AFFORDABLE CLUSTERED HOUSING-CARE: A CATEGORY OF LONG-TERM CARE OPTIONS FOR THE ELDERLY POOR

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AFFORDABLE CLUSTERED HOUSING-CARE: A CATEGORY OF LONG-TERM CARE OPTIONS FOR THE ELDERLY POOR

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ABSTRACT

What we label as affordable clustered housing-care options are making it increasingly possible for poor and frail older Americans to age in place comfortably and securely in residential-like settings combining both affordable shelter and long-term care. The hallmark of these housing arrangements is their sizable population clusters of low-income frail persons in need of supportive services. Despite their greater availability and the compelling factors underlying their growth, the diversity of their supportive services and operations cloud their identity resulting in uncertainty as to whether they have a common mission. In response to the need for a more careful delineation of this aging in place option, this paper describes the distinguishing features of these hybrid settings and constructs a typology of their representative exemplars or prototypes.

Long-term care; affordable housing; supportive services; low-income elderly, assisted living

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Long-term care in the United States now broadly encompasses the “array of health care, personal care, and social services generally provided over a sustained period of time to persons with chronic conditions and functional limitations” with needs that “range from minimal personal assistance with basic activities of everyday life to virtually total care” (Institute of Medicine, 2001, p. 1). Over the past two decades, federal and state government programs have made affordable long-term care options more available to low-income older adults who want to age in place in their ordinary homes and apartments and thereby avoid or at least delay a nursing home stay (O'Brien & Elias, 2004). As one indicator, an increasingly greater share of the Medicaid program’s long-term care expenditures is on services offered outside of nursing homes. In 2004, 36 percent of the long-term care expenditures of Medicaid were paying for such home- and community-based assistance, up from 14 percent in 1991 (Shirk, 2006). The most manifest consequence of these trends has been the declining share of older persons (both the old-old, 75-84 and very old, 85+) who now occupy nursing homes (Alecxih, 2006; Bishop, 1999; Mollica & Johnson-Lamarche, 2005).

Many stakeholders are interested in making noninstitutional long-term care solutions more available to low-income elders. Overwhelmingly, older Americans of all incomes prefer to deal with their vulnerabilities in their ordinary dwellings (AARP, 2000) and research shows that when poor older persons end up in nursing home beds funded under Medicaid, they may receive inferior care (Mor et al., 2004). State governments seeking ways to curb their Medicaid budgets have curtailed their nursing home growth and are more aggressively implementing community-based strategies to deliver long-term care and thus divert and transition their frail and low-income elderly constituencies from nursing homes (Department of Health and Human Services, 2004; Doty, 2000; O'Brien & Elias, 2004; U.S. Congressional Budget Office, 2004). The
managements of affordable rent-assisted apartment projects have to cope increasingly with their aging tenants, even as they have little experience as service providers and their buildings were not designed to accommodate such vulnerable groups. They are looking for ways that their elderly tenants can age in place, yet avoid the management crises connected with addressing their long-term care needs (Golant, 1999; Heumann, Winter-Nelson, & Anderson, 2001). The 1999 Supreme Court Decision, *Olmstead v. L.C.* ruled that under Title II of the Americans with Disabilities Act (ADA) people with disabilities have a right to live in less institutionalized community settings. At the very least, this ruling has encouraged state policy makers to re-examine the institutional biases of their long-term missions (Mollica & Jenkens, 2001).

The focus of this paper is on a category of affordable housing arrangements that has emerged to help low-income older persons cope with their long-term care needs in their communities. These purposively planned or adapted housing options make it possible for their occupants to benefit from both affordable shelter (i.e., room and board) and long-term care. Today, they are known by different names: service enriched affordable housing, affordable supportive housing, affordable assisted housing, affordable housing plus services, subsidized NORC (naturally occurring retirement community) service programs, assisted living in public housing, and service coordinated housing. They share various similarities with private-pay models of seniors housing property types known as independent living communities and assisted living residences (National Investment Center & American Seniors Housing Association, 2005), but unlike most of these options do not cater to higher-income older persons (Golant, 1999; Kane & Wilson, 2001; Zimmerman et al., 2003). To emphasize their differences from other housing and long-term care strategies, we newly label these options, *affordable clustered housing-care* (abbreviated to “housing-care” in this paper).
What these conventional looking residential settings—usually multiunit apartment buildings—have in common is that they are occupied by a critical mass or sizable population cluster of low-income older adults who have at least some difficulties living independently because of their physical or cognitive impairments and chronic health problems. Onsite staff hired by the housing provider, outsourced or partnered home and community-based health and service providers, or a combination of these service delivery approaches supply these elder concentrations with an array of supportive services. These range from information, counseling, referrals, housekeeping, meals, monitored emergency alert systems, and transportation, to personal care, health care, and nursing services. These are offered in a residential environment relying on a “social” as opposed to a “medical” model of care—emphasizing individual autonomy and choice.

Their proponents argue that where people grow old matters (Golant, 1984; Mollica, 2003) and that by offering assistance to geographically clustered rather than dispersed older persons, these planned housing-care arrangements enjoy economies of scale advantages over other settings. They maintain that these arrangements are thereby able to offer a more comprehensive array of services less expensively (lower per commodity/service unit costs), more effectively, and with better results (Evashwick & Holt, 2000; Golant, 1999; Ormond, Black, Tilly, & Thomas, 2004; Pynoos, Liebig, Alley, & Nishita, 2004). When the benefits of these service delivery strategies are combined with independent and comfortable residential quarters, proponents argue that these housing-care arrangements offer frail and low-income older adults attractive alternatives to their aging in place in their current homes and apartments.

Despite the greater availability and visibility of these housing-care arrangements and the compelling factors underlying their growth (Pynoos, Feldman, & Ahrens, 2004), their identity is
clouded by their very different development and management origins, diverse offerings of both high- and low-acuity care, varied service delivery strategies, their both licensed and unlicensed statuses, and the absence of a dedicated nonprofit organization championing their merits. This has resulted in uncertainty as to whether they have a common and distinctive mission. These ambiguities are manifested by the lack of a coherent and compelling body of scientific evidence regarding their residents’ quality of life and care (Pynoos, Feldman, & Ahrens, 2004).

We therefore need a more careful delineation of this aging in place option and its various versions. This is important to advance policy-relevant research that can demonstrate its favorable quality of care and life outcomes and to offer legislators a cogent rationale for increasing their commitment and funding (Pynoos, Feldman, & Ahrens, 2004). In response, this paper has two primary goals: (1) to describe the distinguishing features or attributes of these settings and the different strategies they use to achieve their long-term care mission; and (2) to construct a typology of their most representative exemplars or prototypes that illustrates their diverse appearance, functioning, and organization.

**METHODS**

We employ two analytical strategies. First, we emphasize what is unique about these affordable clustered housing care alternatives, by comparing them to what are arguably more widely available and recognized housing arrangements in which older persons with physical or cognitive disabilities and chronic health problems receive long-term care today—what we label *affordable household-care*. These are the ordinary owner- and renter-occupied households in which low-income seniors typically receive assistance and care that is mostly delivered by family members (often a spouse or a daughter) and to a lesser extent by (direct care) staff hired
through state or local government programs. Second, in the absence of any comprehensive and scientifically collected data by which to analyze systematically the distinguishing features of housing-care arrangements and their identifiable prototypes or exemplars, we empirically review a set of descriptive case studies that catalog and summarize their components and attributes. These literature sources constitute the “data” for this paper and include the following: Feder, Scanlon, & Howard, 1992; Golant, 1999; Harahan, 2005; Heumann, Winter-Nelson, & Anderson, 2001; Housing Assistance Council, 2006; Jenkens, Carder, & Maher, 2004; Kochera, 2002; Milbank Memorial Fund & Council of Large Public Housing Authorities, 2006; Pynoos, Feldman, & Ahrens, 2004; Pynoos, Liebig, Alley, & Nishita, 2004; Sheehan & Oakes, 2003; Stone, Harahan, & Sanders, 2008; Washko & Sanders, 2006; Wilden & Redfoot, 2002.

FINDINGS

Distinguishing Housing-Care from Household-Care Arrangements

Figures 1 and 2 outline the nine components that delineate the multiple features of housing-care arrangements, denote their key attributes or elements, and distinguish them from affordable household-care arrangements. The following descriptive analysis compares and contrasts these two ways of delivering long-term care.

Development and management origins of the housing arrangements

Housing-care arrangements are a product of housing or service providers who intentionally construct or purposively adapt an affordable residential setting and arrange for the delivery of affordable long-term care to a targeted cluster or concentration of low-income older occupants who are having some difficulties living independently. Among the stakeholders initiating these settings: owners or administrators of government-subsidized affordable rent-
assisted apartment projects; nonprofit organizations or government agencies providing affordable long-term care; and owners or developers of privately owned congregate care (independent living) or assisted living residences made affordable to low-income older persons through various government programs or by the financial assistance of charitable organizations. Multiple stakeholders—sometimes from both the private and public sectors—may be responsible for initiating any given project.

The combining of housing and care may have been the original intent of the sponsors of government-assisted rental housing properties, but they may have introduced supportive services only many years later in response to the demands of their frail older tenants. They may also only later have physically retrofitted the units and common areas of their properties to make them safer and more accessible and to accommodate the delivery of supportive services. Such design changes may have been mandated by state or local government regulations.

Sometimes housing-care arrangements are initiated through the cooperative efforts of the residents themselves occupying ordinary multi-unit buildings—known as naturally occurring retirement centers (NORCs) (Hunt & Gunter-Hunt, 1985; Ormond, Black, Tilly, & Thomas, 2004) or deliberately occupied but unplanned elder residences (DOUERS) (Golant, 2002). The selective in- and out-migration and aging in place of the residents have resulted in the occupancy of these buildings by a large number of elderly residents who require long-term care. Sharing common needs, they self-organize themselves into a formal association and contract or partner with nonprofit organizations or public agencies to secure a steady stream of supportive services. Alternatively, the care initiatives originate from some nonprofit social service agency or government public agency that is alerted to the occupants’ care needs.
Irrespective of their origins, the variation in the physical and service infrastructures required or allowed by states and local governments, fiscal limitations, the idiosyncratic motivations and philosophies of care held by individual housing providers, and locality differences in the incentives and constraints underlying the development of these options lead to a wide array of residential properties labeled as housing-care arrangements.

Household-care arrangements distinguish themselves from housing-care arrangements in that their origins are usually more spontaneous, less structured, and more uninformed. Their catalysts are typically one or more precipitating and sometimes unanticipated events that signal the physical or cognitive decline of an older person. At this point, an older person, family member, or professional care manager may obtain supportive services. Although households in need of such assistance may be concentrated in the same building, their care decisions are still being made independently, and they are not recipients of any building-wide organized or targeted affordable service delivery strategy.

Setting Context and Composition of Impaired Occupants

The hallmark of housing-care arrangements and what most fundamentally distinguishes them from household-care settings is that they are purposively occupied by a concentration or sizable population cluster of occupants—a critical mass—of low-income older tenants. These persons have to some extent chronic health problems, cognitive impairments, or activity limitations that result in a housing provider regularly offering them long-term assistance. In sharp contrast, affordable household-care arrangements are occupied by only one or two low-income older persons in need of long-term care—sometimes in a household also occupied by adult family members or paid live-ins—and their dwellings are typically geographically
dispersed across different urban and rural neighborhoods.

What constitutes the minimum size of this concentration or critical mass of frail tenants will vary significantly among housing-care settings. This will depend on the homogeneity of its low-income and impaired occupants (that is, more homogeneity allows for smaller numbers with the same needs); the types and mix of their needed services (similar service needs are more likely to satisfy economies of scale conditions); the urban or rural location (housing projects in rural areas typically have smaller numbers of occupants); and the strategies used by providers to deliver assistance (certain strategies more than others may benefit from a larger consumer base).

The clusters of tenants that make up these critical masses in housing-care arrangements, however, can vary substantially as to the seriousness or acuity of their impairments or health conditions. Some housing providers more than others may seek to stay beneath the regulatory umbrella of their state’s assisted living program (or equivalent program category) and thus refrain from accepting or keeping older persons who would require higher-acuity care necessitating state licensure. Other housing sponsors, relying on an outsourcing model of delivered care (where only the service providers are licensed), will accommodate a more vulnerable group of tenants. In other instances, the building codes of a municipality or state may influence the vulnerability profiles of the residents, such as by requiring that occupants of conventional buildings have the ability to evacuate in the event of a fire emergency.

Alternatively, when states license these housing-care arrangements under their assisted living programs, they are allowed to admit and retain residents only with specified impairment severities and to offer only certain types of care. States, however, differ substantially as to their licensing categories and their requirements (Mollica & Johnson-Lamarche, 2005). Even when they are licensed as assisted living properties (or equivalent state category), operators in most
states may choose to admit older persons with less allowable serious impairments because they are less confident about their abilities as service providers, they believe housing providers should not be in the assisted living business, or they are reluctant to assume the concomitant fiscal and legal responsibilities of delivering care (Golant, 1999; Mollica & Johnson-Lamarche, 2005).

The government program that funds the long-term care services offered by a housing-care arrangement (e.g., a public housing project) may come with care restrictions. Medicaid Waiver funding for long-term services, for example, is often only available to older persons who are nursing home eligible—that is, who have sufficiently serious impairments that they would have qualified for skilled nursing home care.

A comparison of housing-care and household-care arrangements may not reveal any differences as to the frailty profiles of their occupants. When older persons, family members, or professionals are responsible for assistance or care decisions in household-care arrangements, there are usually no predetermined or necessarily precluded impairments or chronic health problems. Rather, what constitutes allowable frailty thresholds mainly depends on the capabilities of the caregivers and whether they feel constrained by their time commitments, their skills or finances, or their emotional makeup.

_Housing setting and site characteristics_

Housing-care settings can variously consist of low- to high-rise apartment buildings, multi-unit condominiums, cottage units on a campus-like setting, or single-family unit dwellings within the same neighborhood or manufactured homes in a trailer park. Their occupants are usually renters, but they are sometimes owners, as exemplified by the occupants of limited equity cooperatives, condominiums, and manufactured home parks (Wilden & Redfoot, 2002).
Architecturally, the building structures of housing-care settings are typically indistinguishable from those of household-care arrangements, and may be prominent only when they are sited on planned campus-like settings.

In contrast, most household-care arrangements are found in owned rather than rented dwellings. Furthermore, their buildings may be distinguishable only because of their poor physical condition. Early built dwellings of older homeowners, who have limited financial means, for example, may show visible signs of physical decline, if they have not been well maintained and periodically upgraded (Golant, 2003a).

*Physical design and retrofitted features for the physically or cognitively frail*

Although the buildings of housing-care arrangements are often not distinguishable from the outside, their interiors and sometimes their sites are more likely to have architectural or design modifications introduced by their owners or managements to make them safer and more user-friendly for their frail occupants (Schwarz, 1999). The design categories identified in Figure 2 only hint at the range of possible architectural responses. Regnier (2002) identifies at least one hundred critical building and site adaptations that are fundamental to good assisted living design. Among the most frequently identified design modifications: grab bars, accessible cupboards, no slip surfaces, emergency pull cords, lighting adaptations, and living areas that are accessible for persons in wheelchairs or relying on walkers. Housing-care arrangements may also have common areas intended for the dining, recreational, and religious activities of their residents and sometimes offices or clinics for their on-site care workers. Their sponsors may also have subdivided their housing setting into different physical spaces—different floors, wings, or buildings—specifically designed to accommodate older persons with varied assistance needs.
Still, we must generalize carefully because housing-care arrangements will vary significantly as to their interior room arrangements, design adaptations, and the extent to which they have been adapted for disabled populations (Schwarz, 1999). Beyond national accessibility requirements, the building codes and assisted living regulations in some states and localities have more stringent architectural or design requirements. Some housing sponsors obtain the financing to more extensively retrofit their buildings. Some rent-assisted buildings were constructed when federal housing programs emphasized a cost-containment policy resulting in smaller properties with limited common spaces and fewer special design features (Calkins & Weisman, 1999; Heumann, Winter-Nelson, & Anderson, 2001; Pynoos, Liebig, Alley, & Nishita, 2004; Regnier, 2002; Wilden & Redfoot, 2002; Wylde, Baron-Robbins, & Clark, 1994). Some otherwise residential-like housing-care settings have features that resemble those found in nursing homes as exemplified by two or more residents having to share their apartments and bathrooms. Other settings consist of residential units arranged not as apartments, but more like a dorm or ward. A minority of settings still have nursing stations (Wilden & Redfoot, 2002). Where older persons receive assistance in a building complex may also vary. Efficiency units accommodating the needs of more frail older occupants may be concentrated in one part of the building; alternatively, they may be dispersed throughout (Milbank Memorial Fund & Council of Large Public Housing Authorities, 2006).

Household-care arrangements will typically not have made physical design or architectural adaptations making their dwellings as safe or user friendly as those of housing-care arrangements (Gill, Williams, & Tinetti, 2000; Gitlin, 2000). Among elderly homeowners who had various disabilities making it difficult for them to fully use their dwellings, less than half had introduced at least one special design modification (U.S. Department of Housing and Urban
Types of offered long-term care

The factors that influenced the frailty profiles of the residents in housing-care settings will also account for the types of their long-term care offerings. These may consist of services as basic as information, counseling, and referrals from a service coordinator or help to perform their instrumental activities of daily living, such as preparing meals, doing light housework, and keeping track of money (IADLs). Other settings, however, may offer heavier care and provide their residents with assistance with performing their activities of daily living, such as bathing, dressing, eating, grooming, walking (ADLs), and administer selected nursing and hospice services (Crystal, 1987; Institute of Medicine, 2001). Thus, settings can broadly divide up into what Mollica and Jenkens (2001, p. 69) referred to as either a “low service” or “high service” models of care. These characterizations, however, do not fully capture the spectrum of assistance offered in these housing-care arrangements, where even the most mundane “job descriptions” of staff ranging from service coordinators to personal aides can vary substantially depending on provider values, staffing practices, and regulatory constraints (Sheehan, 1992).

The organizations charged with creating these housing-care options may introduce very specific service mix arrangements. For example, the Coming Home Program, a nonprofit organization that has achieved an impressive record of administratively and financially packaging these housing-care properties (mostly in rural counties), requires that “25% or more of its units and services [be made] available to persons using Medicaid to pay for services and SSI-level incomes to pay for rent and meals” and “excludes providers who offer only ‘light care’ programs intended as a pre-nursing home service” (Jenkens, Carder, & Maher, 2004, p. 181).
It is often not easy to distinguish housing-care arrangements from household-care settings based on their long-term care offerings. Households in ordinary dwellings have no inherent limits as to the services they can bring into their homes or apartments given the portability of medical and assistive devices and the feasibility of home-based skilled nursing care. Whether they offer light or heavy care will primarily depend on the motivations and capabilities of household members and their family caregivers to cope with their vulnerabilities without moving. Their eligibility for different types of government-sponsored home- and community-based care programs (if available) will be another factor. State-funded managed care programs targeting Medicaid waiver beneficiaries, for example, can offer them a full gamut of long-term care and acute care services, whereas a program funded through the personal care option of their Medicaid’s state plan does not cover skilled nursing and therapy services (Mollica, 2003; O'Keeffe & Weiner, 2004; Stevenson, Murtaugh, Feldman, & Oberlink, 2000).

Modes of long-term care delivery

When older occupants of housing-care arrangements have some unmet need, they typically can depend on staff who can help them access the appropriate supportive services. Housing providers, however, often use very different long-term care delivery strategies to bring services to their tenants. Some housing-care settings directly offer most of their assistance with a dedicated on-site hired full- or part-time staff. A service coordinator or social worker, for example, will offer care counseling and service referral. Some housing-care settings complement this assistance by establishing a Professional Assessment Committee (PAC) (one housing-care arrangement refers to this as a “care consultation team”) (Washko & Sanders, 2006) to individualize and better target service and care coordination, consisting of members of local
social service and health care government agencies, along with other social work and care professionals (Pynoos, Liebig, Alley, & Nishita, 2004; Sheehan & Oakes, 2004; Wilden & Redfoot, 2002). Other onsite hired staff will be variously responsible for offering regular housekeeping services, regular meals in a central dining area, recreational activities, transportation, and unscheduled (i.e., on demand) personal care.

Alternatively, housing-care providers may rely on what Mollica refers to as the “service model” whereby they partner or subcontract with outside vendors or agencies to deliver services in their buildings (Mollica & Morris, 2005). These may variously include volunteers, private businesses (e.g., restaurants), home care agencies, direct care staff, community-based nonprofit organizations, or government-sponsored service vendors. They may offer these services only as needed by their tenants or at regularly scheduled times at the housing site.

The service management styles of housing-care providers will also differ in other ways. In some settings, the older impaired tenants are restricted to one location—one wing or floor—while in others, they are scattered throughout a building (Wilden & Redfoot, 2002). Some providers only guarantee certain types of assistance on a 9 to 5 daily basis, whereas others offer care on a 24/7 basis. Some providers offer only separate packages of services, whereas others adopt an à la carte arrangement, whereby older occupants choose whether to opt for specific services and have more control over their care (Wilden & Redfoot, 2002). The residents in these latter settings may be able to choose, for example, how many meals they want each day. Housing providers who “bundle” services argue that this approach has pricing and accounting advantages and that a “voluntary” service selection approach weakens their economies of scale advantages of delivering services to a “guaranteed number” of tenants.
Another strategy is for housing providers to arrange for their occupants to receive services offered by the charitable organizations in their community—realized by having a nutrition site or an adult day care center co-located on, near, or sometimes in the building. These may respond to the very specific needs of older persons, such as hot meals, transportation, or wellness care, but alternatively may have a very comprehensive focus, as exemplified by the acute and long-term care services offered by the PACE (Program for all-inclusive Care for the Elderly) and state-organized Medicaid Waiver case managed programs (Stevenson, Murtaugh, Feldman, & Oberlink, 2000).

In household-care arrangements, decisions regarding how to provide care are typically the responsibility of the older occupant, usually with the assistance of a family member—a spouse or an adult child. About 78% of older persons who find they have long-term care needs rely exclusively on assistance from family members and friends; the remainder depend on some combination of informal care plus paid providers (8% paid help and 14% paid and family help) (Thompson, 2004). Care is typically delivered in the older person’s dwelling or at community-based centers (e.g., adult day care; congregate meal sites). Family members are often learning for the first time about how to judge the need for care and the opportunities and constraints they face when securing assistance (Foundation for Accountability & The Robert Wood Johnson Foundation, 2001). Thus, the care regimen offered to the older person may be less timely, more incremental, and consist of more trial and error approaches.

On the other hand, when household-care arrangements include professional case or care managers (privately hired or employed by a government-funded social program), who conduct service assessments and make referrals, they may enjoy service delivery strategies that are undistinguishable from those found in housing-care arrangements.
Licensure and regulatory status

Regulatory oversight differs significantly across states and among their localities and helps to explain the variation in the service packages offered by housing-care arrangements and the acuity level of their residents. Some housing-care arrangements may be unlicensed as care settings, reflecting their offering of only “information” or “environmental care” (Figure 2), although they may have to meet state and locality building code standards. When they offer higher acuity assistance, such as personal care, how they are regulated will depend on the distinctive regulations of their state. Under what is called the “housing and services model,” the state will license the property or facility and restrict the older persons it can admit or retain based on the seriousness of their impairments and their types of needed services (e.g., skilled nursing services) (Mollica & Johnson-Lamarche, 2005). A state’s assisted living regulations will often also impose building architectural requirements, such as specifying minimum dwelling unit sizes and requiring private bathrooms. The state and local governments may also have building design and physical infrastructure requirements (e.g., regarding fire evacuation, building height, or wheel-chair accessibility) based on American National Standard Institute (ANSI) or International Building Code (IBC) standards.

On the other hand, under the aforementioned “service model,” the state does not license or certify the property to offer particular services, but rather licenses the outsourced or subcontracted service agencies or providers that offer assistance (Mollica & Johnson-Lamarche, 2005). Under this regulatory model, however, the states may also impose building and dwelling design requirements (Mollica & Johnson-Lamarche, 2005). States sometimes will rely on a combination of these licensure categories (Sheehan & Oakes, 2004).
In contrast, in household-care arrangements, most care and medication management provided by family members, volunteers, and privately hired staff is typically unlicensed and unregulated. Family members can often be trained to carry out a variety of nursing-related services—often by licensed professionals—but there is usually no oversight when they carry out these procedures. Only a small share of households will receive care from licensed home care agencies, sometimes under the auspices of a state-regulated community-based program.

_Affordability of room and board (shelter component)_

The shelter affordability of a large share of housing-care arrangements is made possible by their status as government-subsidized rental properties (Golant, 1999; Heumann, Winter-Nelson, & Anderson, 2001). These mainly include properties or units owned and operated by Public Housing Authorities, those funded by HUD (Department of Housing and Urban Development), Rural Housing Service, and Low-Income Tax Credit programs, and those funded by state or local governments.

These projects are able to charge more affordable rents than private-pay apartments because they have variously received construction or operating subsidies, grants, loans, below-market interest rates, vouchers, or tax breaks that lowered the building construction or rehabilitation costs, debt service, or subsidized their rents (Kochera, 2001; U.S. General Accountability Office, 2005). Financing affordable rental housing is often an especially complex endeavor because prospective housing providers must bundle together funding from multiple programs (e.g., from a city’s Public Housing Authority, Low Income Housing Tax Credits, and Community Development Block Grant Program). Some of these rental properties have benefited from deeper rent subsidies and thus can target extremely poor as opposed to moderately poor
older populations. The rents of the properties and the incomes of the elder occupants will also reflect whether they are located in high- or low-cost housing markets (Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002).

Housing-care arrangements may be occupied by older occupants who have affordable dwelling rents, fees, or debt service obligations even though they are not under the auspices of some government program. These include multi-unit limited equity cooperative buildings, high-rise condominiums, rent-controlled multi-unit apartment buildings, single room occupancy hotels, and manufactured home parks.

Concentrations of low-income and impaired elderly may also occupy the affordable units offered in privately owned assisted living facilities, mostly targeting higher-income markets. About 11% of the units in these properties are occupied by low-income persons (although a significant share are smaller board and care properties), often made possible through a combination of funds from the federal Supplemental Security Income and State supplements to this program (Mollica & Johnson-Lamarche, 2005).

Older persons in household-care arrangements will vary as to the extent that they have affordable dwelling expenses. A significant share of low-income elderly owners (over 40%) and renters (over 60%) pay over 30% of their income on their dwelling expenses (Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002). Thus, after these households pay for their housing costs, they may have difficulty covering their out-of-pocket costs for their long-term care expenses.

Affordability of long-term care

Housing-care arrangements typically rely on a different set of funding sources to make
their long-term care assistance affordable. In a few notable exceptions, HUD programs (which typically help make only the shelter affordable) have at least partly subsidized the care component. A 1978 Department of Housing and Urban Development (HUD) initiative, the Congregate Housing Services Program (still operates, but no longer accepts new applicants) offered privately owned HUD-subsidized rental projects funding of up to 40% of the costs of nonmedical supportive services, such as transportation, personal assistance, housekeeping, meals and the support of a service coordinator. Under the 1992 Housing and Community Development Act, HUD authorized the hiring of service coordinators as an eligible expense for all federally subsidized housing programs occupied by more frail older persons (U.S. Department of Housing and Urban Development, 1996). As a final example, since 2001, HUD’s Assisted Living Conversion Program has funded the costs of physically renovating and retrofitting the apartment units and common spaces of rent-assisted federal properties (except Public Housing) so that they can be licensed by their states as assisted living properties (or equivalent). The grant funds, however, cannot be used to pay for service delivery (Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, 2002).

More commonly, housing providers, such as the owners or sponsors of privately owned multi-unit HUD rent-assisted properties and Public Housing projects, must look to different and multiple funding sources to bundle together fiscal support needed to make their long-term care affordable. These could include, for example, funding from private foundations, Older Americans Act programs, Community Development Block Grant programs, and state development agencies (Mollica & Johnson-Lamarche, 2005; O'Keeffe & Weiner, 2004; Stevenson, Murtaugh, Feldman, & Oberlink, 2000). The availability of these funding sources will vary substantially across states and counties and housing providers themselves have
different abilities and motivations to harness these sources of financial assistance.

States are increasingly using their Medicaid programs to fund the delivery of long-term care outside of their nursing homes, although their coverage and reimbursement provisions can vary substantially (O'Keeffe & Weiner, 2004). Ten states do not offer Medicaid program coverage to subsidize housing-care properties as long-term care settings, although they can cover the services offered by outsourced service providers. Fourteen other states opt to cover the long-term care services provided by housing-care settings through the personal care option of their state plan, thirty-six states rely on their Home and Community Based Services 1915(c) Waivers Program, and eight states rely on both of these approaches. Three states use all three sources (Mollica & Johnson-Lamarche, 2005).

States often favor the Waiver plan because unlike the personal care benefit, they can limit Medicaid eligibility to particular population groups and locations and establish waiting lists (Mollica & Johnson-Lamarche, 2005). They can also offer a fuller range of personal care services not covered under their state plan. When states rely on their personal care services benefit, the Medicaid-eligible older persons are typically less impaired (Summer & Ihara, 2005). Other states favor their Waiver program because it requires that their housing-care settings accommodate residents who have the same level of care needs as residents admitted to their nursing homes (and thus may offer comparable care at less cost). States, however, have very different nursing home admitting standards and some accept older persons with less severe impairments than others (O'Keeffe & Weiner, 2004; Summer & Ihara, 2005). Medicaid Waivers may also be favored because of their more liberal income level eligibility thresholds—older persons are eligible if they have incomes as high as 300% of the Supplemental Security Income benefit. On the other hand, if states rely on the Medicaid benefits under their personal care
option, minimum income thresholds are typically lower—based on the federal poverty level, 100% of the Supplemental Security Income benefit, or the state’s medically needy income standard (O'Keeffe & Weiner, 2004).

As identified earlier, some larger private-pay, for-profit assisted living facilities allocate some of their units to low-income older persons. To defray their long-term care costs, they rely on Medicaid subsidies and state supplements to the federal Supplemental Security Program. Providers vary as to whether they accommodate once private pay residents who have subsequently become Medicaid eligible because they have “spent-down” their incomes and assets. Most assisted living providers do not rely on Medicaid subsidies, however, because of the limited availability of Medicaid slots, because the program does not cover room and board costs, imposes limits on what they can charge, and because the Medicaid reimbursements for their long-term care are too low (O'Keeffe & Weiner, 2004).

Most long-term care provided to older persons in household-care arrangements is not assigned any monetary value despite the typically extensive time commitments of family members. Thus, the out-of-pocket long-term care costs incurred by older persons in household-care settings depend largely on the extent to which this informal care is supplemented by professional care. When they do require such assistance, older persons often rely on comparable government-sponsored home- and community-based programs as housing-care occupants.

**Diverse Housing-Care Prototypes or Exemplars**

Figure 3 identifies eight distinguishable prototypes or exemplars of housing-care arrangements now operating in the United States. Each has a sufficiently distinctive set of component attributes to set them apart from the others (Figure 2). Not every current housing-care
setting will be neatly recognizable as a member of a particular exemplar, however. Some housing-care settings inevitably share key attributes common to two or more prototypes. Nonetheless, a housing-care setting’s prototype categorization usually will reflect the prominence of one or more of its attributes.

This group of eight exemplars does not encompass some housing-care alternatives that might be included by other researchers and advocates. The “critical mass” requirement mostly rules out places such as adult foster care and board and care facilities that typically accommodate very small numbers of seniors. Most private-pay independent living facilities, assisted living properties and continuing care retirement communities (CCRCs) will also be excluded because either (or both) their entrance or monthly fees would put them out of economic reach of low-income seniors, even though their appearance and operating features would qualify them as housing-care arrangements. On the other hand, we would include some independent living facilities (congregate care facilities) and CCRCs when they are operated by faith-based organizations charging affordable fees; and also private-pay assisted living properties when some share of their units are occupied by Medicaid recipients.

Space prevents a discussion of all the iterations of the many possible attribute combinations (Figure 2) that argue for the identity of the eight housing-care arrangements, but below we highlight some of the most important distinctions.

The basis for identifying several of the Prototypes (1-5), is the distinctiveness of their long-term care offerings and how their housing providers deliver them. Prototype 1, a minimalist housing-care arrangement, usually a government-subsidized rental housing project, typically offers its residents only the information and referral services of an on-site service coordinator, some environmental care, like housekeeping and transportation and an emergency response
system. It residents may also have access to a wellness clinic/nurse and common areas for recreation and socializing. Its residents are more likely to be overall less impaired—if only because the absence of an extensive array of offered long-term care services will lead to the selective departure of tenants with higher acuity needs. In contrast, Prototypes 2 and 3, although also government-subsidized rental projects, offer their typically more impaired residents a much broader range of long-term supports relying on more comprehensive and complex service delivery approaches. In turn, their buildings will contain more extensive physical design features and common areas consistent with the needs of a more vulnerable population. Prototypes 2 and 3 will offer some of their services with their own hired staff, but they will also rely heavily on contracts or partnerships with other nonprofits or public agencies to deliver assistance.

Prototypes 2 and 3 in turn differ from each other because of the variations in the organizational origins of their delivered long-term care. Prototype 3 is a product of a comprehensive state-initiated long-term care program; whereas Prototype 2 is primarily the product of initiatives of housing sponsors and their managements.

Prototypes 4 and 5 distinguish themselves because the sources and delivery of their care more strongly depend on community-based services as opposed to the services offered by on-site building staff. Thus, although Prototype 4 will offer some of its services with its own staff, it relies extensively on a senior center for its meals, a home care agency offering ADL assistance, and on an organization that offers a health and wellness clinic (either on- or off-site) for preventative care. The identity of Prototype 5 is linked to its dependence on a co-located or nearby PACE center to deliver a comprehensive array of long-term (and often acute) care to its relatively more impaired older occupants.

Prototype 6 distinguishes itself from Prototypes 1-5, because it represents properties that
are licensed (by a state government) as assisted living facilities (or equivalent category).

Prototypes 1-5 usually will lack such licensing status because the building structure and its operations fall beneath the care or service threshold of their states’ licensing criteria, or because they rely on out-sourced licensed service providers and agencies. The housing-care arrangements of Prototype 6 often will rely more heavily on their own in-house hired staff and services and its occupants will typically need higher acuity care.

Prototypes 7 and 8 are distinguished because of their development and management origins. NORC or DOUER properties (Prototype 7) often were not originally designed as housing-care arrangements and their concentrations of older residents with long-term needs have only emerged later in the history of these properties. The introduction of a care component in these buildings often reflects their cooperative’s or condominium’s tenant associations agreeing on the need to obtain some formal or permanent organized assistance. This response may also be spurred (and initiated) by the concerns of professionals from an outside social service agency (Ormond, Black, Tilly, & Thomas, 2004). Prototype 8 has a very different origin. A small share of private-pay assisted living providers has secured Medicaid (waiver) funding to make some of their units affordable to low-income frail older persons.

The distinctive ways that housing-care arrangements obtain funding to make their long-term care affordable is also the basis for distinguishing these exemplars. At one end of the spectrum are rent-subsidized buildings that must secure funding only to pay for the wages of a service coordinator (Prototype 1) or those relying on a narrow range of community-based services donated by a faith-based social agency (Prototype 4). Prototypes 2 and 6 rely on very different and more diverse funding sources consistent with the broader spectrum of their long-term care assistance. For example, to be eligible for assisted living state licensure, the owners or
providers of a Public Housing or HUD project (Prototype 6) typically must obtain funding to retrofit their buildings (e.g., common rooms, clinics) and make architectural design adaptations (e.g., wheelchair access, safety features). To subsidize their long-term care, they may rely on Medicaid waivers, tenants’ Supplemental Security Income (SSI) benefits, state supplements to SSI and the donations from nonprofit, often faith-based organizations. Their task is further complicated because these funding streams must be compatible (e.g., eligibility of tenants) with their affordable housing financing packages (Jenkens, Carder, & Maher, 2004). Prototypes 3 and 5 distinguish themselves because they both offer a diverse array of long-term care services to their typically more frail older occupants that are funded by relatively large public programs: a state-sponsored managed care assisted living program or the PACE program. NORC or DOUER properties (Prototype 7), on the other hand, are typically securing assistance for their less impaired older tenants, and will often rely on a different package of funding sources. Their residents may not have sufficiently low incomes to qualify for Medicaid and their rents are often already affordable, so they may predominantly rely on Older Americans Act programs (income level is not an eligibility constraint), and the donated services from faith-based charities.

DISCUSSION

Advocates for this housing-care model believe that it holds promise for leveling the unequal aging in place opportunities typically available to low- and high-income older Americans. They also argue that these housing-care arrangements offer various advantages over where older persons predominantly age in place—what we labeled as household-care arrangements. Foremost, they benefit from the economies of scale of serving a relatively large and permanent concentration—a critical mass—of low-income older tenants with common
needs. Thus, the whole spectrum of long-term care can be delivered more effectively and at lower cost than when it is offered to geographically dispersed seniors living in their ordinary homes and apartments (Evashwick & Holt, 2000; Ormond, Black, Tilly, & Thomas, 2004).

It becomes easier to justify the retrofitting of a building to make it safer and easier for their frail tenants to use, the hiring of a service coordinator or case manager, the purchasing of a transportation van, the offering of regularly scheduled on-site meals, and the introduction of a program of social and recreational activities. With a concentration of visible at-risk tenants, it becomes more feasible for on-site nurses to provide health maintenance checks and to introduce onsite personal assistance (Evashwick & Holt, 2000).

Service providers emphasize that they are more likely to be apprised of their target population’s unmet and changing social, psychological, and practical needs and in turn can better educate the older tenants about how they can benefit from long-term care assistance (Evashwick & Holt, 2000). They claim that the organizational climate of these housing arrangements makes it more likely that frail older tenants can get needed help and do not have to act alone (Golant, 1999; Sheehan & Oakes, 2003). Thus, their occupants enjoy a more protective long-term care context than they would in the household-care arrangements of ordinary homes and apartments.

Providers argue that the multiple services often required by a frail older population can be better coordinated—the result being more effective scheduling of everything from staff assignments to special purpose transportation vans (Evashwick & Holt, 2000). Furthermore, they can more easily adjust their service time allotments to fit the clients’ unique needs, and are less likely to offer duplicated services as would be the case if individual tenants were all making their own care arrangements (Mollica, 2003; Ormond, Black, Tilly, & Thomas, 2004).

In contrast, frail elderly living in household-care arrangements can usually receive
assistance from direct care workers only on selectively scheduled days and during limited and inflexible time slots. Providers argue that this care cannot be delivered as timely, cheaply or productively as in housing-care arrangements because they are usually traveling to multiple neighborhoods to serve a geographically dispersed clientele (Medicare Payment Advisory Commission, 2001; Mollica & Morris, 2005). Traveling these distances also results in substantial transportation expenses, increasingly a more crucial budget component, given the higher cost of fuel (Harvey, 2005). When multiple public agencies provide the different types of help needed by these seniors, each governed by different eligibility and scheduling requirements, coordination is especially difficult (Lawler, 2001).

Without a family member to serve as spokesperson and gatekeeper, older persons may be especially disadvantaged. Thus, seniors relying on a household-care strategy may lack help when they most need it, unless they are in states and localities where they can receive a comprehensive case-managed program of home- and community-based assistance (Foundation for Accountability & The Robert Wood Johnson Foundation, 2001; Stevenson, Murtaugh, Feldman, & Oberlink, 2000). They also cannot typically realize the lower per service/commodity costs enjoyed by housing-care arrangements. Their household budgets will be further strained if their dwelling expenses are consuming a large share of their monthly income (Golant, 2003a).

Some of the strongest proponents of housing-care arrangements are the housing sponsors of affordable rent-subsidized buildings who adopted this model after having experienced a host of tenant crises in the absence of offering supportive services. In contrast, now they report (Golant, 2000, p. 3):

> “Building morale will be higher, incidence of fires and accidents will decrease, unscheduled visits from human service professionals
will decline, and fewer housekeeping and repair problems will erupt. Overall, fewer apartments will turn over. With fewer crises, administrators can devote more attention to the bricks and mortar tasks of building management.”

Even as advocates point to their many virtues, it is not easy to develop and manage these housing-care arrangements and potential sponsors confront various obstacles that either prevent or discourage their participation (Golant, 2003b). To make these options affordable, housing providers must secure funding to construct (or physically retrofit) and manage a building and to deliver affordable care. Finding financing to convert an ordinary rental building into one that is physically designed appropriately for offering supportive services is a challenge by itself; finding financing to also offer affordable long-term care greatly raises the property development bar. Although some state governments have organizational strategies to facilitate the packaging of such financing, housing sponsors are often saddled with this challenging responsibility (Wilden & Redfoot, 2002).

These difficulties are illustrated when housing providers try to combine Medicaid (waiver) assistance with affordable rental assistance. They are often put off by the inability of the Medicaid program to guarantee the availability of future waiver funding (the time span of waiver programs is usually less than the loan finance repayment period of the property) (Mollica & Johnson-Lamarche, 2005). As another disconnect, the incomes of the residents eligible for housing-care residences (in higher priced housing markets) may be too high for them to qualify for Medicaid, especially in states that rely on their personal care plan. In buildings that are in rural settings, it is often prohibitively expensive to add the physical infrastructure required for a state’s assisted living licensure.
When packaging their funding, housing sponsors must typically deal with the bureaucracies of governmental agencies that treat housing and care as very separate domains. Thus, while “new affordable senior housing development is possible…it may involve leaving the comfort zone of some providers’ experience” (Van Ryzin, 2006). As Congressional testimony by a large nonprofit service provider emphasized (Volunteers of America, July 17, 2001):

“Providers of long-term housing finance typically do not understand the terminology or analytic framework of the health care community. Health care regulators are unaware of the requirements of housing finance. The need to get participation and approvals for transportation, social service, and other regulatory bodies further complicates the discussion. Housing sponsors often must spend inordinate amounts of time and energy as a go-between because different disciplines give different meanings to important words.”

The result is that housing providers have difficulty trying to package services funded by programs that differ as to their applicants’ minimum income and asset qualifications and the types and severity of their covered physical disabilities, the share of the service cost they subsidize, where the services must be delivered, and their performance requirements (Lawler, 2001). Thus, providers often “confront an organizational puzzle where the pieces do not match up” (Golant, 2003a, p. 37). This contrasts with nursing homes that can depend on a single (Medicaid) subsidy to run their operations and are seldom required to separate out their shelter and care costs. It also differs from private-pay assisted living residences catering to a higher income clientele that do not usually have to separate out their shelter and long-term costs for public sector scrutiny or approval.

Potential housing developers, operators, and their investors have other concerns. They
worry that their developments will begin to resemble nursing homes or assisted living facilities and that they will incur the wrath of their more healthy tenants who do not want to be surrounded by frail neighbors (Golant, 1999). Others fear that their operations will run afoul of outside regulators who will accuse them of providing too much care; and they will incur higher and financially intolerable insurance liability premiums (Aon Risk Consultants, 2005).

The many disincentives confronting the stakeholders, who develop, fund, manage, regulate, and insure these alternatives result in their needing especially compelling evidence to justify their participation. Although there is much anecdotal and case study evidence arguing for the strengths and advantages of this option, there is a shortage of scientifically valid research that has demonstrated that this housing-care alternative can achieve acceptable quality of life and care outcomes. Specifically, evidence is lacking that these housing arrangements can help their occupants improve or stabilize their behavioral functioning, delay or postpone their needs for a nursing home stay, and reduce the overall costs (as opposed to per household) of publicly funded long-term care (Doty, 2000; Shirk, 2006).

The various versions of these housing-care arrangements have made it especially difficult to generalize about their successes and failures (Sheehan & Oakes, 2004). Thus, we lack comparable research findings on issues such as the following: the quality of care consequences of housing-care arrangements variously relying on outsourcing, on-site staffing, or co-location strategies to offer long-term care; the quality of care consequences of licensing the property as opposed to the service provider; what constitutes an operationally feasible critical mass size; what program features most influence resident care outcomes (e.g., minimum hours of on-site care by personal aides or nurses); and how housing-care settings compare in costs and quality of life and care outcomes with household-care strategies or private-pay assisted living residences.
Furthermore, there has been little careful debate regarding the minimum set of attributes that these settings must possess to qualify as “alternatives” to more high-acuity care facilities like private-pay assisted living properties or nursing homes (Ficke & Berkowitz, 2000; Fonda, Clipp, & Maddox, 2002; KRA Corporation, 1996; Mollica & Johnson-Lamarche, 2005; Pynoos, Liebig, Alley, & Nishita, 2004; Research Triangle Institute, 1996; Sheehan, 1999; Sheehan & Oakes, 2003; Sheehan & Oakes, 2004). Such studies are necessary to respond to the concerns of those skeptics (especially in the nursing home industry) who argue that because these housing-care arrangements are less stringently regulated, they cannot provide competent care to the very frail (U.S. Senate Special Committee on Aging, 2003).

Thus, the multiple prototypes of this housing arrangement may be a double-edged sword. On the one hand, low-income older consumers benefit from more choices catering to both their varied housing preferences and very different long-term care needs. A diverse product line acknowledges that one size does not fit all. On the other hand, such variability has contributed to the failure of research to reach generalizations about the worth of these options. An eclectic “product line” obfuscates the identity of these housing-care settings as long-term care solutions and casts doubt on whether they have a distinctive mission and a relatively unique set of core features. This can lead to confusion among consumers and make it difficult for them to make informed choices. Judging the appropriateness of a housing setting becomes especially confusing if potential consumers or their health care and social work advisors lack confidence that it offers a predictable set of services. Furthermore, if there are any incidents of abuse or poor care, the media will quickly dismiss the whole category of options as unreliable, even if they involve only unrepresentative housing-care outliers.

Advocates for this long-term care alternative for poor seniors sometimes mistakenly
assume not only that there is consensus as to the mission of these options, but also that all the key players agree that they constitute a valuable addition to the long-term care resources of this country. These perspectives are embodied in the optimistic words of a nationally prominent housing consultant: “When speaking of affordable housing buildings linked with affordable supportive services, you no longer have to explain what they are any more, why they are needed, why they are beneficial to vulnerable seniors” (Bretos, 2004). This paper has shown that it is far from a straightforward task to distinguish the diverse housing-care exemplars that presumably share a common mission. As a result, we now have insufficient knowledge to make unequivocal evaluations about the strengths and weaknesses of these housing arrangements as long-term care alternatives, even as advocates claim they have been around for a long-time, have successful track records, and are occupied by thousands of satisfied seniors successfully aging in place.
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## Figure 1. Nine Components Distinguishing Affordable Household-Care and Housing-Care Arrangements

<table>
<thead>
<tr>
<th>No.</th>
<th>Components</th>
<th>Affordable Household-Care</th>
<th>Affordable Clustered Housing-Care</th>
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<tbody>
<tr>
<td>I</td>
<td>Development and Management Origins of Housing Arrangement</td>
<td>Low-income older persons with physical and/or cognitive limitations and chronic health problems require affordable assistance to remain living independently in their ordinary owner- or renter-occupied dwellings. They receive care mostly from family members and to a lesser extent from staff or professionals from nonprofit organizations, private pay workers, or publicly funded care and case-management staff.</td>
<td>Low-income older households having some difficulties living independently occupy originally planned or purposively adapted affordable (below market-rate rent) dwellings and buildings. Their sponsors or owners arrange for their residents to receive affordable long-term care. Among the stakeholders initiating these settings: administrators or owners of government-subsidized affordable rent-assisted apartment projects, nonprofit service organizations, privately owned assisted living residences, and self organized groups of older residents in a multi-unit building.</td>
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<tr>
<td>II</td>
<td>Setting Context and Composition of Impaired Occupants</td>
<td>Geographically dispersed dwellings located throughout urban and rural communities occupied by one or two low-income older persons with chronic physical health problems and cognitive deficits, who require assistance with instrumental activities of daily living (IADL) or activities of daily living (ADL); Occupants may need low- or high-acuity care.</td>
<td>Building(s) purposively occupied by a significant concentration or critical mass of older persons with chronic physical health problems and cognitive deficits, who require assistance with instrumental activities of daily living (IADL) or activities of daily living (ADL). The seriousness or acuity of their vulnerabilities can vary substantially and will reflect the availability of assistance or care, in turn determined by service philosophy of provider and by fiscal and regulatory constraints.</td>
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<td>III</td>
<td>Housing Setting and Site Characteristics</td>
<td>Rented and owned dwellings in stand-alone single-family dwellings or multiunit buildings that may or may not be in good physical condition.</td>
<td>Rented and owned dwellings usually undistinguishable from other structures in multiunit buildings including condominiums and limited equity cooperatives, but also single-family dwellings and manufactured homes in the same neighborhood (park) or on campus setting.</td>
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<td>IV</td>
<td>Physical Design and Retrofitted Features for the Physically or Cognitively Frail</td>
<td>Dwellings infrequently have physical design or architectural features addressing the needs of physically or cognitively vulnerable occupants. Dwellings with design modifications are voluntary efforts not mandated by regulation.</td>
<td>Dwelling, site, and sometimes neighborhood settings have purposely designed physical or architectural features often meeting federal, state, or local regulatory requirements that are consistent with addressing the needs of physically or cognitively vulnerable occupants. Common living areas often accommodate the recreational, life-style, and dining activities of residents; and offices and workplaces are available for staff to administer care or assistance.</td>
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<td>V</td>
<td>Types of Offered Long-Term Care</td>
<td>From low acuity or light (e.g., housekeeping, information, and transportation) to high acuity or heavy (e.g., nursing home level) care are offered over a sustained period. The degree of frailty of the occupant(s) and the level of care offered reflect financial or skill limitations of family caregivers or the regulatory constraints imposed on paid home and community based providers.</td>
<td>From low acuity or light (e.g., housekeeping, information, and transportation) to high acuity or heavy (e.g., nursing home level) care are offered over a sustained period. The degree of frailty of the occupant(s) and the level of care offered reflect the care capabilities and service philosophy of housing providers, fiscal constraints, or restrictions imposed by government regulations.</td>
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<td>VI</td>
<td>Service Delivery Modes—Sources and Packaging of Services</td>
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<td>Older occupant in dwelling makes long-term care decisions either alone or with the assistance of family members. Less frequently, care decisions made by professional care workers. Care is typically delivered in the older person’s dwelling or at community-based centers (e.g., adult day care; congregate meal sites). Responsibility for packaging care often assumed by family members with little experience or training. Services typically are added incrementally as the needs of the frail older occupant(s) become more demanding.</td>
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<td>Housing manager or tenant organization hires own staff or out-sources, partners, or collaborates with public agencies, nonprofit organizations (including volunteers), community service agencies, or private businesses who join with frail older residents at the housing setting as initiator, counselor, organizer, or service provider in the long-term care delivery process. Different planned service delivery approaches offer assistance in the dwelling, on the housing site, or at nearby community based centers. Thus, older occupants infrequently make long-term care decisions alone and they are variously involved in the management and programming of their care.</td>
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<th>VII</th>
<th>Licensure and Regulatory Status</th>
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<td></td>
<td>Most care offered by family members, volunteers, and paid hired staff is usually unlicensed and unregulated. Small share of care may be offered by licensed home care agencies or under the auspices of state regulated home and community-based programs.</td>
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<td>Sometimes only building is regulated under local housing and zoning laws; alternatively, building and services offered by housing provider licensed under state laws. Sometimes only the service providers outsourced or subcontracted by housing provider are licensed or regulated by a state government agency.</td>
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<th>VIII</th>
<th>Affordability of Room and Board or Shelter</th>
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<tr>
<td></td>
<td>Household may or may not occupy affordable housing.</td>
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<td>Rental housing units subsidized by federal or state government programs enabling affordable rents. May also include affordable market-rate housing such as limited equity cooperatives, rent-controlled buildings; manufactured home parks; and dwellings in older neighborhoods.</td>
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<th>IX</th>
<th>Affordability of Long-Term Care</th>
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<td></td>
<td>When the unpaid assistance of family caregivers is insufficient, public sector financial assistance often is required to subsidize some or all of the cost of paid staff/equipment assistance. Alternatively, occupants may receive services (at home or in community centers) donated by nonprofit, often faith-based organizations.</td>
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<td></td>
<td>Supportive services typically made affordable by multiple strategies funded by public programs, private foundations, and nonprofit, often faith-based organizations.</td>
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</table>
Figure 2. Attributes of the Nine Components Distinguishing the Affordable Clustered Housing-Care Strategy

I. Development and Management Origins of Housing Arrangement

a) Government-subsidized (federal, state, or local) properties (e.g., primarily built and operated by HUD loan, subsidy, and mortgage insurance and bond programs; Public Housing Authorities, Rural Housing Service; Tax Credit programs; and state-financed programs). Although typically seniors only projects, their owners or sponsors may have converted them into housing-care arrangements only later in their history when they physically retrofitted their buildings and began to offer affordable long-term care.

b) For profit and nonprofit corporate owned or managed purposively planned seniors housing properties (independent housing or congregate housing; assisted living properties, or continuing care retirement communities—CCRCs) made affordable to low-income elderly through various government programs and by charitable donations from nonprofit service organizations.

c) State government health and social service agencies or nonprofit service organizations (faith-based, charitable) initiate and/or administer the delivery of services to housing arrangements occupied by concentrations of seniors.

d) Privately owned or rented housing properties not originally planned or occupied as seniors housing properties, often labeled as NORCs (naturally occurring retirement communities) or DOUERS (deliberately occupied but unplanned elder residences), including limited equity cooperatives, rent-controlled buildings, and manufactured home parks. Now are seniors dominated housing arrangements because of aging in place preferences of past occupants and the selective in-migration and out-migration patterns of older and younger occupants. Self-organized tenant associations arrange for long-term care delivery or are encouraged and assisted by nonprofit service organizations.

II. Setting Context and Composition of Impaired Occupants

a) Cluster of seniors requiring some assistance performing only instrumental activities of daily living (IADLs).

b) Cluster of seniors requiring some assistance performing IADLs and only one or two Activities of Daily Living (ADLs).

c) Cluster of seniors requiring some assistance performing more than two ADLs.

d) Cluster of seniors requiring full assistance performing one or more ADLs.

e) Cluster of seniors who do not require 24 hour a day nursing care.

f) Cluster of seniors with only mild or moderately severe dementia symptoms.

g) Cluster of seniors with very severe dementia symptoms.

h) Clusters of seniors with different combinations of above impairment profiles.

III. Housing Setting and Site Characteristics

a) Urban or rural multiunit elderly-occupied stand-alone rental buildings (low-rise and high-rise) or clustered on campus-like setting.

b) Urban or rural manufactured home parks or subdivisions.

c) Urban or rural multiunit rental buildings or single-family dwellings located in same subdivision, or neighborhood (e.g. cohousing arrangements, unplanned elderly-occupied subdivisions).

IV. Physical Design and Retrofitting Features for the Physically or Cognitively Frail

a) Interior dwelling components and attributes (size of unit, presence of private rooms and bathrooms).

b) Common areas (social, eating, recreation, offices for service providers).

c) Building/site locations of residents distinguished by impairment acuity.

d) Site design and outdoor landscape components and attributes.

e) Neighborhood components and attributes.

f) Multiple combinations of the above design components.

V. Types of Offered Long-Term Care

a) Information: counseling, assessment, and referral: health (early intervention) screening; health condition monitoring; personal care assessment; care planning (case management services); service coordination, referral and assistance with completing applications for service eligibility, and accessing, securing, or coordinating medical, personal, rehabilitative, and nursing services.
b) “Environmental care”: assistance addressing limitations in an older adult’s ability to perform instrumental activities of daily living. Shopping, cooking, laundry, and housekeeping assistance; exercise programs; transportation; delivery of nutritionally balanced meals; home maintenance and modifications; financial and legal advice; companionship; monitoring and emergency alert services; religious services, and recreational activities.

c) Wellness care: blood pressure checks, foot care, medical counseling, immunizations, exercise programs, and related preventative care services provided by nurses or physician assistants.

d) Personal (custodial or nonmedical) care: assistance addressing limitations in an older adult’s ability to perform activities of daily living such as dressing, bathing, using the toilet, grooming, walking, and transferring; medication reminders/management/administration; nutritionist counseling services; provision of assistive devices or equipment; provision of emergency or personal response systems.

e) Rehabilitative care and nursing services: physical, occupational, and speech therapies; and nursing services involving procedures addressing resident conditions such as bladder incontinence, colostomy or ileostomy care, catherization, oxygen supplementation, intravenous medication, and tube feeding.

f) Cognitive and behavioral therapy: supervisory and therapeutic assistance for residents experiencing confusion, orientation, memory, or judgment problems, wandering and other inappropriate behaviors.

g) Palliative or hospice care: physical, psychological, social, and spiritual care for dying persons, and their family members or other significant others.

h) Various combinations of these types of long-term care.

VI. Service Delivery Modes—Sources and Packaging of Services

a) On-site services from housing provider’s hired staff; in building or “borrowed” from other facilities on campus setting.

b) On-site services initiated by housing provider from volunteers.

c) On-site services arranged on an as needed basis by housing provider from various outside providers (public agencies, private-pay, community service agencies, or charitable/nonprofit groups, often on the initiative of residents.

d) On-site and off-site services, subcontracted (or other partnership agreements) by provider, sometimes on a regular basis, from multiple home- or community-based agencies, public agencies, private-pay, or charitable/nonprofit groups.

e) On-site and off-site services received from a comprehensive service program often under the auspices of a state agency or contracted state service providers; program administrators determine eligibility and service package received by eligible tenants.

f) Co-located but usually separately owned and managed services offered on housing site or at proximate location offering limited (a la carte) or comprehensive package of long-term care services (e.g., congregate nutrition site, adult day care center such as found in PACE, On Lok programs).

g) On-site and off-site services arranged by organized tenants’ organization that independently arranges or contracts for as needed assistance.

h) Services may be offered on an a la carte basis (occupants charged extra fees) or variously bundled together as a fixed package (occupants charged a flat rate). Residents often (but not always) have the option of refusing to receive particular services and participating in management and programming decisions. Some services offered on a scheduled basis; others on an unscheduled basis; some available around the clock; others only during the day on weekdays.

i) Various combinations of these service delivery approaches.

VII. Licensing and Regulatory Status

a) Property (owner) licensed to provide selected long-term care services in apartment-like (or equivalent) settings to persons with defined impairment severities.

b) Service providers or programs outsourced or subcontracted by housing provider to deliver long-term care to housing-care setting are licensed or regulated by state agency. State and local housing codes and ordinances regulate architecture and fire evacuation responses of building.

c) Property (owner) unlicensed as long-term care provider but housing codes and ordinances may regulate architecture and fire evacuation responses of building.

d) Neither property (owner) nor outsourced or subcontracted service providers (e.g., food, transportation, housekeeping, personal assistance, and preventative care) are licensed.

e) Different licensing status combinations.
VIII. Affordability of Room and Board or Shelter—Funding Sources
a) Affordable market-rate properties (e.g., rent-controlled buildings; limited equity housing cooperatives; manufactured homes).
b) Community Facility Loan and Grant Program (U.S. Department of Agriculture) provides grants and loans to construct or renovate community facilities in rural areas.
c) Department of Agriculture, Rural Housing Service rent-assisted programs (e.g., Section 515).
d) Department of Housing and Urban Development (HUD) rent-assisted/low-income programs to build or substantially rehabilitate affordable multifamily rental buildings (e.g., Section 202, Section 221 (d)(3) BMIR, Section 231, Section 236, Section 8 New Construction and Substantial Rehabilitation, Public Housing, HOME Investment Partnership program, Community Development Block Grant program.
e) Fannie Mae American Communities Fund Modernization Express.
f) Federal Home Loan Bank affordable housing loans and grants.
g) Federal Supplemental Security Income (SSI) and state supplement to the federal SSI payment.
h) HUD HOPE VI (Housing Opportunities for People Everywhere), capital costs of demolition, construction, and rehabilitation, and replacement of public housing.
i) HUD Section 232 program providing mortgage insurance for the construction or substantial rehabilitation of assisted living facilities, and board and care homes.
j) HUD Tenant-based rent assistance Section 8 Certificates or Vouchers to make market-rate rental housing affordable (e.g., Housing Choice Voucher Program).
k) HUD’s Assisted Living Conversion Program and Public Housing Capital Fund Program (formula grants) to pay costs of retrofitting existing HUD/Public Housing rental assistance multiunit buildings.
l) Public Housing operating funds.
m) State and local affordable assisted living programs for low-income older populations.
n) State and local affordable rental programs for low-income populations to construct or substantially rehabilitate rental buildings or offer rental subsidies (e.g., Affordable Housing Trust Funds, Mortgage Revenue Bonds, and Tax Exempt Bonds).
o) Tax Reform Act of 1986 to construct low-income affordable rental multiunit housing, Low Income Housing Tax Credit (LIHTC).
p) Various combinations of these funding sources.

IX. Affordability of Long-Term Care—Funding Sources
a) Congregate Housing Services Program (CHSP).
b) Department of Transportation (e.g., capital and operating costs for transportation van)
c) Federal Supplemental Security Income.
d) Federal Worker training programs (e.g., housekeepers)
e) HUD, Community Development Block Grant Program (e.g., transportation and meals).
f) HUD, Public and Indian Housing, Resident Opportunities and Self Sufficiency (ROSS) Program/Public Housing Operating Fund.
g) HUD, Service Coordinator program.
h) Medicaid state plan, Personal Care Option.
i) Medicaid Waiver program/Assisted Living waiver.
j) Medicaid Waiver program/Home and Community Based Services Waiver.
k) Nonprofit/faith-based organization contracted supportive services.
l) Older Americans Act programs.
m) Property refinancing proceeds.
n) Public financed long-term care relying on capitated payment systems integrating Medicare and Medicaid funding (e.g., Programs of All-Inclusive Care for the Elderly—PACE).
o) Social Services Block Grant program.
p) Rental fees (e.g., hospital rents space for a health center in building)
q) State general funds.
r) State supplement to Supplemental Security Income.
s) Tenant fees or contributions.
t) Nonprofit/faith-based organization’s charitable contributions.
u) University-based service partnerships.
v) Various combinations of these public programs/financing sources.
Figure 3. Exemplars of Affordable Clustered Housing-Care Arrangements Based on Attributes of the Nine Distinguishing Components

(1) Government-Subsidized Project, Basic Service Coordinator Model
   I. Government-subsidized property sponsored by nonprofit organization; Public Housing project.
   II. Most occupants have only IADL limitations; smaller share with ADL limitations.
   III. Stand-alone multiunit apartment building in urban neighborhood.
   IV. Recreation common areas; common dining room; dwellings have minimal design adaptations (e.g., grab-bars in dwelling; emergency response system; 24 hour security).
   V. Information; environmental; and sometime wellness care.
   VI. Housing property hires service coordinator or relies on staff to offer requested assistance. Offers none of its own supportive services; receives some services from volunteers; no or very limited formal contracts with providers; encourage residents to seek out services on their own.
   VII. Neither property (owner) nor outsourced or subcontracted service providers are licensed.
   VIII. Public Housing; HUD Section 202; Low Income Housing Tax Program, HUD Section 236 program.
   IX. Federal/HUD service coordinator program; property’s operating budget or residual receipts; charitable donations.

(2) Government-Subsidized Project, Service Coordinator and Supportive Service Model
   I. Government-subsidized property sponsored by faith-based organization; Public Housing project.
   II. Most occupants have only IADL limitations; significant share with ADL limitations.
   III. Stand-alone multiunit apartment building in urban neighborhood or rural county.
   IV. Central dining room, social, and recreation common areas; office space for clinic; with basic design adaptations in dwelling units (e.g., grab-bars in dwelling; kitchens adapted to compensate for disabilities).
   V. Information; environmental care; wellness care; and sometimes personal care.
   VI. Services variously offered by hired on-site staff, on site outsourced home care agencies, state social service agencies, and through donated services by partnered nonprofit groups; services offered a la carte or bundled; service coordination often tailored to individual resident needs; sponsor often has formalized arrangements (contracts, partnerships) with various service providers to provide on-site scheduled and unscheduled care.
   VII. Property (owner) unlicensed as long-term care provider; some service providers are licensed.
   VIII. Public Housing projects; HUD Section 202, 221, and 236 programs; Section 8 vouchers.
   IX. Federal/HUD service coordinator program; Older Americans Act; Medicaid (personal care program); Medicaid Waivers; Social Services Block Grant program; Congregate Housing Services Program; nonprofit (church) organizations; state general fund; tenant out of pocket fees; property’s operating budget.

(3) Government-Subsidized Project, State-Sponsored Assisted Living Service Program
   I. Government-subsidized property sponsored by faith-based organization; Public Housing projects.
   II. A large share of occupants have multiple ADL limitations; many are at risk of placement in a nursing home.
   III. Stand-alone multiunit apartment building in urban neighborhood.
   IV. Central dining room, social, and recreation common areas; office space for clinic; dwelling units adapted with design adaptations to accommodate a very frail tenant group (grab-bars in dwelling; handicapped-accessible bathroom; lower countertops; balcony door flush with indoor floor; improved lighting; more accessible entry ways; emergency response system; tenant monitoring devices).
   V. Information; environmental care; wellness care; personal care; rehabilitative nursing services; cognitive and behavioral therapy.
   VI. State-funded home care program/agency conducts needs and case management; most services including information and environmental care provided on-site by state-contracted service providers that in conjunction with on-site service coordinator determine eligibility and deliver services; 24-hours a day (overnight staff and emergency services; may integrate co-located nursing facility.
   VII. Property (owner) unlicensed as long-term care provider; most service providers licensed, sometimes under state government’s assisted living licensure.
   VIII. Funded as Public Housing Program.
   IX. Supplemental Security Income; Medicaid; Medicaid Waivers; private pay.
(4) Government-Subsidized Housing Project Partnering with Selected Co-Located Services

I. Government-subsidized housing property; public housing project.
II. A significant share of occupants have difficulty performing IADLs; smaller share have ADL limitations.
III. Stand-alone multiunit apartment building in urban neighborhood.
IV. Social and recreation common areas.
V. Informally arranged set of selected services: Information; environmental care; and wellness care.
VI. Some services offered by housing providers, but many are available during weekdays or monthly are offered by agencies co-located on premises (or in close proximity) of multiunit apartment property (e.g., nutrition site, senior center, wellness center).
VII. Property (owner) unlicensed as long-term care provider; some service providers are licensed; state services licensed as assisted living.
VIII. Section 236, Section 202 HUD-funded rental buildings; Public Housing Projects.
IX. Older Americans Act programs; nonprofit charitable groups; faith-based social service agencies.

(5) Government-Subsidized Housing Project Partnering with Co-Located Comprehensive Care Services

I. Government-subsidized housing property; public housing project.
II. A large share of occupants have ADL limitations; many are at risk of placement in a nursing home.
III. Stand-alone multiunit apartment building in urban neighborhood.
IV. Congregate meal site, social and recreation common areas; office space for clinics; dwelling units adapted with design adaptations to accommodate a very frail tenant group (grab-bars in dwelling; handicap-accessible bathroom; lower countertops; balcony door flush with indoor floor; improved lighting; more accessible entry ways; emergency response system; tenant monitoring devices; 24-hour security guards;...).
V. Information; environmental care; wellness care; personal care; rehabilitative care and nursing services; cognitive and behavioral therapy.
VI. Contracted or other formal arrangements with both long-term care and acute care providers; most services provided at co-located area on premises of multiunit property or at nearby adult day center; on site hired supervisory staff; 24-hour monitoring by trained staff.
VII. Property (owner) unlicensed as long-term care provider; most service providers licensed.
VIII. Public Housing Project funded by HUD; HUD capital fund.
IX. Medicaid Waivers; tenant contributions; nonprofit organization donations; private foundations; Optional State Supplement; Older Americans Act; state social service programs; PACE (Program of All-Inclusive Care for the Elderly) capitated managed care program funded by Medicare and Medicaid.

(6) Government-Subsidized Public Housing or HUD (privately owned) Project, Licensed as Assisted Living Property (or equivalent state licensing category)

I. Government-subsidized property; Public Housing project.
II. A large share of occupants have multiple ADL limitations; many are at risk of placement in a nursing home.
III. Stand-alone multiunit apartment building in urban neighborhood; clustered garden style apartments.
IV. Central dining room, social, and recreation common areas; office space for clinic; dwelling units adapted with design adaptations to accommodate a very frail tenant group (grab-bars in dwelling; handicap-accessible bathroom; lower countertops; balcony door flush with indoor floor; improved lighting; more accessible entry ways; emergency response system; tenant monitoring devices; 24-hour security guards;...).
V. Information; environmental care; wellness care; personal care; rehabilitative nursing services.
VI. Most services provided on-site by on site hired staff; 24-hour supervision by trained staff.
VII. Property (owner) licensed as assisted living residence or equivalent.
VIII. Public Housing Capital Fund Program; Assisted Living Conversion Program; HOPE VI Elderly Revitalization grant.
IX. Medicaid; Medicaid Waivers; Optional State Supplement; tenant out of pocket contributions.
(7) NORC/DOUER Housing Arrangements with Supportive Services

I. Privately owned or rented old-age dominated housing properties not purposively planned or occupied as seniors housing properties (NORCs and DOUERs), such as housing cooperatives (e.g., limited equity), rent-controlled buildings, and manufactured home parks. Care solicited by building’s tenant association or motivated by concerned nonprofit social agency.

II. A significant share of occupants have difficulty performing at least one IADL; smaller share have some ADL limitations.

III. Stand-alone multiunit apartment building in urban neighborhood; manufactured home parks; clusters of houses within neighborhood.

IV. Libraries, exercise room, activity rooms; sometimes common dining room; dwellings often have no special design features consistent with older persons with disabilities.

V. Information; environmental care; wellness care; and some personal care.

VI. Relatively few permanent on-site service staff, with exception of hired service coordinator; tenants often involved in management and programming decisions; services may be delivered both on and off the site of the building by nonprofit based service agencies, public service agencies; co-located (on or near property) of health care and social services providers.

VII. Property (owner) unlicensed as long-term care provider; some service providers are licensed.

VIII. Lower housing cost private-market housing arrangements (such limited equity cooperatives; manufactured homes; rent-controlled buildings); sometimes, federal rent subsidies.

IX. Older Americans Act; charitable contributions from nonprofit organizations; private foundations; municipal government funding; state social service programs; occupants’ out-of-pocket funds; proceeds from property refinancing.

(8) Private Pay Assisted Living Property Offering Subsidized Shelter and Care

I. Privately owned independent living facility, assisted living or larger board and care facility; may be part of larger CCRC; some share of units dedicated to accommodate low-income elders; may be product of mixed public-private sector financing.

II. A large share of occupants have multiple ADL limitations; many are at risk of placement in a nursing home.

III. Stand-alone multiunit apartment building or large (originally) single-family like structure in urban neighborhood.

IV. Central eating area, social, and recreational common areas; sometimes, office space for clinic; dwelling units may or may not be adapted with design adaptations to accommodate a very frail tenant group.

V. Information; environmental care; wellness care; personal care; rehabilitative nursing services.

VI. Most services provided on-site by hired staff; 24-hour supervision by trained staff; some services outsourced to licensed home care agencies.

VII. Property (owner) licensed as assisted living residence or equivalent.

VIII. Low-income residents only: Out of pocket (consumer savings; Social Security); Supplemental Security Income; Optional State Supplement.

IX. Medicaid Waivers; tenant contributions.