

# Affordable Senior Housing Communities and Health-Related Services

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## *Meeting Resident Needs*

The Institute for the Future of Aging Services (IFAS), the policy research arm of the American Association of Homes and Services for the Aging (AAHSA), with generous support from the McGregor Foundation, has prepared a guide to programs and strategies that bring health and wellness services to low- and modest-income seniors living in publicly subsidized housing. It is intended as a “living” document, to be added to over time as we collect new information. To check for updates or if you have any questions, please visit the IFAS website or contact us at:

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### **I. Overview and Purpose**

The rationale for this guide is straightforward. Approximately 2 million lower-income seniors live in independent, federally subsidized rental properties across the country. The resident base in these properties is aging—the median resident age in Section 202 Housing for the Elderly properties, for example, is 76 years old. Not only are existing residents aging in place, but new residents are moving in at advanced ages. In 2006, almost 20 percent of all new Section 202 residents moving in were age 80 or older.<sup>1</sup>

At least 80 percent of older adults in the United States have at least one chronic condition and half have two.<sup>2</sup> Chronic conditions can lead to severe and immediate disabilities, such as hip fracture and stroke, as well as progressive disability that slowly erodes the ability of older people to care for themselves.<sup>3</sup> Chronic illness, along with poor health status and functional limitations, are more prevalent among the lower-income elderly.<sup>4</sup> As this trend would indicate, a large portion of

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<sup>1</sup> Barbara Haley and Robert Gray, *Section 202 Supportive Housing for the Elderly: Program Status and Performance Measure* (Washington, DC: U.S. Department of Housing and Urban Development, 2008), p. 40.

<sup>2</sup> Centers for Disease Control and Prevention, *The State of Aging and Health in America 2007*, (Whitehouse Station, NJ: The Merck Company Foundation, 2007) p. 4; found at: [http://www.cdc.gov/Aging/pdf/saha\\_2007.pdf](http://www.cdc.gov/Aging/pdf/saha_2007.pdf).

<sup>3</sup> Agency for Health Research and Quality, “Preventing Disability in the Elderly with Chronic Disease,” *Research in Action*, Issue #3, April 2002, found at [www.ahrq.gov](http://www.ahrq.gov).

<sup>4</sup> Kenneth Land and Yang Yang, “Morbidity, Disability and Mortality,” in *Handbook of Aging and the Social Sciences*, ed. Robert Binstock and Linda George (Burlington, MA: Academic Press, 2006), 41-58.

residents in subsidized senior housing communities suffer from chronic illnesses and disabilities. An analysis of the American Community Survey found that subsidized senior renters are much more vulnerable than seniors who own their own homes. They are older, twice as likely to experience conditions and limitations that threaten their ability to live independently and three times more likely to live alone. Due to their low incomes and high levels of disability, subsidized senior renters are three times more likely to be at risk of needing Medicaid assistance.<sup>5</sup>

Independent senior housing communities are not intended to be nursing homes. However, research has shown that even taking relatively simple and inexpensive steps to support residents in adopting healthier lifestyles and getting regular health screenings can dramatically reduce an older person's risk of chronic illness, disability and premature death.<sup>6</sup> Poor management of chronic conditions leads to more frequent ER and hospital visits, and may cause some elderly individuals to transfer to nursing homes prematurely. Easier access to a health professional may provide an opportunity to identify potential problems before they become a health emergency and may also enhance greater continuity of care.

Many publicly subsidized senior housing communities across the country, typically in collaboration with community health providers, have taken purposeful steps to address the needs of their residents and provide them with access to health and preventative services. These services range from creating opportunities for residents to learn about healthier life styles, improve their own management of chronic conditions such as hypertension, diabetes and asthma, and become involved in regular physical activity, to obtaining primary care in the building or even their own apartments.

The purpose of this guide is to help build the knowledge base and capacity within the subsidized housing sector and the larger communities of which they are a part to create opportunities that enable elderly renters with low- and modest-incomes to have adequate access to preventative care and health care services. We hope it will be a useful tool for publicly subsidized housing sponsors, property managers and services coordinators and health providers in the surrounding community.

The guide is organized in four parts:

- A list of the types of health and preventative services identified so far by the authors of the guide that are targeted to elderly residents living in subsidized housing communities;
- Description of services delivery strategies that have been employed to link residents to health and preventative services;
- Lessons learned about the elements of and challenges to initiating and sustaining health and wellness programs at publicly subsidized housing communities; and
- Case examples of medical, health and preventative programs that have been implemented in publicly subsidized housing communities for older adults.

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<sup>5</sup> Donald Redfoot and Andrew Kochera, "Targeting Services to Those Most at Risk; Characteristics of Residents in Federally Subsidized Housing," *Journal of Housing for the Elderly* 18, no. 3/4 (2004): 141.

<sup>6</sup> U.S. Department of Health and Human Services, *The Power of Prevention: Steps to a Healthier U.S.* (Washington, DC: author, 2003); found at <http://www.healthierus.gov/STEPS/summit/prevportfolio/power/index.html>.

### **Potential benefits of bringing health and wellness services to residents in affordable senior housing communities\***

- Increased knowledge of healthy living habits
- Increased level of exercise and fitness activities
- Assistance with coordinating health care appointments and services and communicating with health care professionals
- Early detection of health problems
- Identification of problems with medications
- Increased knowledge of and skills to manage chronic health conditions
- Resource for prompt answers to health-related questions and concerns
- Easier access to care, particularly for those with mobility and transportation difficulties
- More regular contact with a health care professional may lead to a more trusting relationship
- Combined, the factors above may lead to an overall improved continuity of care

*\*Benefits will vary with the type and intensity of services.*

## **II. Types of Health and Preventative Services Employed**

A wide range of health and preventative services have been made available to older residents living in subsidized housing communities across the country. Their availability is influenced by many different variables, including the characteristics and preferences of residents; resident eligibility for different programs, particularly Medicaid; the philosophy and commitment of housing managers; the availability and knowledge base of service coordinators; the availability of health services providers in the community; the relationship between the housing property and potential community collaborators; characteristics of the physical plant (e.g., availability of common space, accessibility, etc.); and the resources available to the housing property, service providers or philanthropic groups which can be used to support the project. Health and preventative service offerings available in selected subsidized housing properties have included:

- Information about available community health and preventative services and referral to providers in the community
- Health screening programs and other prevention initiatives (e.g., eye, hearing and dental exams, measuring blood pressure and blood sugar, weight management programs, flu shots, etc.)
- Health promotion and wellness activities (e.g., health education on smoking cessation, alcohol and substance use, diet and nutrition, diabetes, etc.; exercise and fitness classes; healthy cooking classes; etc.)
- Self-care education and management of chronic conditions such as diabetes, hypertension, asthma, arthritis and cancer
- Comprehensive health assessments covering health status and physical and cognitive functioning

- Care planning/care management in collaboration with a resident's primary care physician
- Coordination of resident transitions between the housing property, the hospital and assisted living or nursing home facility
- Medication assistance, monitoring and/or review
- Mental health/dementia screening, counseling, interventions and referral
- Personal care services
- Home health, physical therapy, occupational therapy
- Adult day health
- Hospice
- Primary care (through on-site physician office or medical house calls program)
- Comprehensive package of health and wellness services

### **III. Types of Service Delivery Strategies Employed**

The selection of service delivery strategies to link residents to health and preventative services is as varied as the services themselves. There is no one right way of choosing services delivery strategies—no one model that will work for all. Strategies may be initiated by housing property staff, community services providers, a not-for-profit agency within the community or by public officials. What is crucial is the relationship building that is necessary among multiple parties if they are to work. The list below is meant to illustrate what has been tried by selected subsidized housing communities.

- Paid services coordinators who provide information and referral to community health providers
- Use of resident volunteers and other lay people trained by health educators to assist residents with the management of chronic illnesses
- Direct employment of health providers, such as nurses or nurse practitioners, by the housing sponsor to serve residents in one or more of its properties
- On-site health clinics operated at regularly scheduled times by community health providers such as a nurse, nurse practitioner or geriatrician
- Formal collaborations with community health providers e.g., health systems, hospitals, managed care companies, physician practices, public health clinics, federally qualified health centers, pharmacies, etc., to bring selected health and medical services, health promotion and preventive care to residents
- Collaboration with academic health centers to provide clinical learning experiences for medical, nursing or other health professional students
- Co-location of health providers in or adjacent to the housing community, such as a physician office, a senior center, adult day health center or PACE site
- Networking one or more residential components co-located within the same campus, such as an assisted living facility and/or a nursing home, with the independent living property so that residents have access to additional health programs and services (e.g., nighttime and

weekend emergency assistance, health education and preventive care offerings, personal care, etc.)

- Operation of a licensed home health agency, owned/managed by the housing provider on behalf of residents and the broader community
- Partnering with a local home health agency to bring personal care services to residents at a more affordable rate

#### **IV. Lessons Learned**

Several lessons have been learned from the experiences of housing and services providers about the value to each of providing health and wellness services at affordable senior housing properties and important factors and challenges to initiating and sustaining such on-site service programs.

*Affordable senior housing communities can provide an efficient means of delivering a broad range of preventative, health and medical services to low- and modest-income older adults.*

1. Building awareness and disseminating new health program opportunities is easier when numerous elderly residents live in close proximity to one another rather than being scattered across many sites.
2. It is convenient for residents, particularly those who are frail and/or have difficulty accessing public transportation, since they do not have to leave the property to participate in programs or access services.
3. Health care and social work professionals able to build trusting relationships with housing properties benefit by delivering services to residents in congregate housing settings for reasons such as:
  - saving travel time by coming to a single site where providers can see significant numbers of patients/clients;
  - assistance from the housing property staff in recruiting program participants;
  - receiving “word of mouth” advertising from a community of residents, if they do their job well;
  - building trusting relationships with patients/clients they might see on a more intimate and/or regular basis;
  - greater chance of involvement and/or adherence to programs by virtue of the peer support nature that often develops in the property;
  - ready access for their nursing, pharmacy, social work and medical students to clinical learning sites that house older adults with a wide range of health care problems and needs.
4. The research evidence about the impact of integrating health services into subsidized housing for seniors is still quite limited. However, what evidence there is suggests that older residents with chronic health problems who participate in these programs improve their health status, and reduce the use of ambulance, emergency room and in-patient

hospital stays. Housing property managers and services coordinators who are able to work with reliable partners from health and social services agencies report they are better able to cope with their aging resident base. The ability to document the impact of housing health partnerships may be a critical factor in convincing funders to sustain their support for these initiatives.

***Programs should be flexible and responsive to resident (and family member) needs and wants.***

1. Finding out what residents want and need in the initial stages of planning a health/ housing partnership may seem obvious. Not surprisingly, though when an unexpected benefactor, such as a newly minted physician or a hospital comes to the door to offer a service to housing residents, this assessment may not occur. Failure to understand what health-related services residents want and do not want and what health services they already use may cost dearly down the road in terms of low participation and wasted resources and goodwill. Also important is a good understanding of the cultural and racial diversity of residents and how it impacts resident preferences and needs for health services and how they should be delivered.

Housing properties could ascertain what types of health and wellness services residents need, want, and will use through a variety of mechanisms, including conducting a survey and/or holding focus groups with residents. While service coordinators and/or property managers generally have a good understanding of residents, they often do not have a complete picture of the whole resident population. Housing properties might also want to engage family members. Some family members might be providing assistances to their family member that they would be grateful to have outside assistance for, and may even be willing to pay for.

2. Insuring that the program ultimately designed is flexible so that residents can pick and choose what they want to take advantage of is likely to increase overall participation in the long run.

***Successful integration of health and wellness services for seniors into publicly subsidized housing properties is dependent on the ability of one or more “champions” in the community. The champions help identify the partners, negotiate goals, and keep the collaboration on track.***

1. The champion may be the housing sponsor or a service coordinator. It may be an academic health center, health system, a health plan or an area agency on aging. It may be most desirable for the champion to be a third party, like a community foundation, with some seed money to bring to the table.
2. Every organization in the housing/health partnership must have an incentive to participate. The partnership is most effective when the capacities of existing agencies are enhanced.
3. The different operating norms of each partner must be respected — changes to plans must be analyzed to insure they do not adversely affect particular partners.

***There are potential incentives for a variety of community organizations to partner with affordable senior housing properties to offer residents on-site health and wellness services. In many instances,***

*these partnerships likely require a minimal out lay of funding or staffing resources for the housing community and often provide services for free or minimal out-of-pocket costs to residents.*

1. Health professional schools (medical, nursing, pharmacy, dentistry, physical/occupational therapy) – All health professional schools require students to participate in some form of clinical rotation or internship where they gain hands-on experience. The schools may be interested in partnering with affordable senior housing sites as clinical sites. Housing properties can provide a venue for students to test assessment, critical thinking, communication and decision-making skills in real world and often culturally diverse situations. Given the need to attract more health providers from all fields into geriatrics, this is also an opportunity to expose students to the elderly population and provide insight into elderly patient's health and life circumstances.
2. Hospitals and health systems – Hospitals may be willing to send a nurse or nurse practitioner to a housing property to offer a periodic wellness clinic or even establish an on-site clinic providing primary care. Hospitals and health systems may already have a community outreach operation of some variety and a housing property would provide an efficient location for reaching a large number of seniors. A hospital may have a charitable mission or obligation and, again, a senior housing community would provide an efficient avenue to meet their goals. For some hospitals, it may provide a way to help seniors who use their facilities better manage their health, preventing unnecessary ER visits and hospitalizations and freeing hospital resources for higher priority (and more profitable) needs.
3. Physician practices – Physician practices that see multiple residents in a building may be interested in operating an on-site clinic or office. Making access easier for patients may increase their regularity of visits, help improving their patients' continuity of care and health outcomes. The site could also be open to patients from the surrounding neighborhood, giving the clinic a larger volume.
4. Federally Qualified Health Centers (FQHCs) – FQHCs are community-based organizations that serve populations with limited access to health care including low-income populations, the uninsured, those with limited English proficiency, individuals and families experiencing homelessness, and those living in public housing. These centers provide comprehensive primary health care services as well as supportive services that promote access to health care, with fees adjusted based on ability to pay. Because FQHCs may be serving residents in a property or because targeted patient group may overlap with residents in a subsidized senior housing property, they may be interested in operating some level of an on-site clinic.
5. HMOs – In some housing properties, many residents utilize the same Medicare, Medicaid or private insurance HMO. In these circumstances, the HMO may be interested in establishing prevention services of some variety in the property as a way to help residents better manage their care and minimize their use of expensive resources.
6. Home health agency – Home health agencies might partner with housing properties in a variety of ways, such as sending a nurse to a property periodically to provide wellness checks and health education, offering a reduced fee and minimum time requirement to make personal care services more affordable to residents, or setting up clinic to provide on-site

physical and occupational therapy. For some agencies, this may be an avenue to fulfill a charitable mission and contribute to the community. It also may be an opportunity for agencies to market and build relationships with residents, so that when a resident is in a situation where they need doctor-prescribed home health or rehabilitation services, they might select the agency as their provider. It is important to note, that a housing provider cannot steer residents to any one provider and residents must be given choice. However, residents may be more likely to choose a provider they are familiar with and/or that provides services in the convenience of their own building or apartment.

7. Area agencies on aging – AAAs or other similar community groups may be interested in partnering with housing properties to provide health and wellness education activities or fitness classes. Housing properties provide an easily accessible pool of participants. Due to the convenience of being right in the building, residents also may be more likely to sustain on-going participation in programs. This is particularly valuable in programs that include multiple sessions.
8. Pharmacies – Pharmacies may be willing to provide free delivery or conduct periodic brown bag medication reviews. This may be a marketing tool for pharmacies to attract residents to their services.
9. Medicaid program - While Medicaid is obviously not a health care provider, it is crucial to obtaining reimbursement for a broad array of health-related services that Medicare will not pay for (e.g., case management, adult day health, social services, personal care etc.). Rule changes have allowed Medicaid home and community-based care funding to be unhinged from nursing home eligibility criteria, although few states have rushed to take advantage. Many elderly residents of publicly subsidized housing, particularly those who are very frail and/or have cognitive difficulties, may be eligible for Medicaid and yet not enrolled. A variety of barriers impede them, including a complex application process, language and literacy difficulties, lack of documentation and long waiting periods. Medicaid is a critical pool of money that can help make health, preventative and medical care affordable to low-income housing residents. It should be tapped to the full extent possible for housing/health partnerships to be financially viable in the long term.

***Federal, state and local regulatory environment can have a significant impact on the housing/health partnerships ability to implement viable programs.***

1. State and local regulation significantly vary from one location to another. Even federal regulation may be unevenly understood across regions.
2. A clear understanding of what populations can be served under the regulations, what health services can be provided, and what and how resident information can be shared is important.

***Property services coordinators are key to developing and sustaining health/housing partnerships.***

1. As part of a service coordinator's role is to build a network of resources for residents, they can be a central player in identifying and developing relationships with potential partners in developing on-site health and wellness services. Service coordinators likely already know of

valuable programs that several residents use or common providers that multiple residents access.

2. Service coordinators can play a valuable role in linking with the service providers to help residents meet their full range of needs. If a health provider identifies a need that is outside of their scope of service or expertise, they coordinate with the service coordinator to help identify appropriate resources. For example, if a physician feels a resident is not getting adequate nutrition, a service coordinator might be able to assist the resident with accessing a meals program. Of course, all providers must be mindful of resident/patient confidentiality and must establish a system of ensuring the resident's approval to for the two to communicate about their needs.

## V. Case Examples

Several case examples of medical, health and preventative programs that have been implemented in publicly subsidized housing communities for older adults are presented here. The included examples are categorized below by both the type of services delivered and by the service delivery mechanism. Following the two categorized lists, the case examples are described alphabetically.

### Type of Service

#### Primary Care

- Center Communities of Brookline, Brookline, MA
- Just for Us, Durham, NC
- Lapham Park, Milwaukee, WI
- Mable Howard Apartments, Oakland, CA
- Saint Elizabeth Place, Providence, RI
- St. Luke's Place, Edgemere, MD
- St. Mary's Court, Washington, DC

#### Wellness/Nursing

- Friendship Terrace Retirement Community, Washington, DC
- Ingleside Homes, Wilmington, DE
- Personal Health Partners, Akron, OH
- Robert Sharp Towers I & II, Miami, FL
- Seven Oaks of Florence, Omaha, NE
- Sixty Plus Program, Piedmont Hospital, Atlanta, GA
- Trinity House, Towson, MD
- Westerly Apartments, Lakewood, OH

#### Home Health Care/Personal Care/Rehab

- Canterbury House, Charleston, SC
- Eaton Senior Programs, Lakewood, CO
- Golden West Senior Residence, Boulder, CO
- Peter Sanborn Place, Reading, MA
- Porter Hills, Michigan
- Westerly Apartments, Lakewood, OH

#### PACE/Adult Day

- Lapham Park, Milwaukee, WI
- Mable Howard Apartments, Oakland, CA
- Presentation Senior Community, San Francisco, CA

#### Health Educator/Advocate

- Canterbury House, Charleston, SC
- WellElder Program, NCPHS, San Francisco, CA

#### Fitness & Exercise

- Golden West Senior Residence, Boulder, CO
- Seven Oaks of Florence, Omaha, NE
- Simon C. Fireman, Randolph, MA

#### Healthy Lifestyle/Chronic Disease

#### Management Education

- Lutheran Senior Services, Missouri
- Simon C. Fireman, Randolph, MA

## **Service Delivery Mechanism**

### Partnership with Health Professional School

- Canterbury House, Charleston, SC
- Lapham Park, Milwaukee, WI
- Robert Sharp Towers I & II, Miami, FL
- Seven Oaks of Florence, Omaha, NE

### Partnership with Hospital/Health System

- Center Communities of Brookline, Brookline, MA
- Just for Us, Durham, NC
- Lapham Park, Milwaukee, WI
- Mable Howard Apartments, Oakland, CA
- Saint Elizabeth Place, Providence, RI
- St. Mary's Court, Washington, DC
- Sixty Plus Program, Piedmont Hospital, Atlanta, GA
- Trinity House, Towson, MD
- Westerly Apartments, Lakewood, OH

### Partnership with Physician Practice

- St. Luke's Place, Edgemere, MD

### Partnership with Home Health or Rehab Agency

- Ingleside Homes, Wilmington, DE
- Golden West Senior Residence, Boulder, CO
- Porter Hills, Michigan
- Peter Sanborn Place, Reading, MA
- Seven Oaks of Florence, Omaha, NE
- Westerly Apartments, Lakewood, OH

### Partnership with PACE/Adult day

- Lapham Park, Milwaukee, WI
- Mable Howard Apartments, Oakland, CA
- Presentation Senior Community, San Francisco, CA

### Partnership with other community organization

- Lutheran Senior Services, Missouri
- Personal Health Partners, Akron, OH

### Direct Employment/Contracting of Health and Wellness Staff

- Canterbury House, Charleston, SC
- Friendship Terrace Retirement Community, Washington, DC
- Saint Elizabeth Place, Providence, RI
- Simon C. Fireman, Randolph, MA
- WellElder Program, NCPHS, San Francisco, CA

### Network between Independent Living & Assisted Living

- Eaton Senior Programs, Lakewood, CO

## **Canterbury House, Charleston, SC**

### ***Program***

Canterbury House staffs a full-time wellness coordinator whose role is to serve as an advocate for residents, helping them navigate the complex medical system. The wellness coordinator also arranges to bring health-related services to the property, such as education presentations and vaccine clinics. She has also facilitated relationships with house calls physicians, pharmacies and the local medical university to bring health resources to the property. In addition, Canterbury House hosts a satellite clinic for a local nursing home, which can provide physical therapy to residents when ordered by their physician.

### ***Sponsor/Partners***

Canterbury House, sponsored by the Episcopal Diocese of South Carolina, employs the wellness coordinator. The property partners with several community organizations, including the Medical University of South Carolina and Life Care Center of Charleston, a nursing home.

### ***Setting***

Canterbury House is a Section 202 property composed of two buildings, Canterbury West, a thirteen-story high-rise with 204 apartments and Canterbury East, a four-story building with 46 apartments. The property is centrally located in an urban area.

### ***Target Population***

All residents benefit from and may access the health and wellness activities. Many of the wellness coordinator's one-on-one efforts are targeted towards frailer residents, particularly those without family in the area.

### ***Objectives***

- Provide residents assistance in guiding the medical system, helping to ensure their health care needs are met.
- Coordinate a range of on-site health resources for residents to help meet their needs and support their ability to safely age in place.

### ***Components***

The wellness coordinator position is staffed by an RN and is funded through a HUD service coordinator grant. The coordinator's role is to serve as an advocate for residents, helping them navigate the complex medical system. For example, she will help residents communicate with their doctors to help ensure physicians are fully aware of a resident's situation and that residents understand their doctor's directions. The coordinator participates in care planning meetings at hospitals and rehab centers to make sure discharge planners understand the resident's circumstances and what the housing property can and cannot offer. The goal is to ensure residents are released appropriately and have the supports in place they need to return safely to their apartment. The wellness coordinator offers residents and family members her assistance in these various areas. Many residents, however, do not have family members nearby and the wellness coordinator tends to focus more on assisting these residents at their request. With a nursing

background, the wellness coordinator is able to communicate effectively between residents and health care providers.

The wellness coordinator also arranges a variety of health-related programs to the property to come to the property. She coordinates individuals to give educational talks on a range of physical and mental health topics. She brings vaccine clinics to the property and has identified a pharmacy to deliver prescriptions at no charge. She has also identified two physicians who have begun making house calls at the property. The wellness coordinator facilitates a partnership with the Medical University of South Carolina, bringing a variety of resources to the property. Physical therapy and dental students visit the property. Medical students are matched with residents. The medical students follow their residents during their 4 years of school, tracking their medical histories. Student nurses visit the property during their community nursing rotation. They come two days per week to do various vital checks and education sessions (diabetic wellness, hydration issues, etc.). The university's eye institute does a complete eye screening twice a year, primarily looking for diseases of the eye.

Canterbury House also provides space to a local nursing home to operate a satellite clinic. The nursing home staffs the clinic with a full-time physical therapist and a part-time occupational therapist. When residents come out of the hospital or in other situations where their doctor may order rehab, they can access these services in the building if they choose them as a provider.

### ***Additional Information***

Canterbury House identified a registered nurse who was willing to work for less than the market salary. This nurse had worked in long-term care for many years and was at the tail end of her career but still committed to the field.

## **Center Communities of Brookline, Brookline, MA**

### ***Program***

Center Communities of Brookline contracts with Urban Medical Group to operate an on-site health clinic for residents. The clinic is staffed by a nurse practitioner 20 hours per week and a physician one to two days each week.

### ***Sponsor/Partners***

Center Communities of Brookline is a property of Hebrew SeniorLife. Hebrew SeniorLife operates Hebrew Rehabilitation Center, an acute and long-term care center; CCRCs and independent housing properties; and an institute for aging research. Urban Medical Group is a non-profit primary care practice. They operate an office-based clinic; see patients in congregate housing settings, assisted living facilities and nursing homes; and have a house call practice. Urban Medical Group prioritizes serving the elderly, the chronically ill, disabled and the urban poor.

### ***Setting***

Center Communities of Brookline consists of three properties, a Section 202 and two mixed-income properties, in near proximity to each other. Together, the buildings have 512 units and

approximately 700 residents. The properties are centrally located in a suburb of a major metropolitan area, with easy access to public transportation, medical and professional services, shopping, and a senior center.

### ***Target Population***

All residents are able to use the clinic for nursing services; however, only Urban Medical Group patients can be seen for primary care visits.

### ***Objectives***

Provide residents access to consistent medical care through a primary care team, helping to preserve patients' independence and avoid institutionalization.

### ***Components***

To be seen for regular primary care appointments, residents must be patients of Urban Medical Group. These appointments are billed as any other office visit to Medicare, Medicaid, or private insurances. Approximately 110 residents are Urban Medical Group clients. However, all residents in the building can access the clinic for nursing care when they are not feeling well, to have vital checks and to ask health-related questions.

## **Eaton Senior Programs, Lakewood, CO**

### ***Program***

Eaton Terrace Residences provides residents access to personal care services through an adjoining assisted living facility.

### ***Sponsor/Partners***

Eaton Senior Programs (ESP) operates Eaton Terrace Residences (ETR), an independent senior property, and Eaton Terrace II (ET II), an adjoining assisted living facility.

### ***Setting***

Eaton Terrace Residences is a 162-unit affordable senior housing property financed through tax-exempt bonds with project-based Section 8 rental assistance. It is located in a suburban community.

### ***Target Population***

Frail residents in need of assistance with personal care activities.

### ***Objectives***

Provide an affordable opportunity for frail residents to access needed supports to help them remain safely in their apartment.

### ***Components***

ET II has both an assisted living license and a home and community-based services license, which allows staff to provide personal care and homemaker services anywhere in the community, including at ETR. ETR residents may purchase personal care, housekeeping, and medication

monitoring services at whatever level they may need. Residents pay out-of-pocket, unless they are participating in a Medicaid program that covers the costs.

## **Friendship Terrace Retirement Community, Washington, DC**

### ***Program***

For over 20-years, Friendship Terrace has contracted with a nurse practitioner to visit the property one day per week. She is available to provide wellness checks, answer health-related questions, help residents communicate with their doctors, and review discharge plans and help ensure residents have the supports they need when returning from a hospital or nursing home stay.

### ***Sponsor/Partners***

The nurse practitioner is paid for by the property's sponsoring organization, Episcopal Senior Ministries. ESM provides independent and assisted living and geriatric care management and volunteer support to elders in the community.

### ***Setting***

Friendship Terrace Retirement Community is a **Section 202** property with approximately 170 residents. The community is located in a large urban area.

### ***Target Population***

All residents.

### ***Objectives***

Provide residents with a resource to answer health-related questions, coordinate health needs, and provide wellness checks.

### ***Components***

The nurse practitioner sees residents for a variety of reasons, including checking vital signs, reviewing medications and answering questions and helping residents communicate with their physicians. She checks on residents when they return from a hospital or nursing home stay, reviewing their discharge summaries with them to make sure the resident understands everything, including any medication changes. In cases where the nurse practitioner feels the resident may need more supports, she might call the resident's family or physician to discuss and secure additional services. The nurse practitioner also gives annual flu vaccines, which are supplied by the property's sponsoring organization, and provides a monthly health education session. The nurse practitioner sees residents in an office, but will also visit those who have difficulty getting down to the office in their apartment.

Residents are charged \$1 or \$3 per visit with the nurse practitioner, depending on their income. The organization thought it was important to do this so the residents were invested in the visit. Every resident, however, gets a free initial assessment. The nurse practitioner generally sees about eight to ten residents in the office and another two to four in their apartment over the course of the day.

The nurse practitioner attends a property staff meeting once a month. She might alert the property staff to residents she's concerned about and staff tell her as well about residents she might want to follow up on. Friendship Terrace provides the nurse practitioner office space and the nurse practitioner provides her own liability insurance.

## **Golden West Senior Residence, Boulder, CO**

### ***Program***

Golden West Senior Residence partners with a local physical therapy and rehab company to operate an onsite wellness center. Residents pay a \$50 monthly membership fee, for which the members receive an individually designed exercise program and can schedule regular times to exercise in a supervised environment. The center is also open to all residents to have their blood pressure checked and for monthly education programs.

### ***Sponsor/Partners***

Golden West partners with Medically Based Fitness, a local physical therapy and exercise rehabilitation company.

### ***Setting***

Golden West Senior Residence is a 255-unit affordable senior housing property located in an urban area.

### ***Target Population***

All residents.

### ***Objectives***

Support residents to maintain a healthy lifestyle with the goal of helping prevent health and functional decline.

### ***Components***

The wellness center is open five days per week. Golden West provides the space and equipment for the wellness center, while Medically Based Fitness staffs the center with a physical therapist and exercise physiologist. Residents pay a \$50 monthly membership fee, for which the members receive an individually designed exercise program and can schedule regular times to exercise in a supervised environment. The Golden West Foundation helps to subsidize those residents who cannot afford the full monthly fee. In addition, all residents in the property can have their blood pressure checked, attend a monthly presentation on a wellness topic and participate in a semi-monthly balance class. These activities are provided for free.

Medically Based Fitness also provides physical and occupational therapy on site for residents whose doctor orders such therapy follow a hospital/nursing home stay or injury/illness. These services are billed to Medicare. Residents are free to choose any provider for these services; however, many select Medically Based Fitness for the convenience of its location in the building.

## **Ingleside Retirement Apartments, Wilmington, DE**

### ***Program***

Ingleside Retirement Apartments offers residents a wellness center staffed by a full-time nurse. The nurse is employed by the parent organization's home healthcare agency and the wellness center's services are included in a service package all residents must purchase. Medication and personal care assistance is available to residents at an affordable rate through the sponsoring organization's home healthcare agency.

### ***Sponsor/Partners***

The property's sponsor, Ingleside Homes, also operates an assisted living facility and a home healthcare agency and provides care management and support to elders in the community.

### ***Setting***

Ingleside Retirement Apartments is a Section 236 property with project-based rental subsidies with 217 residents located in an urban area.

### ***Target Population***

The wellness clinic is available to all residents in the property. The medication and personal care assistance is to support the more frail residents.

### ***Objectives***

- Provide all residents with a resource to answer health-related questions, coordinate health needs, and provide wellness checks.
- Provide frailer residents with access to affordable personal care services that may support their ability to remain safely in their apartment.

### ***Components***

The property's wellness center is staffed full-time by a nurse. The property refers to the nurse's services as a "wellness center," so not to confuse residents and family members about the level of assistance that the nurse can provide. The nurse is employed by Ingleside Home's home health agency, which is a separate LLC from the housing entity. The nurse sees residents for general health-related needs and questions. She conducts wellness checks, such as weight and blood pressure, and will help residents arrange doctor appointments and communicate with their physicians. She arranges for annual flu shots and coordinates various health education presentations. The nurse's services are included in a service package, for which residents pay a monthly fee (the fee is discussed in more detail below). A podiatrist visits also visits the wellness center monthly and a geriatrician sees patients weekly. The property became familiar with the geriatrician when she used to come to the property to see a few patients. Seeing her good relationship with the residents, the property invited the geriatrician to serve on their board. The geriatrician now has an office space in the building to see patients. Residents arrange appointments directly with her office and visits are billed to Medicare, Medicaid or other private insurances. The property does not know how many residents see this physician.

Residents in need of additional supports can purchase services through Ingleside Home's home healthcare agency, which is located on the property's first floor. Residents can purchase medication assistance for \$125 per month. A nurse will order their medications from the resident's chosen pharmacy, ensure delivery to the resident and will remind residents to take their medication regularly. About 35 residents currently purchase this service. The home health agency can also provide residents with a home health aide. Residents can pay privately or through the Medicaid waiver program. To help make this service affordable, the agency provides services in 1-hr increments, rather than the standard four hours, and charges residents on a sliding-scale basis based on their income. Approximately 12 residents currently have an aid through their agency, primarily for bathing and dressing assistance.

### ***Additional Information***

All Ingleside Retirement residents must purchase a service package, which includes three daily meals (apartment units were built without kitchens), cable/telephone, transportation, activities, weekly housekeeping, and a wellness center. The property subsidizes residents who are not able to pay the full monthly service fee. The level of subsidy is based on the resident's income minus health-related expenses and a personal needs allowance. Currently, monthly service fee subsidies range from \$50 to \$500 a month. The property also encourages family members to contribute to the resident's service fee, if they are able. Ingleside Homes subsidizes the service fee through a benevolent fund, which they generate through grants and private donations. Ingleside Home also helps subsidize fees for personal care assistance through the benevolent fund. Annually, they subsidize a total of approximately \$60,000.

## **Just for Us, Durham, NC**

### ***Description***

Just for Us is a collaboration between an academic medical center, public housing and other subsidized housing properties, and other public agencies to provide primary care, care management and mental health services to medically fragile seniors and disabled adults in their own apartments. Participants are cared for by an interdisciplinary care team, which includes a supervising physician, physician assistants, a social worker, nutritionist, occupational therapist, and community health worker.

### ***Sponsor/Partners***

Just for Us is a collaboration between the Duke University Medical Center Division of Community Health, the Lincoln Community Health Center (Durham's federally qualified community health center), the Durham County Department of Social Services, the Durham County Health Department, the Council on Senior Citizens, and the City of Durham Housing Authority. Collaborating agencies operate under a single administrative structure managed by Duke Community Health under contract with Lincoln Community Health Center.

### ***Setting***

The program services thirteen public or subsidized independent housing complexes and other scattered sites throughout Durham, NC.

**Target Population**

Low-income seniors and disabled adults with multiple chronic conditions who are homebound and cannot access health and medical care on their own without great difficulty.

**Objectives**

Enable medically fragile older adults and younger adults with disabilities to remain in independent living settings by providing them with primary care, care management and mental health services in their own homes.

**Components**

Just for Us provides patients with annual physical examinations, consistent monitoring and treatment of chronic medical conditions, treatment of acute care needs that can be treated at home, lab tests and patient health education. Patients receive routine visits from the physician or physician assistant every six to eight weeks, or more often when their medical condition warrants. Patients with specific needs may also be seen by a nutritionist (particularly diabetic patients) or occupational therapist. A social worker provides case management and helps patient apply for benefits, such as food stamps and Medicaid, and access supportive services, such as Meals on Wheels and home health aids (most of the housing properties served by the program do not have a service coordinator). The program can also help arrange mental health services.

Participants are enrolled as patients of Lincoln Community Health Center. The program has served about 350 patients since 2000 and believes there is a larger demand for their services; however, their patient base is limited by difficulty recruiting enough clinicians.

**Additional Information**

An early evaluation of the program indicates substantial decreases in the costs of ambulance and emergency room services and inpatient hospital care for participating residents and increases in prescription drug and home health costs. Just for Us patients with hypertension and diabetics with hypertension also saw their blood pressure and blood sugar levels become controlled.

Among the challenges to be overcome in replicating the model is the need to respond to the goals and norms of the program and the participating agency partners accustomed to operating in a very fragmented health care delivery environment. Financial sustainability is also a significant issue, particularly in cases where patients are not eligible to receive certain services through the Medicaid program. The Just for Us evaluators concluded that the program's viability depended on some core elements: an electronic information system for scheduling and medical charts, minimal support staff, use of less costly physician assistants and clustered housing sites to save travel time.

For more information about the program and to read the full evaluation, see:

<http://communityhealth.mc.duke.edu/clinical/?/justforus>

<http://gerontologist.gerontologyjournals.org/cgi/reprint/46/2/271.pdf>

**Lapham Park, Milwaukee, WI**

**Program**

Lapham Park provides a continuum of on-site health-related services to address residents' preventative, acute, and long-term health care needs.

**Sponsor/Partners**

The primary partners in the health-related aspects of the Lapham Park venture include the Housing Authority of the City of Milwaukee; the Milwaukee County Department of Aging; Community Care Organization, a PACE program; and St. Mary's Family Practice Clinic. Also participating is the Milwaukee Area Technical College Dental program, St. Mary's Family Practice and Community Education Center Student Program, Marquette University School of Nursing, and the YWCA.

**Setting**

Lapham Park is a 200-unit senior-designated public housing property located in an urban area with a predominately African-American population.

**Target Population**

All residents.

**Objectives**

The primary goal is to improve the quality of life and housing stability for the residents of Lapham Park. A secondary goal is to determine whether a Continuing Care Retirement Community model can be superimposed on a publicly-funded housing development to facilitate true "aging in place" for low-income seniors.

**Components**

The venture created a continuum of services to address preventative, acute, and long-term health care needs. The clinic meets routine medical needs during weekday hours and special, more critical needs on a 24-hour basis. Community Care Organization, which operates a PACE program, provides acute, primary, specialty and long-term care for residents enrolled in its capitated program. St. Mary's Family Practice Clinic offers physician care to all residents. Several educational institutions also send students to the property to provide services. Dental hygiene students from the Milwaukee Area Technical College conduct assessments. Nursing, medical and social work students from St. Mary's Family Practice and Community Education Center Student Program provide home visits, health promotion programs and activities. Nursing students from Marquette University conduct assessments of residents' functional status. In addition, the YWCA provides onsite exercise programs. The housing authority significantly rehabbed the building's basement to accommodate the venture's various services and activities, creating several community spaces and a state-of-the-art medical clinic.

**Issues/Evaluation**

The Lapham Park Venture was initiated in 1996 to address the needs of Lapham Park's aging residents. While many agencies were providing care at the property, services were fragmented and were not meeting residents' full needs. The Venture brought together the housing authority, the county department on aging, and several community health and social service organizations to

provide on-site, integrated care to residents. The primary goal for the partners was to deliver effective and cost-efficient services that would support residents' desire to age in place. When designing the venture, the partnership conducted a series of focus groups with residents, which revealed that on-site medical care was one of their highest priorities.

For more information about the Lapham Park Venture, please see:  
[http://www.hacm.org/programs/lapham\\_park\\_venture.htm](http://www.hacm.org/programs/lapham_park_venture.htm)

## **Lutheran Senior Services, Missouri**

### ***Program***

Lutheran Senior Services in Missouri has partnered with a national education organization to offer health educational programs onsite to their affordable housing residents for a nominal fee.

### ***Sponsor/Partners***

Lutheran Senior Services in Missouri offers CCRCs, affordable housing properties and in-home services. OASIS is a "national nonprofit educational organization designed to enhance the quality of life for mature adults," which offers a wide-range of educational programming. OASIS's programs are normally open to the larger senior community at a central location for a fee.

### ***Setting***

Lutheran Senior Services in Missouri operates eight affordable housing properties in the St. Louis area, which have an average of 62 residents.

### ***Target Population***

All residents.

### ***Objectives***

Support residents to maintain a healthy lifestyle with the goal of helping prevent health and functional decline.

### ***Components***

OASIS offers *Active Living Everyday*, a 20-week behavior modification program, and *Healthy Eating Everyday*, a similar behavior modification program, in some of Lutheran Senior Services' affordable housing properties. The housing property provides the space to hold the class and the service coordinators help recruit and sign up the residents, while OASIS conducts the program. Residents pay a reduced cost of \$5 to participate. Sometimes OASIS has grant funding to subsidize the program costs, and sometimes Lutheran Social Services does fundraisers to help underwrite participation for residents who can't afford the fee. An average of 15 residents go through each *Active Living Everyday* class. Several properties are now in their 3rd round of the course. OASIS has tracked participants who participated in the course and has found a decrease in ambulance calls after completion of the class. People from outside the housing property can participate in the programs as well, but they must pay the full fee.

OASIS has also offered *Exerstart*, a program that teaches individuals how to start an exercise program safely. The course is initiated by a professional who then trains a resident volunteer to take over and lead the program. Lutheran Social Services believes because it is peer led, the class is not as threatening to the residents as it might be if led by a professional fitness person and residents are more likely to participate. Some of the exercise programs have continued over a year after the resident volunteer took over the program.

### ***Additional Information***

*Active Living Everyday* and *Healthy Eating Everyday* education courses are also offered by other community organizations. To find out about other groups in your area that might offer the course or to become a provider, see the Active Living Partners website at: <http://www.activeliving.info/index.cfm>.

## **Mable Howard Apartments, Oakland, CA**

### ***Program***

A community health center and Program for All Inclusive Care for the Elderly (PACE) program adult day health center, co-located with a low-income senior housing community, provides the opportunity for residents to age in place. Residents get benefit of a full range of services from less intensive, flexible services from the health center to full medical and long-term care benefits in a managed care plan.

### ***Sponsor/Partners***

This venture is a collaboration between Resources for Community Development, which operates Mable Howard Apartments; LifeLong Medical Care, which operates the Over 60 Health Center; and Center for Elders Independence, which operates the PACE program.

### ***Setting***

Mable Howard Apartments is a 40-unit Section 202 property located above the health center and PACE site. The housing property and the commercial space housing the health center and PACE site were financed separately. The building is located in an urban community.

### ***Target Population***

All residents – well and moderately impaired seniors benefit from the health center, while frail nursing home eligible residents may enroll in the PACE program.

### ***Objectives***

Provide a community based continuum of care for low-income elders that allows them to “age in place” in their own apartments.

### ***Components***

The health center is a federally funded Qualified Community Health Center. It provides preventative care, primary care and case management, including mental health services, podiatry, dental care, health education and screening, physical therapy, and links to home health services.

The PACE program provides nursing home eligible residents access to comprehensive medical, social and long-term care services under a capitated system of reimbursement in an on-site adult day health center. PACE staff provide care in the residents own apartment as needed.

### ***Additional Information***

The collaboration took many years to become financially feasible. Adding more partners to the collaboration, particularly the PACE program which had a steady financial reimbursement stream and combining fund raising among the collaborators into a single capital financial campaign to increase private donations helped to sustain the program.

## **Personal Health Partners Program, Akron, OH**

### ***Program***

The Personal Health Partners Program is a partnership between Laurel Lake Retirement Community and the Akron Housing authority to operate an on-site wellness clinic in two senior public housing properties. Each clinic is staffed by a nurse 4 days per week for a total of about 15 hours. The nurses provide basic health screenings, answer health-related questions, help coordinate health needs and resources, conduct health education sessions, promote and arrange prevention screenings, and coordinate various fitness and social activities.

### ***Sponsor/Partners***

The program is held in two senior public housing properties operated by the Akron Metropolitan Housing Authority. The program is operated by Laurel Lake Retirement Community, a Continuing Care Retirement Community in Akron, OH.

### ***Setting***

The wellness clinics are held in Keys Towers, a 100-unit public housing property located in Stowe, OH, and Sutliff I Apartments, a 185-unit property in Cuyahoga Falls, OH.

### ***Target Population***

The clinic is open to all residents in the properties.

### ***Objectives***

Help residents better manage their health and implement behavioral changes that will support them to live safely and independently.

### ***Components***

The wellness program first started in Keys Towers in 2000 and over time expanded in the intensity of services provided and also opened in a second property. Initially, the nurse just conducted basic screenings like blood pressure checks, but residents began to ask for more one-on-one time. The property provided the nurse an office space and interaction with residents intensified. Today, residents can see the nurses for health screenings such as blood pressure checks and glucose levels and to ask health-related questions such as help with medication concerns, determining whether a problem should be followed-up by a doctor, understanding hospital discharge orders, etc. The

nurses also promote and arrange for a variety of on-site prevention screenings such as mammograms, colon cancer and hearing loss screenings, fall risk assessments and flu shots. The nurses conduct health education sessions on a variety of topics and run weekly weight management and stress reduction groups. They have also arranged a variety of other fitness programs, including an aquatics exercise class at the Laurel Lake campus. The nurses also coordinate many social activities, as they see these as being an important component of wellness. A large proportion of residents participate in the program, but at various levels. Some may participate in many components and activities, while others may only participate in one or two.

Each of the housing properties has a service coordinator and the nurses work closely with them. The service coordinators do a lot of case finding and referrals for them and vice versa. They also coordinate educational activities together.

The program costs about \$100,000 per year to operate and is funded by the housing authority (initially donated the office space, but now also contributes cash), Laurel Lake and the Catholic HealthCare Partners Elder Fund. The majority of program costs are for staff, including 2 part-time RNs and aquatics instructor and a certified exercise instructor (who offers an Arthritis Foundation course). Other expenses include transportation, equipment and supplies, activities, and minimal overhead.

### ***Additional Information***

The program uses a software program with built-in questionnaires to track resident progress. A health-risk questionnaire, for example, ask participants about things like their exercise habits, nutritional practices, weight, blood pressure, body mass index, etc. An overall wellness analysis indicates that participant wellness has grown from 41% rated as good to excellent in 2000 to 94% in 2009 (*note: IFAS has not reviewed this data and how the outcome is measured*). Recently, they began asking participants how often they call 911, go to the emergency room and go to the hospital so they can track that type of data too. The program director believes the availability of data to show the program is making a difference has been very beneficial to fund raising efforts.

The program director notes that participation was slow to start. Residents were afraid the housing authority or other residents would learn their business, so the nurse had to earn their trust. She did this through things like asking permission to talk to their doctors. Having an office space with a door that could be closed and locked was also key. Now, she gets many resident referrals, with residents bringing in fellow residents and saying you need to see her.

## **Peter Sanborn Place, Reading, MA**

### ***Program***

Peter Sanborn Place prioritizes serving seniors needing a high level of care. To ensure the availability of personal care to its frail residents, Peter Sanborn created a sister corporation, Sanborn Home Care, which provides a range of personal care and other supportive services to residents.

### ***Sponsor/Partners***

The real estate is operated by one corporation, Peter Sanborn Place, and services are provided by a sister corporation, Sanborn Home Care.

### ***Setting***

Peter Sanborn Place is a 73-unit affordable senior housing property (refinanced Section 202) located in a residential suburban neighborhood.

### ***Target Population***

Frail residents who need supportive services to help them remain safely in their own apartment. Through its HUD-approved tenant selection plan Peter Sanborn targets 40% of its units for residents needing single to multiple services daily, 30% for residents needing scheduled services during the week, and 30% who may choose to use services.

### ***Objectives***

Support frail lower-income older adults with the necessary supports to age in place and avoid transferring to a higher level of care.

### ***Components***

Sanborn Home Care provides residents of Peter Sanborn Place case management and service coordination; personal care, including assistance with showering, grooming, toileting, meal preparation, feeding, mobility, and medication monitoring; homemaker services such as housekeeping, shopping, and laundry; transportation to medical appointments; companion and respite care; and assistance with local errands and other tasks. Sanborn Home Care also contracts with the Visiting Nurse Association for nursing care and rehabilitation therapy. Sanborn Home Care also provides services to the surrounding community and has a contract with the Reading Housing Authority. Services are paid for through a variety of mechanisms, including self-pay, private insurance, state-funded programs, Medicaid waiver programs, and Medicare. Peter Sanborn Place also refinanced its Section 202 loan, with some of the savings plowed into resident services and renovations to increase the building accessibility features.

### ***Additional Information***

Peter Sanborn created a sister corporation, Sanborn Home Care because few home care agencies served their area and residents had a difficult time accessing these types of services when needed.

## **Porter Hills Retirement Communities & Services, Michigan**

### ***Program***

Porter Hills is piloting a “plus care” program through its home care division to offer affordable personal care services to residents in its affordable senior housing properties who may need assistance with some of their daily activities.

### ***Sponsor/Partners***

Porter Hills Retirement Communities & Services offers multi-level retirement communities, affordable senior housing and home health care services.

**Setting**

“Plus Care” is being piloted in three of Porter Hills’ affordable senior housing communities, which range in size from 42 to 50 units.

**Target Population**

Residents needing assistance with some daily activities.

**Objectives**

Provide an affordable opportunity for frail residents to access needed supports to help them remain safely in their apartment.

**Components**

Porter Hills held focus groups with residents, family members and services coordinators in their affordable senior housing properties to get an idea of what they needed with respect to personal assistance and what services they would be interested in and/or willing to purchase. They identified three services to target: housekeeping, bathing, and medication set up. Porter Hills will send staff from its home care division to each property on a designated day to assist those residents purchasing these services. To make the services affordable, Porter Hills will offer the services in 15-minute increments, rather than the standard 2-hour minimum. Porter Hills’ goal is not to make a profit on the services, but just to cover its costs.

**Presentation Senior Community, San Francisco, CA****Program**

Presentation Senior Community is co-located with an adult day health center, which serves individuals from the housing property as well as the surrounding community who are at risk for nursing home placement. The center provides a range of health and supportive services to program participants.

**Sponsor/Partners**

Presentation Senior Community is a property of Mercy Housing California and the adult day health center is operated by North & South Market Adult Day Health.

**Setting**

Presentation Senior Community is a Section 202 building with 93 units, 60 of which are targeted to frail elders. The property is located in a dense urban neighborhood and has a very diverse resident population.

**Target Population**

The property prioritizes frail elders in its HUD-approved tenant selection plan. To be determined “frail,” a prospective resident must be either currently enrolled in adult day health center, currently living in a skilled nursing or residential care facility, chronically deficient in two or more activities of daily living, chronically deficient in three or more instrumental activities of daily living, or eligible

for at least 60 hours per month of support through the In-Home Supportive Services (IHSS) program.

### **Objectives**

To provide affordable housing to frail low-income elders combined with health services that allow them to continue independent living.

### **Components**

Approximately half of the housing property residents participate in the day health program, which provides a variety of services, including nursing care; personal care, social work services; physical, occupational and speech therapy; podiatry services; mental health support; case management; transportation; and a daily meal. The day health program is able to coordinate a pool of in-home services workers from the state's IHSS program for residents, allowing workers to maximize their efficiency. Residents not enrolled in the adult day health program receive support and services from a service coordinator, the IHSS program and a variety of community organizations. Almost three quarters of residents receive services from the IHSS program, a Medicaid-funded program that provides homemaker and personal care services.

### **Additional Information**

Operating as a separate day health program and independent living property allows the project to avoid state licensing as an assisted living facility while providing roughly the same level of services to residents. Since HUD had not previously allowed a waiver to give preference to frail and/or disabled elderly in an independent housing property, the process for obtaining the waiver was lengthy. Project sponsors also agreed that the initial criteria developed to define frailty were too loose, allowing some older adults with minimal needs to occupy reserved units. Renting out the units when they had to be targeted to frail elderly also took much longer than renting to the traditional elderly population.

For more information on Presentation Senior Community, see a technical assistance manual on the development of the property, which can be found at:  
<http://www.nsmdayhealth.org/pscwebbook.pdf>.

## **Robert Sharp Towers I & II, Miami, FL**

### **Program**

A 10-year partnership with a local school of nursing brings nursing students to the property weekly to provide wellness checks and an exercise class. The nursing school also coordinates an annual health fair at the property.

### **Sponsor/Partners**

Robert Sharp Towers I & II are sponsored by Elderly Housing Development and Operations Corporation. The property partners with Miami Dade College School of Nursing.

### **Setting**

Robert Sharp Towers I & II are affordable senior housing properties with approximately 135 and 120 residents respectively.

### ***Target Population***

All residents.

### ***Objectives***

Provide residents with wellness checks and health education to help maintain their health.

### ***Components***

Nursing students visit the property through the SHARP project, a community-based health screening and education initiative. Under the supervision of a professor, students come to the property each Friday to check blood pressures and other vital signs. If a potential concern is identified, the supervising professor would tell resident that they should follow up with their doctor, or they might alert the service coordinator so that she can help them follow-up. The nursing students see approximately 20 residents each week. The students also lead a chair exercise class while at the property, the equipment for which was supplied by the nursing program. In addition, the nursing program holds an annual health fair at the program with educational materials and additional health screenings. There is no charge to the residents for any of the services.

## **Saint Elizabeth Place, Providence, RI**

### ***Program***

Saint Elizabeth Place hosts an on-site health clinic open three days a week. The clinic is staffed by a nurse employed by the housing property, but clinically supervised by the staff of the sponsoring health system. A nurse practitioner visits the clinic twice per month and a geriatrician approximately once every other month.

### ***Sponsor/Partners***

Saint Elizabeth Place is a property of Saint Elizabeth Community. The clinic is operated as a satellite clinic of LifeSpan Health System/Brown University Medical School.

### ***Setting***

Saint Elizabeth Place is a 149-unit Section 202 property located in an urban area.

### ***Target Group***

All residents of the housing property are eligible to use the clinic; however, residents must become a member of the clinic to utilize its services. Currently, approximately 30-40 residents are clinic members.

### ***Objectives***

- Provide easy access to health care services to residents of the property.
- Improve the coordination and continuity of health care of residents with other providers in the community.

- Provide an expert resource for housing property staff when they have concerns about the health of residents.
- Facilitate residents' ability to age in place.

### ***Key Components***

The nurse will answer questions from all residents of the property and evaluate potential emergencies. However, for nursing care and to see the nurse practitioner and geriatrician, residents must become a member of the clinic and accept the geriatrician as their primary care physician. The health provider requires this because they feel it creates less confusion, provides for better continuity of care and limits the liability risk when they act as the patient's primary physician. The clinic provides traditional nursing services to clinic members, as well as coordinating health care needs such as arranging labs and x-rays, scheduling specialist appointments and booking transportation to physician appointments. A phlebotomist comes to the property weekly and the clinic nurse can also arrange for a mobile x-ray technician. The nurse practitioner and geriatrician will see patients in their own apartments if they are unable to come down to the clinic. If a clinic member needs to see the nurse practitioner or geriatrician outside of the days they visit the property, they may go to their main offices. Clinic services are billed just as a regular office visit is billed, with Medicare, Medicaid and private insurance accepted. There is no charge to see the nurse.

Saint Elizabeth provides the space for the clinic free of charge and employs the nurse, who is paid for through the property's operating budget. As a satellite clinic, the health system provides all the necessary insurance, licensing and credentialing and the supplies necessary to operate the clinic. Because most of the patients are low income and covered by Medicaid and because of the low volume, the clinic is not financially viable. The LifeSpan Health System, however, has committed to the clinic as a component of their community outreach and charity work.

### ***Additional Information***

At its highest point, the clinic has had approximately 45 members. A few barriers to higher participation have been identified. First, some residents do not wish to become clinic members because they are required to give up their existing primary care doctor. Second, some residents are Spanish speaking but the nurse practitioner and physician are not, making it difficult for these residents to communicate with the clinic staff.

## **St. Luke's Place, Edgemere, MD**

### ***Program***

St. Luke's Place provides space to a local physician practice to operate a satellite clinic. The clinic is open 3 days per week and is available to residents and individuals from the community.

### ***Sponsor/Partners***

St. Luke's Place is a property of Catholic Charities of the Archdiocese of Baltimore. Dennis, Dart & Muneer PA, a private physician practice, operates the clinic.

### ***Setting***

St. Luke's Place is a 125-unit affordable senior housing property in a town of approximately 10,000 people located near a large metropolitan area.

### ***Target Population***

All residents are eligible.

### ***Objectives***

Provide residents access to consistent medical care.

### ***Components***

Patients can schedule appointments or walk-in and be seen on an as available basis. The clinic's initial founder approached the property about opening the on-site clinic. Many residents were from the surrounding area and were already patients of the practice. When the current physician practice took over, they decided to keep the satellite clinic open to provide easy access for residents to physician services. The property has an MOU with the physician practice and provides the space free of charge. The physician practice provides all the required licensing, certifications and insurance to operate the clinic.

## **St. Mary's Court, Washington, DC**

### ***Program***

St. Mary's Court partners with a nearby hospital house calls program to provide primary care and chronic care management to frail and disabled residents. Patients are seen in their apartment on an approximately monthly basis and are cared for by a geriatrician and nurse practitioner team.

### ***Sponsor/Partners***

St. Mary's Court is sponsored by the Episcopal Diocese of Washington. The house calls program is operated by George Washington University Hospital.

### ***Setting***

St. Mary's Court is a nine story, 140-unit Section 202 property sponsored by the Episcopal Diocese of Washington. It is located in an urban area, surrounded by George Washington University and in close proximity to George Washington University Hospital.

### ***Target Population***

To receive reimbursement from Medicare, house call program can only serve patients who have extreme difficulty leaving their apartment to travel to a medical appointment. Many residents of St. Mary's Court were already part of the George Washington University Hospital system when the program was initiated.

### ***Objectives***

Provide frail and medically complex residents with access to timely health care that will help support their ability to age in place.

## **Components**

House call patients are seen for all their primary care needs, and many basic diagnostics can be conducted in the patient's apartment, further minimizing the need to travel. The house call practice also coordinates the patients' care with any specialists or other health-related needs. The nurse practitioner and the property's service coordinator discuss patients as necessary. The nurse practitioner updates the service coordinator on her patients in the building, and the service coordinator assists in arranging social services that might be helpful to meet the resident's full range of needs. The service coordinator also calls the nurse practitioner if she notices one of her patients is having a medical problem so that she can check on them. Communication between the physician/nurse practitioner and the service coordinator is done with the consent of residents.

## **Additional Information**

Approximately 8 residents currently participate in the house calls program. In this program, patients must accept the house call geriatrician as their primary care physician. Some older adults are reluctant to give up long-standing relationships with their doctor. House call eligibility criteria are stringent, further limiting the number of residents who participate. While the number of residents who may participate in the program may be small, these residents are often the more medically complex and frail residents in the building who make take up a great deal of the service coordinator and other property staff's time.

To get more information on how medical house calls programs operate and how these programs and senior housing properties can partner, see *Doctor at Your Door: The Senior Housing Community's Guide to Medical House Calls Programs* at:  
[http://www.aahsa.org/uploadedFiles/IFAS/Publications\\_amp\\_Products/house\\_calls.pdf](http://www.aahsa.org/uploadedFiles/IFAS/Publications_amp_Products/house_calls.pdf).

## **Seven Oaks of Florence, Omaha, NE**

### **Program**

Seven Oaks of Florence partners with a local home healthcare agency to send a nurse to the property every Friday to provide routine health and wellness checks. The property also hosts students from a local school of nursing to provide health education presentations and from a school of pharmacy to conduct medication reviews. The property directly provides several fitness activities through its activities director.

### **Sponsor/Partners**

Seven Oaks of Florence is sponsored by the Notre Dame Sisters. The property partners with St Joseph Villa Homecare & Hospice, a local home healthcare agency, and the Creighton University School of Nursing and School of Pharmacy and Health Professions.

### **Setting**

Seven Oaks of Florence consists of two Section 202 properties and one low-income tax credit property with a combined 153 units. The properties are located on the grounds of the former Notre Dame Academy.

**Target Population**

All residents.

**Objectives**

Provide residents with wellness checks, health education and fitness activities to help residents maintain a healthy lifestyle and mobility.

**Components**

A nurse from a St Joseph Villa Homecare & Hospice visits Seven Oaks of Florence every Friday for two hours. She provides routine health and wellness checks such as blood pressure, weight, heart rate, blood sugar, and diabetic foot care. If the nurse feels any follow-up care is needed, she makes suggestions to the resident and may also follow up with the property's service coordinator, if necessary. When residents request her help, the service coordinator will assist them with communicating and coordinating care with their physicians. In addition, students from the Creighton University School of Nursing visit the property approximately 3 times per semester to offer health education sessions on topics such as diabetes, nutrition, foot care, exercise, and so on. The connection was established with the nursing school through a sister of the property's sponsor who works at the nursing school. The visits help the students fulfill their clinical rotation requirements.

Through a Board member who works for the University's school of pharmacy, Seven Oaks has initiated a new partnership where pharmacy students visit the property to conduct reviews of residents' medications. The students see about 10 residents per visit. After documenting all of a resident's medications, and with oversight from a supervising professor, the students conduct a full review, looking for possible duplicate, unnecessary or contradicting medications. They then provide the resident with a letter of suggested changes to their medication regiment. The service coordinator helps the resident fax the letter to their physicians to consider the recommended changes. In some instances doctors have declined to make the suggested changes and in several others they have followed the students' recommendations. The student visits continue until they work through all residents who are interested in having a review conducted. The property hopes to have the students back to perform annual reviews for the residents. Property staff believes that the residents receive a more intensive evaluation through the students than they might with their pharmacist, who might not have the time to spend with individual customers.

Seven Oaks' activities coordinator coordinates multiple fitness programs with the goal of helping residents maintain wellness and mobility. She leads a low-impact chair aerobics class (with a video aid) three days per week and a tai chi class one day per week. She also leads a walking club that offers residents prizes for achieving certain milestones. The property recently received a grant to purchase exercise equipment, which they will set up in a community room for resident use. The service coordinator will work with residents to get approval from their doctors that it is safe for them to use the equipment.

All of these services are provided free of charge to residents.

## **Simon C. Fireman Community, Randolph, MA**

### ***Program***

The Simon C. Fireman Community has instituted several fitness-related activities for residents, including two evidence-based exercise classes, tai chi, and a walking program. The property also offers an evidence-based chronic disease self-management course designed to help residents develop self-care skills to manage and deal with the impact of their chronic illnesses.

### ***Sponsor/Partners***

Simon C. Fireman is a property of Hebrew SeniorLife. Hebrew SeniorLife operates Hebrew Rehabilitation Center, an acute and long-term care center; CCRCs and independent housing properties; and an institute for aging research.

### ***Setting***

Simon C. Firemen is a 159-unit affordable senior housing property located in a suburban community.

### ***Target Population***

All residents.

### ***Objectives***

- Help residents maintain fitness and mobility to help prevent functional decline.
- Help residents with chronic conditions develop self-care skills to enhance their ability to remain in their apartment.

### ***Components***

The property employs an exercise physiologist 22 hours/week to operate a fitness center (the physiologist is employed by another entity of the property's parent organization the remainder of the week). The fitness director is paid for through the property's operating budget under the resident services line item. The property does not have a service coordinator, but has an assistant administrator who helps in this capacity. The fitness director leads multiple activities at the property, including an evidenced-based exercise program. Approximately 50 participants attend twice a week, completing a customized exercise circuit. The fitness director also leads an exercise program utilizing the Arthritis Foundation's exercise program, which is designed specifically for people with arthritis and uses gentle activities to help increase joint flexibility and range of motion and maintain muscle strength. (Instructors are trained by the Arthritis Foundation to lead this course). Approximately 10 to 12 residents attend this twice weekly class. In addition, the fitness director has also created a "virtual" walk across Massachusetts program. Residents are given pedometers and the fitness director tracks their progress. Participants receive incentive gifts as they reach milestones and there is a final prize for the first few to complete the walk (prizes were donated). The property has also hired a couple to teach a semi-weekly Tai Chi class. Approximately 15 people participate in this activity on a regular basis.

Simon C. Fireman also offers the *Chronic Disease Self-Management Program (CDSMP)*, an evidenced-based behavior modification program developed at Stanford University. This program is designed

to help individuals gain skills and self-confidence in their ability to control their disease symptoms and to lead a full life in spite of their chronic illnesses. The fitness director and the assistant administrator have been trained to teach the course, although trainers are often lay leaders with chronic illnesses themselves. The course meets 2 hour per week for 6 weeks. The property has held 3 waves of the program thus far, with about 40 residents participating. The property has received good feedback from the residents about the course and how it has helped them manage their lives.

### ***Additional Information***

To offer the CDSMP program, an individual (health professional or lay person) must go through a train-the-trainer program and the organization must purchase a license. A property might train their own staff or they might also find organizations in the community who are already trained and licensed to offer the program to partner with. For more information about the program and to find out about organizations licensed to offer the program, see Stanford School of Medicine's Patient Education Center website at: <http://patienteducation.stanford.edu/programs/cdsmp.html>.

## **Sixty Plus Older Adult Services Program, Piedmont Hospital, Atlanta, GA**

### ***Program***

The Sixty Plus Older Adult Services program partners with four affordable senior housing properties in the Atlanta area, sending a nurse with geriatric expertise to each property one day a week. The nurse provides disease management education, physical health assessments, acts as a liaison with the resident's physician and provides contact upon hospital admission and post-discharge.

### ***Sponsor/Partners***

The Sixty Plus Older Adult Services program is a program of non-profit Piedmont Hospital. The program's mission is to "assist older adults and their families in leading healthy lifestyles, maximizing independence and experience a satisfying quality of life," with a goal of providing a resource to physicians for assistance in the management of high-risk geriatric patients, and facilitating the efficient and effective utilization of health care resources.

### ***Setting***

Four affordable senior housing properties in the Atlanta area are visited.

### ***Target Population***

All residents.

### ***Objectives***

Help seniors maintain and maximize their independence.

### ***Components***

Residents can schedule individual appointments with the nurse and she conducts post discharge follow-ups with residents who have had a recent stay in Piedmont Hospital. Physicians who work with Piedmont Hospital can also ask the nurse to check in on any of their patients they think might

need attention. The nurse can help residents coordinate any follow-up appointments or other health-related resources they might need. In addition to one-on-one appointments, the nurse also puts on health fairs and other educational opportunities in the properties. There is no charge to the residents or the housing properties.

### ***Additional Information***

The hospital sees the program as part of their community outreach and charitable mission. The hospital also hopes to prevent unnecessary hospitalizations and keep beds free for the greatest needs.

## **Trinity House, Towson, MD**

### ***Program***

In February 2008, Greater Baltimore Medical Center began sending a nurse practitioner to five senior housing properties, including Trinity House, once a week. The nurse practitioner provides a range of health and wellness-related checks and education.

### ***Sponsor/Partners***

Trinity House is a property of Catholic Charities of the Archdiocese of Baltimore. The nurse practitioner is provided by Greater Baltimore Medical Center, a 310-bed medical center.

### ***Setting***

Trinity House is an 82-unit Section 202 property located in a suburban area.

### ***Target Population***

All residents.

### ***Objectives***

Provide residents with a resource to answer health-related questions, coordinate health needs, and provide wellness checks.

### ***Components***

Currently, the nurse practitioner goes to Trinity House once a week for approximately 2 hours. Residents sign up the day before and she is able to see approximately 12 people during her time at the property. The nurse practitioner can see residents for a variety of health-related reasons. She can check on residents who have recently returned from a hospital stay, provide routine wellness services such as blood pressure checks, provide disease specific education, help residents understand a doctor's orders, assist with getting needed medical equipment or assistive devices, etc. The most common things residents come to her for are blood pressure checks, glucose monitoring, and medication questions. Once a month, the nurse practitioner also gives an educational talk on a health issue (memory loss, diabetes, osteoporosis, depression, etc.). The talks generally encourage a few new people to visit the NP. All services are provided free of charge.

The service coordinator and other property staff refer residents to the nurse practitioner and also alert her when they believe a resident might be in need of her services. The property provides the nurse practitioner with a space to see residents. The two entities have an informal agreement between each other.

### ***Additional Information***

The hospital initiated the program with the housing properties as a part of their community outreach efforts. Currently, the hospital is not billing Medicare for the nurse practitioner's services as most of the current activities are not billable. Should this mixture of services change, the hospital will reevaluate the billing issue. As the partnership with senior housing facilities is relatively new, the hospital is still figuring out the extent of the nurse practitioner's role and the amount of time she spends of at each housing property.

## **WellElder® Program, San Francisco, CA**

### ***Program***

The WellElder program provides an on-site health educator (RN or LVN) to work directly with residents to provide one-on-one assistance with addressing their health-related needs.

### ***Sponsor/Partners***

The WellElder® program is a program of Northern California Presbyterian Homes and Services (NCPHS) and the Institute on Aging. NCPHS operates life care communities, affordable housing properties and community service programs. NCPHS contracts with the Institute on Aging (IOA), which provides a range of home and community-based services to seniors, for the health educator position. The IOA supervises the nurse and provides clinical consultation, removing NCPHS from any direct service delivery. Under California law, independent housing providers are not allowed to provide direct services without being subject to licensure as a residential care facility for the elderly.

### ***Setting***

WellElder® is operated in four affordable housing communities in the San Francisco Bay area, including Bethany Center, Town Park Towers, Eastern Park Apartments and Western Park Apartments. These properties are all in urban neighborhoods and have diverse resident populations.

### ***Target Population***

All residents.

### ***Objectives***

The goal is to maintain the health and independence of residents by providing a link to existing health and social programs that are designed to address residents' health issues.

### ***Components***

The WellElder® program provides a part-time, on-site health educator (RN or LVN) to work directly with residents to provide one-on-one consultations and health assessments; advocacy on the resident's behalf with doctors, insurance providers, pharmacies and other health services; referrals to medical services; medication reminders; health-related classes and group programs; and information about medical costs and insurance resources. The health educator is teamed with a service coordinator to provide residents a full array of support and expertise to help residents find what they need to be able to remain in their own home and community.

### ***Additional Information***

At two of the four housing sites the WellElder® program operates in, the properties have been able to work the health educator into their HUD-funded operating budgets. At the other two, the positions are funded through grants.

## **Westerly Apartments, Lakewood, OH**

### ***Program***

Westerly Apartments began a partnership in 2008 with a local home health agency to operate an on-site wellness clinic. The clinic is staffed five days a week by a nurse and a nurse practitioner. The nurse conducts wellness checks and provides residents with health and wellness education. Nursing services are free to the residents. Residents can see the nurse practitioner for any sort of regular health care visit and Medicare or other insurance is billed. Westerly also has a 20-year partnership with a nearby hospital to send a nurse to the property weekly to check blood pressures and answer other health-related questions. The hospital also sends a lab technician to the building on a regular basis to draw blood for residents and a physician comes once a month to give talks on health issues. The services provided by the hospital are free of charge to residents.

### ***Sponsor/Partners***

Eliza Jennings Senior Care Network, which owns and operates a nursing home and rehabilitation center, continuing care retirement community and adult day health program, staffs the clinic through its home health agency. Eliza Jennings had a connection with Westerly's residents prior to establishing the clinic, as many ended up in their nursing home for rehabilitation following a hospital stay and often needed additional therapy when they returned to their apartment. Setting up a clinic on campus was perceived as a way to better serve Westerly residents and to help them remain in their apartment. Lakewood Community Hospital, which also provides health and wellness services on-site, is located nearby and is used by many residents. Westerly Apartments has a long tradition of partnering with community service agencies and is the site of the Barton Community Center serving the whole Lakewood community.

### ***Setting***

Westerly Apartments consists of three high rise buildings (two Section 202s and one Section 236) with a total of 500 units, located within a few miles of Cleveland, Ohio. The surrounding community is a densely populated, largely white, residential community. A community hospital with a long-standing relationship with Westerly is located nearby.

**Target Group**

All residents.

**Objectives**

- Improve resident well-being and forestall the need to move to institutional settings.
- Help residents become active in their health monitoring and care.

**Components**

The clinic provides health education and wellness services, with a goal of helping residents become active in their own health monitoring and care. The clinic has several self-monitoring stations where residents can come and check blood pressure, weight, pulse, oxygen level, etc., and the nurse provides education on managing their health and diseases processes. The nurse is also available to answer resident questions about medications and will help coordinate their health care needs. Residents can see the nurse practitioner for regular health care visits. She will see residents in their apartment or the clinic, whichever they prefer. Eliza Jennings also offers physical and occupational therapy services in the apartments of residents to help them work within and adapt to their specific surroundings. The therapy, which must be prescribed by a physician, is billed to Medicare.

Westerly has a contract with Eliza Jennings and leases the clinic space to them. Eliza Jennings provides all the necessary licensing, credentialing and insurance to operate the clinic.

**Issues/Evaluation**

The clinic is able to operate five days a week because of the large number of residents in Westerly Apartments. Eliza Jennings has plans to initiate similar clinics at two other senior housing properties that are much smaller; however, these clinics will be open part time due to the smaller audience. Eliza Jennings' received a grant from a local foundation to help support the clinic's start up and first year of operations. The goal is to make the clinic self-sustaining within a year by increasing the volume of Medicare and Medicaid billable visits.

Clinic staff and property service coordinators communicate about individual residents, when necessary; however, each is careful about complying with HIPPA rules when sharing information. Clinic staff and service coordinators require residents to sign a release form giving permission for each to talk with one another regarding resident health care needs. For example, if the nurse practitioner thinks a resident would benefit from home delivered meals, she tells the resident she should like to talk to the service coordinator about getting this service set up and asks them to sign the release. The service coordinators are also careful not to steer residents to Eliza Jennings for rehab/therapy, always giving residents at least three possible options. Residents, however, often choose Eliza Jennings as their provider because it is conveniently located and staff is willing to provide therapy services in the resident's apartment.