EXPANDING THE CONTINUUM OF CARE
IN SUBSIDIZED ELDERLY HOUSING

by

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ABSTRACT

Owners of the existing stock of privately owned subsidized elderly housing face a critical decision making phase in the next few years as they are confronted with two separate but potentially related issues. The first issue facing these owners is the impending expiration of subsidy contracts and the use restrictions attached to them. The second of these is the continued aging and increased frailty of the existing residents of these facilities and the implications this process has for the demand for long-term care, housing and supportive services. Each of these issues alone will dramatically impact the future of existing elderly housing, however, it is the potential for linking these two issues as a means of extending the functional and financial viability of these projects that is the focus of this thesis.

To explore this link, this thesis will test the feasibility of expanding the continuum of care available in these facilities as a means of simultaneously improving the quality and cost effectiveness of the existing elderly support service/long-term care system while maintaining or improving the financial viability of these projects. To be feasible, this undertaking must meet the objectives of both the property owners as well as those of the public subsidizing agencies that are linked to the elderly support/long-term care system if each is to be expected to participate.

This thesis examines the appropriate level of service that can cost effectively be implemented in these existing facility, the programmatic and physical changes that must be incorporated into the project to achieve this goal, the cost implications of these changes and how can they be funded or financed. As development of this concept will require substantial public involvement and support, this thesis also examines the role of the housing and subsidizing agencies and how the process might be organized to minimize the cost to public coffers while maximizing the incentive to the private sector to initiate similar efforts in other subsidized housing locations.

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CHAPTER I
INTRODUCTION

OVERVIEW

Owners of the existing stock of privately owned subsidized elderly housing face a critical decision making phase in the next few years as they are confronted with two separate but potentially related issues. The first issue facing these owners is the impending expiration of subsidy contracts and the use restrictions attached to them. The second is the continued aging and increased frailty of the existing residents of these facilities and the implications this process has for the demand for long-term care, housing and supportive services. Each of these issues alone will dramatically impact the future of existing elderly housing, however, it is the potential for linking these two issues as a means of extending the functional and financial viability of these projects that is the focus of this thesis.

To explore this link, this thesis will test the feasibility of expanding the continuum of care available in existing elderly housing as a means of simultaneously improving the quality and cost effectiveness of the existing elderly support service/long-term care system while maintaining or improving the financial viability of the housing component. To be feasible, this undertaking must meet the objectives of both the property owners as well as those of the public subsidizing agencies that are linked to the elderly support/long-term care system if each is to be expected to participate.

The financial objective of the owners of subsidized housing is presumably to maintain or improve the profitability/residual value of their investments. Both
profitability and residual value of these projects are tied to the structure of existing subsidy contracts. These contracts, which consist of financing and operating subsidies, were structured with relatively short terms and substantial tax incentives to maximize the private sector incentive to get the projects developed and were generally not concerned with maintaining the long-term affordability of these projects. As most of the existing elderly housing stock was developed 10 to 20 years ago, many of these contracts have expired over the past few years with hundreds of thousands more expiring by the year 2000. The expiration of these financing and operating subsidy contracts, and the use restrictions associated with them, will have dramatically different effects on individual housing projects depending on the nature of the existing contract, the relative profitability of the property, but most importantly, the condition of the housing market in which it is located. Expiring use restrictions will create profit opportunities for those property owners who have seen the value of their developments appreciate dramatically and who are in a position to realize substantial gain by converting these properties to market rate apartments or condominiums. The value of other properties, located in weak residential markets, has seen little appreciation creating no potential for conversion to market rate units. Instead, these properties are dependent upon the continuation and extension of subsidy contracts to maintain their financial viability. Expiration of these subsidy contracts and the resulting decrease in project income and increase in debt service costs, will place the owners of these properties at risk of default on mortgage obligations and loss of control of the property.

The potential loss of affordable housing both to market rate forces and to mortgage default has raised a public debate around if an how the affordable nature of this
housing should be preserved. Discussed at greater length in Chapter III, recent federal legislation on this issue has begun to define the government's ability and willingness to preserve the existing stock of affordable housing but raises doubts about the continuation of the subsidies for projects with high potential market value as well as those in weak markets that offer other affordable housing options. The question for this latter group of at risk property owners that ties this issue to that of supportive services and long-term care is: can these existing elderly housing projects be restructured to meet the changing needs of the elderly population creating an affordable alternative to existing long-term care options as a means of extending the financial viability of these projects into the foreseeable future? A basic premise of this thesis is: to the extent that restructuring of these projects can extend the available continuum of care, the project owners are in a better position to negotiate the continuation of housing subsidies and sustain the financial health of these projects.

This premise is based upon the recent repositioning of long-term care policy objectives of state and federal governments. These objectives, which will be discussed more thoroughly in Chapter II, focus on generating residential environments for the elderly that not only improve their quality of life, but may serve as cost effective alternatives to existing long-term care options.

Past efforts to provide this continuum of care have created a vast but discontinuous array of housing and long-term care options centered around two distinct models, that of providing supportive services to the elderly in existing housing and the medical services model provided in hospitals, nursing homes and other types of licensed medical facilities. Those elderly who need supportive services not available in their
residential environment but who do not require the intense level of supervision and medical attention provided in a nursing home have fallen into the gap between the two resulting in a number of frail elderly people living in independent housing units beyond their ability to cope with this situation as well as premature institutionalization. See Diagram 1.

Diagram 1

The Continuum of Care - Current Configuration

Elderly With ADL (Activities of Daily Living) Impairments

Elderly Housing Other Residential Options Nursing Home W/ Supportive Services Medical Model

The discontinuity of services available in any one location has also resulted in the necessity for elder persons to be relocated from place to place as their needs change. In short, existing options for the frail elderly fail to adequately serve their needs and result in the waste of scarce subsidy dollars as existing housing resources are not utilized to their full potential and many frail elderly are unnecessarily placed in nursing homes. These options also fail to provide a cost effective continuum of care that is affordable to all as the costs of traditional long-term models such as nursing home care skyrocket beyond the capacity of the federal and state governments, as well as private pay patients, to cope.
Much research has gone into developing more cost effective and humane ways of providing the continuum of care needed by an increasingly frail population. Much of this research has focused on the concept of "Aging in Place", providing supportive services to the elderly in a residential setting in an attempt to delay or supplant the need to place them in an institutional setting resulting in a government policy emphasize on residential long-term care models as a means of controlling long-term care costs.¹

It is this policy objective that establishes the link between the private and public motivation for the expansion of the continuum of care in existing subsidized elderly housing. As restructuring of the existing stock of elderly housing may provide an extremely cost effective way of implementing these long-term care policy objectives, it may also force the government to rethink their willingness to continue to provide housing subsidies.

ORGANIZATION OF THE STUDY

With such a link in mind, this thesis will explore the feasibility of the development of a flexible physical and service environment within existing privately owned subsidized elderly housing that provides a continuum of care and facilitates the aging in place of existing and future tenants. As background, I will first review the recent public policy shift towards residential long-term care models. Chapter II provides insight into the shortcomings of the existing housing and long-term care system and outline the reasoning behind the development of current public policy. I feel this understanding is necessary if any efforts to develop of a continuum of care within existing subsidized housing is to adequately address the policy's objectives and provide

the negotiating leverage needed to encourage governments to maintain their support for subsidized housing.

The next two chapters will serve to establish the private sector motivation to pursue this course, by reviewing the current and future financial crisis facing subsidized housing and the supportive service environment in which they currently operate. Chapter III focuses on the existing housing component and the issues surrounding its preservation as affordable housing. Subsidized housing faces an unclear future as federal and state appropriations tighten compounded by the impending issue of expiring subsidy contracts and the preservation of privately owned affordable housing. Although preservation of affordable housing is a complex subject and the focus of much research, this issue will be explored only to the extent needed to establish the owner's financial motivation behind efforts to broaden the continuum of care in these facilities.

As any attempt to increase the level of supportive services for low and moderate income elderly will necessarily involve state and federal subsidy for the service component as well as the housing component, Chapter IV examines existing federal and state elderly service programs, establishing what services are available, the shortcomings of the current system and evidence of the unmet need in the elderly service system.

Chapter V focuses on a variety of attempts involving interagency and private sector cooperation to bridge the gap between the level of support and care provided in subsidized housing and that found in nursing home models. While none of the three provide a complete answer, each represents a unique attempt to broaden the continuum of care within a residential setting and expand the capacity of residential models to support the frail elderly caught in the service gap shown in Diagram 1. These examples begin to
answer a key question regarding how far the residential model can cost effectively be extended to capture those frail elderly who must currently be relocated to an institutional setting as well as provide valuable insight into the management and administrative issues that impede these efforts.

The first example is a collaborative demonstration program between the Robert Wood Johnson Foundation and 10 state housing finance agencies to increase the availability of support services in existing elderly housing. While this program has failed to dramatically expand the capacity of subsidized housing to support the frail elderly, it is included here as it serves to highlight the limited potential of expanding the continuum of care within the constraints of the existing elderly service system. The similarity between many of the demonstration sites in the RWJF program and the housing under consideration here also provides insight into the type of public/private sector cooperation that will be required to achieve results. In addition, the program demonstrates a unique consumer driven approach that highlights the cost containment advantages of targeting services to the consumer demands of the existing residents.

The second example reviews the efforts of the State of Oregon to control long-term care costs while providing a more humane environment for the very frail elderly. Part of this effort focuses on the development of an affordable assisted living residential model capable of supporting frail elderly persons who would otherwise be forced into a nursing home. The program is unique in that it targets residents with a high level of frailty and more closely resembles a medical model than other supportive service programs, but is included here as it demonstrates the ability to extend the residential model to support the very frail elderly and the potential cost efficiency of this approach.
in lieu of the traditional nursing home model. The program also shows how the consolidation of the administrative agencies responsible for the care and well being of the elderly may be necessary to encourage the private sector to take an interest in this issue and highlights an aggressive approach to the use of Medicaid funds to subsidize alternative long-term care options providing valuable lessons for the future direction of these initiatives.

The final example documents the efforts of one subsidized housing owner to create an assisted living environment at an existing subsidized housing project. Working within the existing elderly service system in Massachusetts, this project extends the continuum of care substantially beyond that typically available in these facilities filling a substantial portion of the service gap referenced in Diagram 1. However, it falls short of reaching the full potential of utilizing this existing housing resource and of creating an assisted living environment as an alternative to nursing home care. I have included this case as it involves a private owner of an existing subsidized facility and makes use of existing elderly service system. This case also presents some unique financing and funding mechanisms that involve public agencies and subsidies from both the housing side and the service side and provide an example of cooperation between the two. In addition, the case begins to answer some important questions about the level of service that can cost effectively be implemented in existing subsidized residential environments, highlights some important shortcomings that will hinder the replication of this model in other locations and demonstrates the difficulty of undertaking this effort under the current funding and administrative system.
Chapter VI tests the feasibility of expanding the continuum of care in an existing subsidized housing project by superimposing the lessons learned from the three previous examples on an existing Section 8 elderly housing complex in Waltham, Massachusetts. Based on the accomplishments and shortcomings of these examples, I examine the appropriate level of service that can cost effectively be implemented in this existing facility, the programmatic and physical changes that must be incorporated into the project to achieve this goal, the cost implications of these changes and how can they be funded or financed. As development of this concept will require substantial public involvement and support, I also examine the role of the housing and subsidizing agencies and how the process might be organized to minimize the cost to public coffers while maximizing the incentive to the private sector to initiate similar efforts in other subsidized housing locations.
CHAPTER II

PUBLIC POLICY AND THE CONTINUUM OF CARE

OVERVIEW

To understand current federal and state policy on elderly support services and long-term care, it is helpful to look at the changing housing and service needs of the residents of subsidized housing, most of which were constructed 10 to 20 years ago. These tenants, who may have moved in when they were in their mid-sixties are now in their late seventies or eighties and grow increasingly frail. In many cases, the needs of the frail elderly in these projects have exceeded the resources and capabilities of those who manage them. While the idea that the housing and service needs of the elderly change as they grow more old and frail is not new, the issue of long-term care for the elderly is coming under increasing scrutiny as the costs of traditional long-term care models such as nursing homes continues to dramatically increase. To control these costs, governments are looking to develop more cost effective and humane ways of providing the continuum of care needed by this increasingly frail population. Before proceeding, it is necessary to define the continuum of care, understand how it is presently provided and review why the elderly housing and service industry has evolved in the way that it has.

A CONTINUUM OF CARE AND AGING IN PLACE

The phrase "continuum of care" refers to the range of services required by the elderly as they grow older, more frail and more dependent upon others. (See Diagram 1) This continuum begins with simple services for elders in independent living units, such

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2 Struyk, Raymond J. and Douglas B. Page, Sandra Newman, Marcia Carroll, Makiko Ueno Barbara Cohen, Paul Wright, Providing Supportive Services to the Frail Elderly in Federally Assisted Housing (Washington: The Urban Institute Press, 1989)
as subsidized housing, provided by family and friends, community organizations, fee for service vendors and, in the case of low and moderate income elders, the federal and state governments. These services may include assistance with housekeeping, transportation and laundry and the provision of occasional meals. As the elderly grow more frail, they may require assistance with more personal activities generally referred to as "Activities of Daily Living" or ADLs that include transferring, mobility, dressing, bathing, toileting and eating. Assistance with these activities requires a more intense level of care and supervision simply because it involves personal contact with the elder and may be required at any time of day or night. This level of service is often referred to as "Personal Care". A third level of frailty is associated with the inability to perform any or most of these ADLs independently due to an acute or chronic medical condition or cognitive impairment that requires intense 24 hour medical supervision.

As noted in Chapter I, efforts to provide this continuum of care have created a vast but discontinuous array of housing and long-term care options centered around two distinct models, that of providing supportive services to the elderly in a residential setting and the medical services model provided in hospitals, nursing homes and other types of licensed medical facilities, resulting in a number of frail elderly people living in independent housing units beyond their ability to cope with this situation as well as premature institutionalization.

The existence of this gap between existing housing and long-term care options is due to a number of factors. State and federal agencies, responsible for the administration and funding of subsidized housing, elderly support services as well as medical and

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1 Struyk, p. 29
nursing home care, have evolved and remain independent from one another with separate policy objectives, regulations and sources of funding. Lack of coordination between these agencies has failed to encourage comprehensive efforts to provide a broader continuum of care. Owners of subsidized housing in particular have avoided attempting to bridge this gap in an effort to avoid the highly regulated nature of the medical model as well as the skilled nursing staff and licensing requirements and liability issues associated with it. This trend is reinforced by the lack of profit potential in the provision of supportive services to the low and moderate income elderly who live in their buildings. For this reason, this service gap is particularly prevalent for elders living in publicly subsidized housing whose ability to purchase home care services as needed is limited.

In efforts to bridge this gap, recent research has focused on the concept of providing a support system around the elderly in a residential setting that changes as their needs do and has led to the frequent use of the phrase "aging in place". "Aging in place" generally refers to the challenge to continue to live independently in a residential setting and to avoid institutionalization as long as possible. The emphasize on improving the capacity of the residential model to support the frail elderly is the result of extensive research which points to a variety of reasons why it may be preferable to allow the elderly to continue living in a residential model as long as possible. These reasons include the perceived superiority quality of a residential environment over that of a nursing home, demographic growth and increased longevity that have swelled the

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number of frail elderly and increased demands on the long-term care system as well as increasing public outrage over the cost of entitlement programs such as Medicaid that subsidize long-term care. (See Appendix A for a more thorough analysis of the arguments behind residential long-term care options.)

ASSISTED LIVING AND RESIDENTIAL LONG-TERM CARE MODELS

Although the concept of integrating services with housing is not a new one, efforts to bridge this service gap on a large scale are relatively recent and have produced a variety of both market rate and subsidized responses. These responses are varied in that they target different income segments and different levels of frailty and need. Their description is also made more complex by the fact that the terms used to describe them are not consistently applied. They include a vast array of other residential care concepts that go by a variety of names including agency supported home care, congregate care facilities, foster care homes, board and care and residential care facilities.

A new term that has come into wide use in the field of residential long-term care is "assisted living". Its meaning may vary depending on who is using it. Brothers and Jorgensen (1989) suggested that assisted living is "that vague zone somewhere between independent living and licensed nursing care". However, to eliminate confusion, assisted living generally refers to a model of residential long-term care that provides a level of personal care and supervision that exceeds that found in other residential models but is less than that of a skilled nursing facility.

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These facilities generally serve a frail population that is physically or cognitively impaired and requires assistance with several ADLs, but does not need the skilled nursing supervision or medical attention available in a nursing home. They provide a full range of services including meals, housekeeping, transportation as well as personal care assistance with ADL impairments and medication supervision all within a residential setting. Residents of these facilities are generally 75 years of age and older, female and widowed or single.\(^7\)

Although each of these types of facilities fills a niche in the care spectrum, they do not necessarily provide the continuum of care to facilitate the aging in place that is the objective of public policy. To accomplish this goal, researchers feel it is necessary to reconceptualize long-term care as a series of components (room and board, support services such as housekeeping and transportation, personal care support services and health and social services) that can be flexibly assembled in ways that maximize the use of available resources and quality of life while minimizing costs.\(^8\) To find an example of this type of facility, one has to look at the private sector response to this issue.

**CONTINUING CARE RETIREMENT COMMUNITIES**

The idea and profit potential of facilitating aging in place has led to the development of a market rate response that is currently proliferating in this country, the Continuing Care Retirement Community (CCRC), which in concept effectively bridges this service gap. I will provide only a brief description of the CCRC concept to serve as

\(^7\) Netting, p. 9

\(^8\) Rosalie Kane, Laurel Hixon Illston, Robert L. Kane and John A. Nyman, *Meshing Services With Housing: Lessons From Adult Foster Care and Assisted Living in Oregon* (Minneapolis: Long-Term Care Decisions Resource Center, University of Minnesota), p. 3
a useful model of what might be achieved in the context of existing subsidized elderly housing.

The CCRC concept combines independent living units for the elderly who can function totally on their own, but who choose to no longer assume the burden of maintaining a household, with a variety of support services and common facilities including meal service, housekeeping and provide a social environment in which the tenants can interact with others of a similar age and interests. Additional support services such as personal care can then be added on an as needed basis to allow the resident to continue to live independently. In this situation, they may no longer simply desire to have these services provided for them but may actually need these because they can no longer perform these functions independently. Other residents, who become more impaired requiring a higher level of personal care assistance and supervision, are transferred to assisted living units in the same complex. These assisted living units are designed to ease the transition by offering a similar residential character and many of the same amenities as the independent living units. Having these assisted living units in the same complex eliminates the social isolation that may result if residents must transfer to another facility. A survey of CCRCs indicated that 73.4% offered assisted living services. CCRCs are often combined with skilled nursing facilities that provide the assurance that the medical model will be available if the resident's condition should deteriorate either permanently or temporarily to the point where they need this level of care. The idea of providing the entire continuum of care in a single facility has proven very attractive yet expensive with access to a CCRC often requiring the payment of an

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9 Netting, p. 10
entry fee that can be as high as $180,000\textsuperscript{10} as well as a monthly service fee averaging $2,900 in the Boston area,\textsuperscript{11} thus placing it beyond the affordability of most of the elderly population including the residents of existing subsidized housing.

SUMMARY

Federal and state policy are increasingly focused on residential alternatives to existing long-term care options as a means of achieving cost control and quality of life objectives. Market rate CCRCs have successfully demonstrated the feasibility of facilities that provides a broad continuum of care that includes assisted living units in a single location facilitating the aging in place of the residents. However, the high cost of construction and operation of these market rate facilities has made the development of affordable alternatives impossible. These problems may potentially be overcome by using existing subsidized housing to accomplish these objectives.

\textsuperscript{10} Christine E. Bishop, Features of Lower-Cost Continuing Retirement Communities: Learning From Cost Analysis, Journal of Housing for the Elderly, Vol. 7 No. 1 (1990), p. 57

\textsuperscript{11} The Standish Care Company
CHAPTER III

THE PRESERVATION OF EXISTING SUBSIDIZED HOUSING

OVERVIEW

Because the focus of this thesis is on the restructuring of existing privately held subsidized housing, it is necessary to provide some background on one of the key underlying concepts, current federal policy on the preservation of subsidized housing and its implications for the future of the elderly housing under consideration. Given the broad complexity of this issue, my discussion here is limited to the motivation of some subsidized housing owners to broaden the continuum of care in their facilities as a means of coping with the "preservation issue".

As originally structured, private sector housing subsidies were not focussed on the long-term affordability of the projects. The subsidy structure, which included lucrative tax incentives and mortgage prepayment options that would terminate use restrictions on the buildings, were designed to boost profitability over a short period of time and create residual value in the projects thus maximizing private sector interest and insuring the projects were built. The later addition of operating and rent subsidies were also limited to finite terms to coincide with the mortgage prepayment options and to limit government liabilities in the future.

Now, the elimination of tax incentives in 1986 and the impending expiration of operating subsidy contracts and mortgage prepayment option terms places a significant

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portion of the existing affordable housing stock of being lost. Estimates of the potential loss vary widely. In the Housing and Community Development Act of 1987, Congress estimated a potential loss of over 330,000 units of Section 236 and 221(d)(3) units by the year 2002. A more recent report by the federal government's General Accounting Office estimates that of a total inventory of 600,000 units, that 367,000 were eligible for prepayment and that various studies indicated that between 154,000 and 243,000 were at risk of being lost to the affordable housing stock. In addition, almost 500,000 Section 8 units will be entitled to opt out of the program by 2002.

These units are at risk for different reasons that are tied to the profitability and market value of the individual properties. Termination of operating subsidies place some projects at risk of default on mortgage obligations. These projects typically have not appreciated in value and in some cases have seen market rate rents fall below those paid through the rent subsidy system. Other project owners, faced with the opportunity to prepay mortgage obligations and opt-out of the use restrictions, will choose to repay in order to capture the residual value of these projects or boost project profitability through conversion to a market rent project. The nature of the underlying subsidy as well as locational factors has led to the variability in the profitability and residual value of these existing projects. (For a more extensive discussion of this issue see Appendix B.)

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15 Bratt, p. 101
16 United States General Accounting Office, p. 5
I have made this distinction, as this thesis is primarily concerned with those projects at risk of mortgage default. It is these project owners who have the most to lose should the federal government fail to renew their subsidy contracts and stand to gain the most by expanding the continuum of care in their projects to address the long-term care policy objectives of the government.

LOW INCOME HOUSING PRESERVATION ACT

With this understanding, it is possible to review the recently enacted federal legislation designed to address the issue of preservation of the existing stock of affordable housing both for families and for the elderly. Known as The Low-Income Housing Preservation and Resident Homeownership Act or LIHPRHA, the 1990 legislation is intended to reduce the loss of low-income housing. It authorizes the use of existing housing subsidy programs such as rent supplements and rehabilitation loans to compensate owners for the alteration of their right to prepay their mortgages and convert properties to a more profitable use. It also encourages the transfer or sale of these properties to "qualified buyers" or those who are willing to maintain them as low and moderate-income properties.

The Act requires owners to file a Notice of Intent that establishes their intention to continue ownership with government incentives, sell to a qualified buyer or prepay. The Act then establishes a procedure or test for determining the fair market value of these properties which is then used to limit the amount of additional incentive the current owner will receive (known as the Federal Cost Limits Test) and to provide a basis for denying incentives where market conditions do not justify them (The Windfall Profit Test).

In short, the legislation establishes a market value zone within which the
government will provide incentives. Properties whose value exceeds the zone can be prepaid if a qualified buyer cannot be found. Properties valued within the zone cannot prepay but must accept incentives that increase the return on the projects and/or provide equity take-out loans. Other projects, in which subsidized rents exceed market rents in the surrounding community, will not be offered incentives.

This creates a dilemma for these property owners as there is no certainty that existing subsidy contracts will be extended beyond their current term given the current administrations attitude towards subsidized housing. Termination of these contracts could lead to default as operating and financing expenses increase while rents fall to market rates and thus project income declines. The strategy of creating a cost effective and affordable assisted living environment in these facilities may provide the motivation and negotiation leverage necessary to encourage the government to remain committed to these projects.

17 United States General Accounting Office, p. 3
CHAPTER IV
EXISTING ELDERLY SERVICE PROGRAMS AND INITIATIVES

OVERVIEW

As noted in Chapter I, an extensive elderly support/long-term care system exists that is administered and funded by the federal and state governments to aid those elderly who cannot afford market rate services. Because a large percentage of the residents of subsidized elderly housing are income qualified to receive subsidized services, any attempt to expand the continuum of care or provide additional supportive services must involve the existing elderly support/long-term care system at one or more different levels. The owner's efforts may involve making better use of existing subsidized services, expanding the continuum of care to include services previously available at more specialized facilities or proposing changes to the existing system that will provide additional care and support to a broader base of his residents. Or involvement may be limited to careful coordination of additional unsubsidized services with existing subsidized services to avoid unnecessary duplication and waste of resources. In any case, the owner should have an understanding of this existing system before undertaking any changes.

This chapter outlines the existing elderly support/long-term care system focusing on those programs and services that are currently available to residents of the housing under consideration here. It also examines some evidence of unmet needs within the existing system to suggest areas where owners efforts at providing additional services might be targeted. In addition, Chapter IV looks at new state and federal initiatives being developed to address the policy objectives noted in Chapter II. Although many programs
are targeted at expanding the continuum of care in residential settings, most are still in an embryonic stage and have yet to be implemented on a large scale. They are included here as they represent potential sources of financing and operating subsidy for any future efforts to expand the continuum of care.

The existing elderly support/long-term care system is complex and stretches across a wide variety of state and federal agency boundaries. The role of the federal government has traditionally been to funnel money for elderly services and medical care to individual states that administer and supplement these funds with additional state appropriations. The federal government provides several sources of funds to individual states with which they may subsidize elderly services. These include Social Service Block Grants and Title III of the Older Americans Act that provides funds for congregate and home delivered meal service as well as nonmedical in-home services and special needs assistance. Appropriations for 1989 totaled $859 million. Both of these programs suffer from inadequate funding as well as uncertainty about future appropriations.\(^{18}\)

Medical and nursing care is delivered in a similar fashion with the feds providing funding through the Medicare and Medicaid entitlement programs.

The lack of a strong federal administrative role has led to a wide diversity of concepts and approaches to supporting the elderly that vary from state to state. Some states dispense available federal and state funds to local service agencies and vendors to provide support services to income eligible frail elderly in existing residential units. Other states provide funds directly to individual subsidized housing complexes to provide services for their residents while others use a combination of both approaches.\(^{19}\) This

\(^{18}\) Struyk, p. 73
\(^{19}\) Struyk, p. 13
diversity of delivery mechanisms and the varying degrees of financial and administrative support provided by individual states, make broad assessments of a property owner's ability to utilize the existing system difficult. For this reason, I will focus on the service delivery system found here in Massachusetts.

MASSACHUSETTS

Massachusetts has been particularly aggressive in developing programs to provide services for the elderly. Conversations with key people involved in support services for the elderly reveal that the system is complex, crossing a variety of agency borders and presenting a daunting maze of eligibility requirements and administrative procedures.

Most state programs supporting elderly services are administered by and funded through the state's Executive Office of Elder Affairs. Their primary service delivery vehicle is an umbrella program known as Home Care. Through this program, state and federal appropriated funds are distributed to 27 non-profit home care coordination agencies who provide case management services to eligible persons and contract with private vendors to deliver services to their clients.

Services are provided free of charge to residents with gross incomes of $6844 per year or less and to those earning up to $15,540 on a sliding scale fee with a maximum co-payment of $105 per month. Services are available to elders living in their own homes, subsidized apartments or in congregate care facilities, however, clients must have a need for the services, be functionally impaired and be at least 60 years old.20 Available services include housekeeping, laundry, shopping assistance, money management,

20 Kristin Kiesel, West Suburban Elder Services. Inc.
transportation, some home delivered meals as well as personal care for those needing assistance with 1 or more ADLs.

EVIDENCE OF UNMET NEED

Despite this relatively comprehensive approach, there is evidence of unmet need in the supportive service system. A 1984 National Health Interview Study reported that 30% of noninstitutionalized persons over age 65 requiring assistance with dressing, 40% needing help with bathing and 44% needing assistance getting around did not receive these services.21 A 1986 study of 100 large public housing authorities representing 200,000 elderly households reported similar service gaps. In the study, 75.6% of managers of elderly housing cited resident requests for services beyond their capacity to deliver as a problem.

The study cited several reasons for these service gaps including insufficient service availability in the community, lack of availability of a broad continuum of care in one location, inadequate coordination between service providers and the low income status of the elderly living in subsidized housing that hindered their capacity to supplement subsidized services with private pay care.22 A related problem is that of the income eligibility gap that exists between low income elderly, who meet income eligibility requirements for state and federally subsidized services, and those who can afford the market rate model. These low-moderate income elderly are often considered at greatest risk of premature institutionalization as they have only one option should they no longer be able to function independently, going to a nursing home. These deficiencies

21 Struyk, p. 11
might also be attributed to a variety of reasons associated with the structure of the current delivery system. Public funds to provide these services are limited and continued funding levels are subject to annual legislative appropriation. Multiple sources of support services and funding has created a tangle of administrative oversight and eligibility requirements that may discourage some elderly as well as housing owners from seeking help and leads to inefficiency in the provision of service. Another stumbling block to the provision of supportive services to the elderly in subsidized housing has been HUD's refusal until recently to permit service costs to be accounted as operating expenses. In addition, existing subsidized housing for the elderly was often constructed without the necessary common facilities and unit features to facilitate both congregate and individual resident services due in part to poor communication and administrative separation between those providing the housing and those responsible for services.

RECENT FEDERAL AND MASSACHUSETTS INITIATIVES

Recent recognition of these deficiencies and its threat to the continued independence of the elderly population, as well as the increasing burden of nursing home care costs on government budgets, has created great interest in broadening the scope of services available to the elderly in subsidized housing and in creating residential model alternatives to nursing home care. While no cohesive strategy has emerged on a national level and only a few states have what could be called a comprehensive strategy for dealing with the issue, these initiatives are important to the owners of subsidized housing.

23 Struyk, p. 12
24 Kane, p. 16
as they could become key components of any future efforts to expand the continuum of care in their projects.

**Federal Initiatives**

At the federal level, HUD has relaxed operating budget restrictions for federally subsidized housing allowing elderly support service costs to be accounted as operating expenses. This action is intended to enhance the level of service available in these projects and reduce premature nursing home placement of the residents as a means of controlling long-term care costs.\(^{25}\) The federal government has also enacted and funded several pilot programs designed to increase the availability of supportive services within federally subsidized housing.

The Congregate Housing Services Program provides funding for the provision of basic service needs within the context of the subsidized housing environment and was designed to avoid the premature institutionalization of the frail elderly. Eligibility requirements, originally limited to all residents who needed assistance with at least one ADL, have been increased, restricting access to those who lack a formal support network and who require assistance with at least two ADLs. Services provided include housekeeping and transportation services as well as a mandatory 14 meal a week food service program although less than half of the sites provide any type of personal care services.\(^{26}\) Although in concept, this program starts to meet the objective of increasing access to supportive services, it has several flaws. Ineffective screening of residents for needed services and the mandatory nature of the meals program led to the delivery of unnecessary and unwanted services thus driving up the cost of the program. The

\(^{25}\) Jean Moltenbrey, State of Massachusetts Executive Office of Elder Affairs

\(^{26}\) Struyk, p. 211
co-payment procedure established in 1987, which limits resident contribution to a relatively low 10% of their gross income, fails to provide the motivation necessary to encourage tenants to conserve services.\textsuperscript{27} In addition, this program was established only as a demonstration project and is limited in scope with only 60 sites serving 2000 residents in 1988.\textsuperscript{28} This program has not been funded by the administration for next year.

The federal government has also developed two conceptual models designed to provide both housing and support services to the frail elderly. Although neither of these programs have currently been implemented, they are of interest to this thesis in that they broach the concept of combining federal subsidies for housing and services as a way of rationalizing the administrative process and suggest a possible funding mechanism for future efforts to broaden the continuum of care in subsidized housing. The first program, entitled the Housing Support Services Certificate Program, would provide vouchers to eligible residents of Section 202 elderly housing projects with which they may purchase supportive services.\textsuperscript{29} A similar concept, entitled the Congregate Housing Certificate Program would provide vouchers to cover the cost of living in a congregate care facility. Under this plan, residents contribute up to 60% of their income towards the cost of the service.\textsuperscript{30}

Another key federal initiative is the development of the Medicaid Waiver Program, which allows federal Medicaid funds to be diverted from institutional care to a wider array of long-term care services such as case management, home care and

\textsuperscript{27} Struyk, p. 68
\textsuperscript{28} Kane, p. 17
\textsuperscript{29} Struyk, p. 5
\textsuperscript{30} Struyk, p. 5
transportation and to fund residential care, congregate care and assisted living facilities. This program is a result of ballooning federal and state budget deficits that have led to increased efforts to control Medicaid costs and is designed to take advantage of the potential cost savings of caring for the frail elderly in a residential setting. Several states have taken an aggressive approach to the use of these funds for a variety of alternative long-term care options (See Chapter V) in an effort to control their own Medicaid outlays and this program is evolving into an important source of operating revenue for residential based supportive service and long-term care options. As an entitlement program, Medicaid funding is theoretically not subject to the same legislative uncertainty as the appropriated funds that subsidize most elderly service programs. However, its impact will continue to be limited by efforts to control Medicaid expenditures.

In addition, the federal government is considering an initiative to address the inadequacy of the physical environment of most subsidized housing to support the frail elderly. Current pending legislation titled The National Affordable Housing Act would authorize the funding of the capital costs of retrofitting existing housing stock to meet the needs of the elderly who are aging in place.

*Massachusetts' Initiatives*

The State of Massachusetts has made use of the new flexibility in Medicaid disbursements through the development of the Group Adult Foster Care Program. The state's Executive Office of Elder Affairs in conjunction with the Department of Public Welfare, which administers the state's Medicaid program, has developed a program to provide additional supportive services to elderly residents living in community based

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31 Kane, p. 11
32 Kane, p. 17
housing or congregate care facilities. This program allows Medicaid reimbursement for supportive and personal care services rendered in a residential setting. The program targets those at risk for nursing home placement and will serve those who are eligible for services through Medicaid. The state has also implemented the Managed Care in Housing Initiative, which is similar to the Adult Foster Care Program in nature but is available to all residents who meet the income eligibility requirements for the Home Care Program which are substantially higher than those for Medicaid eligibility. The legislature has appropriated $8.3 million for the program and EOEIA is awarding $814 per month per client for up to 14 hours per week in service (The rate is $965 per month for clients who are Medicaid eligible) to home care agencies or residential complex staff who provide the services. The programs provide the same services available under the Home Care Program as well as 24 hour access to attendant services with personal care available in the morning and evening. These programs are marketed as creating an assisted living environment in a existing residential setting however limited funding has vastly restricted the availability of these services to only the most needy. The program is of interest here as it is designed to take advantage of economies of scale generated through a clustered services approach to case management and it may serve as a good example of how future efforts should be structured.33

Massachusetts has also undertaken a new assisted living initiative designed to promote "expanded housing options for the elderly". The broad goal of the initiative being to "foster affordable aging in place" for people "whose functional and cognitive impairments limit their ability to live safely and independently unless they receive

33 A Look at Supporting Frail Elders in Assisted Living Environments, Continuum, Vol. 3 No. 5, January-February 1992, p. 3
structured, consistent assistance on a regular basis". The initiative also refers to the creation of service packages tailored to the individual needs of clients within a residential setting. A committee of staff members of various state agencies is currently developing proposals for how the state can encourage the creation of assisted living units, identifying oversight mechanisms, and creating a plan to bridge the gap between current housing options and nursing home care. Although the final committee report is several months from completion, these stated objectives closely parallel those highlighted in this thesis, suggesting the potential of publicly supported assisted living to provide cost effective alternatives to nursing home care is extensive here in Massachusetts.

34 Weld Administration Issues New Proposal on Assisted Living, Continuum Vol. 4 No. 1 (April 1992)
CHAPTER V

CONTINUUM OF CARE INITIATIVES

This chapter will focus on three separate and distinctly different approaches to developing a broader continuum of care within a residential setting. While none of these fill the entire gap between the supportive service environment in existing subsidized housing and the medical long-term care model (See Diagram 1), each presents a unique attempt to extend the residential model beyond its traditional boundaries. These examples will demonstrate the variety of options for a subsidized housing owner to extend the continuum of care in his facility and begin to answer key questions surrounding this issue. How far can the subsidized elderly housing model go towards filling the service gap in a cost effective manner? What resources must be brought to bare to expand the continuum of care and how can these resources be motivated? What organizational, management, administrative and funding barriers that must be overcome? In addition, the positive aspects of these efforts can be extracted to formulate policy for future initiatives.

SUPPORTIVE SERVICES PROGRAM IN SENIOR HOUSING

This is a collaborative demonstration program partially funded by The Robert Wood Johnson Foundation in conjunction with 10 state housing finance agencies whose goal is to demonstrate that state HFA’s, working with housing developers and local service networks can deliver and finance services designed to respond to the needs and preferences of older residents in privately owned publicly subsidized housing projects.36

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36 James J. Callahan, Jr. and Susan C. Lanspery, Supportive Services in Senior Housing: Lessons From The Robert Wood Johnson Foundation Demonstration, (Policy Center on Aging, Heller School, Brandeis University, September 1991), p. 1
This example is included because it involves three key players that must necessarily be involved in any attempt to create a broader continuum of care in subsidized housing, the housing subsidy agencies, the owners of the projects and the existing elderly service network. This pilot program provides an example of the collaboration and cooperation between these three parties that is critical to the organization and funding of these services and provides an opportunity to explore the motivational factors that influence their willingness to participate. It demonstrates a unique consumer driven approach that broadens the availability of services to all residents, not just those who meet the eligibly requirements to receive free or subsidized services. And it demonstrates innovative methods of organizing and financing services in senior housing through traditional and untraditional sources.

The capacity of this program to extend the continuum of care at the project sites is however very limited. Working substantially within the existing elderly support service system, this low level approach may enhance the quality of life of the existing residents but fails provide the level of service required by those with bathing and eating ADL dependencies and most at risk of nursing home placement. See Diagram 2.
Program Description

Nationally, the program has involved over 30,000 elderly people in over 25,000 federally subsidized housing units. In Massachusetts, the program is sponsored by the Massachusetts Housing Finance Agency and is currently serving over 3000 elders in 23 housing developments.

Initiated by the RWJF, the program was designed to address a critical shortage of support services in existing senior housing. It was prompted by some estimates suggesting that many of the estimated 1/4 of the elderly residents in federally assisted housing need help with at least one activity of daily living (e.g., bathing, shopping, transportation) that was unavailable. Factors attributed to the lack of available services included strict income qualifications for subsidized services, inadequate knowledge about service availability, lack of coordination by housing project staff and the fact that housing and service programs, policies and funds generally come from a variety of sources. The program is designed to accommodate aging in place, to extend the ability of elders to maintain an independent lifestyle in their own residential units and avoid premature institutionalization.

The focus of the program is to create an on-site service coordinators who broker affordable or free services from local service providers taking advantage of the economies of scale generated from serving a large number of clients. The client base was expanded by making services are available to all residents who co-pay for them on a sliding scale which the study has indicated is a more cost efficient approach than to take individual assessments of need and to target services to this small group.

37 Struyk,
38 Callahan, p. 2

Maximum
resident participation was encouraged by using consumer preference surveys to target those services that the residents wanted and were willing to pay for. Services offered included service coordination in 170 of the projects, housekeeping (80 projects), shopping assistance and transportation (50), and meal service in 30 of the projects. Several models for providing services emerged dependent upon such factors as what services were available, eligibility requirements for existing service programs, demographic profiles of project residents, physical characteristics of the housing project and the resources of the housing sponsors.

The demonstration program here in Massachusetts should eventually become self supporting and may provide a workable model for implementation at similar projects. Grant funding from the RWJF is gradually being phased out to be replaced with resident fees, increased housing operating budgets, use of cash reserves, and state and federal service subsidies to maintain affordable services available to all residents.

Summary

The program demonstrates the effectiveness in organizing the collective buying power of the residents of these facilities in reducing the cost of private pay services and for the need for a consumer driven approach if residents are to be expected to contribute their limited personal income. It further emphasizes the active role that housing agencies can take in promoting the well being of the residents of these projects. Here in Massachusetts, MHFA staff occasionally served as service coordinators and in all cases played a key role in motivating property owners and managers to participate by demonstrating the cost saving generated through reduced maintenance and turnover

39 Callahan, p. 9
costs. One final noteworthy aspect is the program's emphasis on the integration and coordination of existing agencies and service resources.40

Although, substantial improvement in the level of available service was achieved in some project locations, the program highlights the limitations of this type low level approach. The low incidence and limited extent of meal programs and personal care services (both are available at only 3 sites.) severely restricts the program's ability to support the frail elderly who are often dependent upon assistance for one or more ADLs and provide a viable alternative to nursing home care. This suggests that a more intensive approach may be required to extend the continuum of care to its full potential within this type of residential model.

OREGON

The second example focuses on the efforts of the State of Oregon to provide home and community based services in lieu of more costly nursing home care with the key objective of allowing even the most frail elderly to age in place in a residential setting.41 One of the emerging components of this effort is the Assisted Living Program, designed to support persons who are sufficiently disabled to be in a nursing home in a residential setting by redesigning residentially based long-term care and combining housing and services in a new way.

The program is unique in that it targets residents with a high level of frailty and more closely resembles a medical model than other supportive service programs, providing up to 16 hours a day of licensed nursing care.42 Referring once again to the

40 Struyk, p. 201
41 Struyk, p. 194
42 Struyk, p. 194
continuum of care diagram (See Diagram 3), the facilities in this program are able to accommodate residents with significant health problems and complete ADL impairment although they are not generally permanently bed-bound and do not require 24 hour nursing supervision.43

These assisted living facilities also vary significantly from the other supportive service programs discussed here in that all have involved new construction and the majority of the residents are not publicly subsidized.

The program is included in this thesis as it documents the cost effectiveness and viability of supporting even the most frail elderly in a residential context allowing a larger base of people to be served while controlling the total public appropriation for the Medicaid subsidies that support it. The program also provide a good example of the critical role that coordination and integration of state and federal funding and administration must play in such an effort. It also serves to demonstrate the effectiveness

43 Kane, p. 126
of creating a flexible service environment that can accommodate a wide variety of elderly needs.

Costs for low-income residents of this program, as well as other supportive residential models in Oregon, are funded primarily through the Medicaid Waiver Program mentioned in Chapter IV. The Assisted Living Program is a good example of one state's efforts to redirect funds to a variety of long term care options other than the traditional nursing home model and to liberalize financial eligibility criteria for these services. Changes enacted in the waiver system in 1987 no longer restrict the number of persons being served as long as the total federal contribution to total expenditures is fixed. These changes have allowed the state to expand income eligibility requirements to 300% of the poverty level (approximately $1104 per month for a single person) in order to serve a broader base of residents.

Program Description

The Assisted Living Program provides non-medical nursing home level support in a residential setting much like an apartment complex. Single occupancy units with lockable doors, private bathrooms and kitchenettes and the resident's own furnishings characterize the residential nature of the projects.

Because this program is relatively new, it is difficult to define the average resident. However, these facilities are deemed appropriate for people with non-medical needs similar to the residents of nursing homes and serve a population at the high end of impairment of those found in foster homes and at the low end of impairment of skilled nursing facility residents. The average age of the residents is 85 and they have typically

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44 Kane, p. 24
significant functional impairment evidenced by unofficial estimates that 50% of the residents use walkers, 40% have problems with incontinence and 65% suffer some form of dementia.\textsuperscript{45}

Services are provided in flexible increments that can be added or subtracted as the resident's needs change. Basic core services include three meals per day, housekeeping, laundry and medical supervision, medication assistance and transportation and cover approximately 35% of the residents with dependencies in one or two ADLs. For 50% of the residents with dependencies in three or four ADLs, level two service includes daily personal care and nursing services as well as supervision due to cognitive or medical impairments. Higher levels of service are available for residents requiring intensive licensed nursing care.\textsuperscript{46}

The three existing assisted living facilities were privately developed and targeted to the moderate and high income elderly not receiving state assistance. Eventually the state recognized these facilities as a humane and cost effective alternative to custodial care in a nursing home and authorized it as an option to be funded through Medicaid waiver funds. As of May 1990, 50 Medicaid eligible residents were living in these facilities and long waiting lists have developed because of their popularity. State estimates for reimbursement rates suggest that the cost of this model is about 79% of the nursing home reimbursement rate or $1275. It should be noted that this cost includes a room and board charge of $330 per month that is financed through the residents SSI income. Service rates vary depending on the level of support required by the resident ranging from $455 per month for a client in need of some routine nursing procedures and

\textsuperscript{45} Struyk, p. 196
\textsuperscript{46} Struyk, p. 196
a high degree of supervision to $1305 per month for residents who are dependent in the behavioral ADL.

The development of this program was facilitated in large part by the consolidation of the state agencies responsible for Medicaid administration and funding, regulation of nursing home and community based care and elder services case management and delivery into a single administrative unit. This consolidation has eliminated the need to transfer funding resources, siphoned off from the portion of the Medicaid budget that goes to nursing homes, across administrative barriers.\(^\text{47}\)

*Summary*

This program is significant in that it is supported by private sector. By providing a profit motive, the state is able to encourage private sector participation, while simultaneously providing an affordable alternative to market rate assisted living facilities as well as a more humane alternative to nursing homes. And, while new development costs have ranged from $35,000 to $50,000 per unit, the cost of rehabilitating existing residential care facilities is estimated at $4500 per unit. The low cost of rehabilitation has led proponents of the program to suggest that it could cost effectively be implemented in existing subsidized housing.\(^\text{48}\)

Operating subsidy costs remain significantly below those for nursing homes, particularly for residents who do not need intensive licensed nursing care. And, a decline in the number of nursing home patients in the state over the period that this and other supportive residential model programs have been in place suggests that these are an effective alternative to nursing home care and can play an important role in helping

\(^{47}\) Kane, p. 24
\(^{48}\) Struyk. p. 195
control the state's Medicaid expenditures.\textsuperscript{49}

The programs also attests to the extreme level of frailty that can be supported within a residential setting. Although not to suggest that this broad continuum of care is appropriate or even desirable for all subsidized housing, it indicates that with careful planning, this level of care is feasible.

100 CENTRE PLAZA - PUSHING THE ENVELOPE

100 Centre Plaza is an attempt by one private owner of a subsidized elderly housing project to extend the continuum of care beyond the existing elderly service system. Using an existing building, and motivated by a strong understanding of the needs of the elderly as well as a desire to improve the financial return on the housing component, this owner has developed a residential model that fills a substantial portion of the service gap referenced in Chapter I and facilitates the continued aging in place of his residents. Augmented by a privately developed on-site congregate dining facility and the availability of subsidized personal care services available to the most frail, this project demonstrate the potential for the development of a continuum of care that includes assisted living within an existing subsidized housing project. The owner is proud of what he has accomplished on an affordable scale noting:

"We are now in essence a Continuing Care Retirement Community minus the on-site nursing home."

Although his efforts extend the capacity of 100 Centre Plaza to support the frail elderly with some ADL impairments, this example stops short of the Oregon Assisted Living model in that those with significant medical problems, severe cognitive

\textsuperscript{49} Kane, p. 26
impairment or who require assistance on a 24 hour basis or intensive licensed nursing care cannot be accommodated. See Diagram 4.

The Continuum of Care - Diagram 4

Elderly With ADL Impairments

Elderly Housing W/ Services

100 Centre Plaza

Nursing Home Medical Model

This case is included as it presents several parallels with the type of initiative that lies at the heart of this thesis. It involves a private owner of an existing subsidized facility and makes use of existing elderly service system. This case presents some unique financing and funding mechanisms that involve public agencies and subsidies from both the housing side and the service side and provides an example of cooperation between the two. The case also begins to answer some important questions about the level of service that can cost effectively be implemented in existing subsidized residential environments. In addition, this case highlights some important shortcomings that will hinder the replication of this model in other locations.

*Project Description*

The property is a 215 unit high-rise facility constructed in the Coolidge Corner section of Brookline, Massachusetts in 1970. Originally intended as a three income level
project, it contains low-income, moderate-income and market rate units. The subsidy structure consists of two levels. The building was financed through the Massachusetts Housing Finance Agency (MHFA) using a Section 236 mortgage cost write-down subsidy which provides a fixed monthly subsidy to the owner reducing the effective interest rate of the privately secured mortgage. This subsidy is tied to a 20 year use restriction requiring the owner to maintain the rents of a certain percentage of the units at affordable levels. This subsidy is intended to create affordable units for moderate income elderly. In addition, the project receives a Section 707 rent subsidy (the Massachusetts' equivalent of Section 8 funds) to further reduce the effective rent for low-income tenants. The project currently contains 67 low-income tenants and 71 moderate-income tenants whose rents are subsidized solely by Section 236 funds.

The ownership entity is a limited dividend limited partnership commonly used to develop Section 236 projects. Although this financing structure and the physical construction of the building are not necessarily unique, the innovative approach to the expansion of elderly services to the residents certainly is.

_Elderly Services_

From day one, Roger Stern, the project's developer and manager, envisioned the building as being more than just a home for the residents. With the average age of the initial tenants exceeding 70, Bob felt that it was critical to provide services that would improve the quality of life here. His initial effort was the development of a medical office on the premises. As the average age of the residents approached 80, Bob contracted with Brookline Mental Health to provide case management and service coordination services for his tenants. The service coordinator was paid on an hourly
basis approximately 60% of which was covered by third party insurers such as Medicare and Blue Cross/Blue Shield. The balance of the cost was carried as a line item operating expense for the project and thus subsidized through the tenant rents and rent subsidies. For tenants who met the income eligibility requirements, services were delivered through the State of Massachusetts Executive Office of Elder Affairs' Home Care Program previously described. Available services included housekeeping, transportation and home delivered meals as well as others available on an as needed basis. (For a more complete description of the Massachusetts Home Care Program eligibility requirements, services and structure, please refer to Chapter IV.)

For the medical services, Stern contracted with Urban Medical to provide an on-site nurse practitioner for 1/2 day four days a week and an on-site doctor for the fifth day and converted a then empty apartment to a medical office at his own expense. Expenses for this service were covered in much the same way as the cost of the social worker with third party insures covering the majority of the cost and the balance carried as an operating expense for the project.

With these services in place, Stern felt there were still substantial unmet need, particularly in this mixed-income project in which the majority of the residents were not income qualified to receive the Home Care Services. Through Brookline Mental Health, Bob contracted with the social worker to secure and coordinate outside service vendors to deliver services to the other tenants not served by Home Care. Again, the cost of the service coordinator was carried as an operating expense while the cost of the services, which are similar to those provided to Home Care clients, was carried by the residents themselves. Stern also worked through the local Council On Aging to procure free or
below cost services such as transportation and meals on wheels for the residents. It should be noted that both the service coordination and medical service components are largely possible due to MHFA's aggressive encouragement of property owners to provide on-site services that allows service costs to be carried as operating expenses.

Congregate Meal Service

By 1984, Stern had noticed that many of the residents had joined what he refers to as "The Tea and Toast Circuit" meaning that those tenants who had lost the motivation to prepare meals for themselves were consuming a simpler but less nutritious diet that he felt contributed to their decline in health. To remedy this situation, Stern wanted to instigate an on-site congregate meal service, but, because the existing building contained limited common facilities, substantial physical changes were required to incorporate such a facility on the site. Stern realized that raising the funds to construct the dining facility might also provide an opportunity to alleviate a growing tax shelter problem for the building's equity investors.

The original financing package which limited the return to investors to 6% was made feasible by the liberal tax laws in place when the project was constructed in 1970. The project returns were enhanced by the tax shelter generated by accelerated depreciation and the ability to offset real estate loses against ordinary income allowed under the tax law prior to 1986. This accelerated depreciation however led to the decline and eventual elimination of the tax shelter. The limited dividend generated by these projects was not enough to cover the cost of the tax obligation generated by the recapture tax on the previous tax shelter. Stern felt that by increasing the mortgage on the building
with MHFA, he could provide the money needed to finance the construction and
simultaneously reestablishing the tax shelter for another four to five years.

The development process was slow and the new facility was not completed until
1989. The facility contains a full commercial kitchen and a dining room that also serves
as a community space. It also provides a roof top outdoor deck for the residents
enjoyment. The construction cost of the project was approximately $1.9 million which
includes $250,000 for the cost of installing a sprinkler system throughout the existing
building.

To operate the facility, Stern created another privately owned company named
Elder Center Services. This company employs the kitchen staff, prepares meals and pays
the costs of purchasing the food. Residents pay an amount for each meal that ranges
from $3.50 to $5.50 depending on what they select from the menu. Stern also transferred
the cost of some nonfood related services into the operating budget of Elder Center
Services. Although Elder Center Services pays no rent for use of the space (Rent costs
are in essence subsidized through the rents that the tenants pay) it has taken three years
for the effort to reach a break even point requiring Stern to subsidize the operating
expenses of the meal service from his own resources until now.

Assisted Living

An additional level of service which further expands the continuum of care
available at this facility is provided through West Suburban Elder Services, the state's
designated Home Care services coordinator for the project. Implementation of the State's
Managed Care in Housing Program at this site is providing extended service hours and an
additional level of personal care to income eligible and needy residents not previously
available through the Home Care program. This program serves the very frail elderly with ADL assistance needs creating a partial assisted living environment for residents who would otherwise be forced to move to a nursing home. (For more detailed information on Massachusetts' Managed Care initiative, see Chapter IV)

Summary

There is no question that 100 Centre Plaza dramatically extends the continuum of care available in a typical subsidized housing project, however several issues must be raised before making the owner's claim that it represents an affordable alternative to a market rate CCRC. The assisted living services provided through the Managed Care initiative are available only to income eligible residents leaving a tremendous income gap between those who receive subsidized services and those who can afford a market rate assisted living facility. The Managed Care Program is also limited in its scope of services, providing only 14 hours of personal care per week. Although this level of care will certainly keep some residents out of the nursing home, this system cannot support those who are dependent in multiple ADLs or are incontinent requiring access to personal care services on a 24 hour basis. This suggests that although 100 Centre Plaza may represent the limit for expanding the continuum of care within the existing support system, there is substantial potential to support an even broader cross section of the elderly population within the context of existing subsidized housing.

In addition to being hindered by the inadequacy of the elderly support system, this project is also threatened by the short-term nature of the underlying subsidized housing component. The 20 year mortgage restriction on the property has expired and the project is at risk of being converted to a market rate facility. Although Stern hopes to
maintain the affordable nature of the project, this dilemma further highlights the need for coordination and cooperation that crosses existing administrative boundaries if the housing and service needs of the elderly are to be met.

This project also serves to demonstrate the complexity and inadequacy of the current support system that make replication of this effort unlikely. Development of the service and physical environment at 100 Centre Plaza has required a level of involvement and the commitment of personal financial resources from Stern that exceeds what might be expected from every private developer. Other factors such as the mixed-income tenant profile, MHFA's encouragement of providing services to be carried as operating expenses and even this project's location and physical configuration will vary from project to project dramatically affecting the ability to achieve the same goals at other locations.

On a positive note, this project has gone a long way towards demonstrating the potential of using an existing subsidized housing project to achieve the goal of providing an affordable option that provides a broad continuum of care. In addition, the fixed subsidy nature of the Section 236 financing package has forced Stern to achieve this level of service on an extremely tight operating budget. Other subsidized programs, such as the Section 8 program, which offer a flexible subsidy based on current market rents, provide a great deal more flexibility to the owners as well as the subsidizing agencies to create an enriched service environment. And, even though this project fails to produce the kind of profit potential that might encourage other subsidized housing owners to undertake this effort, the innovative financing structure that produced the congregate
dining facility does begin to demonstrate the kind of public/private and interagency cooperation that will be required.

SUMMARY

Without being overly repetitive, it would be useful to consolidate the lessons that can be taken from these examples to use in formulating a strategy for future initiatives. The Oregon Assisted Living Program, and to some extent 100 Centre Plaza, demonstrate that extremely frail persons can be cost effectively (and more appropriately) supported in a residential environment. This would obviously include those who are currently underserved in existing residential environments as well as a substantial portion of those overserved in nursing homes. More specifically, persons with multiple ADL dependencies could be supported with moderate physical modification of many existing subsidized housing units. The addition of staff to provide access to 24 hour supervision and limited licensed nursing care (similar to Level two care provided in the Oregon Assisted Living facilities) would further extend the capacity of these facilities to accommodate those with incontinence and minor cognitive impairments and establish a true assisted living environment. Evidence from the Oregon study suggests that these staffing requirements can be justified with as few as 20 residents creating a strong potential for developing an assisted living section within an existing subsidized housing complex. Although, a supportive environment that includes assisted living facilities could accommodate the needs of the majority of the frail elderly, this level of care could not accommodate those requiring extensive licensed nursing care. However, the reduced cost effectiveness of supporting these residents in a full scale residential setting may suggest that they are more appropriately placed in more specialized facilities.
These cases also point out that we cannot rely solely on goodwill to provide the motivation for housing sponsors to expand the continuum of care in their facilities. The Oregon and 100 Centre Plaza examples adequately demonstrate the profit potential in providing services to low and moderate income elderly or in enhancing the profitability of existing housing component, but given the relative inability of many of these residents to pay for services, any effort to broaden the available continuum of care will require substantial government involvement. All of these cases further demonstrate the inadequacy of the current service delivery system to support these efforts. Its complexity and discontinuity restrict the ability of housing sponsors to develop a comprehensive supported environment that meets the needs of all residents. Even recent efforts, such as the Managed Care program in Massachusetts, do not provide the resources needed to serve the very frail and fail to maximize the potential for developing assisted living in these existing residential units. The need to draw on the resources of the elderly support and long-term care systems as well as those of the housing subsidy agencies highlights the need for administrative and funding cooperation and possibly consolidation. The Oregon case in particular demonstrates the potential for meeting the objectives of all of these subsidizing agencies as motivation for pursuing this course of action.

And finally, the cases emphasize the need for a flexible service delivery system that can accommodate the changing needs and consumer choice demands of the residents. This flexibility is needed to maximize the cost containment advantages of targeting services and the economies of scale generated by insuring the full participation of private pay residents.
CHAPTER VI
CONCLUSIONS

Chapter 1 of this thesis establishes the conceptual basis for developing a long-term care model within a residential setting which include the cost advantages and enhanced social value of facilitating the aging in place of the elderly population. I am using an existing subsidized housing complex, Francis Cabot Lowell Mill, to test the feasibility of broadening the continuum of care in an existing subsidized elderly housing project. To be implemented, this idea must serve the objectives of all parties concerned. It must first meet the financial objectives of the project owner of maintaining or improving the profitability/residual value of the property. The proposal must also address the policy objectives of the various subsidizing agencies that must necessarily be involved. These policy objectives include fulfilling unmet service needs, extending the capacity of the project to facilitate the aging in place of the existing residents as well as providing cost effective alternatives to the current long-term care system in an effort to control costs. Achievement of this goal is the key to meeting the owners objectives as it provides the negotiating leverage to accomplish it.

OWNER'S FINANCIAL OBJECTIVES AND INCENTIVE

The need to establish a clear financial incentive is essential and had a direct bearing on the proposed site selection, the Francis Cabot Lowell Mill (FCLM) project in Waltham, Massachusetts. Located in a moderate-income community some 10 miles west on downtown Boston, the project is a Section 8 Substantial Rehabilitation of an historic mill and was constructed in two phases in 1979 and 1980. The two phases contain 258
units including 10 studios, 225 one bedroom units and 23 two bedroom units. This site was specifically selected because of its subsidy structure.

Typical of many Section 8 projects, automatic rent increase called for in the Section 8 contract combined with the recent softening of real estate markets have driven "Contract Rents" at the project above those available at market rates in the surrounding community. Although a complete survey of comparable rents in the market area was beyond the scope of this thesis, a small sample of apartment communities in the area confirms the owners belief that market rents are from $100 to $250 below the contract rent at this project. The recent federal low-income housing preservation legislation (See Chapter III), although not specifically addressing Section 8 properties, suggests that the project may be at risk of substantial curtailment or nonrenewal of future Section 8 contract extensions due to the availability of less expensive market rate units in the area. The existing Section 8 contracts for FCLM do not expire for another 7-8 years and the owner clearly has the option to do nothing and hope that market rents recover more quickly than the contract rents escalate. However, given the risks of default and loss of control of the property to the mortgagee if the subsidy is diminished or eliminated, developing an enhanced service environment might provide the negotiating leverage needed in future Section 8 contract negotiations to ensure continued subsidy levels and financial viability.

The expansion of the continuum of care at FCLM may present other ways to maintain or enhance the profitability of the project. Evidence from the Robert Wood Johnson Foundation Program suggests that expansion of that continuum can help reduce the resident turnover rate as well as maintenance and repair costs and may provide
additional profit centers for the housing sponsor depending on how the services are delivered. Given these considerations, I believe this particular site provides the financial incentive needed to encourage the participation of the owner.

PUBLIC POLICY OBJECTIVES AND INCENTIVES

Any efforts to expand the continuum of care at FCLM must also meet the public policy objectives of the subsidizing agencies that will be involved. An assessment of the current situation reveals that elderly services are delivered to FCLM through the Massachusetts' Home Care Program discussed in Chapter III. Services included are typical of those described earlier. The facility also provides a full time on-site social service coordinator who acts as a referral service for the residents and coordinates in-house social activities. Congregate meal service is not available except for one noon time weekend meal provided by a local community service organization.

Chapters II and IV established the basis for assuming there are unmet housing and service needs in the elderly community at large. To establish the need for an expansion of the continuum of care at this particular site, a complete market analysis of the current residents should be conducted to precisely define their level of frailty, current use of supportive services and service needs that are going unmet. Although, this should certainly be the first step taken prior to the implementation of any changes, for now, we can look at the age profile of the residents of Francis Cabot Lowell Mill to make assumptions about their service needs. 81.54% of the current residents are over the age of 70 and 42% of this group is over 80. Statistical evidence, presented in Appendix A, demonstrates that on average 21% of the elderly in subsidized housing over the age of 75 require assistance with at least 1 ADL and 60% of all elderly over the age of 85 are
limited to some degree in performing daily activities. More importantly, conversations with the FCLM's management staff indicate the existence of a shortage of supportive services and the need to expand the continuum of care. The fact that the residents' level of frailty and need for assistance with ADLs will more than double by the time the existing rent subsidy contracts expire further heightens the importance of expanding the continuum of care. (See Appendix A)

It seems evident then that the quality of life and ability to remain independent in the future of the residents of this facility would be enhanced by the increased availability of supportive services thus meeting one of the policy goals of the state of Massachusetts' elderly service agencies. However, achievement of this goal alone may not secure the commitment of all subsidizing agencies, including those responsible for the housing component, that is necessary to achieve the owner's financial objectives and fails to tap the full potential of this existing housing resource. In establishing the appropriate level of service for this facility, it would seem advisable to consider all the government policy objectives noted in Chapter II. This includes the objective of providing a cost effective alternative to nursing home care as the fiscal crisis most governments find themselves in increases pressure to reduce government spending. This suggests the need to provide a level of care that can support the frail elderly who are at greatest risk of nursing home placement. Referring once again to the continuum of care diagram, meeting this cost containment objective would require extending the continuum of care as close as is physically and economically feasible to the existing nursing home model. See Diagram 5.
This would indicate the need to develop a broad range of service capabilities that went beyond basic support services to include congregate meal service and high levels of personal care services commonly provided in assisted living environments. As noted earlier, this would include 24 hour access to supervision and limited licensed nursing care that would allow this facility to accommodate the very frail elderly with multiple ADL dependencies including bathing and eating as well as those with minor cognitive impairment and incontinence problems. Expansion of continuum of care to this level would effectively address the government policy objective of providing residential alternatives to nursing home care that support the aging in place of those most at risk of premature institutionalization. The 100 Centre Plaza example, in which a slightly less intensive level of service was implemented in a similar physical setting, demonstrates the potential for developing this continuum of care here with a more comprehensive service effort and a minimum amount of physical renovation. The development of a limited number of assisted units at minimal cost would also provide the opportunity to tap into Massachusetts' recent initiative to create affordable alternatives to nursing home care.
It should be noted that I have not suggested that the continuum of care be extended to support those in need of extensive licensed nursing care as has been accomplished in some of the Oregon Assisted Living facilities. Although I am not suggesting that this is impossible, there are substantial differences between the physical environments found at the Oregon Assisted Living facilities and those at FCLM (i.e. unit size and common facilities). This suggests the need for extensive renovation at FCLM to accommodate this level of care that may eliminate the cost effectiveness of supporting these residents here as opposed to a more specialized facility. In addition, the high staffing levels required to provide this intense level of service may not be justified by the limited number of residents that would be served at this location.

Another issue to be considered in determining the level of service is the licensing and regulation issues that will be eventually raised by state and federal officials as this concept continues to mature. As the State of Massachusetts is still formulating its policies on the licensing and regulation of assisted living facilities, it is impossible to determine the impact of this issue. Yet, it is clear that the state's efforts to control long-term care costs is pushing them away from a medical model and towards a residential alternative to nursing home care that will minimize regulation.

In summary, the need to control long-term care costs has encouraged the federal and state governments to explore alternatives to the traditional medical model of long-term care and has resulted in a strong policy commitment towards the development of residentially based service models. Market rate responses such as CCRCs have established the marketability of this concept but dramatize the issue of affordability for the low and moderate income elderly. The initiatives of the State of Oregon confirm the
cost effectiveness of residential alternatives to nursing home care and the 100 Centre Plaza projects demonstrates that a relatively comprehensive assisted living environment can effectively be established within the constrains of an existing residential setting. It is reasonable to assume then, that the development of assisted living units at FCLM is practical and that the relatively low cost of developing these units should appeal to the state as a clear alternative to the high cost of new construction.

With this level of service in mind, it is necessary to look at two key questions. What physical changes will be required to accommodate this continuum of care and what sources of capital are available to pay for them? How should the service delivery system be structured and how will the services be paid for?

PHYSICAL CHANGES

The existing physical facilities at Francis Cabot Lowell Mill present a good opportunity to develop a broader continuum of care with a minimum of renovation. The size and configuration of the original mill structure allowed the developer to create a substantial amount of common space in the original development. The existing facility contains a large space currently used for occasional congregate meals and assemblies as well as a meeting space for an adjacent museum that could serve as the congregate dining facility without alteration. This space is adjacent to a large residential quality kitchen which with minimal changes could support congregate dining on-site. The cost of these changes would be minimal, enhancing the cost effectiveness of supporting the frail elderly at this particular location. The existing project also has an extensive number of other public areas that currently function as common living rooms or gathering places for
the residents. The building is also handicapped accessible and would require little if any alteration to accommodate the mobility restrictions of a more frail population.

Development of on-site assisted living units would require more extensive physical modification. It would be possible to undertake a limited renovation program that would change some 1 bedroom units into efficiency units or create a shared living environment in some of these units that could be used as assisted living units. The existing studio units could be more easily adapted with the addition of wheelchair accessible showers and emergency call systems. In addition, a limited amount of staff space would have to be created. Although there is no concrete data on the costs of these changes, the cost of renovating existing residential care facilities in Oregon for assisted living has been estimated at $5,000 per unit. Costs in this case would undoubtedly run somewhat higher, but would remain substantially below the $35,000 to $50,000 per unit cost associated with new construction.

The feasibility of this undertaking must still confront the required capital improvement costs. The narrow profit margins associated with affordable housing preclude the assumption of substantial debt service costs. In fact, it is the high debt service costs associated with new construction that has hindered attempts to develop affordable assisted living models in the past. However, given the limited capital expenditure required to reposition this facility, it seems likely that capital could be attracted from recent federal and state initiatives to upgrade existing elderly housing projects to support the frail elderly and to develop affordable assisted living units. (See Chapter V for a description of these initiatives.)

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50 Kane p. 151
SERVICE DELIVERY

The service package could be modelled after that of a Continuing Care Retirement Community. The facility should provide a basic supportive service package including congregate meals, housekeeping, transportation, laundry services that would be available to all residents on a fee for service or subsidized basis. A key component is to avoid duplication of already available services through the Home Care Program. This could be accomplished by working with designated Home Care service coordinator who in this case is West Suburban Elder Services.

Although, Francis Cabot Lowell Mill contains all Section 8 low-income residents, an analysis of the income profile of the existing residents suggests that a comprehensive supportive service package could be supported through state subsidies and resident contributions. Over 83% of the residents have a gross income of under $15,000 per year, making them income eligible to receive subsidized or free services. However, limited funding does not make these subsidized services available to all who may want them but rather residents must establish a need basis as well. The limited availability of subsidized services means that some services will have to be supported through resident contributions. However, with the Section 8 rental subsidy, residents contribute only 30% of their income suggesting that even those residents with gross incomes under $10,000 per year could contribute personal income to pay for additional services. For example, a resident whose gross income is $7500 per year must contribute $187.50 per month towards rent. (The difference between the resident contribution and the contract rent is paid through the federal government.) Estimates from other assisted living facilities suggests that residents could contribute up to 70% of their income to cover housing, food
and service costs. Returning to my example, this resident could contribute up to $250 per month to support a congregate meal program and to purchase additional services. A resident receiving $12,500 per year could contribute up to $418 per month. Although cost estimates of providing this level of congregate care vary widely, estimates range from $250 to $450 per month indicating that resident and subsidy contributions could support these costs.

The need to solicit resident co-payments and the existence of a large contingent of residents who will be required to pay all of the cost of available services suggests the need to develop a service package that is driven by consumer choice. Any efforts to expand the continuum of care should be preceded by a market analysis that identifies those services that the residents want and are willing to pay for. This should be followed by the development of a flexible service package that allows the elderly to select services based on their own preferences as their needs change thus enhancing their willingness to pay and insuring the maximum level of participation.

Tailoring of services in this manner would require monthly revision of the services provided as well as changes in the number of residents participating. While on the surface, this approach may seem inefficient, evidence from the Supportive Services in Senior Housing Project, described in Chapter V, indicates services, including congregate meal service, that are specifically targeted for those who need them or are willing to pay for them can be cost effectively provided with the use of a flexible vendor system. And, although conventional wisdom suggests that there are economies of scale that can reduce the cost of services, a mandatory service strategy fails to recognize the economy of reducing the number of people served and the necessity of allowing people to make their
own choices if they are to be expected to pay. A flexible service strategy also has the advantage of allowing services to be added incrementally thus reducing upfront costs. In addition, a consumer choice model will help overcome the tendency for the existing residents to resist change. These residents' selection of this particular facility was based on its current service configuration and the costs associated with it and, unlike someone who has chosen an assisted living environment, they may resent the imposition of a substantial service fee to pay for services that they may not want or need.

The assisted living component is somewhat more difficult to justify from an operating expense standpoint. Adding the $455 per month estimated expense for the assisted living service component (from the Oregon example) to the $669.5 per month Section 8 rent subsidy for a resident grossing $7500 per year totals $1,124.50 per month. This does not represent a substantial savings over the current nursing home reimbursement rate of $1260 per month. One possibility for increasing the cost effectiveness of this approach is to reduce the contract rents on the assisted living units. A reduction in rental income for a limited number of these units presumably would not substantially affect the profitability of this project overall. It should also be considered that as the vast majority of the residents who reach the level of frailty to require assisted living are eligible to receive Managed Care services, this alternative could represent a substantial savings over current state expenditures of $814 per month for services alone. In addition, more active use of the Medicaid waiver program could provide additional revenue to support these efforts.

Services can be delivered through a variety of mechanisms. The key to the service delivery system will be an expanded role for the on-site service coordinator and
project management. This on-site development staff member, which this project already has, will be responsible for the assessment of all resident needs and coordinator for the procurement of all services. There are a variety of options for structuring the delivery of services. All services could be contracted through existing vendor systems. The advantage of this approach is it minimizes operating expenses for the building owner and provides maximum flexibility in tailoring services to resident demand. This approach however, eliminates the opportunity for the housing sponsor to generate additional revenue as a service provider. Another option is for the housing sponsor to create a separate service delivery entity who would then contract with the residents and West Suburban Elder Services to deliver services in the project. Although an analysis of the profitability of existing elder service vendors would be necessary to determine the desirability of this option, it can be assumed that reasonable profit margins are earned by existing service vendors and that this option presents an opportunity to generate additional revenue for the owner.

CONCLUDING COMMENTS

This analysis establishes the feasibility of developing an affordable enhanced service model that includes assisted living units within the context of an existing subsidized elderly complex. It suggests that a broad continuum of care can effectively be implemented in this type of residential setting that could support the majority of the frail elderly who do not require intensive licensed nursing care or medical supervision. It also establishes the existence of the motivational forces required to encourage participation from both the project owner and the subsidizing federal and state agencies. Expansion of the continuum of care in existing subsidized housing can meet several public policy
objectives that include improving the quality of life and meeting the service needs of existing subsidized housing residents, providing humane and cost effective alternatives to nursing home care, controlling spiraling long-term care costs and better utilization of existing housing resources. In turn, meeting these policy objectives through the expansion of the continuum of care may provide the needed negotiating leverage for housing owners to renew housing subsidy contracts and maintain the financial viability of their projects.

This thesis has also highlighted the need for changes in the current elderly support service/long-term care system. Coordination and integration of the administration and funding of the existing system as well as implementation and expansion of recent initiatives such as the Medicaid waiver system are needed to encourage further private sector participation in achieving these public policy objectives.

However a substantial amount of additional research is required before this concept could be implemented. This includes a comprehensive resident survey to determine their service needs, what services are currently being provided, gaps in the existing service continuum as well as their willingness to pay for additional services from their own personal resources. Additional research should be focused on determining the most cost effective way of filling the service gaps. This should include a detailed analysis of the costs of physically restructuring existing subsidized housing to support an expanded continuum of care as well as of the costs of delivering supportive and assisted living services in this environment.
APPENDIX A

As noted in Chapter II, there are several reasons that federal and state governments are looking for residential alternatives to existing long-term care options. The first of these reasons centers around the ideal of maximizing resident satisfaction. Nursing homes and hospitals, with their institutional and antiseptic setting, are perceived as a place to be avoided at all cost. Although these facilities fill an invaluable niche in the continuum of care, a residential setting has been shown to provide a superior environment for maintaining and improving the mental well being of elderly people. As noted in a recent study of Oregon's response to this issue:

"Providers and policymakers often concur that the 50 billion dollar investment in nursing homes in the United States fails to buy the life they would want for themselves or their families."^{51}

Resident satisfaction is also enhanced by the ability to make choices about their lives, their physical environment and what services they want to receive.^{52} This concept of consumer choice is severely limited in the nursing home setting as opposed to the residential environment. The ability to make these choices may also reduce the tendency to become prematurely dependent on others and reinforces one's self esteem, self reliance and self respect.^{53}

Another reason is the increasing number of frail elderly. Demographic growth and increased longevity have swelled the number of people requiring supportive services placing additional burdens on the existing long-term care system.^{54} Consider the following facts:

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^{51} Kane, p. 2
^{52} Kane, p. 4
^{53} Regnier, p. 4
^{54} Regnier, p. 6
• The U.S. population of persons 65 and older numbered 28.6 million in 1985 and will be 39 million by the year 2010 or 14% of the total population. 19 million of these will be over 75 and 6.5 million will be over 85.55
• The number of persons 80 years of age and older is expected to increase by 40% over the next ten years.56
• In 1900, one in twenty five Americans was over the age of 65, by 1985, one in nine exceeded this age.
• The size of the population cohort over the age of 85 is expected to grow by seven times by the year 2050.
• About 25% of the elderly with incomes over $20,000 per year describe their health as excellent while only 12% of those with incomes under $10,000 rate their own health in this category.
• One in five elderly report some kind of activity limiting disability. This percentage increases dramatically when you look at those 85 years of age and older among whom 60% are limited to some degree in their daily activity.
• Elder Americans have significantly less cash incomes than Americans as a whole with those over the age 65 having a median income in 1985 of $7,476 per year compared to $16,064 for those between ages 25 and 65.
• The elderly rely heavily on Social Security benefits for their income constituting 38% of their income for all age brackets with 28% coming from asset income, 16% from earnings and 15% from pensions.57

Looking specifically at federally subsidized housing:
• In 1989, approximately 1.76 million households headed by someone over the age of 62 lived in housing the cost of which was reduced through federal subsides 45% of whom are over the age of 75.58
• As many as 25% of these over age 65 fall under some broad definition of frailty and up to 18% of this group are at risk of institutionalization.
• 29% of the frail require assistance with at least 1 ADL and 97 to 99% of the frail require assistance with at least 1 IADL.59
• The need for assistance increases dramatically with age. 21% of those over the age of 75 require assistance with at least 1 ADL and the need for assistance with daily living doubles every 5 years after seniors pass the age of 65.60

55 Struyk, p. 11
56 Ladd, p. 3
57 The above statistics are paraphrased from a thesis by Neil Prashad written in 1987 for the Massachusetts Institute of Technology Center for Real Estate Development who in turn references a Report by the Special Committee on Aging presented to the 100th Congress of the United States (1987).
58 Struyk, P. 11
59 Struyk, pp. 21-33. Note: IADLs are Instrumental Activities of Daily Living and include heavy housework, light housework, laundry, preparing meals, shopping, getting around outside, going places beyond walking distance, managing money and making telephone calls.
60 The Standish Care Company
An equally compelling argument for this residential approach, and the one that provides the reasoning for this thesis, centers around the skyrocketing cost of hospital and nursing home care and the cost efficiencies of maintaining the elderly in a residential setting. 43% of the 2.2 million Americans who turned 65 in 1990 are likely to enter a nursing home at some point. The medical model on which nursing homes are based is characterized by stringent regulation, skilled nursing staffing requirements, rigid routine and close surveillance of patients to reduce operator risk and to ensure the health and safety of dependent individuals. Cost savings can be realized by allowing the resident to take more responsibility for their well being, sharing the risks and reducing the need for strict regulation and supervision. The nursing home also provides a blanket level of care to all patients regardless of need foregoing the cost containment advantages of targeting services. For these reasons, the national average cost of nursing home care now ranges from $25,000 to $34,000 per year. Of course, the cost of nursing home care is of great concern to all elderly persons and their families but has become a politically important issue as the cost of entitlement programs such as Medicare and Medicaid, which subsidize medical and nursing home care costs for low income persons, also reaches crisis proportions. Currently, Medicaid pays about 43% of the cost of long-term care in this country with about 85% of this going to the nursing home industry and nursing home costs constitute from 2% to 10% of state budgets. As medical costs escalate, states spending 4-5% of total expenditures on Medicaid may expect spending to

61 The Standish Care Company
62 Kane, p. 5
63 Regnier, p. 4
64 The Standish Care Company
65 Ladd, p. 3
double in the next 10 years. The public outcry over these costs provide strong incentives for the government to explore options for servicing the elderly population in a more cost efficient manner. Some estimate that as many as 25-40% of current nursing home residents don't need to be there and could be supported in a less expensive environment. Study after study has documented the cost savings attainable by avoiding the unnecessary placement of elders in nursing homes. A recent study prepared for The National Academy for State Health Policy indicated that the costs of supporting nursing home eligible elders in a residential model long-term care facility were 70% to 80% of the cost of nursing home care.

"Ideally, it might be more appropriate to offer services that let the resident cope with daily life in his or her current home. Such services can often be far less expensive, to the person or the taxpayer, than hospitals or nursing homes."  

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66 Ladd, p. 13  
67 The Standish Care Company  
68 Ladd, p. 3  
69 Ladd, p. 1
APPENDIX B

The private sector has always played a key role in the production of low income and affordable housing. By 1989, they had assisted in the production and rehabilitation of over 1.5 million units of housing.\(^{70}\) Beginning in the late 50's, a perception that the entrepreneurial nature and resourcefulness of the private sector would produce greater results more quickly motivated the Congress to create a variety of subsidy programs that would greatly expand the role of the private sector.\(^{71}\) The Section 202 was created as part of the Housing Act of 1959 to provide independent housing units for the elderly.\(^{72}\) It was targeted for the elderly whose income was too high for conventional public housing but was too low to afford unsubsidized market rate units. The program provided direct government loans at 3% payable over 50 years but limited sponsorship to non-profit organizations.

The section 221(d)(3) program was created in 1961 to provide up front subsidies that reduce to 3% the effective interest rate on private 40 year mortgages. The program targeted low and moderate income housing constructed by non-profit or limited dividend organizations expanding the role of the private sector and encouraging the participation of for-profit developers in the creation of affordable housing.

The Housing and Urban Development Act of 1968 created the section 235 and 236 programs in which production, ownership and financing of the projects was controlled by the private sector. Public subsidy came in the form of monthly direct payments to the owners to reduce the effective cost of financing to as low as 1% and

\(^{70}\) Bratt, p. 87  
\(^{71}\) Bratt, p. 89  
\(^{72}\) Bratt, p. 88
replaced both the Section 202 and 231(d)(3) programs as the primary mechanism for
funding new elderly and multifamily housing.\textsuperscript{73} The use restriction that require
occupancy be maintained for low income households is 20 years for projects owned by
limited partnerships that are not additionally subsidized by Rent Supplements or Flexible
Subsidy programs and up to 40 years for those projects that are or are owned by
non-profit sponsors.\textsuperscript{74} Both Section 221(d)(3) and Section 236 were designed to
accommodate a slightly more affluent population than public housing with in 1975 60%
of the Section 236n households earning between $5000 and $10,000 while 71% of public
housing households earned less than $10,000. 50% of the households in the 236 projects
had incomes that were less than 50% of the median national income while 87% of public
housing tenants were below this level.\textsuperscript{75}

These fixed subsidy programs failed to anticipate skyrocketing operating costs
that accompanied the energy crisis and inflation rates of the early 70's driving many of
these projects into default. This along with other factors led the Nixon Administration to
place a moratorium on all federal housing subsidy programs in 1973 leading to a change
in direction that would emphasize the direct subsidy of low income households. This
new direction resulted in the creation of the Section 8 Existing Housing Program in
1974. Subsidies were fed directly to private landlords through contracts with local
housing authorities and included provisions for automatic annual increases to offset
rising operating expenses. These subsidies could be used in conjunction with any
existing housing unit that did not exceed HUD's fair market rent standards. Later the

\textsuperscript{73} Bratt, p. 92
\textsuperscript{74} Bratt, p. 108
\textsuperscript{75} Bratt, p. 95
program was expanded to include rent subsidies for New Construction and Substantial Rehabilitation projects as well as to subsidize new and existing Section 202 elderly projects. These programs provide rental subsidies to income eligible households. The subsidy contracts for 20 to 40 years commit the owner to set aside a certain number of units for lower income households for the length of the contract. A Moderate Rehab program was added in 1979.

As noted, there is tremendous variability in the profitability and financial soundness of subsidized housing projects. This related not only to the type of subsidy with which the projects were constructed and operated but also within programs by the location and level of maintenance of individual projects. The profitability of Section 221(d)(3) and 236 projects which did not go into default continued to suffer due to their fixed subsidies and rising operating costs. Recognizing this problem, HUD has issued Section 8 Loam Management Set Asides since the late 70's tied to specific 236 and 221(d)(3) projects to alleviate operating deficits and growing tenant burdens. Under this program, HUD agreed to pay the difference between fair market rents and 30% of tenants income. Additional relief was issued in the form of a Flexible Subsidy Program, added to provide grants or loans to finance repairs or pay off operating deficits. Despite these efforts the profitability of these projects remains constrained by the limited dividend nature of the original contracts.

Section 8 projects are often a different story. Section 8 New Construction and Substantial Rehab subsidies include automatic increase for rising operating expenses and these projects are generally financially sound. In fact, many owners of these projects

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76 Bratt, p. 94
77 Bratt, p. 99
indicate them to be "cash cows", delivering substantial returns on the original equity investments.

The profitability of these projects is also dramatically impacted by the ownership structure and the tax code. Prior to the Tax Reform Act of 1986, these projects generated substantial tax benefits for the developers as a result of accelerated depreciation rates (200% declining balance method) and a 15 year depreciation term for subsidized housing. The tax benefits often resulted in the construction and syndication of projects that were not financially sound from an operating standpoint but still made sense from a developer's profit viewpoint. Ownership of subsidized housing was rendered substantially less attractive by the tax reforms of 1986.

Other project specific factors have dramatically affected the profitability and value of these projects. Project location and resident composition are perceived as a key factors with some projects experiencing rapidly escalating maintenance costs that reduce profitability and value. The location of other projects in high rent neighborhoods has resulted in vast appreciation in their value.

78 Bratt, p. 99
INTERVIEWS


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