Integrating Health and Supportive Services in Affordable Senior Housing: New Models for Service Coordination

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Introduction

It is well-documented that the population of the United States of people 65 years and older is increasing and living longer. The senior population is currently 49 million and is projected to double to more than 98 million by 2060.[1] Most people today will live past the age of 65 and many will surpass the age of 85 years, placing this population at risk of suffering from multiple chronic diseases during their lifetimes. Over the coming years, this drastic increase in the senior population will become a challenge for both the housing and health care systems. For low-income seniors, the issue will be whether the supply of affordable housing and services will meet their needs or not. Moreover, the cost to the government of providing increased health care services to a substantially larger number of low-income seniors has the making of a looming national crisis, unless changes are made to our delivery systems.

Volunteers of America National Services (VOANS), a subsidiary of Volunteers of America, is a national faith-based nonprofit organization that owns and develops housing for low-income populations in 42 states and Puerto Rico. In addition, VOANS also operates over 46 health care programs for seniors in nine states. These include skilled nursing, assisted living, adult day care, Program for All-Inclusive Care for the Elderly (PACE), and other services. Given this experience as both a senior housing and health care provider, VOANS understands that low-income seniors with multiple chronic illnesses are at risk for poor health outcomes. For more than 20 years, VOANS has been at the forefront of providing health

1. Administration for Community Living, *2017 Profile of Older Americans* (Apr. 2018), https://www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2017OlderAmericansProfile.pdf.

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and supportive services for its senior residents through service coordination practices, which link residents with ever-evolving services in the community. This article discusses VOANS' experience, as a housing owner utilizing the U.S. Department of Housing and Urban Development (HUD) service coordinator program,[2] to develop models that integrate preventative health and supportive services within its senior housing portfolio.

Housing Alone Is Not Enough

For many seniors, housing-related costs are their biggest expense. Approximately 44 percent of senior households spend 30 percent or more of their income on housing.[3] The need for more affordable housing for this population, especially for those whose annual income is $12,000 or less, continues to rise, as many of those in this group are on fixed incomes. HUD provides options for approximately five million households (10 million individuals) through three of HUD's major programs: housing choice vouchers, public housing, and multifamily housing.[4] More than one-third of these households are headed by a senior (defined by HUD as an adult aged 62 years and over).[5]

HUD's multifamily housing consists of two programs: Section 202, serving primarily seniors, and Section 811, serving disabled adults. The Section 202 program provides nearly 400,000 affordable homes for seniors and is the only federal rental assistance program designed specifically to serve seniors.[6] Nationally, most residents living in Section 202 housing are low-income, white, single women ranging in age from 70 to 80, of whom 68 percent are covered by both Medicare and Medicaid.[7] While housing assistance helps low-income seniors become more economically stable, it alone cannot improve health and life outcomes without other services. Stabilized housing with the availability of supportive services for vulner-

2. U.S. Department of Housing and Urban Development, *Draft HUD's Service Coordinator in Multifamily Housing Program Resource Guide* (Oct. 2017), https://hudexchange.info/resourse/documents/Multifamily-Service-Coordination-Guidance.pdf.

3. *2017 Profile of Older Americans*, *supra* note 1.

4. U.S. Government Accountability Office, *Older Adult Housing: Future Collaborations on Housing and Health Services Should Include Relevant Agencies and Define Outcomes* (Apr. 2018), https://www.gao.gov/assets/700/691532.pdf.

5. U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *End of Participation in Assisted Housing: What Can We Learn About Aging in Place?* (Feb. 2011), https://www.huduser.gov/publications/pdf/locke_aginginplace_assistedhousingrcr03.pdf.

6. U.S. Department of Housing and Urban Development, 2018 Summary Statement and Initiatives, Housing for the Elderly (Section 202), https://www.hud.gov/sites/documents/26-HSNGFORELDERLY.PDF.

7. LeadingAge Center for Housing Plus Services, *Housing and Health Care: Partners in Healthy Aging: A Guide to Collaboration* (2015), https://www.ohio-population.org/wp-content/uploads/2015/06/Housing-Health-Care.pdf.

able residents can positively impact the quality of life and reduce high-cost outcomes.

Keeping Seniors Healthy: Using Housing as a Platform Saves Resources and Improves Outcomes

Managing seniors' chronic diseases and providing support for residents experiencing limitations on activities of daily living (ADLs) could prolong their independence and mortality, which has the potential to save substantial resources in the Medicare and Medicaid systems.[8] A chronic disease is considered a condition that will last for more than a year. Diseases such as "cancer, diabetes, hypertension, heart disease, respiratory diseases, arthritis, obesity, and oral diseases can lead to hospitalization, long-term disability, reduced quality of life, and death."[9] In the United States, chronic diseases are among the most common and costly health conditions.[10] In fact, today, one in four adults has two or more chronic conditions[11] while more than half of seniors have three or more chronic conditions.[12] Seniors living with multiple chronic diseases and support for assistance with ADLs will receive treatments from different primary care providers, health systems, and other providers, resulting in a lack of communication due to the fragmentation of health services.[13] An unintended consequence of this lack of coordination often places seniors at risk of poor health outcomes, such as adverse drug interactions and increased costs to the health care system.[14] Moreover, some recent studies show that low-income seniors who live in affordable housing where services are available use fewer hospital and long-term services, thus reducing costs to the health care system.[15]

8. Bipartisan Policy Center, *Healthy Aging Begins at Home* at 16–17 (May 2016).

9. Wullianallur Raghupathi & Viju Raghupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, 15(3) Int'l J. Envtl. Research & Pub. Health 431 (Mar. 2018), https://www.ncbi.nlm.nih.gov/m/pubmed/29494555/.

10. *Id.*

11. U.S. Department of Health & Human Services, *Multiple Chronic Conditions: A Strategic Framework Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions* (Dec. 2010), https://www.hhs.gov/sites/default/files/ash/initiatives/mcc/mcc_framework.pdf.

12. National Council on Aging, *The United States of Aging Survey National Findings* (2013), https://www.ncoa.org/wp-content/uploads/USA13-National-FactSheet.pdf.

13. University of Pittsburgh Stern Center for Evidence-Based Policy, *Addressing the Health Needs of Aging America. New Opportunities for Evidence-Based Policy Solutions*, http://www.healthpolicyinstitute.pitt.edu/sites/default/files/SternCtrAddressingNeeds.pdf.

14. *Id*. at 12.

15. Enterprise Community Partners, Inc. & Center for Outcomes Research Education, *Health in Housing: Exploring the Intersection Between Housing and Health Care* (2016).

The HUD Multifamily Service Coordinator program is one strategy that can help seniors navigate these systems.[16] In the 1990s, HUD funded the service coordinator program, allowing owners and/or management companies to hire or contract a social services staff person to provide residents with access to supportive services already existing in the community, such as transportation to medical appointments, immunizations, and benefits and entitlements. Service coordinators today provide intentional programing and target the needs of the residents by conducting individualized assessments of their social and health needs. The program helps improve residents' transitions from the hospital or rehabilitation centers back to their homes.

With the increase in health issues and functional impairments of residents, the service coordinator program model has expanded its focus to include building closer relationships with health-related organizations and providing these types of services on-site. The future of HUD assisted housing is not a health care or nursing home model, which includes specific medical treatment, but rather a focus on offering preventative/health care management services to residents to enhance their independence and quality of life. The medical models, including nursing homes, hospitals, and other longer term treatments, are not only costly to the health care system, but research increasingly shows that integrating preventative services in affordable housing produces better outcomes.[17]

VOANS' Senior Affordable Assisted Housing with Service Coordinators

The VOANS portfolio is similar to many non-profit senior housing providers across the country, although larger. Seventy-one percent of VOA's residents are women, and 29 percent are men. The racial and ethnic representation of these residents consists of Whites (71%), Blacks (22%), Asians (6%), and Native Americans (1%), including 18% Hispanic/Latino of any race. Almost one-third of the residents are age 80 and over. The residents are extremely low-income, with annual household incomes under $12,000. Over 80 percent of residents are also eligible for some type of publicly funded health insurance, and more than a third have been identified as dual eligible for Medicare and Medicaid benefits.

The five most frequently reported health conditions by residents are hypertension, arthritis, heart disease, diabetes, and lung-related issues. More than half of all residents have been identified as being functionally at-risk (unable to perform one or more activities of daily living) or frail (unable to perform three or more activities of daily living). The activities of daily living that residents report as being the most difficult to perform

16. *HUD's Service Coordinator in Multifamily Housing Program Resource Guide*, *supra* note 2.

17. *Id*. at 12.

include housekeeping, bathing, transferring from a wheel chair to another position, and meal preparation. This is similar to many senior assisted housing populations across America.

Today, VOANS employs 133 service coordinators located in 158 housing sites in 42 states and Puerto Rico, serving more than 9,067 residents. Ninety-five percent of VOANS' senior residents use the service coordinator services. While residents' levels of program participation vary widely across properties, on average a typical resident engages with their service coordinator or services arranged by the service coordinator approximately 22 times annually. The most common services provided through the service coordination program include meal deliveries, social enrichment programs, health and wellness-related programs, and home management services. Assistance with benefits and entitlements, educational programming, and resident advocacy are also highly utilized.

While service coordinators have always been encouraged to provide services that can help residents live healthier lifestyles, as more residents are living longer and becoming more frail, an increasing number of residents are not able to manage their chronic conditions well. This results in frequent hospital visits and transfers to nursing homes. As part of VOANS' new protocols, all service coordinators are required to create and track individualized service and referral plans for residents, especially high-risk residents. High-risk residents have been identified as those who are frail or at risk of being frail, have a history of frequent falls, have frequent emergency room and hospital visits, manage three or more chronic diseases, or show signs of dementia. Focusing more attention on these high-risk residents requires a service coordinator to visit them more frequently, develop individualized service plans, and work closely with their primary care providers to ensure health-related appointments are kept.

With a more targeted focus on this high-risk population, the service coordinator program was able to decrease the number of move-outs for health-related reasons. Of the 8,653 residents enrolled in the service coordinator program last year, roughly 86 percent of all program participants continue to age successfully in place. The remaining 14 percent of residents enrolled in the service coordinator program left the property for the following reasons: death (363 residents); voluntarily opted to move to another independent housing community (315 residents); needed a higher level of care, such as a nursing home (315 residents); and moved to live with family or a group home (218 residents).

Volunteers of America's Service Coordination Program Structure

Service Coordination: In order to be successful, service coordinators must build trust with residents so they can be linked to the services they need and desire. One full-time service coordinator generally can serve up to 100 households, operating similarly to a case manager by providing information, referrals, case management, advocacy, and access to socialization opportunities.

The service coordinator develops community partnerships and collaborates with social service agencies and health organizations to provide onsite services and programs most requested by residents. An individual assessment is conducted for all residents to determine their ADLs. Once this assessment has been conducted, the service coordinator reviews the results with the residents and discusses the possible services in the community that can improve their quality of life.

Funding Structure: Service coordinator programs are often funded by HUD through the HUD Multifamily Service Coordinator grant program. Unfortunately, this program has not expanded in many years and funding levels for existing service coordination programs has remained largely flat. Regardless, VOANS has tried to ensure that service coordination is available at as many sites as possible. Other sources include the properties' operating expenses or residual receipts.

Oversight and Supervision: To ensure that the program is implemented in a coordinated fashion, a national framework for quality assurance was put in place to support and guide each service coordinator. This framework consists of both local and national staff to help the service coordinator address the needs of residents as well as to ensure HUD's protocols are being followed. The supervision structure varies based on local affiliates of VOA, Inc.[18] Approximately 70 percent of the service coordinators are supervised by the housing property managers. The other 30 percent are supervised by staff located off-site, often either the director of social services or the regional housing director of the local office. In a state where there is a high number of service coordinators, a lead service coordinator is also selected to provide supervision. Finally, in addition to the service coordinator supervisor and quality assurance staff, each service coordinator is assigned a mentor. The mentor's role is to provide support and technical assistance to service coordinators assigned to them based on their region.

Training: VOANS provides all service coordinators with ongoing training through monthly webinars and annual in-person conferences, which provide Continuing Education Units (CEUs). VOANS' service coordinators are members of the American Association of Service Coordinators (AASC), which also provides national training and professional guidance.

Web-based Data Collection System: Service coordinators are required to input all resident interactions and assessments into a web-based data collection system. This system allows service coordinators to record and track resident assessment data and other vital information in real time and to create service plans. The data collection system generates HUD-required reports, as well as resident and property-level reports on a variety of subjects (e.g., the most common health problems reported by the

18. In addition to VOANS, VOA has 32 other local affiliates that provide a wide variety of services in 46 states.

residents and the most common types of services provided). These online service plans are intended to meet two goals: (1) to ensure that all residents have the support and services they need to successfully age in place and (2) to document high-risk residents' service needs, program engagement, service utilization, and outcomes over time.

Evaluation Process: VOANS' national staff analyzes the service coordination program data on a semi-annual basis and uses that data to monitor the program's outcomes. The program performance data that is regularly reported includes, but is not limited to:

- number of residents in properties utilizing their service coordination program;
- number of residents with chronic health conditions and physical disabilities and other "risk factors" that place them at "increased risk" for health deterioration or death;
- number of residents participating in educational and preventive health-related and social services programs and services;
- number of residents participating in socialization activities;
- results of the resident satisfaction surveys;
- residents' average length of stay and retention rates; and
- number of residents transitioning to a higher level of care.

The VOANS service coordinator program has changed and expanded over time based on our on-going evaluation of the data to increasingly leverage health-related services. VOANS has taken a preventive health approach by identifying and engaging frail and at risk of being frail residents in services before their problems turn into crises. VOANS trains the service coordinator to use non-clinical screening and assessment tools that have been researched and scientifically proven to assist with detecting issues that might be affecting the residents, such as depression, dementia, and social isolation. The Patients Health Questinaire-9 (PHQ9), for example, is an evidence-based assessment tool for screening depression. The service coordinators use this tool, based on the self-reporting of the residents, to make the appropriate referral.

HUD's Integrated Wellness in Supportive Housing (IWISH) Program

VOANS, like other organizations providing service coordination, has increasingly seen preventative health services as an important intervention for seniors to achieve successful outcomes. Supports and Services at Home (SASH), located in Vermont, is a successful example of using housing as a platform to address the health and needs of residents. This program, composed of a care coordinator and a wellness nurse, is designed to connect seniors living in assisted housing with community health care and supportive services. SASH promotes greater care coordination, improves health status,

and decreases health care expenditures.[19] The Department of Health and Human Services (HHS) and HUD evaluated the SASH program and compared health outcomes and service utilization with Medicare beneficiaries who did not participate in the program. The results showed that participants in the SASH model had a decrease in health care costs.[20]

The positive outcomes of the SASH program laid the foundation for HUD's Integrated Wellness in Supportive Housing (IWISH), formerly called the Supportive Services Demonstration grant.[21] This three-year grant, awarded by HUD in January 2017, was aimed at helping low-income senior residents age in place and delay or avoid the need for nursing home care. The funding covers the cost of providing a full-time resident wellness director (service coordinator-type position) and a part-time wellness nurse.

The IWISH program will be evaluated independently to determine the impact of the enhanced service coordination model in the following areas: (1) success in aging in place in HUD-assisted property; (2) avoiding early transitions to institutional care; and (3) preventing unnecessary and often costly health care utilization, such as emergency room visits and hospitalizations. HUD selected an implementation group, consisting of the Lewin Group, the LeadingAge Center for Applied Research, and the National Center for Healthy Housing to help grantees with the program design.[22] The program provides a three-year grant program to produce data about the effectiveness of this enhanced supportive services model and to evaluate the value of enhanced service coordination and affordable housing on outcomes for this vulnerable population.

The VOANS team was thrilled to be selected for two of only forty grants awarded nationwide. Residents at our Rolling Oaks Apartments (Rocklin, California) and East Cliff Village Apartments (Santa Cruz, California) will receive both the assistance of a wellness nurse and a service coordinator during the grant period. While VOANS has been at the forefront of collecting data on the effectiveness of services in senior properties, the new demonstration will be evaluated based on a rigorous experimen-

19. U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, *Support and Services At Home (SASH) Evaluation: First Annual Report* (Sept. 2014), https://aspe.hhs.gov/report/support-and-services-home-sash-evaluation-first-annual-report.

20. Stuart Butler & Marcela Cabello, *Housing as a Hub for Health, Community Services, and Upward Mobility* (Brookings Inst. Mar. 2018), https://www.brookings.edu/wp-content/uploads/2018/03/es_20180315_housing-as-a-hub_final.pdf.

21. U.S. Department of Housing and Urban Development, Fiscal Year (FY) 2015 Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing Program NOFA (Jan. 20, 2016).

22. Press Release, LeadingAge, CFAR Will Help Implement HUD's Housing Plus Services Demonstration (Feb. 23, 2017), https://www.leadingage.org/cfar/cfar-will-help-implement-hud%E2%80%99s-housing-plus-services-demonstration.

tal research design developed by HUD and the U.S. Department of Health and Human Services (HHS) that uses random controlled testing to evaluate the achievement of outcomes.

Case Studies in Enhanced Service Coordination

The HUD IWISH model is just getting underway. However, VOANS has been using enhanced service coordination with preventative health programs in several properties for more than a decade. VOANS understood early on that residents need more than affordable assisted housing to improve their quality of life. Residents also need to have their basic needs met, including sufficient food, access to social relationships, financial stability, and access to health care. By creating both formal and informal partnerships, the service coordinator program helps ensure these basic needs are met. A typical service coordinator manages an average of 12 different partners providing on-site services. The most successful partnerships are with organizations that share the same vision and mission of the service coordinator program. The most frequently used and effective health-related partnerships include, but are not limited to, universities, pharmacies, home health agencies, and area agencies on aging. These partnerships are beneficial to the resident, property, and health service providers. Candleridge Plaza Apartments and Sunset Park Apartments are two examples of housing sites that exemplify effective partnerships.

Clinical Rotation Site for Nursing Students at Candleridge Plaza Apartments

Candleridge Plaza is a 100-unit apartment building located in Powell, Tennessee, with 102 senior residents. Sixty percent of the residents are managing three or more chronic diseases and 40 percent of those residents have mental and physical disabilities. Candleridge's service coordinator was interested in providing wellness programs at the property to address residents' chronic health issues. The service coordinator developed a partnership with the University of Tennessee Knoxville (UTK) College of Nursing to create a preventive health program. Initially, the university agreed to just provide nurses for the property's annual health fair; however, as the relationship grew, the university discovered that Candleridge Plaza was a great site to help them address their mission of serving high-risk vulnerable populations in the community.

What started out as an informal relationship evolved into a formal partnership with a Memorandum of Understanding (MOU) outlining the activities and services offered by the College of Nursing. Today, Candleridge Plaza is a community classroom site for the nursing school's Community & Public Health course, which includes a Service Learning Component. UTK College of Nursing and Candleridge produced a video[23] to promote

23. The video can be found at https://servicelearning.utk.edu/service-learning.

the Service Learning Initiative, which involved students and housing staff. The following are some of the results of partnering with a health care service provider:

- 911 calls decreased by 10 percent;
- 99 percent of residents have obtained a primary care provider;
- 95 percent of residents are keeping their health-related appointments;
- ER visits have decreased by 10 percent; and
- 40 percent of the residents utilized the services offered by the nursing students, in addition to their regular primary care physician.

This win-win partnership helps to improve the residents' coordination of care, medication management, and identification of potential health dangers. From the university's perspective, this partnership provides these nursing students the opportunity to interact with older adults and help train the next generation of nurses. The students also learn more about the unique needs of older adults. As one student shared, "It's great to see older residents functioning in their own homes, rather than in a rushed clinical hospital setting where they are at their worst, in a hospital bed!" During the nursing students' rotations, they educate residents on health-related topics; provide basic health screening, such as blood pressure readings; and conduct other health assessments, including screening for immunizations and depression.

Dental Services at Sunset Park Apartments

Sunset Park is a 242-unit apartment building located in Denver, Colorado, with 246 residents. Forty-five percent of the residents are managing three or more chronic diseases and 30 percent of the residents self-reported having mental and/or physical health issues. Through the service coordinator's assessment of the residents at Sunset Park, it was discovered that many residents needed dental services, but were unable to access dental services due to cost, lack of or limited dental insurance, limited transportation to appointments, or fear of the dentist.

In 2016, a partnership was created with the Dental Lifeline Network (DLN) to offer dental clinics at Sunset Park for its residents and the residents at the neighboring property of Sunset Towers. DLN is a national charitable organization whose mission is to improve the oral health of people with disabilities and people who are elderly or medically fragile and have no other way to get help. DLN accomplishes its mission by developing and coordinating collaborative relationships that provide essential resources for direct-service programs, especially charitable care. The benefit to residents of having this monthly dental clinic is having dental care provided at no cost and having their service coordinator schedule follow-up appointments and provide assistance with necessary paperwork. Between eight to ten residents are seen by the clinic each month

for procedures that include cleanings, fillings, general work, and dentures. The only procedure not offered at this clinic is root canal surgery.

The dental clinic is open to all residents at both properties who either have Medicaid or no dental insurance and the services are free to those residents. A resident at Sunset Park who is a DLN patient recently stated, "With my outstanding medical problems, I thought I would never be able to afford dental services. I am so happy now that I am pain free. I don't know what I would have done if Sunset Park hadn't found a dental program." DLN and Sunset Park have been able to successfully collaborate, and this has been and continues to be a partnership that meets a very important need of our residents.

Conclusion

While the need for more affordable housing for low-income seniors is increasing, housing can no longer be just bricks and mortar. It has to serve multiple purposes, such as being a focal point for providing health and supportive services for the community. As health providers have begun to realize that housing is a social determinant, we should begin focusing on strategies for linking housing with services that will improve the health outcomes of residents as well as decrease the number of unnecessary hospital visits and premature institutionalizations.

Through its IWISH program, HUD has stepped forward as a collaborative leader working with health providers to deliver enhanced services to seniors. It is hoped that the lessons learned from IWISH and other programs (such as SASH) that use the service coordination program as a base can produce outcomes to improve residents' well-being and be cost-effective. While barriers, including funding, still exist for integrating health and supportive services in housing, VOANS continues to work on developing more health-related partnerships. VOANS hopes that lessons learned from IWISH and other programs be implemented in all senior properties so our residents can age in place and live long and healthy lives.