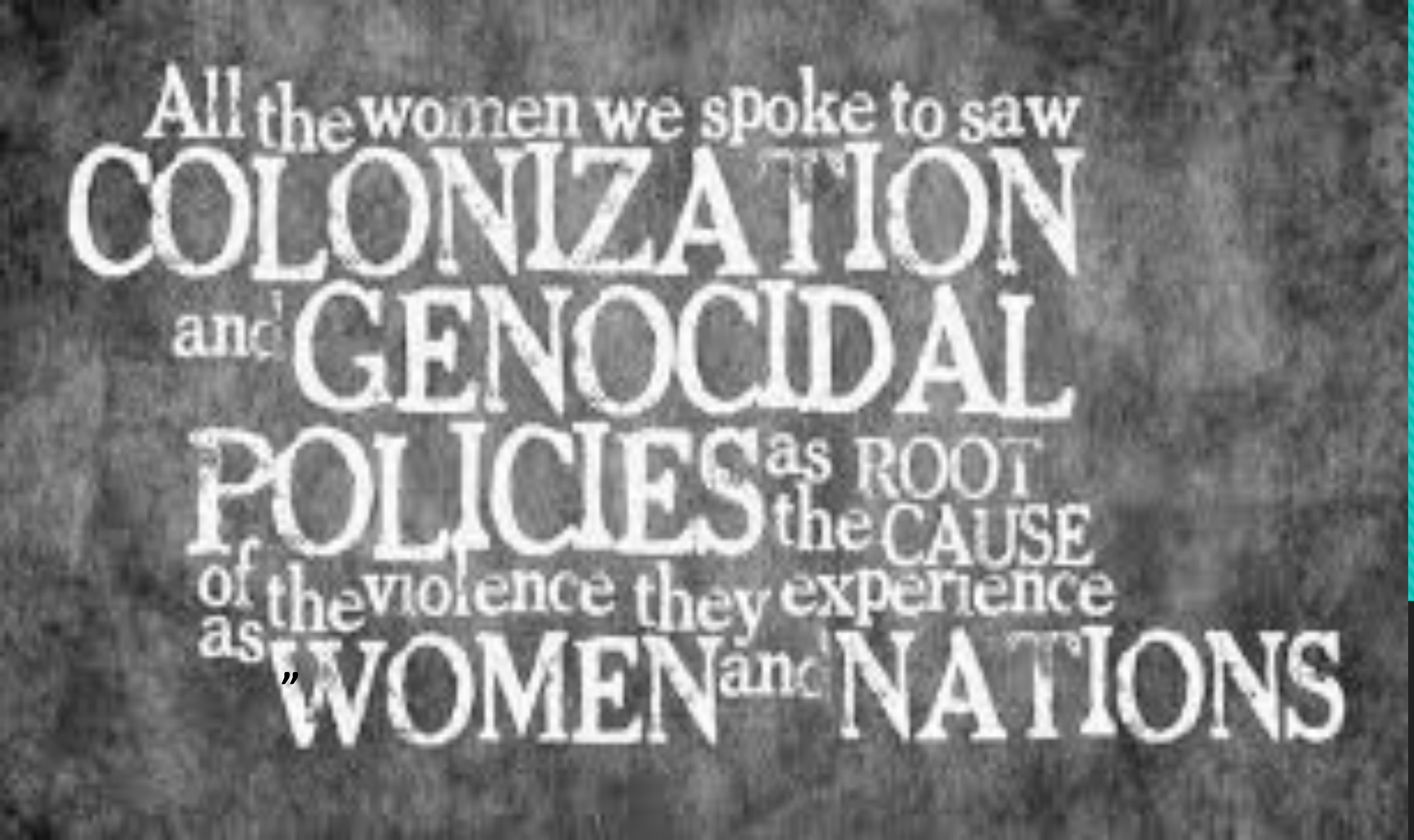
Indian Women

Right Now She is So Demeaned:

- She has lost herself
- She doesn't know the resources
- She can't access them: No phone/Limited Phone Time
- She is helping her children
- She is healing from past abuse: Full time Job
- She holds stereotypes about herself/others
- Medical Needs are a priority - What do I proceed with first?
- Dismissed: not believed by a series of people

Who is she?

- I don't know if I can believe her.
- She isn't telling me the whole truth.
- How did she get to be like this?


All the women we spoke to saw
COLONIZATION
and GENOCIDAL
POLICIES as ROOT
the CAUSE
of the violence they experience
as "WOMEN and NATIONS

In studies of sexual victimization among American Indian women, rates have ranged from 12% to 49%. These high rates are part of the legacy of racism and oppression perpetrated against American Indians, and the loss of traditional family and cultural practices through forced institutional childrearing in boarding schools and other attacks on native culture (e.g., Duran et al., 1998; Hamby, 2000).

Colonization

Colonization

Sexual victimization itself is a part of the terrible history of oppression, violence, and maltreatment that American Indians have experienced at the hands of the United States government and its citizens (Smith, 1999).

Centuries of oppression by the United States government have left many lasting problems (Duran,, Duran, Woodis, & Woodis, 1998; Duran, Guillory, & Tingley, 1993).

Indian Boarding Schools

1819 Indian Civilization Act

The root of sexual & domestic violence experienced by Native Women

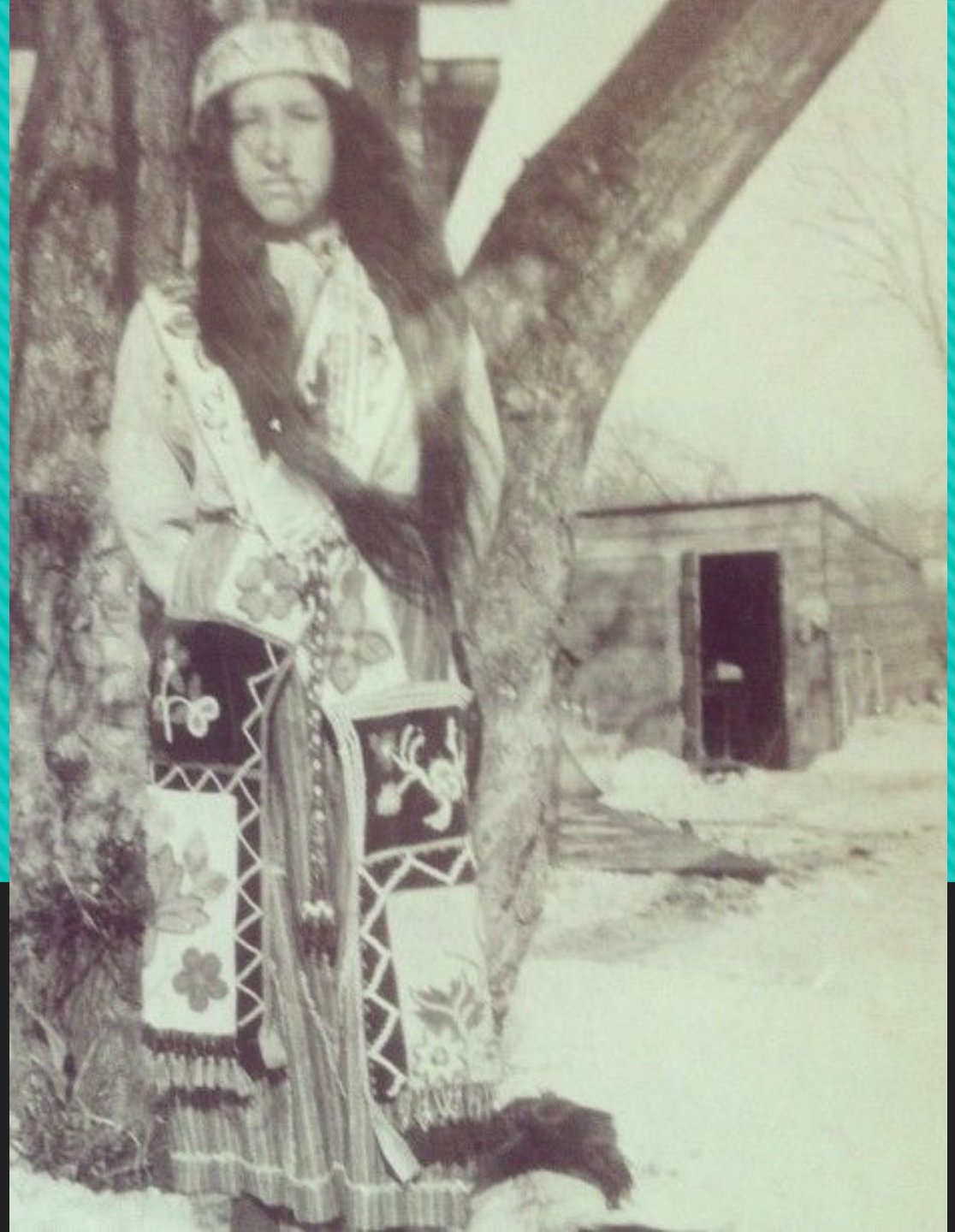
Secondary Victimization

Every man, woman, and child in the community is either a survivor of sexual violence, a 'secondary' victim of sexual violence, or someone afflicted by generational trauma.

The deep silence about sexual violence is embedded in a complex set of circumstances originating in a Tribes history of colonization.

Multiple Victimization

Native women's experience of sexual violence is not clearly reflected in statistics. The numerous times a Native woman is subjected to sexual violence throughout her lifetime is invisible to society and it's institutions. Very rarely is anyone prosecuted.



Historical Trauma

From the times of earliest exploration and colonization, Native women have been viewed as legitimate and deserving targets for sexual violence and sexual exploitation.

In the mid-1500s, the secretary of Spanish explorer Hernando de Soto wrote in his journal that De Soto and his men captured Appalachian women in Florida "for their foul use and lewdness.

Historical Trauma

"Ojibwe are taught that all spirits have a dual nature. For humans, this means that all that brings us happiness and success can also bring pain and suffering. Therefore we make a point to acknowledge this dichotomy in our spirituality. For me, the ruins of the Sister School (boarding school)are the breeding ground for the negative spirit that infused my family's lives like a terrible presence that we could never discuss let alone acknowledge."

Mary Annette Pember, Bad River

"We Have to Know It to Heal It: Defining and Dealing With Historical Trauma"

Historical Trauma

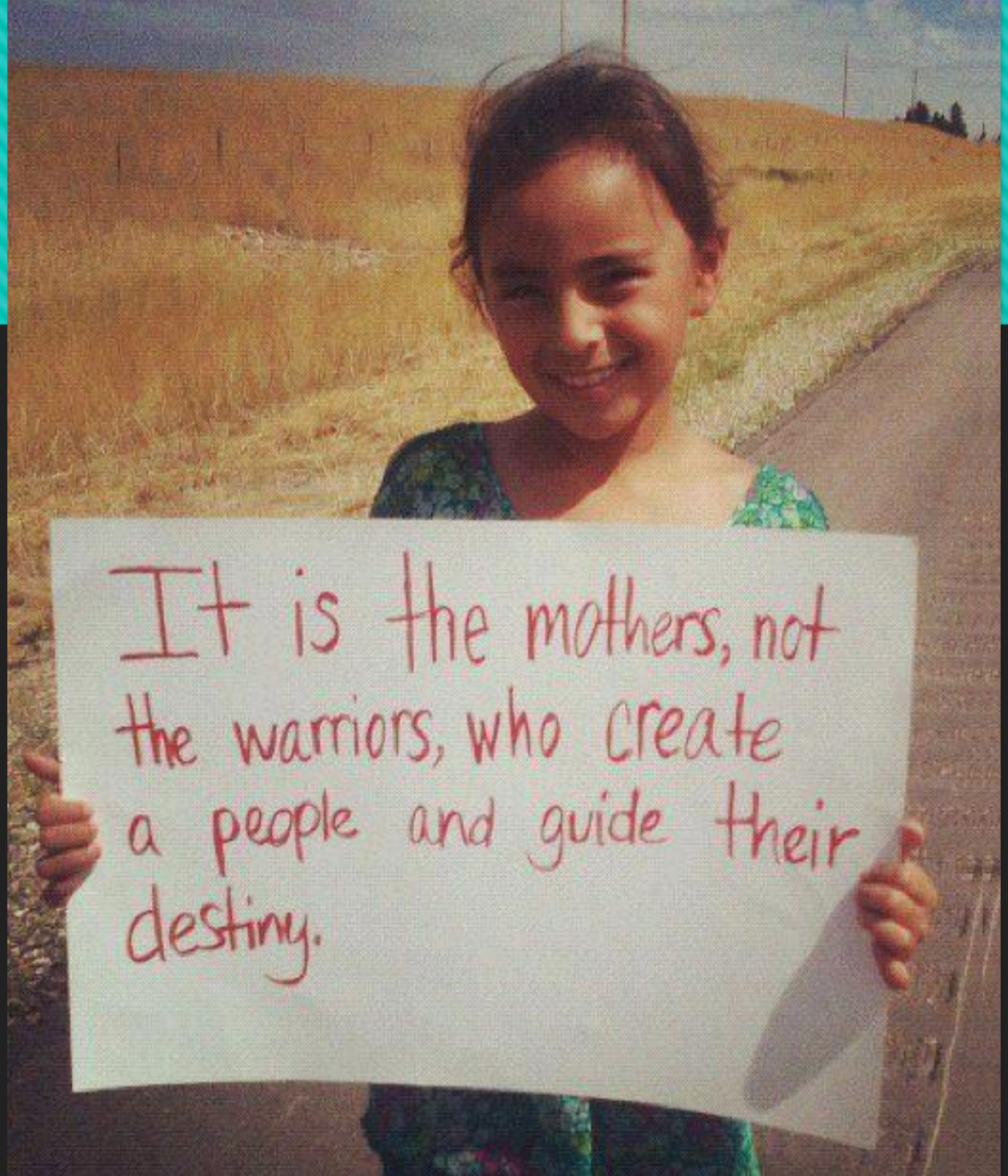
Cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma.

~ Dr. Maria YellowHorse-BraveHeart

Violence Against Women

American Indian and Alaska Native women suffer a higher rate of rape and sexual assault than any other group of people in the United States. (USDOJ, BJS 1999)

34.1% of American/Alaska Native women will be raped sometime during their life. (CDC&DOJ,NVWS 2000)



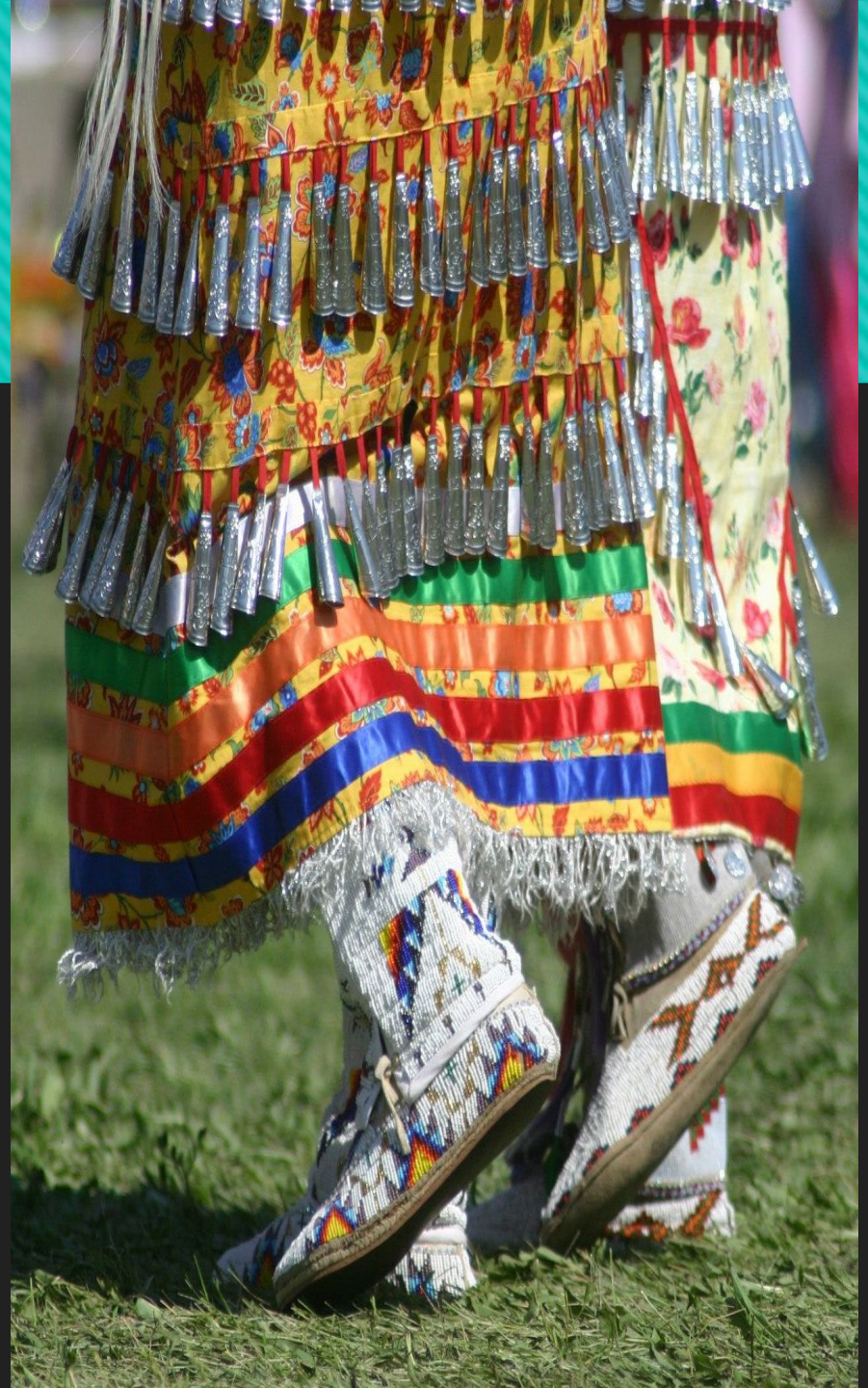
1 in 3 Native women will be raped in their lifetime.

70% of sexual assaults will NEVER be reported....

"Garden of Truth:
Prostitution & Trafficking of Native Women"

Native women are at exceptionally high risk
for poverty, homelessness, and sexual violence –

problems that are also relevant
antecedents in the prostitution and trafficking of women.

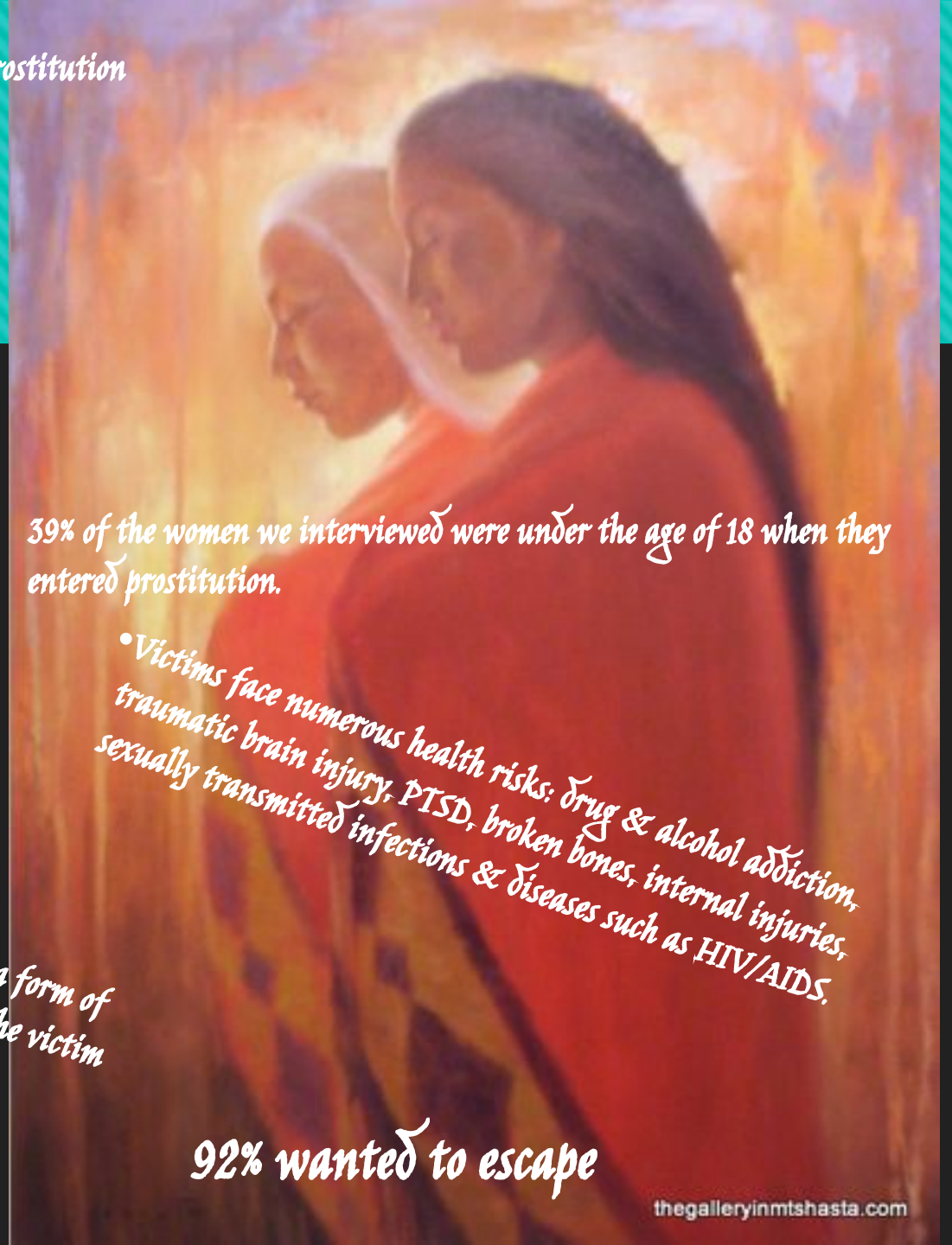


57% had family members used in prostitution

Sex traffickers use a variety of methods to "condition" their victims:

- Starvation, confinement, beatings, physical abuse, rape, gang rape,
  Threats of violence to the victims and their families, forced drug use or threat to shame them by telling family of their activities.

- Victims may also suffer from traumatic bonding - a form of coercive control in which the perpetrator instills in the victim fear as well as gratitude for being allowed to live.



39% of the women we interviewed were under the age of 18 when they entered prostitution.

- Victims face numerous health risks: drug & alcohol addiction, traumatic brain injury, PTSD, broken bones, internal injuries, sexually transmitted infections & diseases such as HIV/AIDS.

92% wanted to escape

"Garden of Truth: Prostitution and Trafficking of Native Women"

79% of the women we interviewed
had been sexually abused as children,
by an average of 4 perpetrators.

Colonization & Sexual Violence of Native Women

1. Uses violence without any consequences
2. Controls the oppressed groups by splitting them into good (collaborators) and bad (resistors)
3. Promotes belief in the superiority of the oppressors
4. Make the oppressed into inferior objects
5. Teaches submission to the oppressed

Prostitution & Violence

- 92% had been raped
- 84% had been physically assaulted in prostitution.
- 72% suffered traumatic brain injuries in prostitution.

- 48% had been used by more than 200 sex buyers
- 16% had been used by at least 900 sex buyers
- 42% of the pimps were gang-affiliated

- 78% had been threatened with a gun, knife or other weapon within the past month

"The Garden of Truth: The Prostitution and Trafficking of Native Women"

Trauma

Depression	78%
Anxiety Disorders	71%
Bi-Polar Disorder	33%

RACISM

Forty-two percent of the prostituted women who were interviewed had been racially insulted by sex clients and/or pimps.

The racist verbal abuse (using words like "savage" or "squaw") was linked to sexist verbal abuse (such as "whore" or "slut").

Racism & Sexism

"Hatred of the women's skin color was reflected in comments such as "Why don't you go back to the rez? Go wash the brown off you." Other racist remarks by johns were homicidal–for example, "I thought we killed all of you."

Safety

48% had been used by more than 200 sex buyers

16% had been used by at least 900 sex buyers

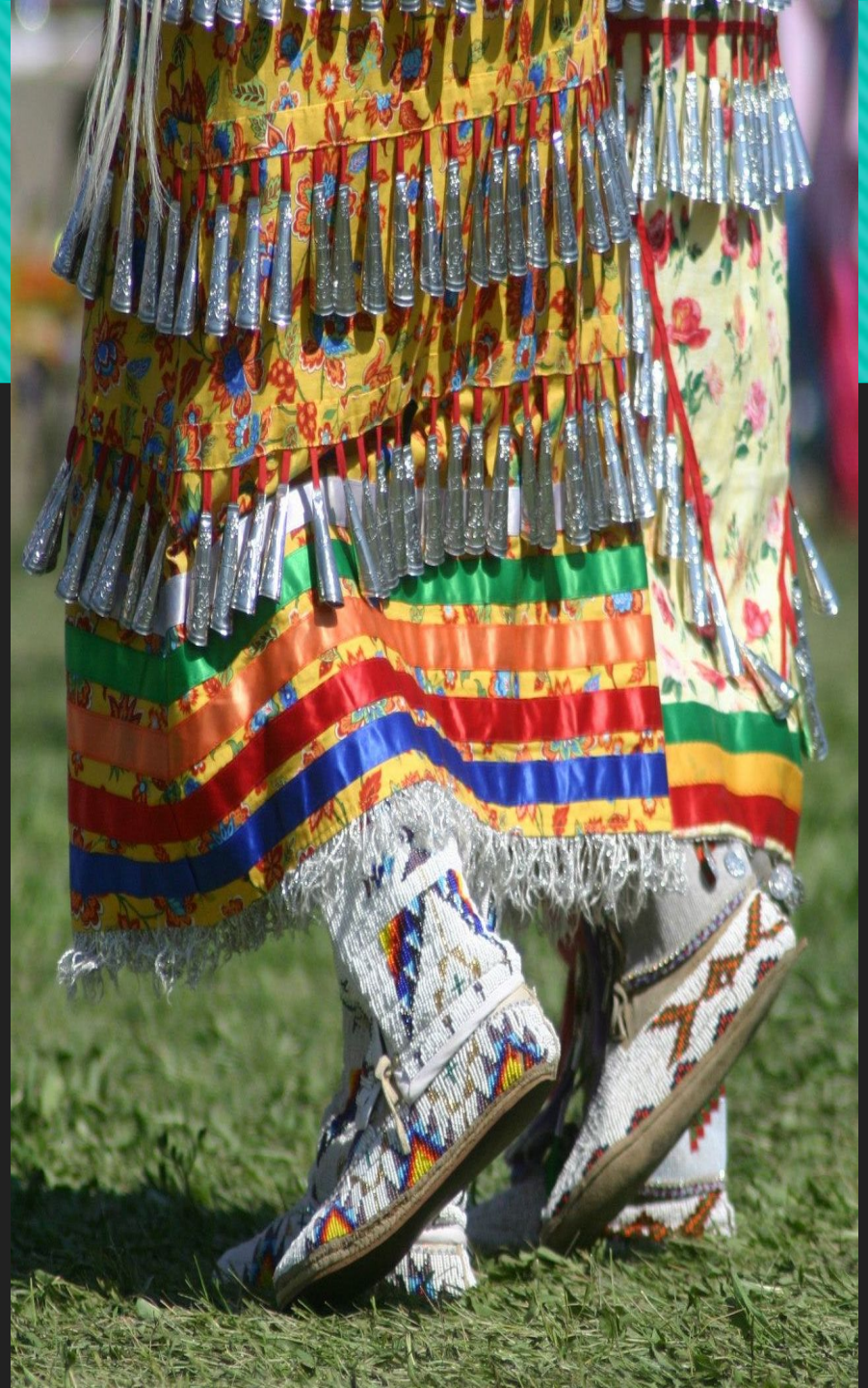
49% reported giving most of their money from prostitution to pimps

42% of the pimps were gang-affiliated

"Garden of Truth: Prostitution & Trafficking of Native Women"

Native women are at exceptionally high risk for poverty, homelessness,
and sexual violence –

problems that are also relevant antecedents in the prostitution and trafficking of women.



Colonization

..... among the Cherokee, a traditionally matriarchal society, the British decreased the power of women by "educating" Cherokee males in European ways, encouraging marriage to non-Native women, and privileging mixed-blood male offspring in nation-to-nation negotiations. During the 1970s, the Indian Health Service (IHS) oversaw the nonconsensual sterilization of approximately 40% of Native women of childbearing age. More recently, Native women's anecdotal reports indicate that Medicare has denied funding for the removal of Norplant contraceptive devices, despite their high risk for deleterious side effects in women with diabetes. The cumulative effects of these injustices have been characterized as a "soul wound" among Native peoples[5] and constitute considerable "historical trauma."

Reconceptualizing Native Women's Health: An "Indigenist" Stress-Coping Model

Karina L. Walters, PhD, MSW and Jane M. Simoni, PhD

Involuntary Sterilization

- Between 1970 and 1976, the IHS sterilized between 25 and 50 percent of Native women in various areas of the U.S.
- IHS records estimated that by 1975, 25,000 American Indian women had been sterilized by this unit of the federal government.
- Sterilization abuse destroyed these Native women's sacred roles as life-bringers.

..... because these women and youths can be disposed of and not missed, people with ill intent view those engaged in the sex trade as castaways without a footprint.


Role of Grandmother's
Women's Power
Women's Leadership
Women's Initiative
Women's Autonomy

AFTER OVER 500 YEARS OF

MASSACRES
EXILE
RESERVATIONS
BROKEN TREATIES
BOARDING SCHOOLS
SMALLPOX BLANKETS
POISONED RATIONS
RELIGIOUS PERSECUTION
ALCOHOL
PRISON
HAZARDOUS WASTE

WE ARE STILL HERE

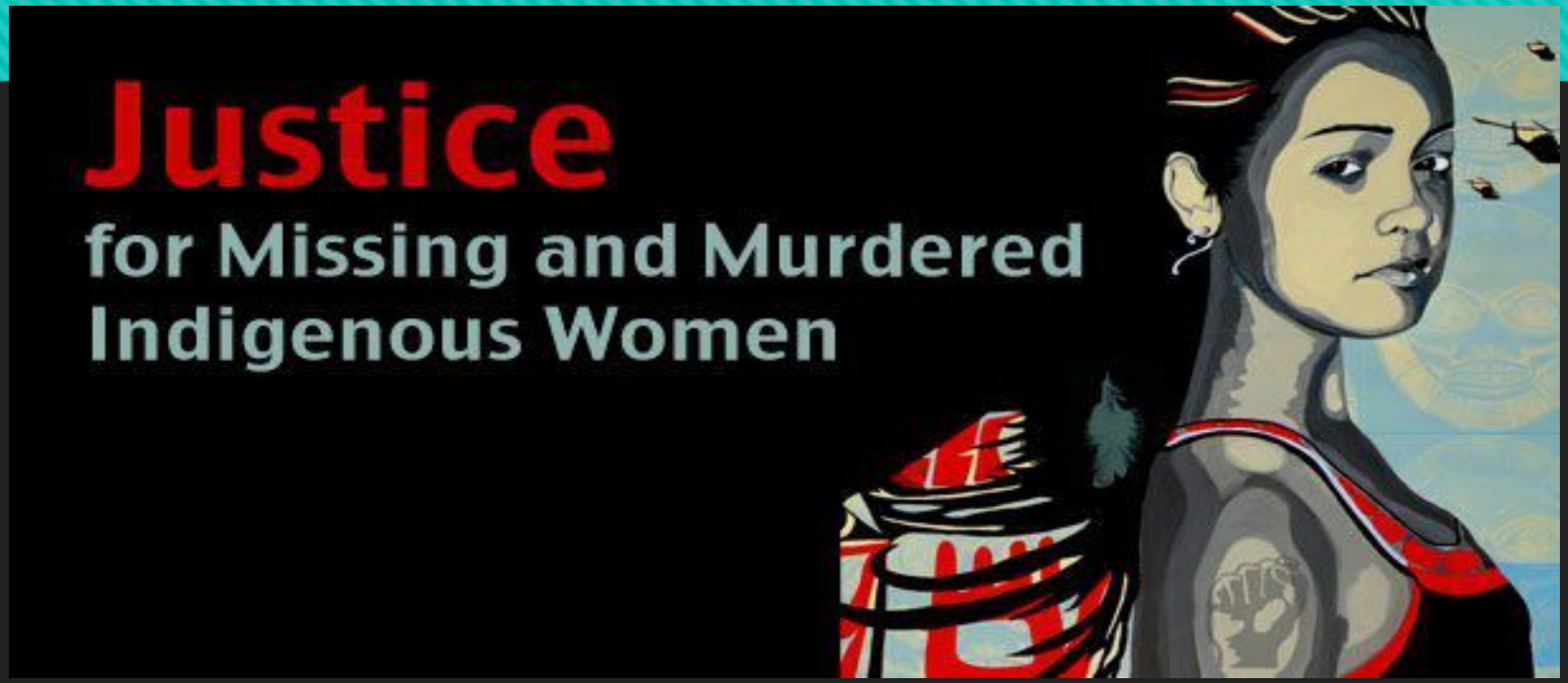
Cultural Respect

Spirituality

Resilienc
y

Traditional Law

Healing
ways


Justice
for Missing and Murdered
Indigenous Women

Native Victims of Sexual Violence use:

outpatient substance abuse programs

homeless shelters

domestic violence services, etc.

Yet, they remain invisible.


NEVER FORGOTTEN


Armed with
No MORE
Than A drum
and A Song

Our Songs and Ceremonies Heal

Healing

It is important to realize that tribal membership offers resources that may help some American Indian women who have been sexually victimized. Many American Indian women have access to both Western and native healers (Kim & Kwok, 1998).

Many American Indians also have culturally specific spiritual practices that can help with their healing (Senturia, Sullivan, Cixke, & Shiu - Thorton, 2000).

land
life
language
culture
ceremony
governance
treaty
justice
equality
freedom
decolonization.

Eileen Hudon 763.250.8498

Title VI of the Older Americans Act

Overview of ACL Tribal Programs

ACL's Mission

Maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

The Older American's Act

- Title I — Objectives
- Title II — Administration on Aging
- Title III — Grants for State & Community Programs
- Title IV – Training, Research and Discretionary
- Title V – Senior Community Service Employment
- Title VI – Grants for Native Americans
- Title VII – Elder Rights Protection

ACL's Title VI Programs

Native American Nutrition & Supportive Services

Native American Caregiver Support Services

Title VI Eligibility

- **Part A – Nutrition & Supportive Services Program**
  - Federally recognized tribe; and
  - Represent at least 50 individuals who are 60 years of age or older; and
  - Demonstrate the ability to deliver supportive services, including nutritional services.
- **Part C – Native American Caregiver Support Program**
  - Have an approved Part A or Part B application.

Part A/B Services

Required Services:

- Nutrition services (congregate and home delivered meals).
- Supportive Services (information and assistance).

Part A/B Optional Services

- Outreach
- Case Management
- Transportation
- Legal Assistance
- Homemaker Services
- Personal Care/Home Health Aide
- Chore Services
- Visiting
- Telephoning
- Ombudsman Services
- Health Promotion Activities
- Snow Removal
- Wood Chopping

Part C Eligibility

- Services for the following types of unpaid caregivers:

√ family caregiver for a frail older individual (age 60+) or to an individual of any age with Alzheimer's disease or a related disorder

√ Grandparent or other non-parent relative 55+ who is caring for a child who is under 18

√ Relative 55+, including a parent, who is caring for an adult 18+ to 59 with a disability

Part C Services

Required Services:

- Information to caregivers about available services
- Assistance to caregivers in gaining access to the services
- Individual counseling, organization of support groups, and caregiver training to assist the caregivers in the areas of health, nutrition, and financial literacy, and in making decisions and solving problems relating to their caregiving roles
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- Supplemental services, on a limited basis, to complement the care provided by caregivers

Please note, this services must be provided to tribal elders, but do not have to be provided by the Title VI program.

Services Title VI Provided in FY20 (nationally)

- Home delivered meals – 3,197,860 meals
- Information and assistance – 151,717 contacts
- Transportation services - 108,340 trips
- Respite services – 72,103 hours

Amounts Awarded in the FY22 Title VI Grants

Part A

FY2022 Part A Amt:			32,928,396
Category	# Pop		2022
0	missing	0	
1	50	100	78,890
2	101	200	89,520
3	201	300	101,660
4	301	400	114,550
5	401	500	126,700
6	501	1500	146,760
7	1501+		192,710
8	Largest		194,556

Part C

FY2022 Part C Amt:			11,126,381
Category	# Pop		2022
0	missing	0	
1	50	100	18,580
2	101	200	27,880
3	201	300	37,170
4	301	400	46,470
5	401	500	55,780
6	501	1500	65,060
7	1501+		74,360
8	Largest		75,951

What can Title VI grants be spent on?

Here are some common things Title VI money is spent on:

Transportation costs (including vehicles)

Congregate and Home-delivered meal costs (including kitchen equipment).

A full list of allowable costs is available here.

Reality

- Tribally determined
- From meals to LTSS
- Every program is different because tribes develop their own
- Keep seniors in their homes and communities as long as possible
- Medicaid billing for expansion

OAA Regulations

- We are working on rewriting the Older American's Act regulations (Title III, Title VI and Title VII).
- Currently, we are seeking feedback on changes we should consider through a Request for Information (RFI).

OAA Regulations Cont.

Published date: May 6, 2022

Access the RFI at: https://www.federalregister.gov/documents/2022/05/06/2022-09713/request-for-information-older-americans-act-regulations

Submit feedback to: OAAregulations@acl.hhs.gov **by 11:59 EST on Monday, June 6, 2022**

Who can I contact with questions?

ACL Regional Administrators			
Region (State)	**Regional Administrator**	**Email**	**Phone**
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5 (MI, MN, WI)	Amy Wiatr-Rodriguez	amy.wiatr-rodriguez@acl.hhs.gov	(312) 938-9858
6 (LA, NM, OK, TX)	Derek Lee	derek.lee@acl.hhs.gov	(214) 767-1865
7 (IA, KS, NE)	Lacey Boven	lacey.boven@acl.hhs.gov	(816) 702-4180
8 (CO, MT, ND, SD, UT, WY)	Percy Devine	percy.devine@acl.hhs.gov	(303) 844-7815
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Questions????

Administration for Community Living

CSH 30 Years of Supportive Housing Solutions

Healthy Aging in Supportive Housing

Toolkit for service providers, developers, and property managers

December 2021

Table of Contents

This toolkit was made possible through the generous support of The Harry and Jeanette Weinberg Foundation and JP Morgan Chase.

The Harry and Jeanette Weinberg Foundation

JPMorgan Chase & Co.

Updated December, 2021

Introduction: A Changing Tide

What is often referred to as the "invisible population," (older adults1 age 50 and above who are experiencing or who formerly experienced homelessness), can no longer be overlooked. The population has grown significantly — nearly half of all single homeless adults are over age 50. The median age of homelessness has risen steadily[2] and the trend shows no signs of reversing.

Projections indicate that the number of older adults will in fact double by 2050.[3] Many people living on the streets are aging and those who have experienced chronic homelessness have been prioritized for housing over the past decade. Further, older adults currently in stable housing are at greater risk of homelessness than ever before.[4]

This population has a unique set of needs that distinguishes it from both the homeless and the general older populations. Aging adults who have experienced homelessness also experience chronic illnesses and geriatric conditions 15-20 years earlier than the general population. They are also more vulnerable when living unsheltered: subject to isolation, rapidly deteriorating health, and premature mortality.[5]

The average life expectancy for an older adult who has experienced homelessness is 64 years versus 80 years for those who have not.

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[1] Note: we are defining "older adults" as individuals who are age 50 and above who have experienced homelessness. Due to their unique characteristics, this population experiences premature geriatric conditions and complex health and mobility issues that are more reflective of people in the general population who are 65 and older.

[2] 2020 Annual Homeless Assessment Report to Congress

[3] CSH, *Home to Stay: Creating Quality Supportive Housing for Aging Tenants.*

[4] Goldberg, J., Lang, K., and Barrington, V. Justice in Aging, Special Report (2016). How to Prevent and End Homelessness Among Older Adults.

[5] The average life expectancy of single homeless adults is 64 for males and 69 for females.

Supportive housing — a proven intervention for meeting the unique and complex needs of formerly homeless individuals — is also experiencing a "graying" tenant population that calls for changes to the way that quality supportive housing is delivered. More older adult tenants now than ever before are living in supportive housing developments.

About 40% of such tenants are now over age 50; tenants housed years ago have aged in place, and newly housed tenants come from a formerly homeless population that has aged.

It is no surprise given this changing tide that affordable and supportive housing developers and service programs across the nation are responding by designing and developing more projects and programs that specifically target aging adults.[6]

Supportive housing providers are finding that they must view quality housing through an aging lens and deliver solutions that meet these unique needs.

It is time to devote attention to solutions that meet the housing, health, and social support needs of older adults to achieve healthy aging.

This toolkit provides key insights, resources, and lessons learned that will equip supportive housing stakeholders to develop the solutions that work for their communities.

It focuses on three populations of older adults that can be served effectively in supportive housing:

1. Older adults (age 50 and older) who have experienced homelessness andhave recently secured housing
2. Older adults who have been living in supportive housing for several years and are aging in place
3. Older adults living in institutional care who could live more independentlyin supportive housing

This toolkit is for those who want to develop housing solutions for older adults by creating, enhancing, and delivering quality supportive housing.

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[6] Supportive and affordable housing pipelines in New York, Massachusetts, Ohio, and California (just to name a few) show many new senior housing projects in development.

This guide will be especially useful for:

- Supportive housing developers who would like to rehabilitate or build new housing projects that effectively meet the needs of older adult tenants
- Property managers who would like to modify or enhance existing or new housing facilities and/or units to effectively meet the needs of older adult tenants and toplan for future modifications or enhancements as tenant needs change
- Service providers who would like to better meet the complex health and housing stability needs of aging and older tenants in supportive housing
- Policy makers who would like to develop upstream solutions to meet the needs of this population

The Unique and Changing Needs of Older Adults

People age 50 and older who have experienced homelessness have unique care needs that distinguish them from both younger people who have experienced homelessness and from individuals in the general aging population.

Older adults living on the streets experience deteriorating health at much faster rates than younger adults living in the same conditions, as they struggle to manage a number of complex and co-occurring chronic, physical, and behavioral health challenges, as well as early-onset geriatric conditions.

Due to poor living conditions and diet, lack of access to preventative health care, and serious physical and mental health issues, individuals experiencing homelessness have mortality rates three to four times that of the general population.[7]

Older homeless individuals experience these same issues as well as alcohol-related illness, frailty, and cognitive impairments at higher rates and are four times more likely to have one or more chronic illnesses.[8]

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[7] CSH, *Home to Stay: Creating Quality Supportive Housing for Aging Tenants.*

[8] Brown, Rebecca T, Dan K Kiely, Monica Bharel, and Susan L Mitchell. "Geriatric Syndromes in Older Homeless Adults." *Journal of General Internal Medicine* 27, no. 1 (January 2012): 16–22. https://doi.org/10.1007/s11606-011-1848-9. Also according to Brown, over 50% of homeless seniors have two or more chronic illnesses.

In comparison to the general population of older adults who are housed, those who previously experienced homelessness have higher rates of geriatric syndromes at a much younger age, whether they are newly housed or have aged in place. These syndromes can include functional, cognitive, and sensory impairment; frailty; susceptibility to falling; incontinence; and difficulty with with activities of daily living.[9]

Due to chronic stress from living on the streets, older adults experience unique behavioral and mental health challenges, physical disabilities, and substance use challenges that can be exacerbated by premature geriatric conditions as they age.

Behavioral Health Needs

Many tenants in supportive housing have long histories of substance use challenges, particularly alcohol use. Older adults who access emergency departments are diagnosed with alcohol dependence more frequently than their younger counterparts.[10] Though supportive housing provides an effective platform for recovery, it must be enriched with the right service interventions to address long histories of substance use and additional health challenges.

Older adults in supportive housing experience age-related cognitive decline at much younger ages than the general population, which often results in conditions like Alzheimer's disease, dementia, and memory loss — all of which have behavioral manifestations. These conditions may require new, intensive service interventions and unit enhancements or modifications with which supportive housing providers may have little or no experience.

Cognitive decline may create additional barriers to services and housing stability that tenants once accessed with less support. These include health systems navigation, locating and attending appointments, remembering to pay bills, following medical advice, and conducting activities of daily living. Cognitive impairments may lead to mental health challenges and isolation as ways to cope with these significant life changes.

Health Care Access

Although many are eligible for health insurance benefits like Medicare and Medicaid, often older adults have difficulty accessing these benefits and may seek care in emergency departments to treat the many health conditions they experience as a result of life on the streets.

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[9] Ibid.

[10] National Health Care for the Homeless Council. "Aging and Housing Instability: Homelessness among Older and Elderly Adults." In Focus: A Quarterly Research Review of the National HCH Council 2, no. 1 (September 2013): 1–5.

Over half of older unstably housed adults use emergency departments and access these services four times more frequently than their younger counterparts.[11]

Moreover, older adults experiencing homelessness tend to postpone seeking treatment for their complex health conditions until they reach crisis levels. As these individuals transition to supportive housing, they may still engage in familiar behaviors, particularly if they do not receive enough intensive support to secure benefits and access to care. There is a need for transition supports and frequent engagement for tenants newly entering supportive housing, and close assessment and monitoring of new health issues and benefits eligibility for those aging in place.

The Need for a Continuum of Coordinated and Specialized Services

Older adults have some specific needs that are best met through coordinating a variety of services, including specialized services. Meeting these unique needs includes providing quality services that are tenant-centered, accessible, and coordinated. Service programs for this population should provide for unique needs such as increasingly complex primary and behavioral health issues, histories of substance use, early-onset geriatric conditions and chronic health conditions, poor nutrition, barriers to accessing benefits, unique legal challenges, the need for transportation, and the need for assistance with activities of daily living. Older adults also need many more in-home services than younger tenants, which can include specialized care services.

Permanent Housing: The Platform to Meet These Needs

Older adults can access a number of different permanent housing interventions, including supportive housing. Although many older adults have needs that are best met in supportive housing, the reality is not all of them will secure it, as inventory is scarce, and individuals have varying levels of complex needs. Some will secure units in either single- or scattered-site public housing that may or may not be targeted to older adults.

[11] Ibid.

Public housing targeted to very low-income individuals aged 62 and older generally falls under what is called the federal Section 202 program. While this does include supportive services, it does not include many of the specialized services that older adults may need.

Other affordable public housing is typically managed by local housing authorities and may or may not have any attached services or service coordination programs. Older adults may also live in supportive housing (defined below), which is the focus of this toolkit.

Within supportive housing, there are various models. Housing programs may be single-site developments that target one or more populations, or may contain units scattered throughout the community in various market rate and affordable housing projects. These developments may target a variety of older adult populations, including those who had experienced homelessness in the past, low-income, or mixed-income.

Supportive housing developments may also target one or more populations, including those who have experienced chronic homelessness, individuals with mental health challenges, veterans, and other special needs populations. Single-site developments may be stand-alone residential buildings or can be incorporated into larger developments with on-site service centers, day centers, clinics, shelters, recreational spaces, and retail spaces.

Supportive Housing and Older Adults

Supportive housing is essential to address the complex needs of older adults and to help them avoid costly emergency room visits and institutionalization.

Proactive tenant engagement in on-site and community-based services has proven effective in keeping tenants housed and working toward their goals.

Delivering *quality* supportive housing, tailored to the unique needs of older adults, is an effective way meet these needs, allowing tenants the choice to age in in place for as long as possible.

Supportive Housing Basics

Supportive housing is a combination of affordable housing and supportive services designed to help individuals and families use stable housing as a platform for health, recovery, and personal growth.

It focuses on balancing four distinct components of the model: housing, supportive services, property and housing management, and community.[12]

Quality supportive housing projects are as diverse as the communities in which they are located, but all supportive housing:

- Targets vulnerable households: The head of household is experiencing homelessness, is at risk of experiencing homelessness, or is inappropriately staying in an institution. The head of household may also be facing multiple barriers to employment and housing stability,

[12] CSH Quality Supportive Housing Toolkit

including mental illness, substance use, and/or other disabling or chronic health conditions.

- **Is affordable:** The tenant household ideally pays no more than 30% of its household income toward rent.
- **Provides real leases:** Tenant households sign a lease or sublease identical to that of a non-supportive housing tenant with no limits on length of tenancy, as long as lease terms and conditions are met.
- **Provides flexible, voluntary services:** Proactively engages members of the tenant household with a flexible and comprehensive array of supportive services, without requiring participation in services as a condition of ongoing tenancy.
- **Effectively coordinates among key partners** to address issues resulting from substance use, mental health challenges, and other crises, with a focus on fostering housing stability.
- **Provides community connections:** Supports tenants in connecting with community-based resources and activities while building strong social support networks.

Quality supportive housing is centered on ensuring the following key outcomes:

1. Tenants stay housed
2. Tenants improve physical health
3. Tenants improve mental health
4. Tenants increase income or employment
5. Tenants are satisfied with available services
6. Tenants are satisfied with their housing

To realize these tenant outcomes, supportive housing must deliver on quality in each of its project components: project design and administration, property and housing management, supportive services, and community. Quality is measured through the following dimensions.

All project components must be:

- **Tenant-Centered:** Every aspect of housing focuses on meeting tenants's needs
- **Accessible:** Tenants of all backgrounds and abilities enter housing quickly and easily
- **Coordinated:** All supportive housing partners work to achieve shared goals
- **Integrated:** Housing provides tenants with choices and community connections
- **Sustainable:** Housing operates successfully for the long term

This framework for quality supportive housing delivery is meant to be applied broadly to any supportive housing model, regardless of the target population.

However, this framework can be viewed with an aging lens to bring practical insights and strategies for effectively meeting the unique needs of older adults, allowing them to age in place while maintaining their independence and choice for as long as possible.

Aging in Place in Supportive Housing

It is possible for individuals to safely age in place[13] in quality supportive housing. The majority of Americans (78%) wish to remain in their homes as they grow older rather than moving to an institutional care setting.[14]

Most older adults can remain in their homes if comprehensive services are provided that meet increasingly complex and demanding needs.

Quality supportive housing works to address homelessness among such older adults, as it meets their unique needs and can prevent premature placement into costly nursing homes or other institutions. Accessible and coordinated supportive housing anticipates the level of services needed and provides them conveniently to residents through collaboration, partnerships, and written agreements to keep tenants housed and living independently.

Not all supportive housing providers, however, are equipped to manage the complex needsof newly housed older adults or the changing needs experienced by tenants aging in place.

According to a survey conducted by CSH with New York Capital District, over 60% of providers did not have any formal relationships with home health aid programsor visiting nurse services, and 75% did not have any social or wellness activities targeted to their older clients.[15]

This gap illustrates the need for developing intentional strategies around new partnerships, collaborations, or services to meet increasingly complex and variable health needs. Providers may not have experience with these types of changes to service delivery or in partnering with other agencies providing these services. Providers have typically accommodated aging in place on a case-by-case basis, working with each tenant on connecting to more or different services or making unit modifications when needed.

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[13] Aging in place is defined as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." (Centers for Disease Control)
[14] AARP: Aging In Place Brief
[15] CSH, *Home to Stay: Creating Quality Supportive Housing for Aging Tenants.*

However, as more providers gain skill and experience serving older adults, key insights and lessons learned can be gleaned from their efforts.

These insights can be used to employ a more strategic approach to meeting this population's unique needs, using quality supportive housing as a framework. Supportive housing providers should bring dimensions of quality, tailored to older adults, to each of the project components.

Designing a Services Program

Older adults living in supportive housing have unique needs that can be met throughrobust and strategically coordinated systems of service delivery.

As supportive housing welcomes more older tenants, and as providers support aging in place, services should be enhanced, tailored, and in some cases, redesigned to meet increasingly complex needs. Programs and services provided to older adults in supportive housing must be comprehensive, age-appropriate, and made available on-site or close to community services such as:

Specialized outreach services for older adults, assistance with activities of daily living, 24-hour crisis assistance, physical health care, mental health care, substance use treatment, transportation services, representative payee services, care coordination with community providers, nutrition and meal services, and community-building activities aimed at reducing isolation.

The need for these specialized services may place additional financial burdens on supportive housing providers. Thus, some communities or providers may choose to prioritize access to resources like home and community-based services (HCBS) waivers for supportive housing tenants.[16] Supportive housing providers may need their own support to rise to meet these opportunities.

[16] ASPE: Overview of Home and Community Based Waiver Services and Medicaid

Designing or Modifying the Services Program

Designing or modifying service programs to better meet the needs of older tenants requires an understanding of tenant needs and how these can be met through quality services. It requires considerations for how services will be delivered and who will deliver them — the primary services provider, by a partner agency, or through referral.

Any new services incorporated into an organization's services program will need to come with funding or partner resource options, organizational policies and procedures to operationalize these services, and must determine staff to deliver these services.

To ensure a quality services program that delivers outcomes, the CSH *Dimensions of Quality* framework can be used for services that target older adults:

Tenant-Centered: Services are voluntary, customized, and comprehensive, reflecting tenant needs. Older adults who have experienced homelessness have unique and complex health and support needs, including co-occurring disorders, behavioral health challenges, and histories of substance use. Strategies and examples are below, providing guidance on how to meet these unique and changing needs.

Services assessments: Services assessments include multidimensional assessments that identify the needs of older adults who previously experienced homelessness.[17] Quality assessments cover these unique tenant needs and accommodate various modes of delivery (e.g., multiple languages, options for hearing and/or vision impaired, etc.) that may require patience and repetition to ensure tenant comprehension. Case managers should administer assessments at intake and throughout a resident's tenancy to identify and monitor changing service needs. It is beneficial for intake assessments to assess food security, mobility, and health needs, and include the signing of HIPAA release forms.

Accessible: Tenants are aware of the services available to them and services are offered at convenient hours and locations, or arrangements are made to ensure tenants can access these services. Older adults have high accessibility needs when it comes to services, including needs for reliable transportation, in-home or physically accessible service locations, as well protocols in place for accessing emergency services at any time of day due to health emergencies, falls, etc.

[17] LeadingAge provides comprehensive resources and a toolkit for resident assessment for seniors

Ensuring services accessibility for older adults also requires establishing procedures for facilitating tenant awareness and comprehension of available services.

24-hour crisis assistance: Supportive housing projects make 24-hour crisis assistance accessible in case of emergencies or individual crises. This is often a joint effort. Property management usually has primary responsibility except in cases of psychiatric crisis, when social service staff members will need to take the responsibility. It is important to develop clear emergency policies and procedures for dealing with safety and crisis, spelling out the chain of command in case of emergency, what information should be provided to emergency services, when to involve on-call staff, when to call 911, knowledge-sharing regarding tenant profiles and mobility needs, and procedures for disseminating protocols to tenants.

Coordinated: The primary services provider has established connections to mainstream and community-based resources. Resident services coordination is especially important for older adults who have varying services needs throughout their tenancy, and may require more specialized services than younger tenants. See below regarding staffing for social services programs that serve older adults.

Integrated: Staff supports tenants in developing and strengthening connections to their community. Quality integrated services also means integrating service delivery across systems to more effectively and efficiently serve tenants. Integrating health care and housing support services is especially effective for this population.

Sustainable: The supportive housing project has sufficient funding to provide services to tenants on an ongoing basis. Funding is flexible enough to address changing service needs of aging tenants that tend to become more complex over time. Higher service demands increase the need for funding or resources to cover these services for the long term. Many service and insurance options for older adults are available, but less so for those who are under age 65. It is important for program staff to monitor service, insurance, and benefits eligibility to ensure that tenants receive the care and services to which they are entitled.

Meeting Needs Through Services

Meeting the Needs of Older Adults

Individualized service- and self-directed care plans[18] must take into account the interplay of chronic, often co-occurring health conditions with the normal physical and psychological changes that come with accelerated aging as a result of years of unattended health needs while living on the street or in shelters.

At minimum, new or modified service programs for aging tenants should include strategies for addressing the following issues:

- Primary Health Care
- Behavioral Health Care and Substance Use
- Care Coordination
- Wellness and Nutrition
- Activities of Daily Living
- Income and Benefits
- Legal Challenges
- Transportation
- Transitions to Higher Levels of Care
- End of Life Support & Care

[18] Self-directed care gives increased autonomy to clients to make choices in which services (usually mental health and recovery) are best for them. In a sense, clients act as their own case managers and may manage their own services budgets. The Centers for Medicaid and Medicare Services provides guidelines for self-directed services covered through Medicaid.

Managing Unique Health Challenges: Primary Health Care

As aging individuals with complex health needs attempt to navigate the health care system, they often encounter a very complicated, fragmented, and confusing system that leads to gaps in care and reduced quality of life.

While supportive housing is prepared to meet the needs of individuals with special needs who previously experienced homelessness, current programming falls short in meeting the physical and behavioral health needs of those who are older who wish to age in place, and to prevent premature displacement into costly institutions like nursing homes.

People who previously experienced homelessness often need specialized supports as they age, and it is important that housing providers consider these needs when designing or modifying service programs for this population.

Integrating health care into supportive housing can be particularly beneficial for a population with increased health care needs over time. This can be an important step in addressing emerging health issues early and preventing the need for institutionalization among those who require frequent health services.

In-home health care and visiting health staff: Preventing tenants from entering institutions is paramount and may require specialized health staff like nurses and in-home caregivers to serve tenants in their units or on-site. Supportive housing providers should consider establishing health care partnerships to identify opportunities for in-home health care.

Mobile health services: Older tenants are less mobile than younger ones and may need full services to come to them, as they are either unable to or will not travel off-site for these services. Some community health centers offer mobile services, and technology is becoming increasingly important in serving older adults remotely through programs like telemedicine thatcan deliver patient assessments, monitoring, and follow-up as well as mental health therapy. Telemedicine may also help prevent seniors from entering institutions like nursing homes.[19]

Discharge planning with hospitals and care facilities: Discharge from any care setting can be a vulnerable time for older adults, as there are often few resources to adequately care for patients

[19] Pofeldt, Elaine. Telemedicine keeps seniors out of nursing homes. CNBC.com, January 14, 2014. https://www.cnbc.com/2014/01/13/telemedicine-keeps-seniors-out-of-nursing-homes.html.

moving between care settings. Without proper care or advocacy to receive needed care, health and safety risks increase, which could lead to hospital readmissions. The Center for Medicare and Medicaid Services (CMS) requires discharge planning for all inpatients covered by these benefits.[20]

Discharge planning is a team approach among service providers, frontline care staff, and housing staff, though it should be noted that hospitals and treatment facilities have their own discharge procedures. Supportive housing services staff and property management staff or housing partners should develop plans for older residents that can accommodate high levels of support and provide advocacy when needed. Although each discharge plan will differ by both resident and care facility, service teams should develop procedures for coordinating continuous care across multiple systems and for connecting with a variety of resources that meet complex tenant needs. Housing providers should begin communication with treatment providers about discharge needs and procedures at the time of admission to minimize risks and potential gaps in support or care. An effective practice is for executive- level housing provider staff to develop proactive outreach with the discharge staff of the local hospital or care facility.

Discharge plans or strategies should include considerations for transportation, food security, linkages to home health aides, and access to/assistance with required medications. It will be important for service teams and property management staff to work closely together during this critical transition period. Property management staff should consider more flexible housing policies that permit hospital stays without losing housing or service program eligibility. Supportive housing funders like the U.S. Department of Housing and Urban Development (HUD) are generally flexible about the duration of hospital stays, provided there is proper documentation.

Older tenants who have experienced homelessness suffer from higher rates of chronic conditions and may have limited knowledge of how to manage their conditions. Service team staff in supportive housing is responsible for encouraging compliance with doctors's treatment orders and offering guidance on behaviors that improve health outcomes. Case managers and other services staff should educate tenants about the importance of regular doctor visits, nutrition and diet, medication adherence, and stress management.

Medication assistance: Managing medications may become increasingly difficult for tenants experiencing cognitive decline or mental illness. Older residents, particularly those who previously experienced homelessness, take more medications than any other age group. Changes in tenant behavior may be due to complications or noncompliance with medication and can create other

[20] Discharge planning requirements

health problems. Supportive housing providers have limitations on directly providing medication management for tenants but can provide medication assistance.[21] Medication management restrictions and requirements vary by state, and providers should be well informed of what is possible.

Supportive housing staff should work closely with residents and their physicians to develop plans for in-home medication assistance, as well as contingency plans when regimens are not followed. This requires service teams to have accurate, complete and current medication information. A helpful practice is for agencies to also keep a list of pharmacies used by tenants and their contact information. Providers should also review medication lists with clients and document these reviews, giving copies to tenants and updating these lists as needed.

If on-site staff does not have the capacity to implement medication assistance internally, supportive housing providers can enter into written agreements with medication assistance or management providers, recognizing the need for this service is inevitable for aging tenants with extensive physical and behavioral health issues. Separate written agreements with primary and behavioral health providers may be needed.

Further, providers should build in coordination of medication management into their services programs and maintain contact information for medication management services provided by external partners. Ideally, housing and services staff should be trained on medication ordering and medication delivery/receipt procedures.

Anticipating early-onset cognitive decline: Older tenants generally experience cognitive decline at much earlier ages than younger tenants. Case managers and resident service coordinators should anticipate this condition for tenants over age 50 who have previously experienced homelessness and ensure that changes in behavior or their ability to perform activities of daily living are communicated to the tenant's health care professional, and that additional supports such as occupational therapy or in-home care are provided when needed. The physical environment of the supportive housing unit or site may also complement service supports for cognitive decline.

Specialized geriatric supports: Service staff in supportive housing can assist tenants in managing symptoms related to geriatric conditions; however, tenants may be best served with specialized professional support. If a single- or scattered-site supportive housing project cannot afford to hire an on-staff geriatrician, local medical groups or health centers that accept Medicare or Medicaid

[21] Medication assistance includes giving tenants reminders about when to take medication, storing and handling medications, and documenting resident medication history.

may prove to be valuable resources, and can make well-informed referrals to other specialists and doctors as needed. Providers may also consider strengthening chronic disease management services with partnerships to provide frontline geriatric nursing triage and and nurse case management.[22]

Preventing falls: Older tenants in supportive housing are prone to falling at younger ages. Also, falls are the leading cause of injury for this population.[23] This can lead to hospital stays and serious health conditions. Service programs that incorporate strategies to promote balance and regular health assessments and screenings are effective in preventing falls among older tenants. The Centers for Disease Control recommends a number of health and wellnesspractices to prevent falls, including having regular eye exams, evaluating medications for side-effects, and promoting exercise for balance.[24]

Programs of All-Inclusive Care for the Elderly (PACE):[25] provides a comprehensive set of social and medical services to older adults that allow them to continue living in their own homes for as long as possible.

According to a report by the Center for Health Care Strategies, experts noted that many older adults who are frail are moved unnecessarily to more costly long-term care settings such as Medicaid-funded skilled nursing facilities due to the lack of coordinated and flexible in-home supports and services that could help them remain at home. These findings prompted the creation of community programs to provide mobile and flexible supports to help older adults remain in their homes.

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, able to live safely in the community at the time of enrollment, and live in a PACE organization service area. A PACE organization's interdisciplinary team delivers in-home care, therapies, rehabilitation, social services, transportation, adult day care, meals, medical care, and respite care. Seniors may visit a PACE Center a few times a week or the PACE team may bring services to the senior's home. PACE providers also contract with mental health specialists to deliver behavioral health treatment. The cost of PACE can be covered by Medica id, though not all states offer this benefit and not all communities have PACE-certified organizations.[26]

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[22] https://nhchc.org/
[23] Administration on Aging
[24] http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_americas_older_adults_2014-ch4.pdf
[25] PACE Program Overview: https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html
[26] Determine if your community has a PACE Center: https://www.medicare.gov/find-a-plan/questions/pace-home.aspx

Adult Day Health Centers (ADHCs): Adult Day Health Centers (ADHCs) are not as intensive as PACE programs, but do provide a safe and secure location for older adults to access social and health services delivered by health care professionals. ADHCs accept PACE participants who are dual eligible (Medicare and Medicaid), but neither fund ADHC as a specific benefit unless through a Medicaid waiver. In some instances, Medicare pays for certain services offered by an ADHC when prescribed by a doctor.

Managing Unique Health Challenges: Behavioral Health, Mental Health, and Substance Use

Individuals of any age who have experienced homelessness are more likely to experience co-occurring mental health and/or substance use issues than the general population.[27] Moreover, people who have experienced extensive homelessness experience much higher rates of mental health and substance use issues.[28] Older adults experiencing homelessness or who have experienced homelessness are also more likely to have cognitive impairments than their younger counterparts. With long histories of mental illness and co-occurring disorders, these individuals have behavioral health needs that can require specialized care and ongoing or long-term treatment.

Mental health symptoms and substance use disorders can aggravate other medical conditions and lead to earlier functional decline. Tenants who previously experienced homelessness who are now in supportive housing may have histories of substance use or might currently be experiencing substance use challenges. Such substances can interact with an individual's prescribed medications causing additional health challenges.

Supportive housing that serves older adults with co-occurring health and substance use challenges requires high-quality behavioral health treatment to ensure long-term housing stability. Current best practice includes establishing or coordinating integrated care teams that serve tenants with co-occurring medical and behavioral health challenges.[29]

Many service providers in supportive housing enter into written agreements with mental health care providers recognizing the need for effective referrals in times of mental health crisis. If a

[27] According to the Substance Abuse and Mental Health Services Administration, 20-25% of the homeless population experiences severe mental illness This is compared to 6% of the general population.
[28] 30% of chronically homeless individuals have mental health conditions and 50% have substance use issues.
[29] SAMHSA: Integrated Care Models

tenant experiencing unmanageable symptoms is engaged in mental health services, then the goal is to coordinate treatment with the entire team so everyone is aware of behaviors, living conditions, and interventions.

For tenants who are not linked to mental health services, it is important that such services are available when they are ready. Providers should have referral forms for appropriate mental health services and treatment programs and make linkages as quickly as possible.

Leading Programs in Behavioral Health

Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors).[30] Healthy IDEAS is an evidence-based program managed by Care for Elders and Baylor College of Medicine, and is designed to detect and treat the symptoms of depression in seniors with chronic health conditions and/or mobility issues. The program integrates depression awareness and management into existing case management services provided to older adults. The model has been replicated by organizations in 22 states across the nation. The main components of Healthy IDEAS are:

- Screening and assessment of depressive symptoms
- Education about depression and self-care for clients and caregivers
- Referrals and coordination with mental and physical health services
- Empowering older adults to manage their depression through involvement in meaningful activities

Care Coordination: Developing appropriate service plans for older adults is often complicated by the interplay of chronic physical illnesses, mental illnesses, and addictions with the normal physical and psychological changes that come with age. Individualized health treatment plans should take this into account and work to coordinate services across systems, offering them simultaneously — preferably in one location when possible. Care coordination and continuity of care are particularly important for older adults, as they frequently have health issues that are treated by several clinicians who are often located in different places. Further, older adults often have co-occurring and/or chronic conditions. Of individuals with chronic conditions who are hospitalized, nearly half are re-hospitalized within 90 days.[31] Treating multiple conditions simultaneously and effectively requires careful coordination of services.[32]

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[30] The Healthy IDEAS website provides program details, educational material and trainings.

[31] Peikes, Deborah, Randall Brown, Greg Peterson, and Jennifer Schore. Publication. The Promise of Care Coordination: Models That Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses. Mathematica Policy Research, Inc., 2009.

[32] Wenger, Neil S, and Roy T Young. "Quality Indicators for Continuity and Coordination of Care in Vulnerable Elders." *Journal of the American Geriatrics Society*, 2, 55 (October 1, 2007).

Levels of care coordination needed for each resident in supportive housing depend on their complexity of needs. Care coordination is typically a component of the health system, though often neither proactive nor comprehensive enough to meet the complex care needs of older adults.[33] Best practices for care coordination for individuals with complexconditions include a comprehensive needs assessment, individualized care planning, facilitating access to needed services, and communication and monitoring.[34]

Making use of multidisciplinary service teams that can provide "one-stop" access and facilitate coordination has been shown to be a successful approach. Providers understand that offering services on-site is ideal for older tenants who might have difficulty traveling to off-site services. Lessons learned from evidence-based models of care coordination for such populations include the need for access to timely data on care delivery for members of an interdisciplinary team, a focus on smooth transitions between care settings, and that mental and psychosocial health must be incorporated into the team's efforts.[35] For older adults, effective care coordination includes comprehensive geriatric assessments and transitional care coordinated as a team effort by physicians, nurses, and the housing and social services staff.[36]

Activities of Daily Living

Older adults may have significant challenges in completing activities of daily living (ADLs), such as cooking, cleaning, doing laundry, and bathing as well as instrumental activities of daily living (IADLs), such as travelling to medical and other appointments, taking medications, and paying bills.

Such challenges may be due to limited mobility or cognitive impairments, so aging tenants may benefit from living in housing that has been thoughtfully designed with their safety and independence in mind.

Staff in supportive housing must be properly equipped through training and staff development to assess any indication of physical and/or cognitive decline of a tenant that may require arranging for additional services (e.g., in-home care, visiting nurse services, housekeeping, or hospice care) in order to prevent or delay a person from having to move into an institution in their final days. Some in-home care options follow.

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[33] Challenges in coordinating care
[34] Ibid.
[35] Eldercare Workforce Alliance: Care Coordination and Older Adults
[36] CHAMP: Care Coordination, Management, and Transitions

Home and community-based (HCB) services: HCB services provide assistance with the goal of providing the support needed so tenants can remain in their homes. Services include support with bathing, dressing, running errands and personal care. These services are delivered in a number of different housing settings, including supportivehousing.

Funding/Resources: Every state allows Medicaid to cover at least some of these services, a reason to ensure that tenants are enrolled in Medicaid if they are eligible.[37] In some cases, however, tenants may need to prove they are at risk of nursing home placement in order for Medicaid to cover HCB services.[38] The Older Americans Act also covers in-home assistance, meals and adult day services.[39] These funds are allocated in varying amounts to each state and programs can apply for these funds through grant opportunities.

Occupational therapy: Aging tenants may find a new need for occupational therapy, either due to gradual changes in mobility, health challenges like arthritis, or the inability to perform ADLs. Occupational therapy can also help improve the quality of life for tenants experiencing memory loss,[40] and can make recommendations for fall prevention.

Promoting Wellness and Nutrition

Older tenants may be on restricted diets or may have difficulty preparing their own meals. Linking tenants with meals benefits can help them follow dietary restrictions and can provide healthy meals when tenants are not able to prepare them. Supportive housing providers should consider offering nutrition and meals-focused classes or groups to educate and support older adults to meet health goals such as:

Examples include resident cooking classes, nutrition workshops related to commonly experienced health challenges, how to prepare low-cost healthy meals, cholesterol control, and recipe exchanges. Providers might also consider partnerships and collaborations with farmers markets, grocery stores, restaurants, and bakeries to coordinate donations of heathy food. Public benefit programs like Meals on Wheels and government-funded programs like the Supplemental Nutrition Assistance Program (SNAP) and Medicaid-funded meals programs can all be important sources of prepared

[37] Home and Community-Based Long-Term Services and Supports for Older People: Fact Sheet
[38] Ibid.
[39] Resource for how to coordinate Medicaid and Older Americans Act funds for HCB services
[40] Occupational therapy for seniors overview: http://www.seniorhomes.com/p/occupational-therapy/

meals or free assistance for tenants.[41]

Though older tenants may have mobility challenges, exercise and fitness resources can help meet health goals and improve cognitive functioning. While this can be an on-site fitness center, this could also include classes and activities such as group walks, mild aerobic classes, strength training, balance and coordination training, dance, and yoga.

These supports can be offered free to seniors in the community (depending on the community) or housing providers can bring professionals such as occupational therapists and fitness trainers on-site. Many public swimming pools also offer low-cost or free swimming and water aerobics classes to seniors (age 65 and older).

Securing Income and Benefits

Securing income supports is crucial for any population, and more so for older adults who have experienced homelessness, given their complex primary and behavioral health challenges that result in their need for a wide variety of services.

Many such older adults will not reenter the traditional workforce,[42] so public benefits are likely the only source of income they will receive for the rest of their lives, and they should be maximized to ensure long-term tenant financial stability.

The majority of older adults are eligible for public benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI),Medicaid, and Medicare. Many are considered dually eligible for Medicaid and Medicare, which can bring additional benefits programs that vary by state.[43]

Supportive housing providers should ensure that tenants are enrolled in the benefits for which they are eligible and should keep track of when tenants may become newly eligible for benefits in order to provide enrollment support. New benefit sources may also impact housing assistance, and new housing situations may impact benefits, but this can be addressed with proactive support tohelp tenants report changes in income or housing status.

Special considerations should be made when providing benefits enrollment support to older

[41] http://www.senior-meals.org/Medicaid-Meal-Delivery.html
[42] This refers to traditional employment as opposed to one-off jobs or entrepreneurship.
[43] Center for Medicare and Medicaid Services: Dually Eligible Beneficiaries

tenants. For example, they may need special accommodations for loss of hearing or sight and mobility challenges. They may also have a reduced understanding of their eligibility, applications, and requirements due to cognitive decline.

The importance of securing SSI benefits: Many tenants with disabilities qualify for SSI benefits. It is important to support tenant enrollment in this benefit, as other benefits like Medicaid may depend on SSI eligibility.[44]

Health care insurance: Older adults newly housed in supportive housing and those aging in place have a variety of unique health challenges, many of which increase in severity over time. Health care services will likely be a large component of an older tenant's long-term services plan, and affordable health insurance removes barriers to the majority of needed health services, as costs for these services rise as tenants age. Low-income older adults are entitled to free health insurance coverage through programs such as Medicaid, Medicare, and the Veteran's Administration.

It is imperative that supportive housing providers understand the eligibility requirements for these benefits programs and provide enrollment support for those tenants who are not yet enrolled in the programs for which they are eligible. Tenants may also become newly eligible for Medicare, for example, when living in supportive housing. It is also important to monitor changes to eligibility and service entitlements so that tenants can access the entire array of services that are available to them.

Medicaid: Medicaid is public health insurance that provides essential medical and medically related services. The states and the federal government jointly finance the Medicaid program.

Eligibility: Medicaid eligibility varies by state, but federal law and regulations from CMS require a core set of benefits that all states must provide. The remaining eligibility requirements are determined separately, state by state. Many states have elected to expand Medicaid coverage under the ACA, while others have not. For non-expansion states, Medicaid eligibility may require the tenant to have a disability that would make them eligible for SSI.[45]

Coverage: In every state, Medicaid generally covers certain basic services such as in-patientand out-patient hospital services, physician services, skilled nursing facility services, home health care services, and some transportation and prescription drugs. Additional coverage can vary by state.

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[44] A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Supportive Housing: https://aspe.hhs.gov/sites/default/files/pdf/77121/PSHprimer.pdf
[45] Ibid.

Medicaid can also pay for some service in supportive housing, including case management, services coordination, and rehabilitative services, all of which vary by state.[46] Supportive housing providers should understand the new and emerging Medicaid coverage opportunities in their communities,[47] to ensure that older adults can connect with those opportunities that benefit them.

Managing the Benefit: Providers will need to partner with other service providers who bill Medicaid if they do not bill Medicaid themselves, to ensure that Medicaid-eligible services are covered. If your agency provides Medicaid-eligible services, you may also consider becoming a Medicaid biller. Even if your agency does not bill Medicaid, your supportive services staff should understand how to manage this benefit. This includes managing Medicaid asset spend-downs, understanding how Medicaid interacts with other benefits and helping tenants navigate the eligibility and enrollment processes.

Medicare: Medicare is the federal health insurance program for people who are 65 or older regardless of income, and certain younger people with disabilities (having physical, mental health, or intellectual disabilities).

Eligibility: Medicare is a nationwide program, meaning that persons with "non-managed" Medicare receive the same benefits, regardless of the state in which they reside. It should be noted that this contrasts sharply with Medicaid (above), with a benefit package that differs from state to state.

Coverage: Medicare is separated into Part A, Part B, and Part D. Broadly defined, Part A covers inpatient care, Part B covers outpatient care, and Part D covers prescription medications. While Medicare covers persons regardless of income, for people with specifically determined low incomes, Medicaid is the most common secondary payer, paying for Medicare deductibles and other services that Medicare does not or cannot cover completely.

Medicare coverage most commonly begins after two years of income supports from SSI or SSDI. If a person previously had Medicaid coverage, it is highly variable when or if they will be enrolled in Medicare prior to age 65. Those with long-term disabilities are eligible for the same coverage as those who have reached age 65.

Plan Types: Medicare beneficiaries have the option of enrolling in Managed Care or what are called Medicare Advantage plans.[48] Medicare Advantage offers the coordination of care and

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[46] A Quick Guide for Improving Medicaid Coverage for Supportive Housing Services
[47] The Medicaid website provides comprehensive state profiles on Medicaid administration, eligibility, and coverage.
[48] How Medicare Advantage Works

flexibility of health plan coverage. The term "straight Medicare" means the person is covered by the national program and entitled to the same benefits regardless of which state they live in. Medicare Advantage plans, as commercial carriers or health plans, are subject to the insurance laws of the state in which they operate. Some plans cover Part A and Part B (inpatient and outpatient), while other plansinclude those benefits plus Part D (prescription drug coverage).

Coverage: Medicare Part A covers hospital stays and the first 20 days in a skilled nursing facility after a qualifying hospital stay. Beneficiaries pay a copay for days 21-100. After the 100th day, the beneficiary is responsible for the full cost. Part A will pay for up to 190 days at a psychiatric facility throughout a person's lifetime. Part A can also pay for hospice care and "skilled" home health care if ordered by a doctor. The tenant must be homebound defined as leaving the house only occasionally and with great difficulty. Home health services may be approved for no more than 28 hours per week and services must be delivered by a Medicare-certified agency.

Coverage: Medicare Part B pays for doctor visits, services, and tests. Part B premiums are deducted from a senior's Social Security payouts.

Coverage: Medicare Part D is the prescription drug program. The Low-Income Subsidy also known as the Extra Help Program offers discounts for qualified households.

Navigating Medicare: Medicare communicates primarily through mail or email and oftenin health care language, which can be very confusing to most people. The ACA-funded navigator positions are filled by staff trained specifically in this language. Where navigators operate, they can help both supportive housing residents and staff understand what Medicare correspondence means in terms of coverage and benefits. Some of these navigator positions can be found at Federally Qualified Health Centers (FQHCs).

It is beneficial for supportive housing service providers to designate and train key staff members to understand these communications and their implications for the care your residents will receive. During the enrollment process — or when coverage changes — Medicare will use a process called "auto enrollment," meaning that people will have choices regarding their health plans. However, if choices are not selected in a timely manner, the program will automatically enroll the person in a health plan. For Medicare, this means the person cannot elect another health plan until the Open Enrollment period begins.

Managing the Benefit: Just as supportive housing providers track their residents's income source and amount, it is recommended that they also track each residents insurance coverage and carrier to be sure that tenants are receiving the benefits to which they are entitled and for ease of advocacy, should issues arise. If a provider is advocating for services, either within their own

agency or another, they will need to know who covers the service. And while this will be a challenging short-term project, the information will be helpful in planning for service program sustainability andaccessing services long-term. If collecting this information is part of your lease-up packet, for example, the information can be an easily accessible part of your agency records.

Medicaid/Medicare Dual Eligibility: Most older adults in supportive housing are dually eligible for both Medicaid and Medicare. "Dually eligible beneficiaries" are persons who are eligiblefor both Medicare and Medicaid insurance coverage. These people fall into the following categories: senior and low-income, senior disabled and low-income, or long-term disabled and low-income. They receive Medicare because they are 65 and older, and receive Medicaid due to their low incomes. Medicare passes on significant co-pays, deductibles, and premium costs to the consumer, while Medicaid often covers these costs for low-income beneficiaries. Medicaid functions as a "third party payer" in relation to Medicare for persons who are dually eligible. A person's Medicaid coverage cannot pay for a service, however, without prior documentation from Medicare that the service is not covered or the person has already received their lifetime limits for the service. Navigating this system can be rather complex, so it is recommended that in specific cases a supportive housing provider might need to consult with the legal aid, medical-legal partnership,[51] or health law experts in their community.[49]

Over the years, advocates have noted the lack of alignment between Medicare and Medicaid. "Alignment" in this case means that there is overlap as well as gaps in coverage between the services funded by Medicare and Medicaid. To address these issues, as part of the ACA, CMS currently operates a dually eligible demonstration project in 13 states.[50] In these demonstrations, the state or health plan manages the resources of both Medicare and Medicaid and can resolve the alignment issues within their operations. CMS hopes that through these integrated entities, they will discover all the places where Medicare and Medicaid are not aligned and build that alignment for current and future dually eligible people.

Benefits Advocacy: CSH recommends that supportive housing providers collect and have easy access to the insurance coverage information for their residents. It is important that supportive housing providers understand eligibility requirements for the various types of health insurance and may need to work with state agencies to fully understand the unique circumstances and nuances of eligibility, enrollment, and coverage.

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[49] http://medical-legalpartnership.org/

[50] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination

As tenants age in supportive housing, their needs for services will change.

Some level of staffing or resources can be adapted, though some residents will need specific home health or specialized services such as visiting nurses and physical therapy. Supportive housing providers will likely need to form new partnerships with specific expertise to effectively meet long-term needs.

Anticipating and Preventing Legal Challenges

A comprehensive service delivery program should include legal services as part of a tenant's individualized services plan to retain housing stability over time. Older tenants may have more legal service needs than younger tenants.

Older tenants are susceptible to financial exploitation and elder abuse and may require legal services if they fall victim to these. Aside from establishing internal policies and strategies to prevent various types of elder abuse, supportive housing services programs should develop advocacy strategies and procedures for when an elder tenant is targeted.

Tenants experiencing cognitive decline may need or want a third party to make medical and/or financial decisions for them according to an advanced directive. Legal services to support advanced directives can proactively help tenants manage their housing stability and health. Service providers can partner with low-cost legal or paralegal services to provide advanced directives for residents. Many attorneys and law firms also have a requirement to provide pro bono legal services. It may be worth considering partnership and collaboration opportunities such as on-site legal clinics or service days to meet these needs.

Estate Planning and Effects of Medicaid/Medicare: One of the most overlooked legal issues for older adults is estate planning considerations for preventing unintended financial burdens for a tenant's family. For example, if a tenant was enrolled in Medicaid at the time of his/her death, there may be financial or eligibility impacts for his/her children if they are also enrolled in Medicaid; Medicaid will make a claim on that parent's assets at the time of death. In some states, this can be avoided through the creation of a living trust.[51]

[51] Summarized interview with Stephen Bezaire, a certified specialist in estate planning law in California and Wisconsin.

Estate planning documents can also help direct caregivers and appointed executors to carryout an older adult's wishes as they near the final stages of life or if they become incapacitated and unable to make financial and medical decisions. Documents like living trusts, wills, and powers of attorney can prevent financial burdens and enable designated people to act on the resident's behalf to carry out their wishes pertaining to their life and assets. Many older adults may not have significant assets to protect, particularly if they have had to spend them down to become eligible for Medicaid. However, living trusts and wills can still be beneficial, especially if the resident has family members who may be impacted by his/her assets or debts. Therefore, it is important for supportive housing providers to locate affordable legal services in their communities.

Medical-Legal Partnership: The National Center for Medical-Legal Partnership embeds lawyers as specialists in health care settings. When some of the most complex and intractable problems — like an illegal eviction — are detected, clinical staff can refer patients directly for legal services. And like other members of the health care team, legal staff are available to consult with clinical and non-clinical staff about system and policy barriers to care.[52]

The integration of health and legal services is especially beneficial for aging individuals with complex health challenges who may need professional advocacy to receive the care they need. Medical-legal partnerships across the U.S. have had success in improving housing conditions and decreasing hospitalizations for those with chronic illnesses. The Center provides toolkits for establishing medical-legal partnerships and provides state profiles on existing partnerships.

Transportation Services

Transportation is often one of the most important aspects of accessing services and amenities located outside of a housing site.

Many older adults might not access resources simply because transportation is insufficient, preventing them from accessing needed medical or behavioral health appointments, and from visiting with family and friends.

Providers should secure as many transportation resources as possible for any services or amenities located off-site. They can do this by establishing partnerships, using volunteers, and taking advantage of transportation costs covered by Medicaid.

[52] National Center for Medical-Legal Partnership

Resources:[53]

Volunteer driver programs: Local faith-based and nonprofit organizations frequently have networks of volunteers who offer flexible transportation for shopping, doctors's appointments, recreation, and other activities.

Paratransit Service: Public transit, aging organizations, and private agencies provide door-to-door or curb-to-curb transportation using mini-buses or small vans. Paratransit and van services offer reduced fares for older adults and persons with disabilities.

Door-through-Door (Escort) Service: Agencies provide drivers or escorts who offer personal, hands-on assistance by helping passengers through the doors of their residences and destinations, as needed. Persons with severe physical or mental disabilities typically use this service.

Public Transit/Fixed Route Service: Public transit agencies provide bus and rail services along established routes with set schedules on a non-reservation basis — also referred to as "public transportation" or "mass transit". Reduced rate fares and additional transportation services are available for older adults and persons with disabilities. Information about routes, schedules, fares, and special services are available through your public transit agency.

Transportation Vouchers Programs: Area Agencies on Aging, Aging and Disability Resource Centers, and other social service organizations often provide fare assistance programs that enable qualified persons (usually economically disadvantaged older adults or persons with disabilities) to purchase vouchers for transportation services at a reduced rate. The vouchers are then used to pay for services from a participating transportation provider that can include public transportation, volunteer programs, or taxis and other private companies.

Mobility managers[54]: In addition to the services described above, some communities have mobility managers[55] who know the community-wide transportation service network, understand how it operates, and can serve as guides through the available transportation resources and services. Mobility management is an approach to designing and delivering transportation services that starts and ends with the customer.

[53] https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/resources/171/mobility-management-brochure.pdf
[54] https://nationalcenterformobilitymanagement.org/for-mobility-managers/
[55] https://nationalcenterformobilitymanagement.org/for-mobility-managers/state-local-mobility-management-websites

It begins with a community vision in which the entire transportation network — public transit, private operators, cycling and walking, volunteer drivers, and others — works together with customers, planners, and stakeholders to deliver the transportation options that best meet the community's needs. Contact your local aging organization or public transit agency to determine if a mobility manager is available in your area.

Transitions to Higher Levels of Care

The goal of supportive housing is to ensure long-term housing stability while maintaining each tenant's ability to make choices, live independently, and remain in their homes for as long as possible.

As tenant needs increase, some may need higher levels of care than what a supportive housing provider is able to deliver. Older tenants experiencing severe health crises and challenges might not find the level of care they need in supportive housing, and therefore may discharge to residential care facilities, nursing homes, or hospice care.

Providers should make every effort to keep tenants housed in their own homes, but there should also be strategies in place for transitioning tenants. This requires knowledge of the terminology, types of care settings, and alternative community-based programs that can prolong an older adult's independence in supportive housing.

The provider should establish collaborations with long-term care facilities, hospitals, and residential substance use treatment facilities that could provide more intensive services if those needs arise. Having services staff regularly assess clients for new accommodation needs can help anticipate these changes with enough time to secure the resources.

End-of-Life Planning and Care

Most people prefer to spend their last days in their own homes when possible.[56] Support staff in supportive housing know tenants well and tenants may be more comfortable communicating their end-of-life needs in this setting than in less service-enriched housing. Older adults often experience anxiety or fear related to aging and their end of life.

It is crucial to have staff with geriatric training to help guide seniors through these processes and plan for end-of-life care. Additional training and support for all staff may be needed for supportive

[56] https://www.americanactionforum.org/insight/a-better-approach-for-end-of-life-planning/

housing that includes older tenants. End-of-life care often involves connecting with a tenant's family, close friends, or community supports. Some tenants do not have family to support them as they approach their end of life and it is generally the supportive housing primary service providers who must deliver this intensive and personal support.

A note on assisted living vs. supportive housing: *Although assisted living plays a key role in the continuum of housing and service options for older adults, it is important to understand how this model differs from permanent supportive housing. Both models provide a range of supportive services targeted to the needs of older adults, but assisted living facilities typically provide a wider array of more intensive services and are certified and regulated at the state level.*

Assisted living facilities have 24-hour staffing, provide assistance with medication management, personal care, housekeeping, and provide most meals. Many assisted living facilities have special units for memory-impaired individuals. Typically, an older adult might move from supportive housing to assisted living if the need for more assistance becomes necessary.

Staffing and Services

Service Program Staffing

As in any supportive housing project, appropriate staffing needs should be considered for projects that target and serve older adults and those requiring higher levels of support.

Whether your service program is a new one that targets older adults who have experienced homelessness or one that is being modified to accommodate those aging in place, it is advisable to have staff who understand the needs of aging tenants and have had experience with geriatric populations.

If current staff do not have this expertise, supportive housing providers should partner with organizations that do, or provide trainings on services for those who have geriatric conditions, are frail, or have mobility impairments in addition to other complexconditions.

Staff should also be trained to support residents during their end-of-life, helping tenants understand their options, connect with family, and help manage logistics. It is a best practice for caseloads to be small for this population (no larger than 40:1 generally and 14:1 for those with complex conditions)[57] to allow for more intensive services and support.

Staff members are consistent sources of meaningful support: Older adults who have experienced homelessness often require more intensive support than younger residents in supportive housing. Many do not have the family supports that their general population counterparts who live in senior housing do. Therefore, service provider staff often take on roles more typically filled by family members in supporting those who are aging: assisting with benefits access; managing legal paperwork; advocating for services; providing meaningful social and celebratory experiences; and managing the logistical, psychological, and emotional aspects of transition periods throughout the older adult's tenancy.

Essential staff roles: Housing projects that target older adults or those who are accommodating aging in place will likely find that new staff roles are needed to better meet identified needs. Training of existing staff in new areas is essential, but completely new types of service roles may

[57] CSH, *Home to Stay: Creating Quality Supportive Housing for Aging Tenants.*

be needed. These roles can be newly hired staff or service partners who provide care on-site.

It may be beneficial to have an integrated service provider and property management team who are both trained in geriatric health issues, cognitive difficulties, and the need for activities of daily living (ADL) supports.

For scattered-site developments, this could be a very closely coordinated team that can identify these issues together.[58]

- On-site nurse practitioners to assist with acute medical needs, psychosocial services, preventative services, and links to primary care (once per week is recommended)
- Behavioral health providers
- Behavioral health case managers
- Rehabilitation specialists (as needed)
- Resident service coordinators (see below)

Service Partnerships: Very few supportive housing providers can provide every service that older adults may need throughout their lives, so collaborations and partnerships are necessary. These can take the form of service coordination through referrals with "warm handoffs," having partners come on-site to provide services, or integrating services with partners to serve older adults in a new service site such as an on-site clinic.

Service partnerships differ by type, but all partnerships should commit to serving older adults, have similar partnership goals, fill one another's service gaps, and follow through on commitments.

[58] Center for Urban Community Services. (2003). *Developing the "Support" in Supportive Housing*. prepared by Tony Hannigan and Suzanne Wagner. http://www.csh.org/wp-content/uploads/2011/12/Tool_DevelopingSupport_Guide.pdf

Community Connections

Building Connections to the Community

As the population in supportive housing ages, social engagement is critical to ensuring that residents can safely age at home. The ability to connect with people and places is essential to overall wellbeing, and access to social networks and religious institutions help lower the risk of isolation.[59]

Robust social programs aimed at decreasing social isolation and malnutrition, as well as wellness groups that focus on chronic disease and end-of-life care issues for aging tenants should be targeted to older residents and sufficiently financed. Supportive housing providers should create a culture of healthy aging among their tenants and help build positive relationships and increased community support.

Older tenants in supportive housing may isolate more than younger residents, often as a means of coping with new or compounded health or ability challenges. Cognitive decline or mobility challenges may bring changes to relationships with friends and relatives.

Quality supportive housing requires taking intentional measures to ensure that residents have opportunities to connect within the residential community and to the broader community.

Tenant-centered community connections: Efforts to engage residents in the community should come from an understanding of the tendency for older adults to isolate due to complex health challenges, transportation issues, and the impact of health crises. Simply providing opportunities for social interaction is not enough. Older adults may need extra encouragement or support to participate in activities. Activities — preferably those based on resident feedback — should

[59] CSH, *Home to Stay: Creating Quality Supportive Housing for Aging Tenants.*

interest and provide value for them.

Accessible community connections: It is important that both internal and external efforts to engage residents in the community offer activities that are physically accessible and available at convenient hours and locations. Activities provided off-site should have transportation arranged when possible and should also be cognitively appropriate for the population.

Coordinated community connections: Providers should be aware of the local community resources provided to older residents, as well as the eligibility requirements, and make efforts to coordinate participation in these programs. These programs include local senior centers, activities at the local library, exercise and wellness classes, and classes offered at community recreational centers.

Integrated community connections: It is important that planning for community activities is integrated with other housing programming and property management initiatives, as some activities may be coordinated by property management staff and others by service program staff. It is also important to have meaningful opportunities for community engagement like leadership opportunities and connecting with cultural centers or family, rather than just social activities.

Sustainable community connections: Sustainable community connections are those that are accessible, can be offered on-site and off-site, meet varying tenant needs and interests, and can be provided for the long term.

Property managers and/or service providers can provide on-site recreational and social events that older residents would want to participate in: bingo games, movie afternoons/nights, peer "buddy" programs for new tenants, special interest groups, classes, workshops, and community outings. Some communities offer on-site no-cost classes, social activities, and community engagement events.

Property Management

Providing quality supportive housing requires establishing accommodating and flexible property management practices that will meet short- and long-term environmental needs that allow tenants to safely age in place.

As this toolkit has illustrated, housing presents a unique challenge for the older adult population with its higher prevalence of fixed income, physical disability, and limited mobility. Some existing supportive housing requires only modest environmental modifications, but in a scattered-site model, significant rehabilitation is often needed to make buildings and units accessible.[60]

Modest capital improvements may include distinct entryways to apartments, ramps, accessible kitchens and bathrooms, grab bars, emergency communication, and adaptive technologies.

Adherence to universal design principles and the creation of dementia-friendly spaces are key examples of how providers are improving accessibility to help maintain independence.

Tenant-centered property management: Staff educates tenants on their rights and responsibilities as lease holders. Tenant assessments and feedback should inform needed unit modifications that go beyond the minimum Americans with Disabilities Act (ADA) requirements. Older adults will likely need additional support with rental applications, unit leases, and other housing paperwork. This may include special accommodations for the hearing impaired, the cognitively impaired, and those with vision issues.

Accessible property management: Tenants move into housing quickly when it is accessible and available. Accessible housing accommodates varying backgrounds, cultural needs, and physical abilities. Property managers should develop a clear process for tenants to request unit

[60] CSH, *Home to Stay: Creating Quality Supportive Housing for Aging Tenants.*

accommodations and ensure a fast turnaround when they are made. Leading practices go further than this, anticipating modifications outside of legal requirements to allow tenants to age safely and comfortably, and to prevent tenants from entering institutions.

Coordinated property management: Coordinating across housing and service systems is incredibly important for meeting the needs of older adults. When coordinating property management activities, property management staff works closely with service providers and landlords to ensure tenants sustain stable housing. This can include establishing a communication strategy for when tenants require accessibility adaptations or need modifications to facilitate in-home care and supports. This also involves having a clear emergency protocol that is communicated to tenants and all involved partners across systems.

Emergency personnel should be able to easily access a list of tenants requiring mobility assistance in the event of an emergency. Property managers should also be aware of behavioral health crisis protocols and should have 24-hour access to crisis support for their residents.

Integrated property management: Independence and choice are paramount in supportive housing. When property management is integrated, tenants have a lease just like anyone else. Tenants are also able to choose from multiple housing units in the community when options are available. This can include choice in unit configuration or color scheme, and can be particularly important for older adults who may benefit from visual features and cues that can help with memory loss issues.

Sustainable property management: Sustainable property management means that units are maintained and managed over time to meet tenant needs. This includes regular repairs and unit modifications as required by law, and — when possible — unit features that go beyond legal requirements to meet long-term needs. Unit sustainability requires a quick turnaround on unit modification requests and repairs as well as seeking and securing the funding to accommodate features, structural changes, or equipment that may be funded by various sources.

Housing Unit Modifications

Older adults entering supportive housing may need unit adaptations that differ from younger tenants due to mobility issues and early onset geriatric conditions.

Tenants who have been aging in place may find themselves in housing units that were designed to meet their needs at a time when their needs were less complex. Meeting needs that will vary over time requires making accommodations for the long term that continuously support tenants as they

age.[61]

Property modifications include structural changes, the installation of special equipment, and adjusting the location of items like furniture. Unit modifications promote independence and make living spaces safer and more secure.

Examples of modifications for tenants with disabilities are:

- *Structural changes*: Widening hallways and doorways, adding a first-floor bathroom, ramps, stair lifts
- *Features, equipment, and technology*: Grab bars, handrails, removable shower heads, phones for hearing impairment, monitoring technology and alert systems, brighter lighting, emergency lights, rugs/carpets fastened to floor, adjustable-height closet rods
- *Assistive devices*: Bath/shower benches, walkers, canes, emergency pull chords and buttons, wheelchairs, Braille for sight impaired/blind, magnification devices
- *Changing location/configuration*: Moving furniture, raising furniture, raised toilet seats, lowered beds, lowered counter tops

Property managers in supportive housing often respond to ADA accommodations requests[62] as they arise, but more proactive measures can be taken. Some developers and property managers employ universal design[63] elements that anticipate issues that may arise for tenants aging in place and provide for future home care needs.

The majority of existing supportive housing units does not have one or more of the five key elements of universal design that are beneficial for older adults: no-step entry, single-floor living, wide doorways and hallways, accessible electric controls and switches, and lever-style doors and faucets. Costs to make these upgrades can be rather prohibitive and resources vary by locality.

Paying for unit modifications: Unit modifications can be cost prohibitive for property managers, especially if modifications include expensive equipment, appliances, or renovation. Medicaid may help finance certain accessibility modifications in many states, though funding them in this way can only happen if there are no other sources of funds to cover them.

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[62] Federal law requires reasonable unit modifications from both private and federally assisted rental housing for tenants with disabilities. Landlords participating in the Housing Choice Voucher program are not required to pay for unit modifications, but they must permit them.

[63] A detailed overview of universal design is provided in the next section.

Other sources vary by state and locality and may include Consolidated Plan funds, state housing finance agency programs, U.S. Department of Veterans Affairs programs, vocational rehabilitation programs, or state assistive technology programs.[64]

There are also local grants and publicly funded programs that can pay for adaptations such as unit modifications.

Physical Supports for Geriatric Conditions

Preventing Falls

Older tenants are prone to falling, with falls being the leading cause of injury for this population, leading to hospital stays and serious health conditions. Project and unit design features and intentional furnishings can help prevent falls.

These include installing grab bars in bathrooms and elsewhere in the unit, installing ample lighting in the unit and in common areas, eliminating tripping hazards in furnishings such as low stools and tables, and considering built-in furniture that could be used as support.[65] The CDC also recommends a number of health and wellness practices to prevent falls, including regular eye exams, evaluating medications for side-effects, and promoting exercise for balance.[66]

The Cathedral Square Corporation in Vermont recently piloted a model for better coordinating on-site health services to help aging residents stay independent, a program called Support and Services at Home (SASH). In its first year alone, the SASH program helped reduce falls by 22 percent and hospital admissions by 19 percent. Those outcomes translated into an estimated $40 million in health care savings, mostly from Medicare.[67]

Click here to access CSH project profile on Mercy Housing Lakefront

Adaptations for cognitive impairment and dementia: Intentional design features or modifications can be made to a housing project's physical environment and in units to lessen the challenges of dementia.

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[64] Housing Capacity Building Initiative for Community Living: Reasonable Modifications Under Fair Housing Laws and Potential Funding Sources

[65] http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_americas_older_adults_2014-ch4.pdf

[66] Ibid.

[66] https://leadingage.org/sites/default/files/Cathedral_Square_Corporation_Cast_Study.pdf

The use of color has been particularly effective in helping tenants navigate their environment and remember concepts over details, reinforcing spatial memory.

Woodside Place, an assisted-living community in Pennsylvania, incorporated the use of different colors for residents's units that matched staff uniform colors, which were easier for residents to remember. Hallways use themed art installations to serve as environmental landmarks and visual cues.[68]

[68] James Gaines. "How Subtle, Clever Architectural Decisions Can Help People Living with Dementia." Upworthy.com, May 31, 2016. https://www.upworthy.com/how-subtle-clever-architectural-decisions-can-help-people-living-with-dementia.

Project Design

Project design and administration is the process of planning and leading the supportive housing project, including key decisions about physical structure, team members, and funding. This generally refers to new single-site or scattered-site housing projects, although it can also involve remodeled housing developments.

Whether the supportive housing project is a new or remodeled one, its design is a comprehensive process that requires considerations for how tenant needs may change over time, and how environmental and physical features and service programs can work together to meet tenant needs in every stage of his or her life.

New projects should pay special attention to project quality in the design phase. The project should aim to meet the needs of older adults by ensuring that the new or remodeled project is tenant-centered, accessible, coordinated, integrated, and sustainable.

Tenant-Centered Project Design

Tenant-centered project design involves feedback and participation in the planning and design process, and a commitment from project stakeholders to ensure that tenants are able to thrive in the housing.

This requires an understanding of the unique needs of older adults and should incorporate input from this population in the design phase. This could include focus groups, tenant representatives involved in project planning, surveying the population, and/or hosting facilitated meetings to solicit community feedback.

Involving various housing project stakeholders in the project design process will lead to better understanding the short- and long-term needs of tenants, staff, and service partners. Housing that targets older adults should also consider connecting with other supportive housing providers or project developers who serve the same target population to build anticipated future tenant needs into the project design.

Accessible Project Design

An accessible project is affordable to tenants, is in a physically accessible location, and accommodates tenants's special needs. Even though choices of site location of a single- or scattered-site housing development can be limited, the project site, building, and units can be designed in ways that increase accessibility for older adults.

The project may require some specific design considerations. For example, since older adults have a greater need for health care services, it would hinder access to these vital services to choose an area without nearby health clinics, hospitals, or health centers. Supportive housing providers or project developers may find that it would best serve tenants to build an on-site medical and/or mental health clinic operated by the housing project team and partners or, for example, to provide the space for a partner agency such as a Federally Qualified Health Center (FQHC) to operate a full-service or satellite clinic.

On-Site Health Care

One approach to design, mentioned above, would be to build a space for an FQHC into the supportive housing project and contract with it to operate a full-service or satellite clinic in the space. Often, most new tenants are already connected to health care and will not transfer to the on-site FQHC. Planning for this approach must therefore include a careful assessment of demand for health care services in the community and due diligence around legal and funding restrictions that such a model may bring.

Other On-Site Amenities to Consider

New housing projects might consider multi-use areas, rooms, or spaces on-site, depending on the size of the site, funding, zoning restrictions, and other various factors.

Many single-site housing projects, especially newer projects, are going beyond housing units only. In the design of a housing project that serves older adults, consider the following amenities, which may require build out:

- On-site community or senior centers: These could be great spaces for on-site service delivery through partnership with a community senior center. Alternatively, it could serve as a community center for various area residents, thus increasing social opportunities and decreasing isolation.

- Fitness rooms: The site might consider these to promote health and wellness, though it is advisable to seek advice from other supportive housing providers or developers of similar projects that have incorporated fitness centers or gyms, to ensure that tenants will use these spaces.
- Communal kitchens: These promote tenant socialization and can serve as spaces for tenants to invite friends and family, host resident events, used to cook meals for residents who are unable to do so themselves, and host cooking classes to support residents who are able to cook.
- Outdoor spaces: These should be planned carefully to ensure they are accessible for tenants with mobility issues. Designated outdoor smoking areas are strategies that can be built into design to prevent tenants from smoking in their rooms, if housing rules require them not to do so. Outdoor spaces can also include recreational areas, gardens, small parks, and patios.
- Learning/technology centers: Older adults may not have their own technology devices or the internet. A learning center or computer lab could provide the means for tenants to communicate with friends and family, retrieve information, and learn how to use technology.
- On-site retail: Some housing projects are multi-use and include ground-floor retail space. This space could be used in a number of different ways, including renting it to an external business or launching a social enterprise that benefits older adults (e.g., a café with social activities, convenience store, a restaurant that could make meals for residents, etc.).

Access to Transportation

Some communities offer financial incentives for developing projects along transportation corridors. Lack of transportation is a barrier to accessing many services and community amenities, and it can lead to missed appointments and isolation.

Anticipating this need during the design process can bring more options than managing the problem as it arises. Developers can plan sites near transportation lines when possible, or work with the community to determine the feasibility of extending transportation service to the location of the housing site (e.g., altered bus/tram route).

Build Transportation Services into the Plan

When there are limited to no transportation options within a few hundred feet, the project could consider building transportation services into program operations.

This could include:

- Partnering with local agencies to create a public transportation stop at the residence site (e.g., bus, tram, subway, etc.)
- Securing dedicated vehicles such as vans managed by property management (single site) or the service team (scattered site)
- Considering innovative partnerships: using special education school buses, collaboration with Uber or Lyft (e.g., using taxi vouchers for these services for on-demand senior transport, or exploring grant opportunities)
- Maximizing the existing resources in the community

Design Units for Accessibility

Accessible unit design is configuring units and including features that meet tenant needs in the long term. This includes structural accommodations like wide hallways and doors, larger-sized rooms and bathrooms, storage closets for scooters, and no-step entryways. Features include grab bars, lowered counter tops, adjustable-height closet rods, emergency pull chords, adjustable-height furniture, and raised toilet seats.

The use of universal design features in housing is a best practice for serving populations of any age, including older adults — although it should be noted that older adults require some accommodations that are not specifically mentioned in universal design resources. See the Sustainable Project Design section below.

Coordinated Project Design

In coordinated supportive housing projects, the housing partners (developer, property manager, and services providers/partners) work collaboratively to ensure that all housing and service operations are coordinated with clear communication and written agreements.

When designing a project, it is crucial to consider the many different health care system partners that will need to be engaged to effectively serve tenants as they age. It is also important to consider the way the physical environment can facilitate — or hinder — independent and safe living. Involving key stakeholders in the project development team with intentional efforts to coordinate design will result in a project that better meets the needs of older adults.

This includes involving members of the tenant population, service partners, and property management staff. Including peer organizations that have developed similar housing projects will help mitigate risks and can bring new insights and ideas to your project, whether it is single- or scattered-site.

Integrated Project Design

Integrated projects meet or exceed community standards, and housing and community partners collaborate throughout the project design process.

Sustainable Project Design

Designing sustainable projects means that the project will remain financially viable in the long-term and can remain affordable. For the aging population, this also means that the building and units can accommodate the unique needs of older adults now, as well as their changing needs as they age in place.

Some developers have employed universal design principles into their developments as a way to anticipate aging in place and accommodate increasing needs for in-home care and physical supports.

Universal design[69] provides a comprehensive framework for addressing housing accommodations by using features and products that make homes safer and more comfortable, that promote independence, and that are flexible to allow for changing physical configurations when needed. Some units may need to abide by ADA guidelines and others may simply need to have built-in adaptability in the case that tenants require accommodations.

In addition, universal design aims to increase health and social participation.[70] Required elements of universal design standards include barrier-free or adaptable showers; extra-wide stairs, hallways, and doors to accommodate those in wheelchairs; reachable switches and outlets; a fully accessible bathroom on the ground floor of the building; step-free entranceways; rocker-panel light switches; non-slip floor areas; installation of kitchen sink, drainpipes, and countertops at a lower height; and lever-style handles.[71]

There are also unique physical unit features that developers often overlook when designing a project for older adults. One common need among these individuals is a space to charge mobility equipment like scooters.

As residential units for seniors are often small, there is also the need for mobility equipment

[69] The Seven Principles of Universal Design are outlined here: http://nhi.org/online/issues/148/housingforall.html
[70] Habitat for Humanity pilots universal design principles: http://www.buffalo.edu/news/releases/2016/07/016.html
[71] http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_americas_older_adults_2014-ch4.pdf

storage. Potiker City Heights Residence, [72] an affordable and supportive housing project in San Diego, Calif., used lessons learned from a previous housing project to incorporate features that meet these unique needs. The project-built storage closets into resident hallways that had raised electrical outlets for charging scooters. This gave residents a place to store and charge their scooters so they would not take up space in their units.

Other lessons learned included:

- *Residents worry about their safety in the event of an emergency.* Developing a comprehensive emergency evacuation plan is vital and includes ensuring that emergency professionals know which residents/units require special assistance during an evacuation.
- *Many older adults rely on electricity for mobility equipment, in-home care equipment, communications, medications, etc.* Residents worry about power outages and how that might impact their lives. Housing projects that have back-up generators can minimize these fears and provide a way for residents to have power in the event of an emergency or natural disaster.
- *Units with full-size refrigerators better accommodate older adults who receive meal deliveries.* This population often keeps several days's worth of frozen meals stored in their kitchens. The small refrigerators provided in many supportive housing units may not be large enough to accommodate multiple frozen meals, drinks, and — in some cases — medications.

[72] http://www.cityheightssquare.com/

Funding and Policy Considerations

Supportive Housing Project Funding for Seniors

Developers of permanent supportive housing have been successfully creating housing for older adults using a variety of resources. Many such developments have been financed using sources of capital and operating funding that are not specifically targeted to this population.

These sources have been commonly used in the development of permanent supportive housing for persons experiencing homelessness of any age. They include state and local capital funds, the Low-Income Housing Tax Credit program, New Markets Tax Credit program, the Federal Home Loan Bank Affordable Housing Program, Housing Choice Vouchers, and state and local rental subsidies. Of particular note, over half of the people currently served with Veterans Affairs Supportive Housing (VASH) vouchers are older adults.

In addition to these funding sources, the U.S. Department of Housing and Urban Development's (HUD's) Section 202 is the primary dedicated funding source for capital and operating funds for developments targeted to low-income older adults.

Going forward, HUD has proposed to concentrate new Section 202 funding in operating contracts, with capital coming through other sources. Although Section 202 developments do not automatically contain the robust services needed in permanent supportive housing, this funding can be combined with supportive services targeted to the needs of older adults in all or some of the units in a given development. Regardless of the funding source used to develop them, targeting units of housing to older adults who have experienced homelessness can both facilitate the inclusion of design features to address issues of aging and allow for the development of a

package of services in line with best practices.[73] For example, 11 states incentivize the use of universal design in the allocation of Low-Income Housing Tax Credits. HUD has also periodically offered Assisted Living Conversion Program (ALCP) grants to adapt affordable housing to a higher level of service needed to allow residents to age in place.

Experimentation is occurring with different financing models for transitioning people out of institutional care. Money Follows the Person (MFP) initiatives have offered states incentives to develop transition projects.[74] Although the majority of those transitioned have been younger adults with intellectual and physical disabilities, an evaluation by Mathematica indicates that residents aged 65 and older who have been transitioned to the community under MFP have improved quality of life.[75] For people who do not need full nursing home care, such transitions frequently result in reduced public expenditures, on an individual if not system-wide basis. CSH's Frequent Users Systems Engagement (FUSE) program is a close analogue. Right-sizing the nursing home stock and adding more independent, community-integrated options in compliance with the Olmstead mandate is an important policy trend for the older adult supportive housing stakeholder community. While Medicaid, the main payer of nursing home expenses for this population, is barred by statute from paying for "room and board" outside of a clinical setting, states are experimenting with supportive housing programs that are funded by reinvested savings from avoided health care expenditures.

Lack of coordination between Medicare and Medicaid is a particular policy challenge for the older adult supportive housing population. In late 2015, states began participating in demonstration programs to improve care for people who are dually eligible for both Medicare and Medicaid, by testing different financing models and improving alignment between the two programs. Despite progress, work remains to be done to ensure that Medicaid-funded tenancy support services are available to the dually eligible population. In addition, the Independence at Home (IAH) demonstration has shown promise for funding long-term care for Medicare recipients. Participants remain in their communities and receive coordinated, multi-disciplinary medical care for their long-term health challenges, and the program is financed by savings, compared to more intensive long-term care. Congress is working to expand IAH into a permanent program, and will hopefully take into account the challenges of serving a dually eligible population.

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[73] https://www.chapa.org/sites/default/files/ELI_policypaper_final.pdf

[74] James, M. L., E. Wiley, and B. E. Fries. "Predicting Nursing Facility Transition Candidates Using Aid: A Case Study." *The Gerontologist* 47, no. 5 (2007): 625–32. https://doi.org/10.1093/geront/47.5.625.

[75] Simon, Samuel E, and Matthew R Hodges. Rep. *Money Follows the Person: Change in Participant Experience During the First Year of Community Living*. Mathematica Policy Research, Inc., May 30, 2011. https://www.mathematica.org/publications/money-follows-the-person-change-in-participant-experience-during-the-first-year-of-community-living.

Despite the high stakes, public policy has failed to keep pace, underestimating the profound nature of the demographic transformation now underway. As a result, the U.S. is dramatically unprepared for the challenges that lie just ahead.[76] This unprecedented growth may drive a need for increased funding specifically to serve aging adults in housing settings as well as reconfiguration of existing funds.

CSH is working on the following policy changes:

- Allow for adjustments to supportive housing service contracts that were intended for a younger population so that providers can tailor their services to the unique needs of older adults who previously experienced homelessness.
- Create specialized services for frail older adults who previously experienced homelessness and who are in need of such services but are not eligible to receive them until they are 62 years old. This will allow providers to begin screening and treating for geriatric services early and will result in improved health outcomes and decreased costs for treating aging individuals.
- Develop or facilitate the use in permanent supportive housing of state-funded in-home personal care and domestic support services designed to help tenants maintain their independence in housing.
- Create or expand upon existing interagency collaboration (including between state departments on aging and Medicaid) in developing policy with regard to older adults who previously experienced, are currently experiencing, or who are at risk of experiencing homelessness.
- Expand the use of Pay for Success (PFS) or savings reinvestment strategies to create supportive housing for super-utilizers of health services who could live independently in the community.

Pay for Success (PFS): A Financing Mechanism for Successful and Innovative Programs

[76] Healthy Aging Begins at Home – Bipartisan Policy Center

PFS refers to the concept of performance-based contracting between government and the organizations responsible for implementing a given intervention, typically non-profit organizations.

Under this model, impact is measured rigorously and government makes "success payments" based on results, not on activities. This focus on paying for positive social impact, rather than paying for services performed, helps ensure that incentives are properly aligned to achieve social impact and provides a mechanism for the government to ensure it pays only for what works. PFS financing mechanisms support PFS programs by providing the upfront working capital required to implement an intervention that is proven to create value over time, but requires a significant start-up investment.

This upfront capital investment can be provided by institutional investors as well as philanthropic sources, which typically receive a modest return on investment and the potential for success payments depending on the intervention's performance. The savings generated by the successful execution of the intervention can be used to repay the investors and/or can be reinvested into the project, allowing further growth.

PFS can be used to implement a range of interventions, but pairs particularly well with an intervention like supportive housing with a strong evidence base showing its impact. Further, the greatest impact in terms of both outcomes and potential cost savings or avoidance can result from a focus on a target population with high costs in the status quo such as older adults.

Studies such as "A Research Note: Long-Term Cost Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing" document significant potential cost savings that can result from ensuring that older adults have access to integrated and supportive housing in the community that meets their needs. Communities interested in creating supportive housing for older adults should consider whether PFS can be a tool to help further these efforts. PFS financing can be used as supportive services funding, rental subsidy, or both. For more information, please visit https://www.csh.org/csh-solutions/community-work/

General Resources for Healthy Aging in Quality Supportive Housing

Nationwide Agencies

- Area Agencies on Aging
- Centers for Independent Living
- National Council on Aging
- American Association of Retired Persons
- Medicare
- Medicaid information by state
- The Center for Aging Services Technology
- National Aging and Disability Transportation Center
- National PACE Association

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The Emerging Crisis of Aged Homelessness:

Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs?

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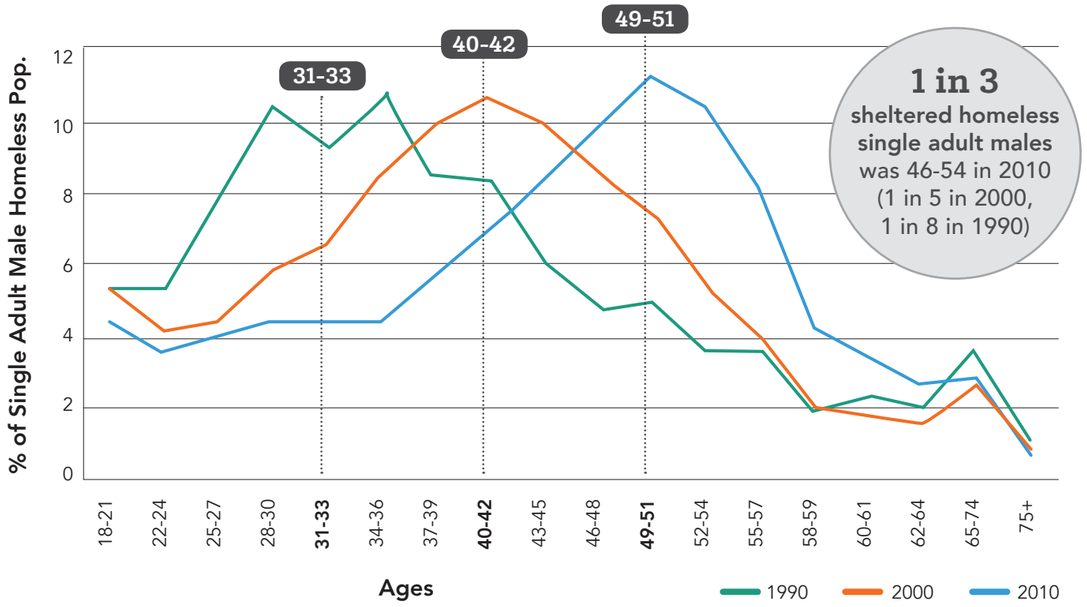
Contemporary homelessness is in large part a *birth cohort* phenomenon, disproportionately affecting people born in the latter half of the post-War baby boom (1955-1965).

Figure 1: Age Distribution of Adult Male Shelter Users in the United States

Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation



Data from three decennial censuses have revealed that contemporary homelessness among single adults is concentrated among persons born in the latter half of the post-War baby boom (1955-1965) and in the years immediately adjacent to that period (Culhane et al, 2013).[1] Demographers refer to this as a "cohort effect," or more specifically an "Easterlin cohort effect," named after the demographer Richard Easterlin. Easterlin hypothesized that individuals born after the peak of a baby boom are more likely to be economically disadvantaged relative to their predecessors due to an excess supply of workers at the time of their labor market entry, among other factors (Easterlin, 1987; Macunovich & Easterlin, 2008.).

[1] Figure 1 includes adult male shelter users only, as the decennial census data available could not disaggregate females who were single adults versus heads of family households, skewing the results toward the younger mothers.

Preceded by a surge in the supply of workers and in housing demand, people from the second half of the post-War baby boom faced crowded labor and housing markets with higher competition for employment, downward pressure on wages, and upward pressure on housing prices. Combined with back-to-back recessions in the late 1970s and early 1980s, young adults coming of age in the 1980s faced challenging economic circumstances. This was especially true for those with a high school education or less, as they were the least prepared to compete in these tightened marketplaces. Consider that young black men in their 20s had an unemployment rate of nearly 25% in 1983, a rate unmatched in recent history, and nearly double the rate ten years earlier or ten years later (U.S. Bureau of Labor Statistics, 2019).

Unemployed and underemployed young adults, many accompanied by their children, became the face of homelessness in the mid-1980s, as the problem was newly visible on our nation's streets for the first time in decades. As Figure 1 illustrates, this cohort effect has persisted for 30 years. While the people who experience homelessness are not the same from day to day--or even year to year--the 1980s saw the emergence of a generational dislocation that would sustain a heightened risk for homelessness among this birth cohort.

Now, that generation is prematurely aging and dying. Older homeless adults have medical ages that far exceed their biological ages. Research has shown that they experience geriatric medical conditions such as cognitive decline and decreased mobility at rates that are on par with those among their housed counterparts who are 20 years older (Brown et al., 2017; Brown, Kiely, Bharel, & Mitchell, 2012). As a result, health care and nursing home costs are likely to increase significantly over the next 15 years.

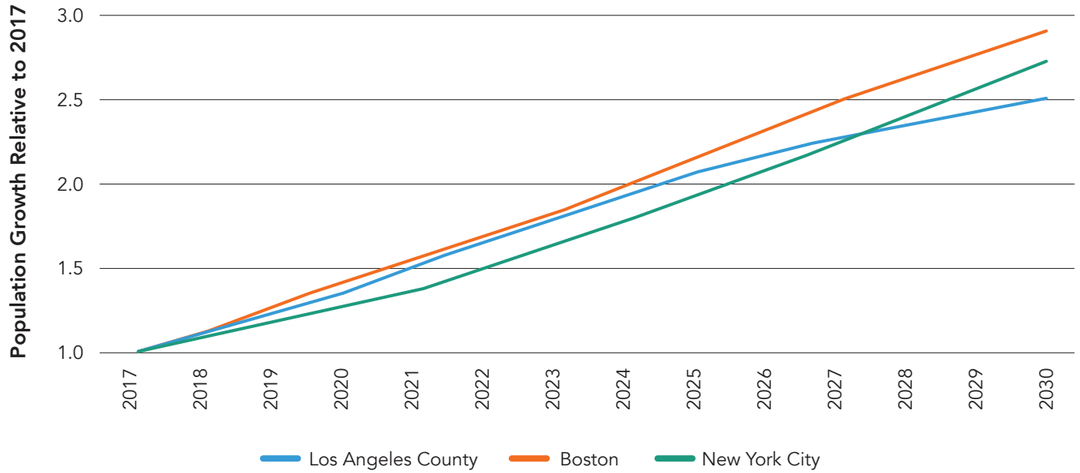
This report summarizes a multi-site study in three localities – Boston, New York City, and Los Angeles County – of the anticipated future of the aged homeless population, its likely impacts on health and shelter systems and resulting costs, and the potential for housing solutions. Specifically, this report summarizes the following analyses:

- Forecasts of the size of the aged homeless population to 2030
- Projected costs associated with the use of shelter, health care, and long-term care by this aged homeless population
- Segmentation of the forecasted aged population based on the intensity of health and shelter use by various subgroups
- Proposed housing and service intervention models matched to the varying level of housing and services needs of these subgroups
- Potential service cost reductions associated with housing interventions based on scenarios from prior literature
- The net cost of the proposed housing interventions based on the potential for shelter, health, and nursing home cost offsets

The report concludes with some considerations regarding how to pay for potential housing solutions, given the complexity of the various funding streams. Absent new housing solutions, substantial public resources will otherwise be spent unnecessarily on excess shelter, health, and long-term care use.

The aged homeless population is growing rapidly and will continue to grow for the next decade.

Figure 2: Forecasted Relative Change in the 65 and Older Homeless Population Compared to 2017



Recent historical shelter records from the three study localities were used to develop forecasts of shelter use by persons 55+ and 65+ through 2030. Multiple forecasting models were developed and tested by the research team with minor methodological differences between sites to account for site-specific factors (see the site-specific reports for details). The final forecasts reflect the intermediate estimates and incorporate expected declines in shelter use associated with death and other age-related exits.

The results, depicted in Figures 2, 3 and 4, project significant growth in aged homelessness, especially among people aged 65+. The forecasts appear quite similar across the three localities, with a nearly threefold growth rate in Boston for those aged 65+ at the higher end and a 2.5 times growth rate for Los Angeles County on the lower end (Figure 2).

In New York City (Figure 3a) the number of homeless adults 65+ will grow from 2,600 in 2017 to 6,900 by 2030. The corresponding growth in Boston (Figure 3b) is from roughly 570 in 2017 to roughly 1,560 by 2030, and in LA County (Figure 3c), 4,700 in 2015 to 13,900 in 2030.

Figure 3a: New York City, 65+ 2011-2030

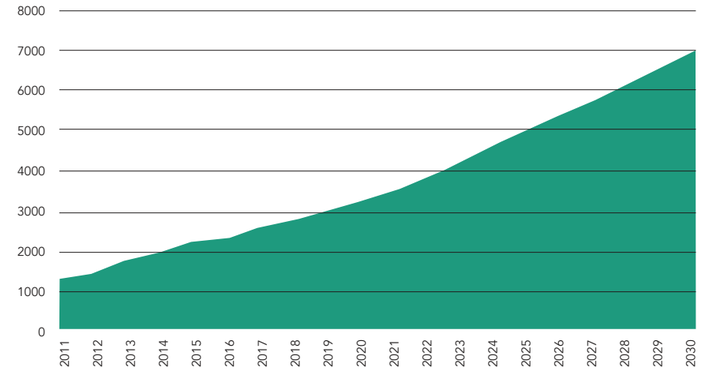


Figure 3b: Boston, 65+ 2011-2030

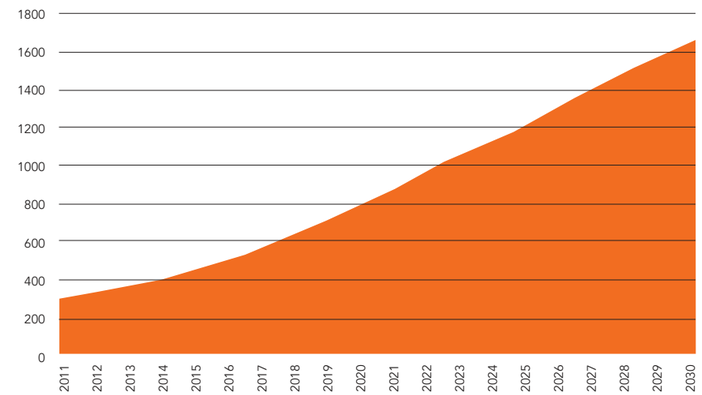
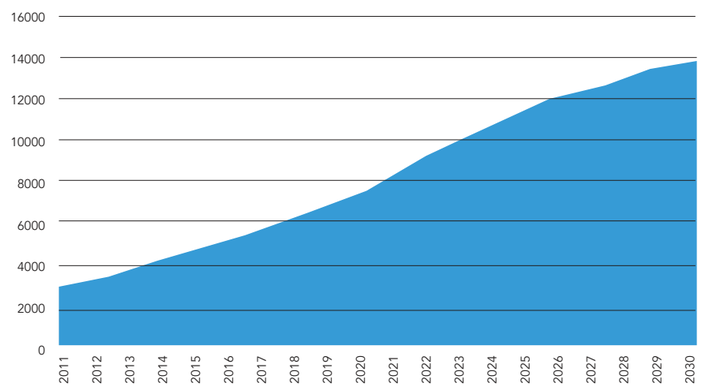
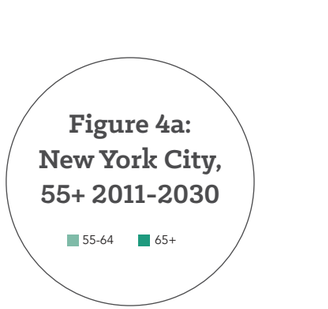


Figure 3c: LA County, 65+ 2011-2030



Figures 4 a, b, and c show the growth rate for the 55+ population, which includes the 65+ population. As expected, the growth of the age 55-64 population slows over time, as the impact of the post-War cohort on this age group tapers off by 2025. Importantly, these figures reveal that much of the impact of the post-War baby boom on the aged homeless population is already well underway. In other words, the growth in the 65+ homeless population does not reflect a newly increasing risk for homelessness among aged adults, but merely the continuation of unprecedented levels of homelessness among the late Baby Boom cohort from late middle age into older age.

Figure 4a: New York City, 55+ 2011-2030



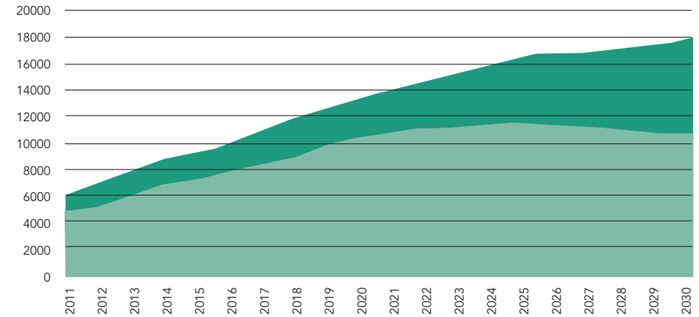
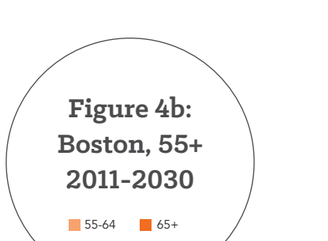


Figure 4b: Boston, 55+ 2011-2030



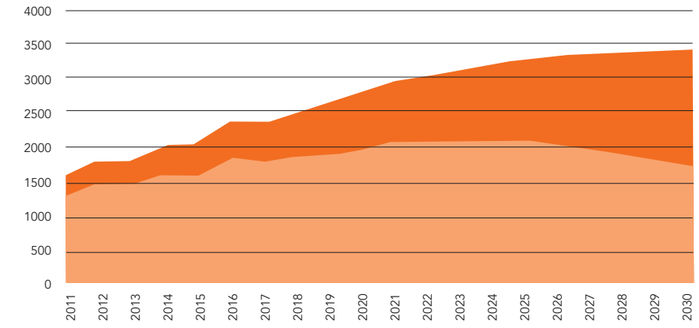
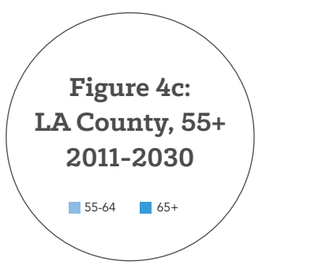
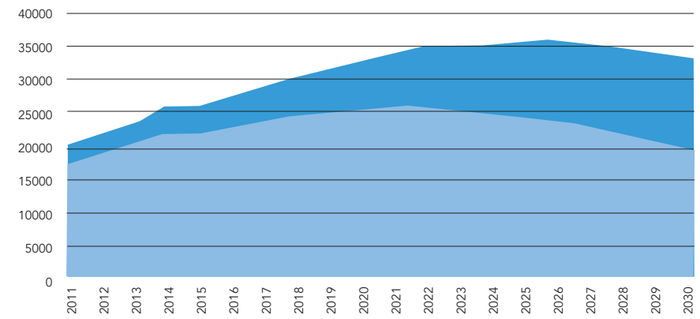


Figure 4c: LA County, 55+ 2011-2030





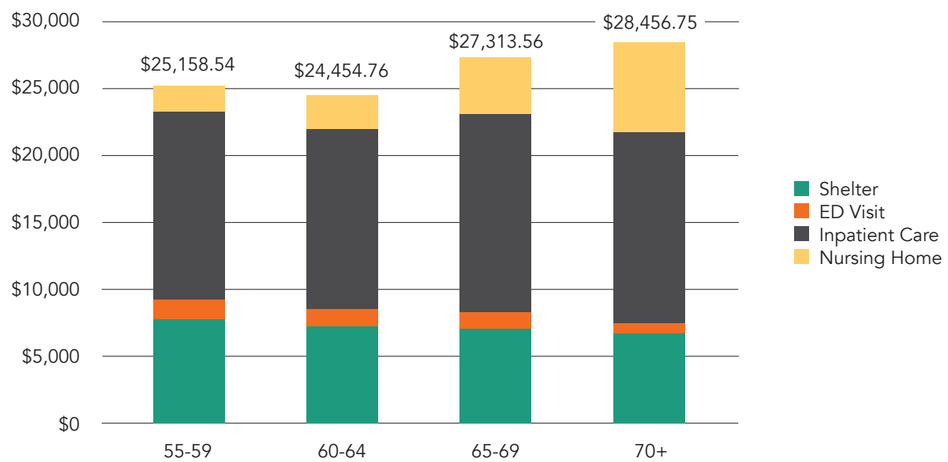
Los Angeles County is the only site in which the total 55+ population is likely to peak before 2030, growing by 75% from 20,550 in 2011 to 36,045 in 2025 before decreasing by 2,600 through 2030. This is primarily because the LA County homeless population is already older than the NYC and Boston populations. The 55+ population in Boston is expected to level off by 2029 and decrease thereafter, with New York expected to show decreases beginning in the early 2030s.

As aged homelessness grows, so too will service use and costs, including for hospital and nursing home stays.

Recent historic shelter data from the three study sites were merged with corresponding data on health services use, as well as from national nursing home data from US DHHS CMS for LA County and NYC.[2] In one important difference, the NYC and Los Angeles County sites were matched with the all-payer data in their respective states, thereby including Medicaid-, Medicare-, and private- or self-paid hospital services use. In Boston, however, health records were limited to Medicaid fee-for-service and Medicaid managed care encounter claims. Therefore, the Boston health records do not include health services use paid by Medicare or other insurers, representing a key limitation. In addition, the specific types of services (e.g., outpatient, inpatient, emergency department) available in the health care data varied somewhat among the three sites, meaning health care cost estimates for each site are not directly comparable to one another.

Figure 5a shows the average annual cost of the four services – shelter, emergency department (ED), inpatient hospitalization, and nursing homes, included in the NYC analysis for each 5-year age group in an average year.

Figure 5a: Average Annual Costs by Age, New York City



[2] See the site reports for details on the data sources and cost estimation methods. They can be accessed at https://www.aisp.upenn.edu/aginghomelessness/

Figure 5b: Average Annual Costs by Age, Boston

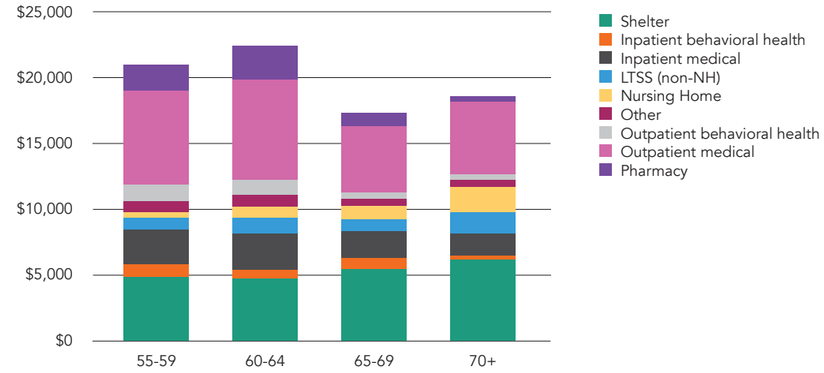
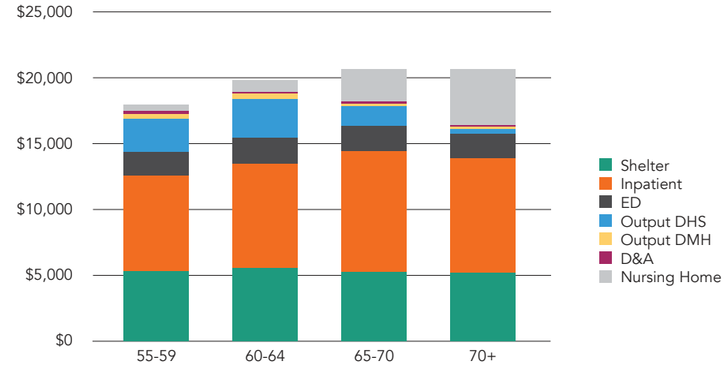


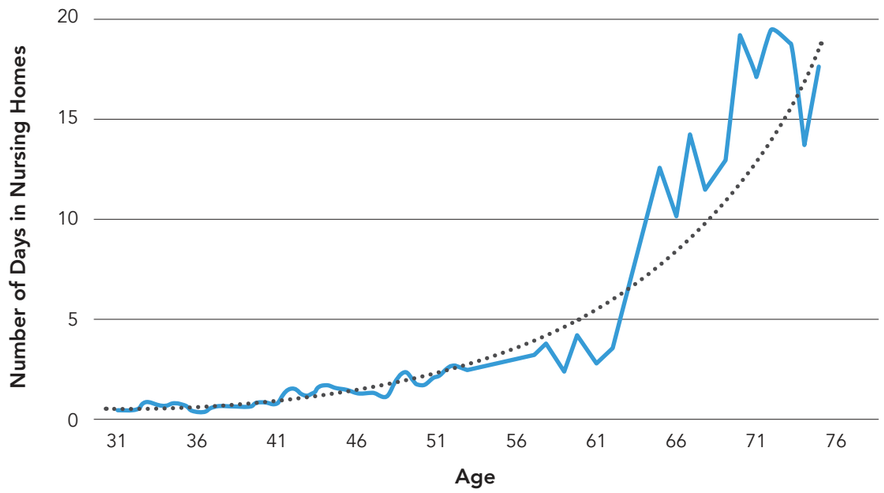
Figure 5c: Average Annual Costs by Age, LA County



In general, costs increase with age. The overall costs are slightly higher in New York City than in Boston and LA County, owing to higher shelter and health care reimbursement rates there. But, the overall trend is consistent, with the one exception being Boston, where the lack of Medicare data is likely contributing to a drop in measured health services for persons 65+. Again, the site reports provide greater detail on measurement and cost estimates.

The increased use of nursing homes by age was a consistent trend across the three study localities. As seen in Figure 6 for LA County, for example, nursing home days shows a big jump at age 65 and continued growth as age progresses.

Figure 6: Nursing Home Use by Age, LA County



Combining annual shelter and health care costs with the population projections from the previous section allows us to estimate future costs across systems and time, as seen in Figures 7a, b, and c. Figure 7a, presenting New York City data, suggests that annual costs are projected to triple from 2011 to 2030, from approximately $150m to $461m annually.

Boston (Figure 7b) follows a similar trajectory, with costs more than doubling, from $33.2m in 2011 to $67.4m in 2030. Again, these projections do not include Medicare data and associated cost increases.

In LA County (Figure 7c), total shelter and healthcare service costs are likely to peak in 2026 at $540m, after increasing by 80% from 2011, and then slowly decline through 2030.

Figure 7a: NYC Combined Shelter & Healthcare Costs 2011-2030 (in millions of $)

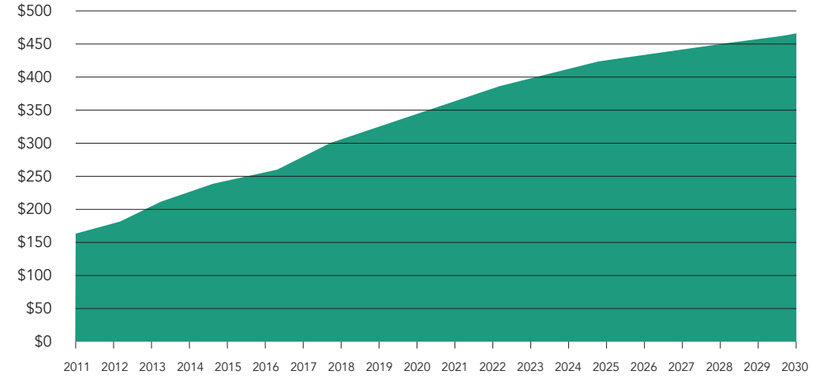


Figure 7b: Boston Combined Shelter & Healthcare Costs 2011-2030 (in millions of $)

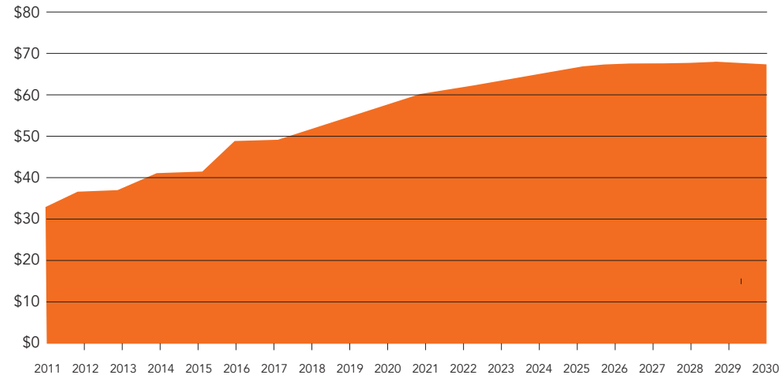
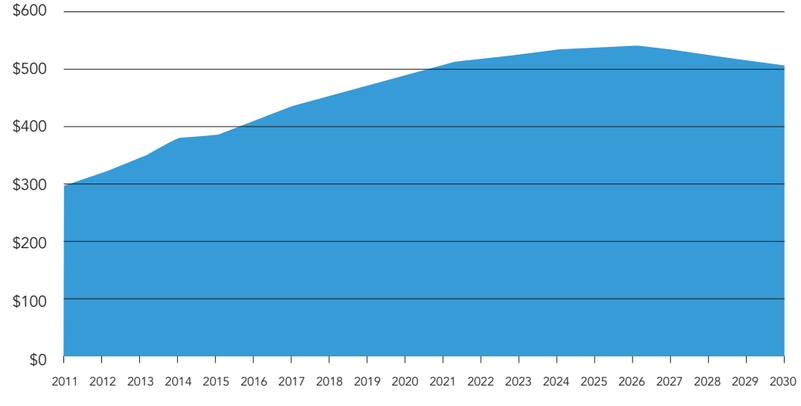


Figure 7c: LA County Combined Shelter & Healthcare Costs 2011-2030 (in millions of $)

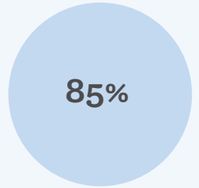
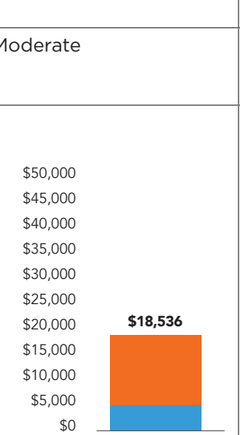
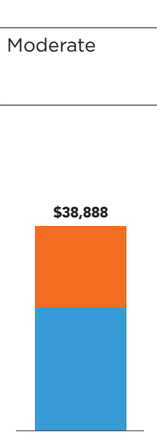
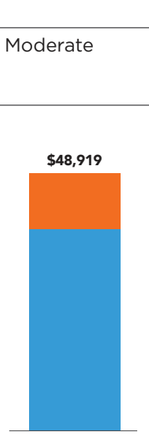
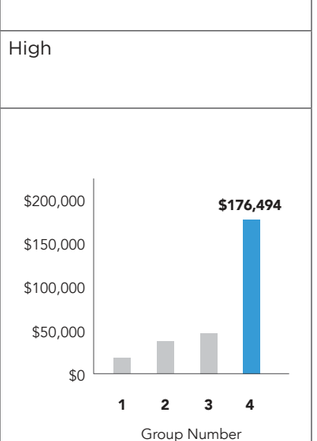
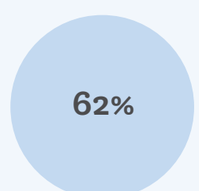
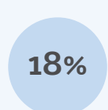
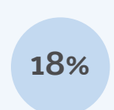


Subgroups among the aged homeless adult population can be segmented to reflect varying degrees of morbidity and intensity of shelter use.

Older adults experiencing homelessness remain a heterogenous population with respect to their housing, health care, social, and other needs. While there is an elevated level of health care need among older homeless adults in comparison with both their younger homeless and contemporary housed counterparts, there remains substantial variation in their use of health care services (Flaming, Burns, & Matsunaga, 2009). Also, homeless persons in general have different patterns of shelter use, with most people's total homeless experience lasting for one or two short episodes, but with substantial minorities experiencing longer and more frequent periods of homelessness (Kuhn & Culhane, 1998). This means that different subgroups of individuals will require different types of housing interventions to obtain housing stability. To better represent the varying needs of older homeless adults, a clustering algorithm was developed to group individuals based on combined shelter and health care use characteristics. Figure 8 presents results from NYC, as illustrative of the three sites, although the number of subgroups and relative distribution across subgroups differs slightly across the sites. Note that these subgroups represent cross-sections in an average year; people are expected to move across these groups over time.

- In NYC, four distinct groups of people categorized by their shelter and hospital service use emerged. The largest segment (85% of the sample) had moderate service use across the board, with an average of 44 shelter days, 3 inpatient days, 1 ED visit, and 9 nursing home days each year. Two groups (12% and 1% of the sample, respectively) used larger amounts of shelter (7 and 11 months average annually, respectively) while still having moderate hospital and nursing home use. Group 4, comprising 3% of the sample, had the lowest shelter use but the highest hospital and nursing home use and was, by a factor of nearly four, the most expensive group.
- As expected, costs in any given year are relatively concentrated among a small group of high-users. While group 1 represents 85% of the whole cohort, they account for only 62% of costs. Groups 2, 3, and particularly 4, on the other hand, account for a disproportionate share of the total costs. Group 4 makes up 18% of the total costs despite accounting for only 3% of our sample.

Figure 8: Understanding Distinct Groups of Service Users

	Group 1	Group 2	Group 3	Group 4
Percent of the Sample				
Shelter Use	Moderate	High	Very High	Low
Hospital & Nursing Home Use	Moderate	Moderate	Moderate	High
Average Annual Costs				
Percent of Service Costs				

Housing interventions could be targeted to these segments, with intervention intensity matching need.

The housing and health care use patterns for each of the subgroups correspond to housing approaches already operational in assisting older adults experiencing homelessness. Continuing to use New York City (NYC) as an example, seen in Figure 9, a progressive engagement model that matches intervention intensity to client needs is proposed[3]. It should also be noted that these models assume that nearly all of this population, and certainly those over the age of 65, will be eligible for some Social Security income, such as Supplemental Security Income (SSI), and that SSI outreach efforts like SOAR (SSI/SSDI Outreach, Access, and Recovery) will need to be expanded as part of the overall effort to address aged homelessness.

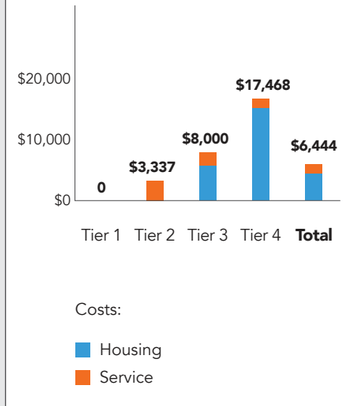
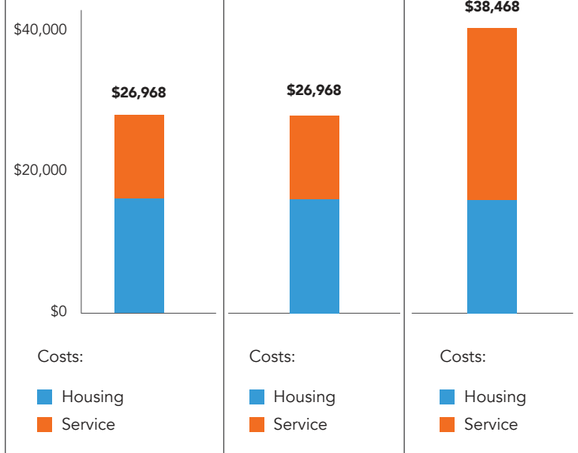
For Group 1, the largest group, a range of "light touch" case management and housing-oriented interventions are proposed, including rapid rehousing, shallow rental subsidies and standard rent vouchers. Previous research has found that most adult homelessness is temporary, and that a substantial minority of homelessness is self-resolved without formal intervention. Indeed, about one-third to one-half of people who experience sheltered homelessness will exit within 30 days without intervention or with only minimal assistance. Because not everyone who exits homelessness will exit to housing, this "self-resolving" group is estimated here conservatively as one-third of group 1. Other interventions provided to the remaining two-thirds of group 1 are proposed to distribute through a progressive engagement approach:

- Rapid Rehousing, for those needing relocation grants and case management services, and time-limited rental assistance as necessary (22% of group 1)
- Shallow rental subsidies with relocation and case management services for those who need ongoing, modest rental assistance for shared living arrangements (e.g. with family, friends, partners) (22% of group 1)
- Rental vouchers, like those available through HUD's Section 202 program, in addition to light case management, for those expected to be living alone (22% of group 1)

Groups 2, 3, and 4 are proposed to be candidates for Permanent Supportive Housing (PSH), justified by either high shelter use or health care use. All three of these groups will likely need support for enhanced case management and home care services to allow aging in place. In addition, the 3% of adults with the highest health care use in group 4 may also require palliative and nursing home transition services. It is worth noting that the assumption that all of these groups will require PSH is a likely overestimate, and will overstate expected costs, as many in these groups could be candidates for rapid rehousing and other lower cost housing interventions, through a progressive engagement approach.

[3] We use the "progressive engagement" approach as defined in Culhane, Metraux, & Byrne's "A Prevention Centered Approach to Homeless Assistance: A Paradigm Shift?" (2010). The progressive engagement model described does not reflect the current strategy employed by the Coordinated Entry system in the City of Boston

Figure 9: Potential Interventions by Group

	Group 1	Group 2	Group 3	Group 4
Group Descriptor	Moderate shelter & health care use	High shelter use, moderate health care use	Very high shelter use, moderate healthcare use	Low shelter use, high health care use
Percent of Population	85%	11%	1%	3%
Intervention Need	Housing-oriented Progressive Engagement Approach **Tier 1:** Self-resolve, housing advice only **Tier 2:** Rapid re-housing **Tier 3:** Shallow rental subsidy & light case management **Tier 4:** Housing voucher & light case management	Permanent Supportive Housing (PSH)	Permanent Supportive Housing (PSH)	PSH + additional supports like palliative care and nursing home transition services
Average Annual Per Person Costs of the Intervention				
Percent of Total Intervention Costs	43%	40%	5%	13%

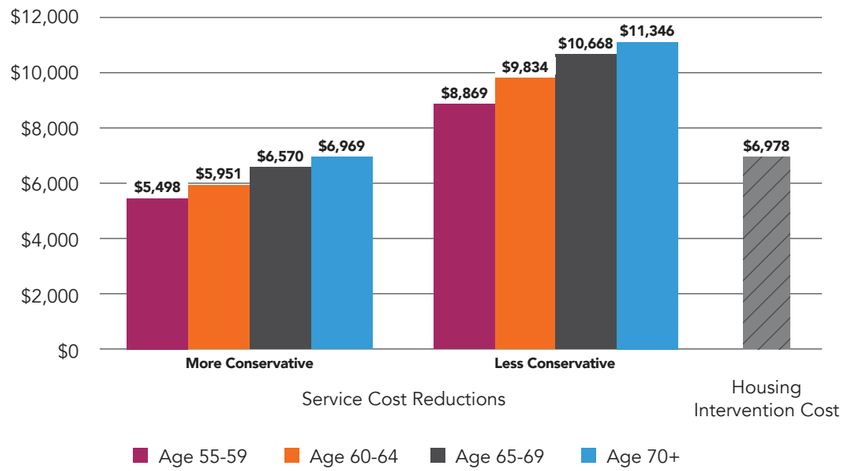
Based on the published literature, the placement of people who are formerly homeless in permanent housing is associated with reduced use of shelter, health and nursing home services, and related expenditures.

Assuming that the proposed housing models are brought to scale in line with the approaches described above, excess service use costs associated with homelessness are expected to decline. To estimate this decline, data from 15 studies of permanent supportive housing were gathered to estimate the expected service cost reductions associated with housing placement. To incorporate the uncertainty around cost offset estimates from these prior studies, two scenarios were generated: a more conservative projection in which findings from all prior studies—including those identifying no change in health care costs in certain cost categories—were considered equally, and a less conservative projection that included only findings of significant cost reductions in calculating anticipated average cost offsets. This latter scenario represents cost reductions that might be expected should the implementation of the housing interventions have an effect more in line with what studies identifying relatively larger impacts have found. In both scenarios, the most methodologically rigorous studies received more weight than others (see the site-specific reports for a detailed list of the studies and weightings included in these estimates). The estimated offsets by service type are shown in Table 1, and more detailed information on which service costs are included for each locality is available in the site reports.

Table 1: Cost Offset Scenarios

Cost Category	Scenario 1 (more conservative)	Scenario 2 (less conservative)
Inpatient medical	-18%	-33%
Emergency Department	-6%	-45%
Outpatient medical	-6%	-45%
Outpatient behavioral health	48%	-29%
Inpatient behavioral health	-35%	-56%
Nursing home	-42%	-90%
Shelter	-71%	-71%

Figure 10a: Range of Cost Reductions Across Age Groups: LA County, Average Per Person, Per Year



Because increasing age is associated with higher service use, cost reduction estimates also increase with age. Figure 10a shows the service cost savings, for each 5-year age group under each of the cost reduction scenarios in LA County, and suggests that the shelter and health care service costs recouped will grow as clients age. For those 55-59, the net offset (cost reductions minus the cost of the intervention) for a scaled intervention ranges from a cost of $1,500 ($5,498 - $6,978) in the more conservative scenario to a gain of nearly $2,000 ($8,869 - $6,978) in the less conservative scenario. For individuals 70 and older, the projection is for a break-even ($6,969 - $6,978) result in the more conservative projection and a net offset of approximately $4,400 ($11,346 - $6,978) in the less conservative scenario.

For ease of presentation, Figures 10b and 10c present similar findings, aggregated across age groups, for the other two sites.[4] As seen in Figure 10b, New York City's net offsets for a housing and services intervention scaled across all 55 and older homeless adults could be between -$1,900 per person per year in the more conservative scenario and a gain of approximately $2,200 per person per year with less conservative savings assumptions.

Figure 10b: Cost Reduction Possibilities in NYC, Average Per Person Per Year

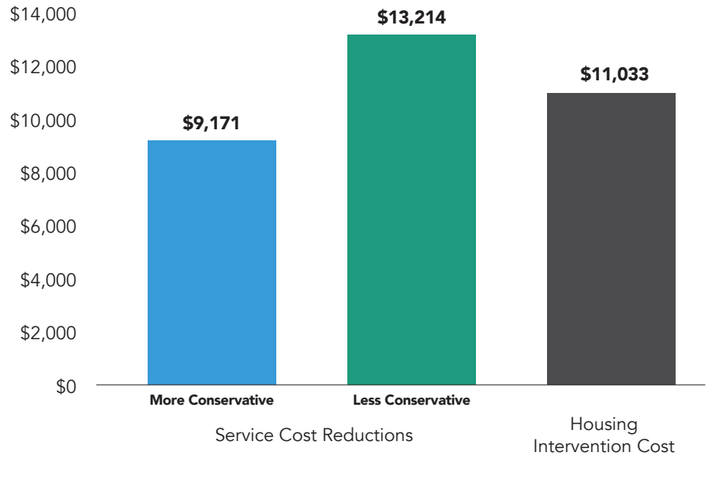


Figure 10c: Cost Reduction Possibilities in Boston, Average Per Person Per Year

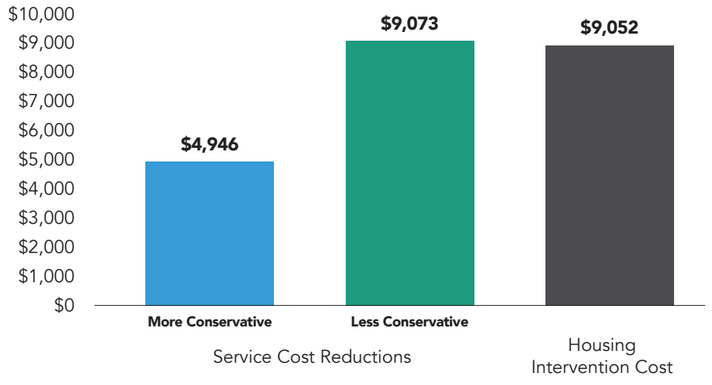


Figure 10c presents the potential cost offsets in Boston. Compared to New York City and Los Angeles County, the average service cost offsets are lower, especially in the more conservative scenario. This is mostly because Medicare reimbursement services were not included in the Boston analysis. In other words, the cost offsets in the Boston analysis represent a lower bound estimate of the actual health care cost offsets from the shelter and health care systems. A forthcoming estimate that includes potential Medicare contributions to these service cost reductions would suggest an estimate that is nearly break-even, even in the more conservative scenario.

[4] The site-specific reports contain detailed estimates by scenario and age group. They can be accessed at https://www.aisp.upenn.edu/aginghomelessness/

Figure 11 continues to use New York City's analysis to illustrate the distribution of people, service costs, housing intervention costs, and service cost reductions across the four population subgroups. As expected, the greatest per-person cost offsets are observed with the highest cost groups. But examining the proportion of intervention costs versus cost reductions across the sample reveals a different picture. While Group 1 has the lowest expected cost reductions, it also requires the least expensive intervention, and therefore accounts for a higher total share of the offsets (64%) relative to its share of intervention costs (43%). This suggests that a scaled intervention even for the lowest cost group could contribute to positive cost offsets overall, not to mention that being housed may increase the potential for avoidance of even higher cost services use in future years when needs among members in this group may change.

Figure 11: Potential Cost Offsets by Group

	Group 1	Group 2	Group 3	Group 4
Group Descriptor	Moderate shelter & health care use	High shelter use, moderate healthcare use	Very high shelter use, moderate healthcare use	Low shelter use, high healthcare needs
Percent of Population	85%	11%	1%	3%
Intervention Need	Housing-oriented Progressive Engagement Approach	Permanent Supportive Housing (PSH)	Permanent Supportive Housing (PSH)	PSH + additional supports like palliative care and nursing home transition services
Percent of Total Intervention Costs	43%	40%	5%	13%
Total Service Cost Reductions Per Person (average scenario)	$7,978	$21,072	$30,599	$49,639
Percent of Total Shelter & Health Care Service Cost Reductions	62%	22%	4%	12%

How can society invest in housing solutions to realize these potential offsets?

The purpose of this study was to engage in an empirically informed thought experiment and to foster dialogue about an impending public health crisis. A coming wave of aged homelessness among the latter half of Baby Boomers is certain, and with it will come an equally certain increase in their aging-related health care costs. The *excess* costs associated with their homelessness—not to mention the avoidable illnesses, exacerbated morbidity, premature disability, and accelerated mortality should compel us to reflect and act.

By simulating potential cost offset scenarios and comparing those to potential intervention costs, this report is calling for urgent reflection on how society could advance funding for housing solutions, from the future savings to be realized from the avoidance of excess shelter, health, and nursing home costs. The complex streams of funding that are currently accessed to address homelessness and health care among this aged cohort make this no easy task. However, that large sums of public funding will go toward this crisis whether we act or not should motivate us to find the best and most responsible use of those funds. We can spend those dollars on potentially unnecessary hospital and nursing home days, or we can improve the quality of life of these vulnerable citizens, reduce the daily demands on hospitals and emergency departments to care for them, and relieve shelters of the burden for large-scale, aging-related care for which they are ill-suited.

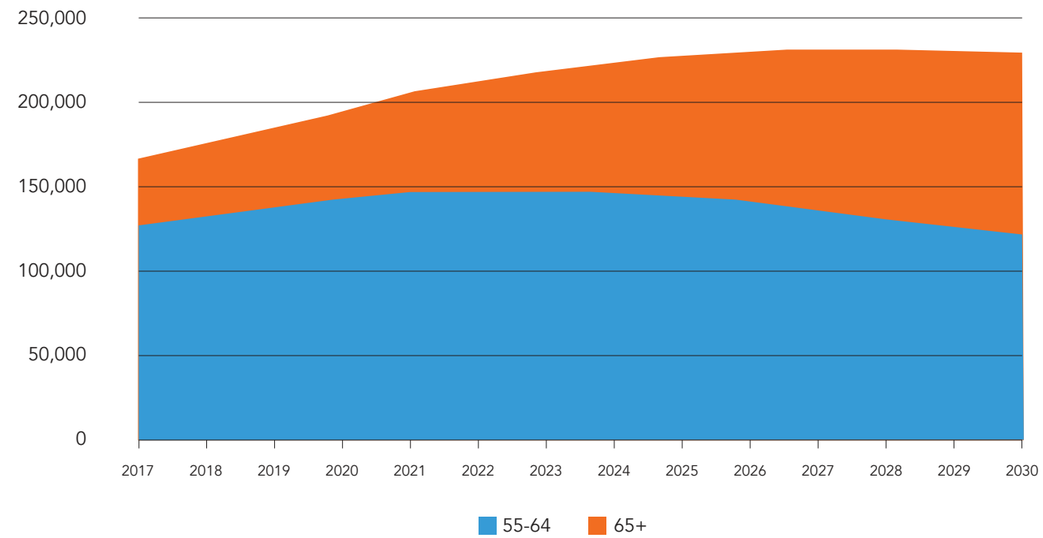
The three localities in this study enabled us to envision some of the parameters for this discussion. Table 2 provides a summary for each locality, including the average annual expected shelter, health, and long-term care spending should we do nothing, the average annual costs of a comprehensive housing strategy; and the cost offsets we might anticipate from implementing a comprehensive housing strategy (based on an average of the more and less conservative scenarios). The results for New York City and Los Angeles County are comparable, with estimated returns on investment of 13% and 14% of intervention costs, respectively. The Boston results indicate a net negative offset (or a positive cost) of 23% of the intervention cost. However, the Boston results do not include Medicare spending, and thus represent a lower bound estimate of actual health care cost offsets. Further, a forthcoming analysis of the Boston data, including an estimation of Medicare spending, would suggest that the negative offset may be entirely mitigated even in the conservative offset scenario. Therefore, the estimates here indicate that potentially all of the proposed intervention costs across the sites could be recouped from avoidance of future shelter, health, and nursing home costs.

Finally, for purposes of fostering further national discussion, the three locality projections in this study were projected to the U.S. as a whole based on Annual Homelessness Assessment Report (AHAR) data from 2017 (Figure 12). While this extrapolation should be treated with some caution, as the study localities are not representative of the nation, they suggest that the number of U.S. aged homeless over age 55 could grow to 225,000 by 2026, up from 170,000 in 2017. This growth is mostly driven by a 165% increase in the population 65 and older, from 40,000 in 2017 to 106,000 by 2030. Extrapolating the cost data from this study to the country as a whole, the aged homeless population could cost the nation $5 Billion on average annually in health and shelter use over the next decade.

Table 2: Annualized Average Projected Costs & Offsets (in millions of $)

	Service Costs without an Intervention	**Intervention Costs**	**Average Service Cost Reductions**	**Net Offsets** (Service Cost Reductions – Intervention Costs)
NYC	$408	$157	$177	$20
Boston	$67	$39	$30	-$9
LA County	$621	$241	$274	$33

Figure 12: National Projections of Older Homeless Adults: 2017-2030



Key Questions for Further Consideration

In the hopes of advancing dialogue and action among relevant stakeholders, here are some concluding questions for consideration:

- What role can federal agencies, such as the Departments of Housing and Urban Development, Veterans Affairs, and Health and Human Services, play in supporting expanded access to permanent supportive housing for the highest need subgroups which require that level of subsidy and support?
- What role can private Medicaid Managed Care Organizations (MCOs) play in shifting some of their resources to housing solutions, such as rapid rehousing and shallow subsidies, insofar as they may stand to gain from health care cost avoidance associated with housing placement? What regulatory and other barriers do they face? What incentives can be provided? Could cost sharing or matching of funds by other entities, like local homelessness and hospital systems, entice their participation, recognizing that not all of the cost offsets studied here will be realized by MCOs?
- What role can hospitals play, as they are on the front lines of addressing the health needs of people who are aging and homeless, and which face care and cost burdens associated with longer-than-necessary hospital stays?
- What role can state Medicaid agencies play in planning and funding housing solutions for the aged homeless population, including enlisting MCO and hospital engagement?
- What role can local governments play, including agencies responsible for shelter and homeless services, in the outreach for, enrollment in, and deployment of housing solutions, especially rapid rehousing? Can local homeless programs contribute to housing intervention costs through the substitution of shelter funding for housing assistance?

Limitations

This study was based on historical shelter and health care records, and the forecasts for future population growth and costs involve some uncertainty. Intermediate estimates were used in choosing population projections, and conservative choices were made whenever possible to estimate health care costs (see site specific studies for methodological details). The averaging of cost offsets based on the more and less conservative scenarios, as provided in Figures 10b, 10c and 11, and in Table 2, is an intermediate estimate. Although the best available statistical methods were applied, actual population counts and costs in the future will be somewhat different than predicted, even if the projections are strongly anticipated to be in the direction and magnitude reported here. Also, the projections applied here assume no change in patterns of homelessness exits or health care use, and those may change due to unanticipated policy changes.

The analyses reported here are also limited in being cross-sectional. The study results are not based on following cohorts of individuals over time to estimate their trajectories of services use, or subgroups of persons and their trajectories. A study based on trajectories would yield more specific results than reported here; but such an approach was beyond the scope of this project and should be considered for future research. Policy and program planning based on this study will also require further analysis of the impact of varying eligibility and enrollment criteria, the trajectories of people across and between interventions, and the rates at which people will exit or accrue within programs (a “stock and flow” analysis). Such analyses were also beyond the scope here but would be needed to inform more discrete intervention planning decisions.

Finally, this study is limited in that it did not include data on people who are exclusively unsheltered. The Los Angeles County study results were generalized to include estimates for the unsheltered population, and the population projections were adjusted based on unsheltered Point-in-Time data, but it is possible that exclusively unsheltered persons may have patterns and costs of services use that are dissimilar to sheltered populations. Unsheltered persons also incur public costs from sanitation, policing, and emergency medical services, among other areas, and data on these costs were not available for this study and are typically not possible to track and allocate at an individual level. Such costs are therefore undercounted here.

References

Brown, R.T., Hemati, K., Riley, E.D., et al. Geriatric conditions in a population-based sample of older homeless adults. (2017). *Gerontologist*, *57(*4), 757-766. doi:10.1093/geront/gnw011. (n/u)

Brown, R.T., Kiely, D.K., Bharel, M., & Mitchell, S.L. (2012). Geriatric syndromes in older homeless adults. *J Gen Intern Med*., *27*(1), 16-22. doi:10.1007/s11606-011-1848-9.

Culhane, D.P., Metraux, S., Byrne, T., Stino, M., & Bainbridge, J. (2013). The age structure of contemporary homelessness: Evidence and implications for public policy. *Anal Soc Issues Public Policy*, *13*(1), 228-244. doi:10.1111/asap.12004.

Easterlin, R.A. (1987). *Birth and Fortune* (2nd ed.). Chicago, IL: University of Chicago Press.

Flaming, D., Burns, P., & Matsunaga, M. (2009). *Where we sleep: Costs when homeless and housed in Los Angeles*. Los Angeles, CA: Economic Roundtable. https://economicrt.org/wp-content/uploads/2009/11/Where_We_Sleep_2009.pdf

Kuhn, R., & Culhane, D.P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. *Am J Community Psychol*, *26*(2), 207-232. doi:10.1023/A:1022176402357.

Macunovich, D. & Easterlin, R. 2008. “Easterlin Hypothesis” in Steven N. Durlauf and Lawrence E. Blume, eds., The New Palgrave Dictioanry of Economics, Second Edition.

U.S. Bureau of Labor Statistics. (2019). *Unemployment Rate: 20 years and over, Black or African American Men*. Retrieved from https://fred.stlouisfed.org/series/LNU04000031

QUESTIONS?

Any questions or comments about this report should be directed to TC Burnett at burnettt@upenn.edu or 215.573.5827. To access a copy of this report online, as well as the technical site reports from Boston, NYC, and LA County, visit www.aisp.upenn.edu/aginghomelessness

IMPACTFUL INNOVATIONS: Serving a Vulnerable Aging Population

CSH

About CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided $1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at csh.org.

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Introduction

Housing that is accessible, affordable, and connected to appropriate services is essential for older adults to age in their communities.

The American population is experiencing profound demographic changes; over the next decade, the number of adults aged 50+ will increase by 20%, and 1 in 5 Americans will be over the age of 65. This "graying of America" comes with important implications for the country's approach to housing and providing services for its aging households. Housing that is accessible, affordable, and connected to appropriate services is essential for older adults to age in their communities. However, seniors are currently facing escalating housing and medical costs, while the existing housing stock lacks basic accessibility features necessary for safely aging at home.[1] For our nation's most vulnerable seniors, including those who are living in poverty, with mental health or substance use disorders, physical or intellectual disabilities, or facing other challenges, the scarcity of safe, affordable housing and services is particularly acute.

Among the nation's extremely low-income households who are rent burdened, seniors are disproportionally represented, and the number of rent-burdened senior households has reached an historic high of 10 million.[2] Similarly, the average age of individuals experiencing homelessness has steadily risen in recent years. Today nearly half of all single individuals experiencing homelessness are over the age of 50; by 2050, the senior homeless population is expected to double. [3] Approximately one third of people experiencing homelessness today were born during the second half of the "baby boom"—a cohort of the American population who has experienced homelessness at rates twice that of

[1] https://www.jchs.harvard.edu/sites/default/files/jchs-housing_americas_older_adults_2014-ch1_0.pdf.
[2] https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Housing_Americas_Older_Adults_2019.pdfU.
[3] Brown RT, Goodman L, Guzman D, Tieu L, Ponath C, Kushel MB (2016) Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. PLoS ONE 11(5): e0155065. https://doi.org/10.1371/journal.pone.0155065; https://www.justiceinaging.org/wp-content/uploads/2016/04/Homelessness-Older-Adults.pdf

any other cohort—and have aged while homeless,[4] yet rates of first-time homelessness among all older adults are rising as well.

Homelessness not only leads to poor health outcomes for individuals but results in high-cost, potentially avoidable interventions, such as acute medical care, shelter stays, and institutionalization. The toxic stress, violence and lack of medical care associated with homelessness cause pre-mature aging and death; a 50-year-old experiencing homelessness presents with geriatric conditions, such as functional impairment, falls and memory loss, typical of a housed 70-year-old. The life expectancy of a person living on the streets is twenty years lower than the national average—years before age 65, which is the eligibility age for numerous benefit programs. Older homeless adults are four times more likely than younger people experiencing homelessness to have at least one chronic condition. High rates of mental illness, behavioral health challenges and isolation further put these adults at risk of institutionalization. All of these poor outcomes disproportionately affect seniors of color who face the compounding results of decades of discrimination and lack of opportunity in healthcare, housing, and employment.

[4] https://www.aisp.upenn.edu/wp-content/uploads/2019/01/Emerging-Crisis-of-Aged-Homelessness-1.pdf, pg. 2.

Background on Housing and Services for Older Adults

Supportive housing is a proven intervention that empowers older adults by pairing affordable housing with wrap-around voluntary support services to promote independence and allow people to thrive in their own homes as they age.

Communities across the country are responding to the needs of their vulnerable seniors in innovative ways using a mixture of resources available to them. Housing and services for low-income older adults can take a variety of forms and financing structures, ranging from low-subsidy affordable housing with minimal on-site services, to supportive housing. Supportive housing is a proven intervention that empowers older adults by pairing affordable housing with wrap-around voluntary support services to promote independence and allow people to thrive in their own homes as they age. It is a community-based alternative to assisted living and nursing homes.

Affordable and supportive housing both require capital and operations (or rental subsidy) funding, as well as funding for programs that offer services. Common sources of capital financing include the federal Low Income Housing Tax Credit (LIHTC), the Home Investment Partnership Program (HOME), and state or local Affordable Housing Trust Funds. Funding for rental subsidies often comes in the form of vouchers which allow a tenant to pay no more than 30% of their income toward rent. Most vouchers come from various programs offered by the U.S. Department of Housing and Urban Development (HUD) and are administered locally, including the 811 voucher specifically for older adults. Common sources of funding to cover operating costs include money allocated from HUD to the local Continuum of Care (CoC), a regional or local planning body that coordinates housing and services funding for homeless families and individuals. States, counties, and cities are also a common source of funding for rental subsidies. Service financing can come from CoCs; Area Agencies on Aging (AAAs); state, county, or city initiatives; philanthropy; and Medicaid or Medicare. For more information on capital, operations and service financing, visit your state's Home and Mortgage Finance Agency's website or CSH's resource library.[5]

Impactful Innovations: Six Models

This paper highlights six diverse projects and approaches that address local communities' need for housing and services for vulnerable older adults. Each of the models target different groups of vulnerable seniors and utilize a mixture of the funding sources listed above, along with other creative policy measures such as changes to zoning laws or money from Medicaid demonstration projects.

While these projects are local in nature and none will offer a "silver bullet" solution to the complex causes and effects of senior homelessness and housing instability, each presents a promising model that could be replicated across the country as part of larger strategic efforts to end and prevent homelessness for our society's most vulnerable members.

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1. **New Jersey - I Choose Home NJ**

2. **New York City - SARA and AIRS Programs**

3. **San Diego - St. Paul's Program of All Inclusive Care for the Elderly (PACE)**

4. **Massachusetts – Surge Initiative**

5. **Vermont - Sash Model**

6. **Los Angeles County – Santa Monica Preserving Our Diversity Initiative**

New Jersey - I Choose Home NJ

I Choose Home NJ (ICH-NJ) is a state-wide program with the goal of moving people out of nursing homes and developmental centers back into their homes. ICH-NJ began in 2007 with grant funding from the Centers for Medicare & Medicaid Services (CMS). The grant's aim is to move away from institutional health care to a more community-based approach with more individual control and freedom. As community-living is far less expensive than institutions, the program creates Medicaid savings. The state, as the Medicaid administration can reinvested those savings back into community-based housing and services. This funding can be used for training staff members, building small group homes and creating of more affordable housing options. New Jersey's program is a collaborative effort among divisions within the Department of Human Services: Division of Developmental Disabilities, Division of Disability Services, and the Division of Aging Services; and the Long-Term Care Ombudsman's Office.

ICH-NJ aims to demonstrate that, "a nursing home may not be the only option" for Medicaid-eligible individuals who prefer the comfort and independence provided by a home with appropriate supportive services. Any individual who has lived in a nursing home or developmental facility for 90+ days and is Medicaid-eligible can participate in ICH-NJ. While at-home services vary depending on the community Medicaid program in which the person is enrolled, they can include home health aides, adult day care, transportation and meal delivery. Before moving back into the community, the individual works with an interdisciplinary team, including a social worker, discharge planner and family, to establish a comprehensive care plan and services.

Since 2008, ICH-NJ has successfully transitioned 2,906 people from institutions back into community settings, surpassing its initial goal of 2,200 individuals by 2020.

Since 2008, ICH-NJ has successfully transitioned 2,906 people from institutions back into community settings, surpassing its initial goal of 2,200 individuals by 2020. Nearly all nursing home residents age 65+ (989) and younger individuals (ages 18-64) with physical disabilities (965) have been able to move back into the community. The program has also allowed for the investment of $33.3 million in Medicaid cost savings into groundbreaking initiatives to increase home and community-based options. For example:

- Money Follows the Person Housing Partnership Program (MFPHPP): The Division of Aging Services partnered with the New Jersey Housing and Mortgage Finance Agency (HMFA) and invested $6.2 million of its ICH-NJ savings to develop housing for people 18+ who wish to leave nursing homes. Developers who apply to HMFA for project funding can also apply to receive $75,000 in capital funding from the MFPHPP to set aside 1-bedroom units (up to 5 in one development) in targeted counties for individuals transitioning out of nursing homes.
- ICH-NJ advocacy also secured federal HUD 811 vouchers, to be used specifically for each of these units, making it very attractive for NJ developers. To date, 32 1-bedroom units have been allocated, 21 are pending HMFA approval, and several units are now open and occupied and/or under construction.
- ICH-NJ proposed and advocated for a contractual requirement that NJ's managed care organizations (MCOs) must hire dedicated and experienced Housing Specialists to help find and maintain housing for their members receiving Managed Long-Term Supports and Services Medicaid services. In addition to individual advocacy, Housing Specialists must develop an overarching housing plan/vision in conjunction with MCO management. All of NJ's MCOs now have Housing Specialists who report quarterly progress towards Medicaid/Housing metrics to the ICH-NJ team.

Through the State's participation in ICH-NJ, the Department of Human Service divisions and the Long-Term Care Ombudsman's Office, New Jersey Medicaid, New Jersey nursing homes, and NJ's managed care organizations have incorporated ICH-NJ's mission and processes into their operations. The success of this initiative makes a strong case for the continuation of the program, as well as systems-level transformations to expand Medicaid-funded services to assist with housing navigation and tenancy support services as part of NJ's next 1115c Medicaid Waiver Renewal Application.

New York City - SARA and AIRS Programs

The crunch for affordable senior housing is particularly severe in major cities like New York, where 6 in 10 renters age 65+ pay more than 30% of their income toward rent.[6] As part of New York City's plan to dramatically increase the number and range of affordable housing units,[7] the City's Department of Housing Preservation and Development (HPD), in coordination with other city departments, launched two initiatives to spur development: **The Senior Affordable Rental Apartments (SARA) Program and the Affordable Independent Residences for Seniors (AIRS) Program**.

SARA provides capital gap financing in the form of low-interest loans of up to $75,000 per unit. These loans are for developers and can be used for the construction and renovation of affordable housing for seniors, 62+ years in age, with low incomes. Projects developed with SARA funding are required to set aside 30% of the units for homeless seniors referred by a City or State agency, typically the New York City Department of Homeless Services. The loan term is the development's construction period plus a minimum of 30 years post-conversion at an interest rate of 1% per annum plus a 0.25% servicing fee during construction. This program utilizes Project-Based Section 8 vouchers for rental subsidy for all senior units. The New York City Department for the Aging also dedicated $5,000 of service funding for each non-supportive housing unit, for a period of five years.[8]

"It's a pleasure to have a roof over my head and have everybody here stick by me to make sure I keep a roof over my head. It's an honor."

- Patricia Marlou
New York City Supportive Housing Resident

[6] https://comptroller.nyc.gov/reports/aging-with-dignity-a-blueprint-for-serving-nycs-growing-senior-population/.
[7] https://www1.nyc.gov/site/housing/index.page.
[8] https://shnny.org/fundingguide/senior-affordable-rental-apartments-sara-program/.

The Affordable Independent Residences for Seniors (AIRS) program similarly aims to incentivize developers to set aside housing units for low-income seniors by enabling zoning allowances permitted under the NYC Zoning Resolution. This program incentivizes developers by increasing the density, or Floor Area Ratio (FAR), allowed on development sites, thereby increasing the revenue for the developer and the number of units in a project.[9]

These programs have both seen early successes in increasing the flow of senior affordable units coming online and have potential for scaling and replication across the country in other dense cities facing housing shortages. Successfully replicating these programs would require cities' Housing Development Agencies and Aging Agencies to work together to assess the local need for units and affordability levels. A program modeled after SARA would likely require funding from multiple agencies for services and operating funds. While replicating the AIRS program does not require any funding to subsidize a policy, a city's planning department will have to make changes to the zoning regulations.

[9] https://www1.nyc.gov/site/planning/plans/zqa/zoning-for-quality-and-affordability.page.

San Diego - St. Paul's Program of All Inclusive Care for the Elderly (PACE)

St. Paul's Program of All Inclusive Care for the Elderly (PACE) in San Diego is pioneering innovative PACE projects "specifically designed to keep you in your home by providing services in-home and at our wellness centers."[10] While PACE is a well-known model for providing comprehensive medical and social services to frail older adults enrolled in both Medicaid and Medicare, PACE programs do not typically provide housing for their participants. PACE programs do provide all-inclusive medical, social, and home care services, equipping each individual with a care team comprised of medical professionals who can facilitate connections with specialists and service providers.

In order to help address San Diego's growth in elder homelessness, St. Pauls' began partnering in 2013 with California-based housing developers. The developers provide housing, and St. Paul's offers the wrap-around supportive services to seniors who have or are currently experiencing homelessness and are eligible for the PACE program. This early work led to St. Paul's partnering with local San Diego developers and the San Diego Housing Commission to develop a low-income, supportive housing building for seniors who qualify for St. Paul's PACE. The Talmadge Gateway supportive housing development, which is open to seniors age 55+ who are experiencing homeless or exiting an institution where they were homeless prior to entry, is one result of the partnership between St. Paul's and Wakeland Housing & Development Corporation.

[10] https://www.stpaulspace.org/about/.

200 formerly homeless seniors with medical needs requiring ongoing support have been connected to housing and supportive services

Since the opening of Talmadge Gateway, the first 100 percent supportive housing community in San Diego, 200 formerly homeless seniors with medical needs requiring ongoing support have been connected to housing and supportive services. Similar partnerships have led to the development of 11 apartments in the Parker-Kier development, 63 in the Celadon development, and 47 apartments in the Park West development.

This pioneering work to connect PACE with housing resources as a creative pathway out of homelessness for older adults is being scaled across the state of California. St. Paul's PACE is working with the state PACE association, CalPACE, Center for Elder's Independence (CEI), local PACE providers, and other organizations, including CSH, to adapt this model and pair PACE Services with housing. Currently, five housing developers are working to develop supportive housing buildings paired with PACE services. As a national model, PACE can be matched with local housing resources across the country to meet the service and housing needs of vulnerable seniors.

Massachusetts - Surge Initiative

Both the Commonwealth of Massachusetts and the City of Boston have made significant efforts to end chronic homelessness. In 2018 there were 471 chronically homeless individuals in the City of Boston, with 50% aged 50 years or older. Recognizing the increasing number of older adults experiencing chronic homelessness, the City and Commonwealth Executive Office of Elder Affairs launched a unique partnership within Boston's Way Home initiative linking housing and with a local PACE program. Together they created a "**Surge Event**" - a one-day initiative for attendees to be enrolled in services they need through PACE and to leave with an address of their own that very same day.

The Boston Housing Authority provided the housing units, while Mass Health and Executive Office of Elder Affairs coordinated the services. Leading up to the event(s), planning meetings were held with PACE providers to solicit input on program design and implementation, while MassHealth Nurses conducted a clinical eligibility review in advance to identify a potential cohort of eligible participants using health claims data. The Surge represented the first time in Massachusetts when public housing and Medicaid-funded care services were jointly available.[11]

[11] https://www.usich.gov/news/bostons-housing-surges-helping-older-adults-experiencing-chronic-homelessness-find-a-permanent-place-to-call-home/

According to City and State Leaders for *Boston's Way Home*, the success of these events relied on several key factors:[12]

- **Securing housing preferences**: Negotiations between the City of Boston and the Boston Housing Authority (BHA) resulted in specific set-aside units for participants. The Continuum of Care provided tenant-based vouchers to individuals otherwise ineligible for a BHA unit.
- **Data Sharing**: The City of Boston and MassHealth entered into a data sharing agreement. This allowed MassHealth to pre-screen the city's list of people experiencing chronic homelessness to identify those who are also enrolled in MassHealth, and would most benefit from attending The Surge.
- **Scheduling and Transportation**: The event took place early in the morning, and shelters and outreach vans provided transportation to The Surge.
- **Providing individual pathways:** Individuals arriving at The Surge event were greeted at the door, received a "passport" customized to their unique needs and were assigned a volunteer ambassador to guide them through the day-long process.
- **Same-day housing:** The event's planners made vacant units immediately available to participants. Event staff screened participants on-site for income and eligibility, and the Social Security Administration attended the event to assist with documentation.
- **Coordinating health care services:** MassHealth connected eligible members with health care services and individualized care coordination including the Program of All-Inclusive Care for Elders (PACE), and health plans Senior Care Options and One Care.
- **Identifying a Primary Organizer:** To better coordinate operations and communications between participating agencies, the city contracted with an independent third party organization to act as the primary organizer and contact. This additional layer of support and organization was essential to the event's success.

The Massachusetts Surge events illustrate an innovative, rapid approach to linking comprehensive services and housing, which are typically separate, labyrinth systems, for highly-vulnerable elders experiencing chronic homelessness. The success of the Surge events highlights the potential for scale and replication in other cities facing elder homelessness.

[12] Ibid.

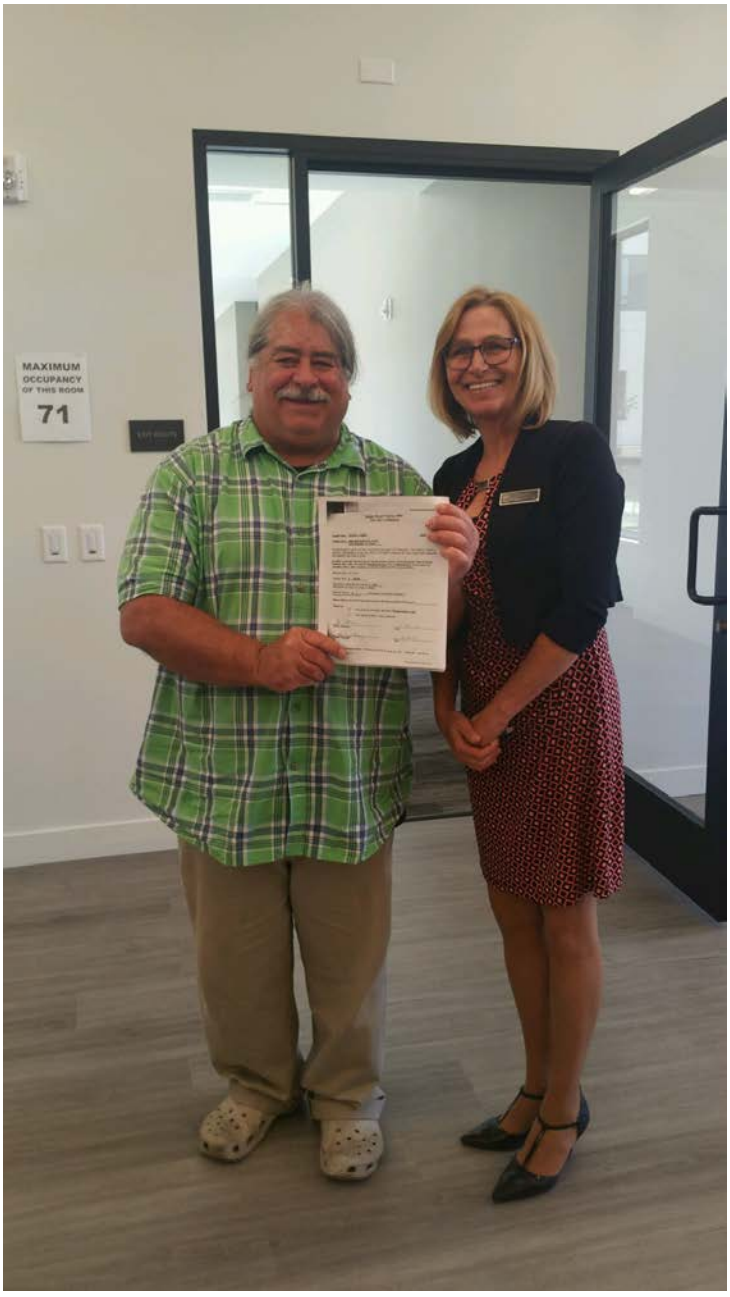
Vermont - SASH Model

Launched in 2008 by the nonprofit housing provider *Cathedral Square Corporation* (CSC) in Vermont, the **SASH (*Support and Services at Home*)** program connects frail, elderly residents living in CSC affordable housing buildings to community-based supportive health and social services. SASH is an integrated affordable housing plus services model aimed at promoting care coordination, improving health outcomes and slowing the growth of Medicaid costs for high-need elders, who prior to the program were not receiving sufficient services to be able to remain safely in their homes. Groups of 100 participants are served by an integrated team that includes a coordinator and a wellness nurse. Services provided to SASH participants are driven by individualized case plans and include health and wellness assessments, on-site one-on-one nurse coaching, care coordination with providers, and health and wellness group programs. Local service providers often offer additional services including community activities and wellness workshops.

Early successes led to a state-wide expansion, and today SASH operates across the state with more than 4,000 participants who are Medicare-enrolled and living in a participating affordable housing residence. Several locations have also launched community programs to enroll seniors outside the target residences. CSC oversees the program at the state level, while six Designated Regional Housing Organizations (DRHOs) oversee the program implementation in their specific region. At the community level, services are delivered via SASH panels, which are operated by more than 20 affordable housing organizations in their properties (SASH sites). Among the 54 panels of participants, a majority are residents of U.S. Department of Housing and Urban Development (HUD) properties or Low-Income Housing Tax Credit (LIHTC) properties.

Between 2011 and 2016, the HHS Centers for Medicare & Medicaid Services (through the MAPCP Demonstration) served as the primary funding source, which provided a per-beneficiary, per-month payment to cover the cost of the coordinators and wellness nurses. Medicaid, the State of Vermont, and a combination of agencies together helped to fund program operations and expansion across the state.

In 2017, HHS conducted an evaluation to assess the impact of SASH looking at quantitative and qualitative review of four years of Medicare claims data and interviews with SASH staff, participants, and key stakeholders. The study found uneven results in slowing Medicare expenditures across the different panels, but for some cohorts the growth in annual Medicare expenditures was slower by an estimated $1,227 per-beneficiary per year. Medicare claims data also demonstrated that the same cohort of participants experienced slower rates of growth for hospital and specialty physician costs. However, the evaluation found no evidence of decreased Medicare costs for participants in later panels. All-cause hospital admissions were lower for SASH participants when compared to nonparticipants. However, there was no evidence that the SASH program reduced the rates of emergency room visits.[13] The qualitative evaluation, based on experiences of staff and participants, found that SASH had a positive impact on participants' quality of life and functional status.



These findings present an opportunity for scaling and replication by building on lessons learned to improve efficiency and establish a sustainable funding model. A comprehensive training program, both at program outset in and as regular course of business, ensures that staff maintain the necessary knowledge and skills to best serve SASH participants. Staff interviews for both site-based and community-based panels identified the number of hours for the wellness nurse as a major challenge. Increasing nurse hours could result in greater impact for participants, especially for community-based participants. Building relationships and fostering collaboration across service provider agencies is a key component for success in SASH. Researchers concluded that any replication of SASH should plan for time spent educating agencies and clearly defining roles and responsibilities to avoid any "real or perceived duplication of services." 14 Finally, states and localities looking to replicate the SASH model will need to partner to find funding for program operations.

[13] Kandilov, Amy, et al. "Support and Services at Home (SASH) Evaluations: Evaluation of the First Four Years." *Washington, DC: Office of the Assistant Secretary for Planning and Evaluation* (2017).
[14] Ibid.

Los Angeles County – Santa Monica
Preserving Our Diversity Initiative

The City of Santa Monica launched a rental subsidy pilot in 2017 to assist long-term city residents who are rent burdened. The pilot emerged as a response to the city and country-wide homelessness crisis, which has grown by 50% since 2011.[15] The **Preserving our Diversity** pilot offered rental assistance ranging from $200 and $600 a month to 22 seniors age 62+ who had lived in rent-controlled apartments since at least 2000. The pilot proved a success, with 17 of the 22 participants still in their apartments by the pilot's end. Of those who left the pilot, three received rental assistance vouchers through another program, one moved to another city, and one passed away.

The City issued a survey of elderly residents in 2019 and found that many were sacrificing needed medical care and/or groceries in order to pay their rent. Recognizing the continued need for rental assistance, the Santa Monica City Council voted in August 2019 to allocate $2 million to scale the pilot and offer rental subsidies to approximately 400 residents. The program, set to being in 2020, will offer a rental subsidy ranging from $250 to $700, depending on household size and income.[16] In order to be eligible, seniors must be age 65+, have lived in a rent controlled apartment since January 1, 2000, and have a household income equal to or less than 50% of area median income (AMI), which is the HUD's standard metric for "Very Low Income."[17]

Advocates for the initiative cite the fact that a $2 million investment might only create 3-4 units of newly constructed affordable housing, but it will also prevent 100 times from being displaced from their current home. Councilmember Mitch O'Farrell, 13th Council District in the City of Los Angeles, wants to replicate the Santa Monica rental subsidy program in Los Angeles due to its success. This initiative, while small in scale, is an effective short-term way to prevent homelessness and the poor health outcomes and costs particularly acute amongst older adults. This initiative can be replicated in across Los Angeles county, as well as other urban areas where rapidly rising rents and dislocation are affecting large numbers of seniors. The Santa Monica Preserving Our Diversity initiative is part of a larger regional approach to address the causes of homelessness.[18]

[15] https://www.latimes.com/local/lanow/la-me-ln-homeless-count-encampment-affordable-housing-2019-results-20190604-story.html.
[16] https://www.smdp.com/low-income-seniors-can-apply-for-rent-subsidies-starting-today/182416
[17] https://www.santamonica.gov/housing-pod.
[18] https://www.smdp.com/low-income-seniors-can-apply-for-rent-subsidies-starting-today/182416.

CONCLUSION

Each of the models and initiatives described in this paper aims to address a critical challenge for communities across the country: ensuring that the growing population of older adults is able to age with dignity in their homes. The causes and consequences of homelessness and housing instability are complex, but the solutions will require creativity and collaboration across aging services, the healthcare sector, homeless services, supportive and affordable housing developers, and all levels of government. To effect change, local stakeholders need to come together, assess the scope and scale of need, design policies and programs leveraging currently available resources, and advocate for system-wide change that can stem the tide of homelessness and housing insecurity for older adults in their community. The models described above should serve as a starting point for conversation sparking ideas and innovation.