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Healthy Aging in Supportive Housing

Los Angeles Edition

Toolkit for service providers & developers

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Healthy Aging in Supportive Housing

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I. How This Guide Can Help

Healthy Aging in Supportive Housing is designed to improve providers' capacity to support formerly homeless seniors as they adjust to living in a new housing unit or as they experience obstacles to aging in place. You will find content written for program staff who want to align services to meet the needs of aging tenants.

CHIEF PROGAM OFFICER

If you ***plan and implement new projects***, this guide will help you:

- Understand the appropriate level of services for homeless seniors;
- Create a service plan for supporting long-term tenancies;
- Develop the staffing and partnership infrastructure necessary to support homeless seniors in housing; and
- Make the case for funding services.

PROGRAM MANAGER / CLINICAL SUPERVISOR / LEAD SOCIAL WORKER

If you ***supervise a team of service coordinators or social workers***, this guide will help you:

- Assess your team's current capacity;
- Identify topics for in-service training opportunities to fill gaps in knowledge;
- Create or revise policies to better serve senior tenants;
- Identify partners to complement your team's work.

CASE MANAGER

If you are a ***case manager assisting senior tenants***, this guide will help you:

- Develop your expertise and gain a better understanding of their unique needs;
- Maximize seniors' access to cash and non-cash benefits;
- Locate senior-specific resources in Los Angeles County;
- Learn practical ways to resolve routine issues; and
- Find opportunities to connect with colleagues.

II. Understanding Homeless Seniors in Los Angeles

Homelessness among seniors occurs when: 1) chronically homeless individuals remain homeless into old age or 2) individuals without prior episodes of homelessness become homeless for the first time as a senior.

Chronically homeless seniors remain homeless for similar reasons as individuals in the larger chronically homeless population. A 2008 study by Shelter Partnership found that 28% of homeless seniors in the Los Angeles study group most recently lived on the street, 25% in an emergency shelter and 15% with friends or family.[1]

Many seniors become homeless later in life due to physical health, mental health, substance abuse, finances, employment and relationships. At-risk seniors often become homeless due to the death of a partner/family member or the onset of a disabling condition.

Demographics

Including seniors who are chronically homeless and those who have recently become homeless, seniors comprise a large portion of the homeless population. In 2015, 25% of the total homeless population in Los Angeles County was older than 55 (17% were between 55-61 and 8% older than 62).[2]

The Downtown Women's Action Coalition surveyed 371 women living in the Skid Row area of Los Angeles and found a majority were older women. In the last six years, the group has documented a 13% increase in women 50+ responding to the survey up from 47% in 2010 to 60% in 2016.[3]

The 2008 study conducted by Shelter Partnership found this profile of homeless seniors:

- More than two out of three were male;
- 57% were Black, 27% were White and 37% were Latino;
- Almost two out of three received income from either SSI or Social Security and fewer reported income from General Relief or SNAP (food stamps); and
- Almost 85% were unsheltered.

[1] Shelter Partnership, Inc. (2008). *Homeless Older Adults Strategic Plan*. Retrieved from http://shelterpartnership.org/Common/Documents/studies/HOAPlanCompiled.pdf
[2] Los Angeles Homeless Services Authority (LAHSA). *2015 Homeless Count Results*. Retrieved from http://www.lahsa.org/homelesscount-results
[3] Kassenbrock, R. (2016). *Downtown Women's Needs Assessment.* Retrieved from http://www.downtownwomenscenter.org/needsassessment

The Los Angeles region accounts for nearly 25% of California's senior population. Out of the 1.2 million 65+ seniors living in Los Angeles County:

- 43.1% were male and 56.9% were female;
- 40.2% were living alone;
- 49% spoke English only at home and 51% spoke a language other than English; and
- 81.9% were not in the labor force, and 18.1% were in the labor force.

Demographic Trends

The homeless senior population is increasing in a way that mirrors the aging of the general population and may be even more pronounced. In the Los Angeles region, there has been a 47% increase in homeless persons who are older than 55 since 2005.[4] Nationally, homelessness among seniors is expected to increase 33% by 2020 to 58,772. [5]

Homeless senior veterans are growing older too. It is estimated that by 2025 there will be over 22,000 homeless veterans in the U.S. who are older than 60.[6] Additionally, senior homeless veterans have unique issues and Shelter Partnership found that 79% of the homeless senior veterans included in their study abused alcohol.[7]

Housing Insecurity Among Seniors

A large portion of seniors pay more than 30% of their income on housing. For example, 65.4% in Los Angeles County are spending more than 30% of their income on housing.[8] This is considered a "housing burden" and puts seniors at greater risk for losing their housing.

Compounding the problem, there is not enough affordable housing for seniors. The city of Los Angeles is home to 125,000 seniors in need of affordable housing and only 7,800 units targeted at rents they can afford (a ratio of 16:1).[9]

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[4] Los Angeles Homeless Services Authority (LAHSA). *Homeless Count Results*. Retrieved from http://www.lahsa.org/homelesscount-results

[5] National Healthcare for the Homeless Council. (2013). Aging and Housing Instability: Homelessness among Older and Elderly Adults. *In Focus*: *A Quarterly Research Review of the National HCH Council, 2* (1). http://www.nhchc.org/wp-content/uploads/2011/09/infocus_september2013.pdf

[6] Byrne, T. (2015, November 19). Projecting Changes in the Scope and Health Service Utilization of Older Veterans Experiencing Homelessness [PowerPoint slides]. In *Homeless Evidence and Research Synthesis Roundtable* series.

[7] Shelter Partnership, Inc. (2008). *Homeless Older Adults Strategic Plan*. Retrieved from http://shelterpartnership.org/Common/Documents/studies/HOAPlanCompiled.pdf

[8] U.S. Census Bureau. *Population 65 Years and Older in the U.S., California and Los Angeles County*. 2014 American Community Survey 1-Year Estimates. Retrieved from https://www.census.gov/programs-surveys/acs/

[9] Los Angeles City Planning Department. (2013). Housing Needs Assessment. In *2013-2021 Housing Element* (Chapter 1). Retrieved from http://planning.lacity.org/HousingInitiatives/HousingElement/Text/Ch1.pdf

Between 2015-2035, the Los Angeles region's overall 60+ senior population is projected to grow by 68% and the 80+ population is projected to grow by 118%. The City's senior population is growing seven times faster than other age groups. In the coming decades, the region will continue to have one of the highest proportions of seniors and seniors of color in the state.

Unique Needs and Issues

Homeless service agencies and housing providers have well established policies and partnerships for addressing the traditional health needs of formerly homeless tenants. The aging of the homeless population presents new challenges. In addition to mental illness and substance use disorders, seniors must cope with age-related conditions such as incontinence, poor vision, co-morbidities, and higher rates of chronic diseases such as cancer, diabetes, and arthritis.

Health and Function

Approximately 80% of seniors in the U.S. have at least one chronic health condition, such as diabetes, COPD, arthritis and hypertension.[10] For seniors, poor health is a more significant contributor to homelessness, compared to other age groups. Chronic health conditions present a serious barrier towards the independence and health outcomes for seniors. For example, in 2014, 36.6% of non-institutionalized 65+ seniors in Los Angeles County reported having a disability (i.e., hearing, vision, cognitive, ambulation, self-care, or independent living difficulties).[11] If left un-/under-treated, these issues may contribute to homelessness.

The increased prevalence of health issues and disability among the senior population is exacerbated by the chronic stress and limited access to health care that accompanies homelessness. This contributes to:

Premature Aging/Early Onset of Geriatric Conditions: homeless seniors experience health problems of those in the non-homeless population who are 15-25 years older (i.e., homeless seniors in their 50s have illnesses similar to non-homeless seniors in their 60s and 70s).[12] Geriatric conditions such as functional impairment, falls, incontinence and sensory impairment are serious health concerns for homeless seniors.

[10] National Council on the Aging. (n.d.). *Chronic Disease Self-Management.* Retrieved from https://www.ncoa.org/news/resources-for-reporters/get-the-facts/chronic-disease-facts/
[11] U.S. Census Bureau. *Population 65 Years and Older in the U.S., California and Los Angeles County*. 2014 American Community Survey 1-Year Estimates. Retrieved from https://www.census.gov/programs-surveys/acs/
[12] CSH. (2011). *Ending Homelessness among Older Adults and Elders through Permanent Supportive Housing*. Retrieved from http://www.csh.org/wp-content/uploads/2012/01/Report_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing_112.pdf

Increased Morbidity: Homeless seniors are diagnosed with alcohol related illness, cognitive impairments and other chronic illnesses more than younger homeless individuals. Health problems of many kinds are prevalent among homeless seniors. For example, a 2008 study by Shelter Partnership found that homeless seniors in their sample reported dental problems (60%), eye problems (50%), hypertension (50%), arthritis (50%), back problems (40%), pain (40%), diabetes (30%), heart problems (30%), depression (20%), and stroke (20%).[13]

Increased Mortality: life expectancy for homeless adults is 64 for males and 69 for females, with heart disease and cancer as the leading causes of mortality.[14]

Mental Health

It is estimated that 20% of seniors experience mental health issues, the most common being anxiety, severe cognitive impairments and mood disorders (e.g., depression or bipolar disorder).[15] Of the women surveyed for the Downtown Women's Action Coalition, 65% reported a mental disability and 66% reported an ambulatory disability. Depression is the most prevalent of all mental health issues among seniors. Because depression is under-recognized, -diagnosed and -treated in the senior population, it may contribute to homelessness.

Isolation

Decreased mobility, lack of transportation options, and increased single-individual households has escalated the prevalence of isolation among the senior population. For example, 40% of seniors in their 70s and 60% of seniors in their 80s live alone and the number of 75+ seniors who are living alone is projected to increase from 6.9 million in 2015 to approximately 13.4 million in 2035.[16] Isolation may exacerbate issues that contribute to homelessness.

[13] Shelter Partnership, Inc. (2008). *Homeless Older Adults Strategic Plan*. Retrieved from http://shelterpartnership.org/Common/Documents/studies/HOAPlanCompiled.pdf
[14] Byrne, T. (2015, November 19). Projecting Changes in the Scope and Health Service Utilization of Older Veterans Experiencing Homelessness [PowerPoint slides]. In *Homeless Evidence and Research Synthesis Roundtable* series.
[15] Centers for Disease Control and Prevention. (2008). The State of Mental Health and Aging in America. Retrieved from http://www.cdc.gov/aging/pdf/mental_health.pdf
[16] Joint Center for Housing Studies of Harvard University. (2014). *Housing America's Older Adults: Meeting the Needs of an Aging Population*. Retrieved from http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_americas_older_adults_2014.pdf

III. Healthy Aging in Supportive Housing by Project Component

Designing or Modifying Services

Supportive Housing and Health Services

RESOURCES

- Dimensions of Quality Supportive Housing
- Integrating FQHC with Supportive Housing in Los Angeles

Supportive housing integrates long-term services and support with affordable housing and offers a framework for realizing improved outcomes for older adults. As a cornerstone of the supportive housing model, services should be voluntary and tenant-centered. To learn more about the supportive housing model, review: Dimensions of Quality Supportive Housing. Supportive housing for seniors requires intensive services delivered by staff who can navigate systems of care and work with seniors who have mental health and co-occurring disorders. Service plans must recognize that seniors' physical limitations and health problems will likely worsen as they age. The need for robust services becomes more pronounced over time and is critical to the long-term success of a project.

The essential elements of supportive housing for seniors are:

- Ensure that rents are affordable,
- Provide tenant-centered services for physical health, behavioral treatment, and substance use on-site or nearby,
- Build trust gradually,
- Interact frequently with tenants with attention to gathering their input about services,
- Facilitate peer engagement, and
- Evaluate program effectiveness.

Seniors require specialized services to meet their needs. Some examples include: help with activities of daily living (ADLs), 24-hour crisis response, geriatric healthcare, transportation, payee services, nutrition and meals, and community building activities to prevent isolation. As mobility is often an issue for seniors, it is ideal for services to be offered on-site or at nearby locations accessible by more than one mode of transportation.

Access to comprehensive health care is especially critical for this population. University of California San Francisco researcher Dr. Judith Hahn found that "new programs that integrate healthcare with more stable housing, may be important steps for avoiding end stage disease and institutionalization in older homeless persons with complex medical regimens needing frequent office visits." Supportive services address issues that otherwise make transitions to assisted living or higher levels of care the only option for tenants without such support.

There are many approaches that ensure seniors in supportive housing have access to the health care they need. Any of these approaches should allow tenants to have a permanent and convenient medical home to help manage their health needs effectively and to reduce use of expensive safety net services.

One approach is to design space for a Federally Qualified Health Center (FQHC) into the supportive housing project and contract with a FQHC to lease the space and provide health care services. In planning such an approach, one cannot assume that all tenants will make use of these services. Often, new tenants are already connected to health care and will not transfer to the on-site FQHC. Planning for this approach must therefore include a careful assessment of demand for health care services in the surrounding community.

Another approach is to enter a written agreement with a health care provider to facilitate referrals of tenants. Qualified health care providers typically will commit to providing basic health care services for residents, including primary health care, X-rays, EKGs, wellness services, HIV testing, laboratory services, prescription services, medication management, and referrals of tenants for health care services that they do not provide, such as dental care.

Local Innovation **– La Coruna and Home Health Services**

Access to health services improves the likelihood that tenants can receive the support they need to remain safe in their apartments. La Coruna is innovative because it introduces Medi-Cal funded services into senior housing to create a service-rich community for tenants who are nursing home eligible, some of whom might otherwise experience homelessness. Meta Housing completed the La Coruna project in the San Fernando Valley in 2013. Western Senior Housing manages the property. EngAGE and Libertana Home Health Care provide supportive services.

La Coruna has 87 units for persons over the age of 55. Thirty-five of the units are reserved for tenants who are enrolled in the Assisted Living Waiver, a Medi-Cal program that funds services delivered in a person's home or in a residential care facility. Libertana has a Space Use Agreement with the building owner that gives them access to the building's amenities and office space for staff. Libertana was chosen as the service provider because they have expertise delivering health care services through Medi-Cal waiver programs.

Libertana provides onsite staffing (17 employees) at La Coruna to cover three shifts a day, seven days a week. In addition to home health aides, Libertana employs a site manager licensed as a vocational nurse, an activities coordinator, and a driver who transports tenants using the building's van. For tenants who qualify, Libertana staff assist with: medication monitoring, transitions between health centers, care coordination, transportation, bathing, dressing, grooming, transfers, and house cleaning.

Strengths-Based Aging

Over time, the aging process will affect an individual's acuity level and lead to increased reliance on services. Staff should design programs that anticipate this progression and help tenants compensate for limitations. Professionals working with seniors should acknowledge physical and mental deficits while using a strengths-based perspective that respects personal resources and resiliency. Control, choice, and independence are particularly important motivators for seniors who are experiencing losses. Supporting what tenants *can* do reinforces their autonomy and celebrates their capacities.

The LeadingAge Center for Applied Research, which studies the applicability of research policy and practice, makes these recommendations to help seniors age well at home:

- Identify simple and inexpensive solutions to help senior tenants accomplish normal activities like cooking and bathing;
- Provide handyperson home repairs to minimize accidents such as falls that can threaten health and independence;
- Facilitate occupational therapist home visits to assess how tenants function in their housing;
- Ensure that a wellness nurse or occupational therapist reviews the tenant's physical environment and makes recommendations.

Cultural Competency and Seniors

The U.S. Administration on Aging (AoA) defines *Cultural Competency* as "the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs of consumers and their communities," and *Culture* as "a group with shared values, religion, language, and/or heritage."[17]

In practice, *cultural competency* refers to guiding principles developed to improve the ability of service providers and their systems to meet the needs of diverse communities, including racial and ethnic minorities.[18]

[17] U.S. Administration on Aging, *A Toolkit for Serving Diverse Communities*. Retrieved from http://www.aoa.gov/AoA_programs/Tools_Resources/DOCS/AoA_DiversityToolkit_Full.pdf

[18] The importance of cultural competency is demonstrated by a recent health care pilot program targeted to *dual eligible* — fragile older seniors and disabled young people who receive both Medi-Cal and Medicare benefits. Health care experts believe that the state-managed health care pilot program would be beneficial for most *dual eligibles*, but 45% have opted out of it. There are significant differences in opt out rates by ethnicity. Spanish speakers in most counties offering the program had among the lowest opt-out rates, from 26% to 29%. Russian-speaking eligibles in Los Angeles County had the highest opt-out rate: 92%, and 90% of Armenian speakers in San Bernardino County opted out. High opt-out rates suggest a need to incorporate cultural competency in the program's marketing techniques.

The AoA states, "professionals who work with aging populations can authentically understand differences without falling into the trap of generalizing by evaluating how diverse communities respond to your agency's services." To do so, AoA recommends that organizations providing services to older adults carefully assess how services should be designed and delivered to the population by asking:

- What do we need to know about this population?
- What groups does this population trust?
- What types of data can help us improve our services?

The AoA recommends partnerships with trusted community organizations that possess relevant knowledge and skills for cultural brokering and peer-to peer training. Consider the cultural barriers that limit services to this group, including stigma over accepting help, values concerning gender or family roles, and religious and spiritual beliefs.

Tenants may experience ageism from their neighbors and peers because of the stigma associated with disability and frailty. Be sensitive to ageism perpetrated by other seniors and promote a culture of inclusiveness that avoids assigning individuals to groups categorized by level of need.

Evidence-Based Practices for Seniors

Evidence based practices (EBPs) combine evidence gained from research with expertise gained from professional experience. EBPs have emerged dealing with energy levels, motivation, depression, physical activity, management of chronic health conditions, housing, and more.

Refer to the Resources section of this document to find information on EBPs that apply to all persons who have experienced homelessness, including: 1) Housing First, 2) Motivational Interviewing, and 3) Harm Reduction. This section focuses on senior-specific EBPs. The following EBPs provide examples of programs that address health issues commonly experienced by seniors.

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

Healthy IDEAS is designed to detect and treat the symptoms of depression in seniors with chronic health conditions and/or mobility issues. The main components of Healthy IDEAS are:

1) Screening and Assessment of Depressive Symptoms
2) Education about Depression and Self-Care for Clients and Caregivers
3) Referrals and Coordination with Mental and Physical Health Services
4) Increased Engagement in Meaningful Activities

Program goals include:

- Reduce severity of depressive symptoms
- Target populations who lack knowledge of depression
- Train staff at community-based agencies to provide EBP
- Improve relationship among senior service providers and healthcare professionals

Chronic Disease Self-Management Program (CDSMP)

CDSMP is a participatory program developed for people with chronic health conditions (including seniors) where participants learn practical skills for managing their chronic health conditions. The program is designed to complement other treatment and help participants manage co-occurring health conditions. Topics include:

1) Techniques to address frustration, fatigue, pain and isolation and other issues;
2) Age and mobility-appropriate exercise for strength, flexibility, and endurance;
3) Medication management;
4) Communicating effectively with family, friends, and health professionals;
5) Nutrition;
6) Decision-making; and
7) Evaluation of new treatments.

CDSMP has been highly successful in helping participants manage their chronic health conditions. In certain studies, participants spent fewer days in the hospital and had fewer outpatient visits compared to the control group who were not enrolled in the program.

Fall Prevention Programs – *Local Innovation*

The core components of an effective Fall Prevention Program are: risk assessment and screening, medication management, physical activity (balance and strength training), and environmental modifications. In Los Angeles, the Downtown Women's Center (DWC) established a Fall Prevention Program to serve older women living at their two residences and in properties scattered throughout the city.

DWC's program incorporates best practices from CHAMP's Geriatric Fall Prevention Toolkit. The program includes: health screenings; classes on fitness, stretching, and strength training; medication reviews; referrals to specialty care; access to assistive devices (canes, walkers, etc.); home visits; and home modifications (grab bars, etc.). DWC has twenty apartments that are fully accessible and they work with property managers to conduct room inspections to remove hazards or modify apartments when a tenant requires additional physical supports.

The integrated team at DWC includes the Health Program Manager (MPH/LCSW), two medical social workers, and housing case managers who see tenants on a more frequent basis.

UCLA Memory Training Course

Many seniors experience memory loss (e.g., 85% of seniors report trouble remembering names) and this issue is the focus of the UCLA Memory Training Course – an EBP endorsed by the City of Los Angeles Department of Aging. Trained facilitators lead participants in interactive group discussions, memory checks, and skill-building exercises. The pen and paper style course is designed to help participants:

- Remember facts – like names and faces,
- Increase ability to recall appointments, phone messages and other plans,
- Avoid misplacing objects - like keys, glasses or a wallet, and
- Increase ability to overcome not knowing something that you cannot immediately recall.

Participants report improvements to memory after the first session and can retain improvements for many years.

Staffing Services

RESOURCES

- ❖ Refer to Sample Job Descriptions in the Resources section

Services can be provided by the lead service provider or through partnerships with other agencies. At a minimum, the lead service provider should establish formal agreements with partner agencies for core services, such as mental health care. Services can be provided on-site or off-site; however, it is the responsibility of the lead service provider to ensure that off-site services are accessible to tenants, which requires transportation planning and assistance.

Flexible Nature of Service Planning

The service programming will require modifications as tenants' needs and interests change. The service provider must be flexible and adjust the services so they continue to be relevant and beneficial to tenants. Effective service providers involve the tenants in the development of service programming over time, employing surveys and other feedback mechanisms.

Coordination with Property Management

As a best practice in supportive housing, services staff serving seniors must work closely with the property management team. While they have distinct roles, ongoing communication helps to preserve tenancies. Property management and services staff should work together to address gaps in services and operations, identify tenant concerns, and prevent evictions. Effective lead service providers offer all tenants the opportunity to sign releases that allow the service providers and property management staff to share information when it relates to preserving tenancies.

Staffing Levels

Staffing patterns vary depending on the size of the program, tenant needs, local requirements, presence of ancillary services, co-location arrangements, partnership agreements and funding levels. HUD recommends that supportive housing programs typically follow a staff-to-tenant ratio of 1:10 to 1:30 per case manager.[19] Programs working with recently homeless seniors should maintain a ratio in the lower end of that range, certainly no greater than 1:22, to deliver intensive services while minimizing staff burnout.[20]

Supportive housing programs generally have staff members onsite during regular working hours, ideally with some coverage on weekends. Staff schedules should be developed with the goal of having staff available when it is most convenient for tenants. Supervisory staff should be available on an as-needed, on-call basis.

Staff Qualifications

The social worker and case management positions require degrees in human services, social work, or gerontology. Ideal candidates will have field experience serving difficult populations. Professionals who have completed social work curriculum but have yet to work directly with formerly homeless seniors can develop their clinical skills, but will require careful supervision and mentorship.

Staff Positions

Onsite staff share fluid responsibilities and must be willing to deliver a combination of hard and soft programming. The service team is responsible for providing access to services, such as

[19] U.S. Department of Housing and Urban Development. (n.d.). *Developing the Supportive Housing Program. Curriculum: Supportive Housing Training Series.* p16. Retrieved from https://www.hudexchange.info/resources/documents/SHPDevelopingSHP.pdf

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

medical care, behavioral health services, and substance abuse treatment, while advocating on tenants' behalf with the property manager. The team also coordinates group activities and onsite programming to foster a sense of community and create opportunities for engaging tenants who are resistant to accepting services.

There are several positions that are integral to effective supportive housing programs for recently homeless seniors. These positions should either be filled by internal staff or by external staff from an agency that has a formalized relationship via a MOU, contract or some other method of establishing a formal working relationship. Ideally, these services are offered onsite, or with guaranteed and reliable transportation to the specified location.

Core positions include:

- **Program Director / Supervisor**
- **Case Manager**
- **Mental Health Practitioner (on or off-site)**
- **Health Professional (on or off-site)**

Working with seniors is a multidisciplinary effort which requires leadership from a Program Supervisor who is well-versed in aging, mental illness, basic geriatric health principles, medical insurance requirements and common practices in healthcare settings.

Program Director / Supervisor

The Program Director/Supervisor is responsible for the oversight and management of all program components:

- Development, implementation, coordination and evaluation of program;
- Coordination of services;
- Partnerships;
- Policies and procedures;
- Reporting and compliance; and resources
- Regular supervision to direct service staff;
- Staff orientation/training on program mission, goals, policies and procedures;
- Staff performance; and
- Personnel management problems.

Case Manager

The case manager is responsible for helping the tenant secure and retain housing through care coordination, advocacy and direct service provision and is at the core of supportive housing for seniors. In part, the case manager is responsible for:

- Conducting tenant assessments;
- Developing individual service plans and goal planning;
- Supporting tenants in achieving goals and tracking progress;
- Helping tenants develop independent living skills;
- Encouraging tenant involvement in community activities;
- Making referrals to community-based and public services;
- Providing education on tenants' rights and responsibilities; and
- Ensuring that tenants receive all the services they need to remain stable, live as independently as possible and avoid a return to homelessness.

Mental Health Practitioner

Also known as a "therapist", "counselor", or "social worker", the mental health practitioner is responsible for:

- Individual or group counseling/therapy;
- Support groups;
- Recovery groups;
- Peer mentorship; and
- Coordination with psychiatric appointments or other mental health services.

Health Professional / Geriatrician

Because many tenants in supportive housing have chronic or serious health conditions, it becomes crucial for a nurse, doctor or health professional to provide:

- Regular medical care, including knowledge of geriatric conditions;
- Medication management and monitoring, medication self-management assistance;
- Pain management services;
- Health and wellness education;
- Physical therapy; and
- HIV/AIDS services.

Specialist and Ancillary Positions

Depending on the program, there may be many members of the care team who are not employed by the lead service agency but who offer services to address more specialized or intensive needs of frail seniors. These ancillary positions may include:

- Personal Care Attendant (also known as IHSS worker)
- Substance Abuse Specialist
- Benefits Specialist

Personal Care Attendant (IHSS worker): Personal care attendants are not employees of the housing provider or service team. Instead, they are employed directly by the tenant. They are an integral part of a tenants' support system and services staff work closely with them to meet tenants' needs. The main responsibility of a personal care attendant is to support the tenant by:

- Providing support and assistance to tenants with ADLs and IADLs;
- Helping tenants develop skills of daily living; and
- Accompanying tenants to appointments and providing transportation.

Substance Abuse Specialists: Substance Abuse Specialists typically do not have their own caseload but perform other important functions:

- Direct work with tenants with substance issues;
- Recovery groups and readiness, relapse prevention and recovery planning; and
- Individual counseling for tenants with substance issues.

Benefits Specialists: Benefits Specialists help tenants secure and maintain public benefits by:

- Assisting tenants with initial and ongoing paperwork;
- Accompanying tenants to benefits-related appointments;
- Advocating on behalf of tenants; and
- Assessing how earned income will impact benefits.

Peer Support

Peer support can be incorporated into supportive housing in various ways. It could mean that staff shares certain life experiences with the tenants, and can thus relate more easily to and assist the tenants in such areas. Or, it could mean that tenants themselves have opportunities to take on leadership roles in the program and can work with their peers to problem solve.

The researcher James J. O'Connell explored the consequences of a housing placement that does not include the essential component of peer engagement[21]. For example, one formerly homeless senior client became lonely and depressed in her new permanent housing due to a lack of support, accessible services or frequent opportunity to engage with peers. As a result, she returned to a transitional shelter where only minimal services were provided. This can be avoided by incorporating peer support into supportive housing programs.

[21] O'Connell, J., Summerfield, J., and Kellogg, R. (1990). The Homeless Elderly. In P. Brickner (Ed.), *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States* (151-168). New York, NY: W.W. Norton & Company

Supervision, Self-Care and Training

Supportive housing can be a challenging work setting for staff. Providing quality supervision should be a key component of any agency's staffing program. Supervision should be geared towards the needs of staff members, whether they are professionals (e.g., MSW) or paraprofessionals (i.e., BA-level).

Staff should receive regular supervision from qualified professionals who can provide guidance, support, and clinical insight. Supervision is provided one-on-one or in group settings. Effective supervision will support the development of healthy and successful relationships between staff and tenants, and the maintenance of a strong tenant community.

Self-care is an important practice for all staff working with formerly homeless seniors in a housing setting. Working daily with tenants experiencing acute issues, including depression, physical health challenges, and the aging process, can cause stress and burnout for the case manager or service coordinator. To be effective, staff must reduce stress and enhance their overall well-being.

Service providers should develop self-care plans that cover physical health, psychological health, emotional needs, spiritual needs, and relationships. Self-care strategies vary based on what the individual finds helpful but can include a range of activities, such as support from mentors or peers, pursuit of personal hobbies, engaging in exercise, and taking vacations. Service agencies must recognize the critical role of self-care and make it a priority for supervisors and case managers.

Professional development opportunities facilitate skill development among onsite staff. In addition to formal trainings and workshops, roundtable groups and working groups expose providers to colleagues facing similar challenges. In Los Angeles County, there are groups that meet regularly to share resources and discuss topics related to supporting seniors in housing. The meetings are often hosted at sites that give staff a chance to visit different housing developments and learn about their successes and challenges. Engaging with colleagues gives staff a support system and opportunity to learn from others about what is working and not working for meeting the needs of aging tenants.

Peer Learning Groups for Service Providers in Los Angeles

Peer Group	Lead Agency	Description	Contact Person
CES Navigation Meetings (Coordinated Entry System)	Lead Agency for your Service Planning Area (SPA)	Community resources for homeless individuals	SPA Contacts for CES
LAAAC Los Angeles Aging Advocacy Coalition (membership-based)	St. Barnabas Senior Services	Conducted via conference call the group discusses policies and resources relevant for seniors	Brandi Orton
Older Adult Supportive Housing Group	Los Angeles County Department of Mental Health	Housing and resource updates relevant for DMH's older adult clients	Kevin Tsang
PSH Providers Meeting	United Way and Enterprise Community Partners	Policy and funding updates, and information sharing	Emily Bradley
Resident Services Roundtable	Enterprise Community Partners	Group discussion on topics relevant to onsite services in affordable housing	Marc Tousignant

Delivering Services

Intensive Case Management

Intensive case management is the cornerstone of service delivery and helps senior tenants stay safely housed while maintaining the greatest level of autonomy and quality of life. In addition to the traditional case management duties, housing case managers must also assess housing readiness, measure housing stability and help consumers develop goals that are specific to retaining housing.

In order to provide effective case management to senior tenants, case managers must be uniquely equipped to work with seniors because seniors may experience:

- Difficulty understanding processes for accessing resources;
- Difficulty maneuvering systems of care;
- Feelings of estrangement and isolation;
- Avoidance and/or procrastination in asking for help and seeking needed assistance; and
- Difficulty in responding to outreach efforts and building trust because they may have faced past rejections.

Case managers provide direct services, including outreach and engagement, assessment, individualized service planning, support and counseling, crisis management, medication monitoring, and independent-living skills training. Case managers help new tenants adjust to their living arrangements and work assertively with tenants to motivate them to address issues that led to their previous homelessness, and may threaten their return to homelessness.

Under a *Housing First* model, housing is prioritized before dealing with issues that contribute to housing instability. Therefore, in supportive housing case management services are typically provided on-site, either in staff offices, in the community rooms, and/or in tenants' apartments. There are a series of steps that comprise the typical Case Management process, although this process is not always linear and consumers may transition through these stages iteratively.

Engagement is the first step in the relationship between any social services staff and its consumers. Collaborative Solutions, Inc. states that engagement of formerly homeless seniors is particularly difficult because they often feel a combination of loss of power, loss of role, loss of connection and/or a lack of basic needs.[22] This sense of loss intensifies the need for engagement and trust

[22] Collaborative Solutions, Inc. (2011) *Housing-Based Case Management: Best Practices to Assist Clients with Housing Options* [PowerPoint slides]. Retrieved from http://www.collaborative-solutions.net/aboutus/NEWS%20STORIES/Ashley%20Kerr%20and%20Crystal%20Pope%20Presentation%20-%20Housing%20Case%20Management.pdf

building between the case manager and the tenant. Building a relationship with tenants requires time and patience, but it is virtually impossible to do substantive work without this foundation of trust.

Seniors may isolate out of fear or because of mental health or mobility issues. When seniors are in denial about their need for assistance or afraid to seek help for fear of being forced to move to a skilled facility, they will avoid the social services team. Onsite staff should present themselves as advocates and partners who want to work with the tenant to make daily tasks easier.

There are also some special opportunities for engagement with the senior population. Hearth, Inc. describes the *Senior Epiphany* phenomenon that can motivate homeless seniors to find housing later in life. This epiphany provides a "window of opportunity" to engage the homeless senior in intensive case management.

The epiphany emerges in these steps:

1) A health issue begins to negatively impact lifestyle and quality of life;
2) The senior begins to contemplate changing certain behaviors;
3) The senior begins to contemplate end of life issues; and
4) The senior decides not to die as a homeless person.

Assessments

RESOURCES

- For a sample list of what to include in a tenant's case file refer to page #21 of A Guide to Providing Services in Housing.[23]

As part of the intake process, every senior should receive an initial assessment. The assessment gathers information to understand a person's baseline and to identify strengths and unmet needs. Information is collected on a variety of topics including motivation for seeking case management, income, employment and education, literacy, cultural background, family composition, social supports, personal strengths, physical, mental and cognitive health and more.

Case managers in a housing setting must also assess housing stability by collecting detailed information on what actions, behaviors and circumstances led to past housing instability and/or homelessness (e.g., mental health, health, and substance abuse), independent living skills, housing history, and what supports are needed to ensure long-term housing stability.

The most important aspect of the assessment is to make the tenant feel comfortable. When working with seniors, this can be achieved through these strategies:

- **Listen during the assessment and allow the individual to share stories**. Seniors have diverse life experiences, which offer opportunities for finding commonalities and making a personal connection. Expect to develop a complete picture of the tenant over a series of follow-up meetings and pay attention for signs of fatigue or distracted behavior if the tenant gets tired or loses interest during the assessment.

- **Home visits are helpful for observing a senior's living conditions and how they function in their environment**. Use professional judgment to determine if it is safe to meet alone with the tenant or if another staff person should be present. If the tenant is uncomfortable meeting in their apartment, then meet in your office or another location that provides privacy. After you have established rapport with a tenant it could be a concern if they repeatedly refuse to meet in their apartment. If this behavior persists, then collaborate with the onsite resident manager to schedule an inspection of the apartment.

- **Conduct the initial assessment one-on-one if possible**. This limits undue influence from other parties and gives the senior a chance to be heard. If language or cultural norms are a

[23] CSH. (2003). *Developing the "Support" in Supportive Housing*, prepared by Tony Hannigan and Suzanne Wagner. http://www.csh.org/wp-content/uploads/2011/12/Tool_DevelopingSupport_Guide.pdf

barrier, then invite someone who can facilitate a productive conversation such as a family member or off-site caseworker who has a history with the tenant. To gather additional information, it may be necessary to consult with the tenant's other service providers, in-home support worker, peer mentor, family or friends. Request the tenant's permission to speak with these individuals.

- **Assessment Is an Ongoing Process**. While the initial assessment is like an intake, the task of assessing how an individual performs activities is an ongoing process. Staff will observe and document behaviors over time to build a complete picture of the tenant. Eventually, staff will be able to recognize changes in the tenant's behavior that indicate decompensation and underlying problems.

- **Assessments are Tenant-Driven**. A successful assessment starts the process of formulating tenant-driven goals and determining whether more clinical tests or specific screenings are needed. By addressing a senior's immediate challenges, you are moving the senior closer to integrating with the community so they may develop natural supports.

Local Innovation – **Assessments & Wellness Planning at Vermont Villas**

Assessments are intended to help staff understand a tenant's needs and to engage tenants in their care planning. Individuals aging in supportive housing often live alone, have minimal social supports, and experience anxieties about falling or having an emergency when no one is around to help. To alleviate these concerns and proactively address tenants' desire to feel safe, PATH Ventures developed a Wellness Planning Policy first implemented at its Vermont Villas site in south Los Angeles near Gardena.

Vermont Villas offers 78 apartments for veterans and individuals with chronic illnesses who are over the age of 55. The staffing team is comprised of four PATH case managers, two PATH interns, one case manager from the Veterans' Administration (VA), and two VA peer support.

At intake, staff have tenants review and complete:

- Wellness Check Acknowledgement form that grants staff permission to contact a tenant's emergency contact in the event of a crisis
- Wellness and Recovery Action Plan
- Vial of Life, and
- 5 Wishes

The Wellness Planning Policy outlines procedures for staff to follow if they have not seen a tenant or if they believe the tenant may be in distress. (See the Resources Section for a sample copy of the Wellness Policy.) Wellness checks are intended to balance tenants' right to privacy with their

overall safety. Staff have weekly meetings that allow them to check-in on the whereabouts of specific tenants. If staff are unable to contact the individual after completing certain steps, then they visit the tenant's unit with the property manager. The Wellness Planning Policy gives staff steps to follow depending on what they encounter in the apartment.

Property managers may be reluctant to waive the 24-hour notice rule when entering a tenant's apartment, even in a suspected emergency. Tenants at Vermont Villas had to obtain 40 signatures on a petition in support of the Wellness Planning Policy before the property manager agreed to cooperate with case managers.

Goal Setting

In the housing context, a case manager must ensure that the tenant's service needs and income requirements are being met and agree on goals with the tenant that reflect the steps needed to retain housing in the long-term. Some goals that are common for tenants include:

- **Housing**: retain housing;
- **Find Primary Care Physician**: establish medical home; review prescriptions; evaluate hip pain; and
- **Other Issues**: develop independent living skills; obtain substance abuse treatment, obtain mental health and other services.

Service Planning/Individualized Service Plans

The assessment and goal planning stages inform the service planning process. This information allows the case manager and consumer to collaborate on a service plan that is customized to each consumer's needs, goals, interests, and preferences. This often happens in partnership with referring agencies such as the VA, or county health and behavioral health agencies. The Individualized Service Plan (ISP) is a consumer-driven, living document that may be modified as the greater stability is achieved, new skills or interests are acquired, and/or as new needs emerge.

Monitoring/Follow-up/Evaluation

Ongoing monitoring is an essential part of effective case management. Monitoring is achieved through comprehensive documentation, regular communication with the consumer and the use of standardized tools and evaluation. Depending on the jurisdiction and agency, requirements and policies will vary regarding contents of information to be documented and frequency of documentation. However, it is always crucial to keep records up to date and to obtain releases from consumers on collecting and/or sharing their confidential information.

Regular and ongoing monitoring is crucial for housing retention. A study focusing on 64 homeless seniors who were re-housed found that effective monitoring required:[24]

- Developing reliable methods of contact with tenants;
- Allowing monitoring to be flexible (e.g., frequency and intensity);
- Developing procedures and protocols for assessing and adjusting counseling and supports;
- Utilizing instruments that measure tenants' levels of distress, loneliness, and morale; and
- Communication among the developer, landlord and service provider.

Formal evaluation maximizes the well-being of the consumer, assesses the appropriateness and effectiveness of services provided to consumer and ensures a high quality of care. Evaluation can take many forms, some examples of how to evaluate case management services include:

- Collect and integrate tenant feedback and satisfaction information;
- Strategic planning to help consumers achieve case management objectives;
- Use of standardized tools (e.g., assessments, indicators, surveys, and guidelines);
- Measurement of outcomes; and
- Qualitative/quantitative research, dissemination and application of findings.

[24] Crane, Maureen (1999). *Understanding Older Homeless People; Their Circumstances, Problems And Needs*, (Buckingham UK and Philadelphia: Open University Press) : 162.

Income, Health Insurance, and Other Benefits

RESOURCES

- Refer to the Resources section for a description of benefit types.
- Refer to the *Advocacy for Seniors – A How to Manual* created annually by Bet Tzedek and Justice in Aging. Contact Bet Tzedek to request a copy.
- Refer to SSA's FAQ for information on setting up a representative payee.

Barriers to Benefits Enrollment and Retention

Homeless seniors often encounter difficulty in the application process for various benefits programs because they may:

- Lack proper identification and/or documentation;
- Lack current and/or complete medical records;
- Encounter difficulty in accessing mail, phone and/or electronic correspondences; and
- Encounter difficulty proving eligibility for long episodes of homelessness.

Often, this results in incomplete applications, a prolonged application process, or denied applications because required information is missing. While these documents are crucial to apply for and access housing, many of these issues require resolution by case managers working with seniors who are housed. Connecting homeless seniors to benefits for which they are eligible presents a unique set of challenges because homeless seniors:

- May need application accommodations for age-related physical problems (e.g., loss of hearing/sight, mobility problems, or frailty);
- May have a reduced understanding of benefits eligibility due to cognitive decline; or
- May not have familial support system to assist in the application process.

This can produce under-enrollment in benefits among the homeless senior population. For example, a 2008 study by Shelter Partnership found that only one third of homeless seniors who self- reported having a disability were accessing SSI. Further, 17% of physically disabled and 13% of mentally disabled homeless seniors reported no benefits income.[25] These challenges

[25] Shelter Partnership, Inc. (2008). *Homeless Older Adults Strategic Plan*. Retrieved from http://shelterpartnership.org/Common/Documents/studies/HOAPlanCompiled.pdf

demonstrate why it is important to have trained staff who can assist homeless seniors in completing accurate and timely applications for benefits.

Supportive housing staff must also be aware of how benefits interact with other services. Homeless seniors receiving SSI experience a reduction in benefits after moving into housing. The program reduces the level of benefits when an individual resides in a home with cooking facilities. If rent is calculated based on income, staff must assist tenants in reporting changes in income so rent can be adjusted accordingly.

Case Managers assess all new tenants' eligibility for public benefits, including Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), General Relief (GR), Medi-Cal, and, for veterans, various VA benefits. Subsequently, case managers assist and advocate on behalf of tenants to receive all benefits for which they are eligible but are not presently receiving. They help tenants secure and maintain public benefits by minimizing the typical barriers that tenants face in the application process. Strategies for reducing barriers include:

- Assessing new tenants for benefits eligibility;
- Assisting tenants with initial and ongoing paperwork;
- Helping tenants find or obtain required documentation and/or identification;
- Accompanying tenants to benefits-related appointments;
- Corresponding on behalf of tenants;
- Advocating on behalf of tenants in obtaining benefits for which they are eligible but not currently receiving; and
- Assessing how earned income will impact benefits.

Representative Payee Services

Many service providers in supportive housing enter into written agreements with representative payee service providers, recognizing the need for this service will only increase over time as tenants age in place. In some states, a property management company or a lead service provider may provide representative payee services. In other states, this is viewed as a conflict of interest; one can appreciate how a tenant might be suspicious of a representative payee provider who retains a substantial portion of the tenant's income for rent.

Often, tenants are reluctant to agree to representative payee services, even if threatened with eviction for non-payment of rent. In these instances, intensive case management and family intervention can help.

Health Insurance

RESOURCES

- The Center for Healthcare Rights provides counseling and advocacy for Medicare beneficiaries who encounter issues. Call (213) 383-4519 for assistance.

- Home Health Compare is an online service offered by the federal Centers for Medicare and Medicaid Services to provide information about the quality of Medicare-certified home health agencies.

- The Benefits Enrollment Center operated by Wise and Healthy Aging in Santa Monica has operators who help seniors enroll in the Part D Low Extra Help Program, the Medicare Savings Program, and Medi-Cal. Call (855) 636-7655 for assistance.

Being knowledgeable about health insurance coverage is important for coordinating treatment and helping seniors understand their options. Seniors who have experienced homelessness may be uninsured and may not have a primary care doctor. The doctor could also be located far away and tenants may have trouble getting to appointments. Identify medical groups near the supportive housing site that have a geriatrician on staff and accept Medi/Medi or Medi-Cal managed care plans. Whenever possible, connect formerly homeless seniors to geriatricians when they need doctor referral. Some medical groups provide transportation to appointments for their clients. Ask about transportation when scouting nearby medical groups and geriatricians.

During the initial assessment staff will collect information on a tenant's primary care doctor and specialists. Keep a copy of the tenant's updated doctors' information, health insurance card and prescription drug card in the case file.

Medi-Cal
Individuals are automatically enrolled in Medi-Cal when they submit a SSI application. Persons not eligible for SSI can enroll in Medi-Cal without a share of cost deductible if they fall below the countable income limit. Medi-Cal covers nursing home care, doctor visits, hospital stays, non-medical home care, hospice, hearing aids, ambulance services, drug and alcohol treatment programs, physical therapy, home health care and dental services.

Dental services paid for by Medi-Cal are delivered through Denti-Cal and cover examinations, x-rays, cleanings, fillings, root canals, crowns on front teeth, and complete dentures. Poor dental hygiene can lead to infection, decay and extractions. Teeth extractions can lead to an inability to annunciate, eat, or smile, all of which are serious issues that diminish a person's confidence and sense of dignity. While Medi-Cal covers routine dentals services, Medicare does not.

Medicare
Seniors 65 years and older will qualify for Medicare if they have a work history (same as Social Security requirement). If a senior does not automatically qualify, the senior can enroll and pay a monthly premium. Medicare Part A covers hospital stays and the first 20 days in a skilled nursing facility after a qualifying hospital stay. Seniors pay a copay for days 21-100. After the 100th day the senior is responsible for the full cost. Part A will pay for up to 190 days at a psychiatric facility throughout a person's lifetime.

Part A can also pay for hospice care and "skilled" home health care if ordered by a doctor. The tenant must be homebound, defined as leaving the house only occasionally and with great difficulty. Home health services may be approved for no more than 28 hours per week and services must be delivered by a Medicare-certified agency. **Part B** pays for doctor visits, services, and tests. Part B premiums are deducted from seniors' Social Security checks. **Part D** is the prescription drug program. The Low Income Subsidy also known as the Extra Help Program offers discounts for qualified households.

Enrollment Periods for Medicare

The eligibility and enrollment period for Medicare Part B begins three months before a person's 65th birthday and continues for three months after the birthday month. Part B also has a general open enrollment period from January through March.

All Medicare recipients are eligible for Part D. The open enrollment period for Part D plans is between October and December. Seniors enrolled in the Extra Help Program can switch plans any time through the year. Seniors who sign-up late (after eligibility period) for Part B and Part D will face increased monthly premiums. These penalties are waived for seniors who qualify for the Extra Help Program.

In Los Angeles County dual eligible tenants who have Medi-Cal and Medicare coverage are enrolled in a managed care plan as part of the Coordinated Care Initiative. Medi-Cal only beneficiaries are enrolled in LA Care or HealthNet. Undocumented formerly homeless seniors will receive services through the County of Los Angeles Department of Health Services in county-operated hospitals and clinics.

Aging Services Network

A major resource available for seniors living in supportive housing is the Aging Services Network. The Aging Services Network is a group of local agencies that offer community-based services for persons over 60 years of age.

Services include nutrition and meals, transportation, non-medical care, health promotion, social activities, legal services, and caregiver support. Every State has a State Unit on Aging and local Area Agencies on Aging (AAA). In Los Angeles County the AAA is Community and Senior Services and the City's AAA is the Department of Aging. Both agencies are a gateway for finding services in a specific geographic area. Availability and quality of services varies across communities. Providers within the Aging Services Network are valuable allies for assembling wrap-around services and they can assist with navigating resources that have inconsistent eligibility requirements.

Senior Resources in Los Angeles County

Benefit Type	Program	Eligibility	How to Apply
Transportation Ride-sharing service	Access Paratransit	For persons with a disability that limits their ability to ride public transit.	Contact Customer Service at 1-800-827-0829 cserv@accessla.org Schedule an in-person evaluation at the Access Evaluation Center.
Transportation Reduced costs for taxi and dial-a-ride services	City of LA Dial-A-Ride	For seniors age 65 or older and qualified disabled persons in the City of Los Angeles.	Go to www.ladottransit.com to download an application and click on the City Ride link. Each quarter participants receive a $42 value on their City Ride cards. West Hollywood and Santa Monica have their own dial-a-ride programs for residents.
Energy Bill One-time Financial Assistance	LIHEAP Home Energy Assistance Program	<$23,963 annual income for a 1-person household.	Check eligibility and find service providers on the California Department of Community Services and Development website: http://www.csd.ca.gov/Services/HelpPayingUtilityBills.aspx
Basic Local Phone Service Discount	Lifeline	Participants in these programs qualify: SSI, S8, Medi-Cal, CalFresh and seniors with incomes ≤135% FPL.	Call the phone company and tell the sales department you want to sign up for the Lifeline program to receive a discount on your phone bill.
Captioned Telephone	CapTel	For persons with hearing loss.	Call 1-800-806-1191. Phone is free with authorization from an audiologist or hearing aid specialist. Need analog phone line.
Personal Care Assistance	In-Home Supportive Services (IHSS)	All Medi-Cal recipients are eligible with a medical professional's certification.	Call 1-888-944-4477 to request an application. Obtain signature from a medical professional verifying the applicant is at-risk of outplacement. Submit application. Wait for in-home assessment by County staff.
Food Assistance Meal Delivery	Meals on Wheels	For homebound seniors who have difficulty preparing meals.	Call St. Vincent Center 213-484-7775 or fill out the form at: https://stvincentmow.org/if-you-need-meals/. If you are out of St. Vincent's network, call 1-800-510-2020.
Emergency Alert Response System	EARS	62+ in city of LA. Frail, homebound, and meet income reqs.	Call 213-473-5990 or 1-800-510-2020. Service offered at no cost or subsidized cost to qualified seniors (when available).

Independent Living Skills

RESOURCES

- The Los Angeles Metro's On the Move Riders Club offers information about discounted fares and tips for seniors who rely on public transit (213) 922-2299.

- Request an application to California's In-Home Supportive Services (IHSS) program by calling 1-888-944-4477

By providing training on independent living skills, service providers support tenants in maintaining their housing. This service can be provided to tenants via group workshops or one-on-one coaching. The assessment portion of individualized service plans makes it possible for case managers to tailor the trainings according to each tenant's needs. The trainings can be conducted by lead service provider staff or by outside agencies. Common topic areas include:

- Household maintenance and chores;
- Nutrition and cooking;
- Budgeting and money management;
- Stress management;
- Use of public transportation;
- Neighborhood orientation (e.g., markets, libraries, and senior centers).

While assistance with independent living skills is considered a basic function of the service coordinator or case manager position, housing projects generally do not have dedicated funding for this service. However, funding from federal agencies is available for "home and community-based services and related supports" for seniors, including nutrition services, in-home services, transportation, and affordable housing. There are other resources that can facilitate tenants' daily functioning.

Non-Medical Home Care and Assistive Devices

As everyday tasks like dressing, bathing, cooking, toileting, and cleaning become more difficult a senior can apply for in-home care and install devices designed to make tasks safer and easier. In California, Medi-Cal will pay for non-medical home care that provides seniors with personal care assistance, domestic services and supervision. Veterans may qualify for in-home care through the Veterans Administration. Staff can call 877-222-8387 to check eligibility requirements

In-Home Supportive Services Program (IHSS)

For non-veterans and U.S. citizens, County Departments of Public Social Services administer the IHSS program, which assists elderly, blind, and/or mobility-impaired tenants with home cleaning, meal preparation, laundry, grocery shopping, and personal care. Case managers or resident service coordinators should assist tenants with IHSS application forms and communication with IHSS administrators.

Request an IHSS application by calling 1-888-944-4477. The IHSS application requires a home assessment and documentation from the tenant's doctor that verifies that they are at-risk of outplacement if they do not receive supplemental assistance at home and. Information contained in the application helps determine the number of IHSS hours approved by DPSS. Finally, the senior has to find, interview and hire an individual to be the IHSS provider and deliver the in-home assistance. Onsite staff are often asked to facilitate and support this process.

Personal Assistance Services Council (PASC) operates a registry of home care providers. Individuals can call 1-877-565-4477 or print the application from the website and mail it to the Council. The form is available in English and Spanish. PASC will send a list of names with contact information for IHSS providers who meet the senior's preferences.

TIP A senior can hire two IHSS providers and use one as a back-up provider if the primary person is ever unavailable.

It may be easier for a senior to quickly hire an experienced worker if they live at a housing site where many tenants are enrolled in the IHSS Program. IHSS workers can provide assistance to multiple tenants in the same building and maximize their billable hours without having to travel. Onsite staff can maintain a list of names and contact information for IHSS workers in the building so when tenants need to hire someone they can first contact providers already onsite who have extra hours to fill.

IHSS workers help tenants compensate for lower functioning without compromising their quality of life. An IHSS provider can be the difference between someone transitioning to a higher level of care and someone continuing to live independently, so they are vital members of the care team. They spend more one-on-one time with the senior than any other service provider.

TIP A staff person should be present for the annual IHSS reassessment and speak with the county social worker if the tenant requires approval for additional hours.

Handy Worker Program

Modifications to the physical environment aid seniors in completing tasks or make it easier for caregivers to safely assist. Grab bars in the bathroom, a raised commode, removable showerhead, and nightlights are examples of modifications to make living spaces more usable for a senior who is experiencing limitations.

Renters in the city of Los Angeles who are 62 years and older or those with a disability can qualify for the Handy Worker Program, which provides safety devices, such as grab bars and bath/shower seats. Call (213) 808-8803 or (866) 557-7368 to request more information. The Program may have a waiting list and services are based on availability of funds. Different cities within the county operate their own versions of the Handy Worker Program. Check with the local housing and community development department. If the program is closed, advocate to the property management staff to install needed devices for tenants.

Fall Prevention

Assistive devices and in-home care are helpful interventions for lessening seniors' risk of falling. Repeat falls heighten a person's likelihood of transitioning to a higher level of care. Home care assistance, assistive devices, removal of tripping hazards, and additional education are important fall prevention tools. Staff from the City Department of Aging can deliver a 45-minute fall prevention workshop to tenants and staff. Call the Los Angeles City Department of Aging at (213) 482-7252 to request a presentation at your site.

Transportation Planning

Case Managers help tenants establish routines for regular transportation to appointments and jobs. Case managers will help tenants with mobility challenges schedule rides with local paratransit operators, whose services are usually subsidized. Access is the name of Los Angeles County's paratransit operator: http://accessla.org/home/.

Case Managers should develop an education program on the use of the local bus and other rapid transit systems. Ideally, these will include field trips to transit stops to demonstrate ticketing options. Services staff should have at least a limited quantity of bus tokens to distribute.

Lead service providers may also choose to raise private funds or solicit a discounted van from an auto dealer. A van is useful when public transportation is not available or practical (e.g., for field trips and for transporting new tenants and their belongings to the site). Before deciding to purchase a van, service providers should consider who will drive the van and the costs of insurance and routine maintenance. Volunteer drivers who are not employees of the agency are not typically insured under an agency's insurance policy.

Behavioral Health

RESOURCES

- The County's Department of Public Health's Community Assessment Service Centers (CASC) link tenants to substance abuse treatment. Professionals conduct screenings and make treatment referrals. To find a CASC in your area visit the website or call 1-800-564-6600.

- The Los Angeles County Department of Mental Health GENESIS – Seniors Hoarding Task Force created a Resource Guide to Help Consumers, Families, and Professionals Manage Hoarding

Homeless individuals of any age are more likely to experience co-occurring mental health and/or substance abuse issues than the general population. Further, homeless seniors are more likely to have cognitive impairments than younger homeless adults. Seniors with mental illness and co-occurring disorders require specialized care and ongoing treatment. High-quality behavioral health treatment is crucial for seniors' long-term housing stability.

Mental health symptoms and substance use disorders can aggravate other medical conditions and hasten an individual's functional decline. Substances can also interact with an individual's prescribed medications causing serious medical problems. Early intervention will help avoid long hospitalizations or worse outcomes. Ideally, at least one case manager in permanent supportive housing will be a certified addiction counselor. All case managers should be available to provide education, assessment, counseling, and referrals on substance abuse and recovery to tenants with a history of substance abuse

Recognizing early signs of decompensation will help staff support tenants and will become more clear when you are familiar the tenants. Decompensation includes "exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace" (Social Security Administration). Common indicators that an individual's symptoms are out of control include:

- Abnormal behavior compared to the individual's usual self (e.g., sleeping differently);
- Complaints from other tenants about individual's behavior;
- Medication non-compliance;
- Increased agitation, isolation or paranoia;
- Depression or mania;
- Poor hygiene or inability to perform daily living skills;

- Public intoxication;
- Failed unit inspections; or
- Multiple 9-1-1 calls within a short time.

Behavioral Health Impacts Housing

Within a supportive housing context, behavioral health issues can manifest in a variety of ways, such as isolation, conflict among tenants, difficulties remaining independent, and more.

Failed unit inspections are usually the result of safety or sanitary issues related to hoarding, bed bug infestations or poor housekeeping. Hoarding is caused by mental illness and cannot be fixed overnight. The social service team should work with the senior to establish incremental goals and clearly communicate action steps to the property manager. The date of the re-inspection can serve as a short-term motivator for the tenant. Failed inspections provide impetus for working with tenants who normally resist services.

If an issue is brought to the attention of onsite staff by means other than a failed inspection, then other steps may be necessary. After viewing a unit that is unsafe services staff can alert the property manager to the issue. The property manager can post a 24-hour inspection notice and give the tenant a deadline for correcting any findings.

For tenants with a history of hoarding, the property manager should schedule pre-inspections in advance of housing authority and other official inspections. This will allow tenants time to correct problems and prevent failed inspections. If the tenant does not correct the issues by the deadline and staff determines it is a safety risk, then staff is mandated to call Adult Protective Services and file a report.

Both hoarding and bed bug infestations require strength and stamina to mediate. Seniors may have difficultly moving furniture and organizing clothes and personal belongings to clear space for the exterminators. Tenants may also require assistance disposing of a mattress or other large items that are too infested to salvage. Onsite staff should support tenants by supplying large bags or boxes if needed and coordinating with the senior's IHSS worker, friends, and peer specialists or hired workers to help the tenant lift, move, and organize items.

TIP Give seniors advanced warning of the scheduled extermination. They may require more time than other tenants to complete the preparation checklist.

Behavioral Health Treatment for Formerly Homeless Senior Tenants

Many new senior tenants will already be connected to mental health care services, typically with a county department of mental health or, for eligible veterans, the VA health care system. The case manager verifies at assessment if tenants have a provider. For new tenants who are not connected to mental health care, the case manager conducts mental health screenings and makes appropriate referrals. Case managers facilitate referrals for comprehensive mental health services, including psychiatric care and supplemental support for mental health services to be provided by qualified staff, who ideally will provide mental health services on-site.

Many service providers in supportive housing enter into written agreements with mental health service providers recognizing the need to make effective referrals in times of crisis. If a senior whose symptoms are out of control is engaged in mental health services, then the goal is to coordinate treatment with the entire team so everyone is aware of behaviors, living conditions, and interventions. For seniors who are not linked to mental health services, have referral forms for appropriate mental health services and treatment programs and make the linkage as quickly as possible.

Many seniors are active enough to visit a clinic or mental health center. For those with mobility challenges or who need a higher level of care, home-based services are another option. In Los Angeles County, the Department of Mental Health (DMH) defines seniors as 60 years and older and their programs include:

- **Full Service Partnership** (FSP): the FSP program is appropriate for seniors who need the most intense level of support and care. Care is provided on a 24/7 basis.
- **Field Capable Clinical Services** (FCCS): the FCCS program will serve people ages 55-59 too but with less intensity and "service extenders" that include friendly visits.
- **Prevention and Early Intervention** (PEI): is designed for someone experiencing mild to moderate mental health challenges and needs short-term intervention for minor symptoms. PEI services are time-limited and delivered for less than a year.
- **GENESIS**: is a field-based program that can deliver a variety of services and is well suited to treat seniors who are experiencing emotional challenges as they confront the realities of aging.

Emergency Psychiatric Evaluation

When there is a crisis during business hours, service staff assesses the situation and contacts 911 if there is an immediate threat of harm. Absent an immediate threat of harm, onsite staff de-escalates the situation and determines if it is necessary to call an emergency psychiatric team to evaluate the tenant. The Psychiatric Evaluation Team (PET) is dispatched via the ACCESS line at 1-800-854-

7771. The PET clinicians will decide whether involuntary hospitalization, also known as a 5150 hold, is appropriate.

TIP Staff can call Verdugo Hills Hospital's crisis line (818) 952-2270 to see if they have a bed in their geriatric psych ward and ask if they can respond faster than the County's Psychiatric Evaluation Team.

It can take several hours for an evaluation team to arrive. When they arrive, they will assess whether the senior is "gravely disabled" or a threat to the tenant or others. While waiting, staff should continually evaluate the situation for personal safety and remind the tenant that staff is there to keep the tenant safe. Staff should assess the tenant's willingness to voluntarily go to the hospital for further assessment. Attempts to communicate with the tenant to gather more information could be useful for de-escalating the situation until help arrives.

For afterhours emergencies, the property manager and security personnel should have a written copy of the emergency/crisis procedures so they know whom to call. Effective communication among the team before and after an incident is important for responding to concerns from other tenants. It is also necessary for maintaining proper documentation of incidents.

After incidents involving an immediate threat of harm the resident manager, security personnel, and services staff should each receive a copy of the incident report. That same day or next working day all staff should meet to debrief. Depending on the type of incident, social service staff and/or the property manager will follow-up with the tenant to issue a written notification of the event and indicate if it constituted a lease violation. The property manager will be clear about expectations moving forward. Social services will offer interventions for addressing the underlying issues to minimize the likelihood of future crises.

Mental Health First Aid and Mental Health 101 workshops help non-clinical staff respond to tenants experiencing a mental health crisis in a manner that is safe and appropriate. The Los Angeles County Department of Mental Health offers these workshops as part of its Housing Institute held every spring. Other trainings may be hosted on or off-site are useful for all staff. Regular participation in peer learning groups will increase staff's awareness of trainings offered through DMH and other community groups.

Medication Management

On average, seniors take more medications than any other age group. This is particularly true for formerly homeless seniors who have complex physical and mental health issues. To manage multiple chronic conditions, seniors are expected to follow complicated medication regimens. When staff notices a change in a tenant's behavior, the first step is to rule out medication non-compliance or interactions. If a tenant falls or displays other physical symptoms, schedule an appointment with a doctor to check for an underlying medical issue. If a tenant has not taken medications for a long time and is exhibiting extreme symptoms (e.g., delirium, hallucinations, falling, or dizziness), then lab work may be necessary. On-site staff will have a better sense of next steps after the tenant has seen the doctor and received results from lab work.

On-site Medication Management
Medication management strategies are important for helping stabilized tenant remain stable. There are steps that staff can take to help tenants manage their medications.

- Review medications
- Help tenant reduce negative side-effects
- Track medications
- Medication Reminders
- Record Keeping/Pill Counts
- Medication Management by an External Provider

Review Medications with Tenant
When visiting the tenants' housing units, check their pill bottles and ask if they are taking their medications. When tenants say they are taking medications "as needed," ask why they are not taking them as prescribed. Is it because of side effects or do they have difficulty remembering? Are the prescriptions too expensive? Depression and other mental health issues can interfere with medication compliance. Talk with tenants to understand their concerns and address the situation with their doctors or psychiatrists as needed.

TIP If a senior has trouble opening pill bottles, call the pharmacy and ask the pharmacist to fill the prescriptions using only bottles with easy-to-open tops.

Help Tenant Find Correct Medication Regimen
In the case where the tenant is taking psychiatric medications, it can take substantial time to adjust the dosages and specific types of drugs to maximize effectiveness and reduce negative side effects (e.g., dry mouth, constipation, dizziness, fatigue, or restlessness). In fact, negative side effects may dissuade some tenants from taking prescribed medications. Staff can help tenants advocate for a

medication regimen that avoids these issues by coaching tenants to have this discussion with their psychiatrist.

Track Medications
With the tenant's permission, create a daily schedule of prescriptions with the dosage and instructions for each medicine. The medication "cheat sheet" can include information from the sample chart below formatted to follow a daily 24-hour schedule. Print the schedule and make a copy for the tenant and one for the case file. Use the list as a tool for coordinating care with the tenant's IHSS worker or visiting nurses. Update the list as the tenant's medications change.

Drug Name	What it does	Dose	How to take it	When to take it

Medication Reminders
After creating the medication schedule discuss the instructions with the tenant and talk about ways to stay organized. Assign one person from the tenant's care team to oversee helping the tenant follow the schedule. A family member, IHSS worker, home health nurse, or onsite staff can provide medication reminders to encourage the tenant to take them as prescribed. This can also become a routine part of counseling or case management services.

Record Keeping/Pill Counts
In cases where tenants self-managing medication, staff can help tenants stay organized by tracking prescription dates, dosages, and pill counts.

Medication Management by an External Provider
If onsite staff does not have the capacity to implement medication management internally, there are other options. Many service providers in permanent supportive housing enter into written agreements with medication management providers recognizing that the need for this service is inevitable as formerly homeless tenants with extensive physical health and behavioral health issues age. Medication management providers offer various arrangements for dosing and administration in accordance with tenant needs.

Often, physical health and behavioral health providers administer medication management services independently of each other. In these circumstances, the case manager can provide valuable service of ensuring that they communicate with each other so that they deal with any interactions among prescribe medications.

Case Scenario – **Medication Management Intervention**

Tenant Profile: 68-year-old male

Primary health issues: Bipolar 1 D/O, Hepatitis C, neuropathy, hypertension, gout, coronary artery disease, history of stroke, lower extremities amputee, and wheelchair-bound

Behavior Change and Decompensation
Tenant complained of a bed bug issue in his apartment. Resident manager reported that the pest management company had found no activity of bed bugs in his unit. The Lead Social Worker made a home visit with the resident manager. The tenant started pointing to things on the floor and wall claiming to see bed bugs where the manager and staff did not see bugs. The tenant showed lesions on his legs and abdomen from picking at bugs and asked if staff could see the bugs coming out of his lesions. Staff did not observe bugs.

Staff noted this as abnormal behavior for this tenant who was usually independent and had no history of hallucinations. He said he stopped going to the doctor because the doctor did not believe him when he talked about the bed bugs. Medications were visible in the tenant's apartment and he stated he took most of them "as needed."

Intervention
Since the hallucinations and behavior were out of the ordinary for this tenant, staff immediately referred him for an appointment with his doctor to get lab work. The first available appointment was several weeks out, so staff asked the tenant if he would be open to having a home health nurse visit and he agreed. The Home Health Agency came to the tenant's apartment and transported the tenant to see the agency's doctor within a few days.

Staff also contacted the tenant's psychiatrist and mental health team. The psychiatrist made a home visit within two days and recommended the tenant get lab work and follow-up medication management as it appeared he was not medication compliant, which was the suspected cause of the hallucinations.

Outcome
The onsite team worked together with other providers to deliver comprehensive care while monitoring the tenant's compliance with his medications. A home health nurse began visiting the tenant 2-3 times a week to provide wound care and medication management. The tenant continued to hallucinate for several weeks at which point he stabilized and the delusions subsided. The level of care and medication monitoring remains unchanged to prevent another episode of decompensation.

Hospital Discharge

Seniors who have experienced homelessness suffer from higher rates of chronic conditions and may have a limited knowledge of how to manage their conditions. Staff's role in supportive housing is to encourage compliance with doctors' treatment orders and offer guidance about behaviors that improve health outcomes. Staff can educate about the importance of regular doctor visits, nutrition and diet, medication adherence, and stress management.

It is crucial that supportive housing programs serving formerly homeless seniors have policies that permit hospital stays without losing eligibility or disqualifying for the program. The time during and following a hospital admission or outpatient procedure is critical for helping seniors maintain their functioning after an incident. Typically housing funders, such as HUD, are flexible about the duration of hospital stays, with appropriate documentation. Health events require staff to intensify their involvement and carefully manage transitions between medical settings and home.

During the Hospital Stay
Complications during planned or unplanned hospitalizations can prolong a tenant's absence from housing and require special accommodation and hospital visits from onsite staff. During a lengthy hospital stay, in order to retain housing, a tenant may need assistance in:

- Completing housing-related recertification paperwork with tenant;
- Facilitating rent payments with tenant (e.g., set up automatic payments);
- Placing a hold on mail or meal deliveries;
- Arranging or extending pet care; or
- Updating the resident manager on when the tenant is expected to return.

Absences
Different housing programs have different policies regarding absences from the housing unit. For example, the Housing Authority of the City of Los Angeles (HACLA) permits absences for 30 consecutive days for any reason. Absences that last 31-90 days are considered extended absences and require prior approval of the HACLA. Participants in the Shelter Plus Care Program are allowed absences of 31-180 days before their contract is terminated. Allowable reasons for extended absences include health, rehabilitation, convalescence, incarceration, domestic violence, or other personal needs of the tenant.

Psychiatric Hospitalization
In some cases, senior tenants may need psychiatric hospitalization. California's Welfare and Institutions Code (WIC) Sections 5150-5155, 5250-5259.3 and 5270.10-5270.65 outline involuntary psychiatric holds. In the case that psychiatric hospitalization is appropriate, staff takes on an important role in this transition:

- Discuss the prospect of hospitalization before it becomes imminent; discuss how hospitalization can benefit the tenant.
- Discuss potential resistance to hospitalization including fear of hospitalization, feelings of abandonment, loss of control/independence/privacy or negative experiences in past hospitalizations.
- Accompany tenant to hospital, if possible.
- Help process involuntary hospitalizations, as needed.
- Stay abreast of tenant's status during hospitalization.

Discharge and Post-Discharge Support
During the hospital stay, communicate directly with the hospital's discharge planner. The discharge planner is interested in gathering information about the patient's housing situation to learn what supports are available to the patient when the patient returns home. Tenants will usually sign a release of information when they are in the hospital. When onsite staff receive a call from the discharge planner, they neither confirm nor deny information about the person in question unless the discharge planner reports that the hospital has a release on file. Staff should ask if the release grants permission to confirm residency or to discuss discharge care.

Discharge planning requires:

- Determining the most appropriate setting for patient post-discharge;
- Identifying what the patient needs to facilitate a smooth discharge and transition;
- Meeting patient's needs throughout the entire discharge process;
- Ensuring that patient and/or patient representative understands the discharge process;
- Crafting a concrete discharge plan, as necessary;
- Evaluating the discharge planning process to assess patient's initial and continuing care needs and to document the patient's stay in the hospital;
- Documenting the process, including possible discharge destinations and community-based resources; and
- Coordinating the process among a variety of disciplines (e.g., mental health or in-home care).

During the discharge process, an individual may overstate the amount of support they have at home for fear of going to a nursing facility. On-site staff's role is to provide the discharge planner with an accurate description of the tenant's home environment and available supports so hospital staff can match the patient to the most appropriate and safe discharge site.

When onsite staff speaks with a discharge planner, it is their responsibility to understand the doctor's recommendations for follow-up care and to communicate this information to the rest of the team (e.g., IHSS worker or mental health clinician). Each member of the tenant's care team will provide different elements of post-discharge support.

Staff should ask the discharge planner specific questions to understand the senior's level of functioning. Conversations with the discharge planner give staff the opportunity to make sure the hospital and doctor arrange for adequate care. Sample questions:

- Were there medication changes during the hospitalization?
- Has the doctor called in the prescriptions to the pharmacy?
- What complications or potential side effects should staff watch for?
- Will the tenant need help with transferring, toileting, dressing, bathing, or cooking?
- What follow-up therapy has the doctor ordered?
- Will the tenant require medical equipment? Who will arrange for this?
- Can the doctor provide a written copy of the discharge instructions?
- What is the anticipated discharge date?
- Can the hospital provide transportation to get the tenant home?

With this information, staff can help tenants comply with discharge orders and recover from the health event. On-site staff can coordinate transition-related tasks among the care team. Tasks may involve arranging for prescription deliveries, scheduling follow-up appointments, or assisting the tenant with shopping. Support from onsite staff will help tenants return to their previous levels of functioning or make adaptations to compensate for permanent deficits.

Discharge to a Higher Level of Care

In the case where the current supportive housing environment no longer sufficiently meets the needs of a tenant who was hospitalized, other discharge options are available, such as nursing facilities, skilled nursing facilities, board-and-care facilities, assisted-living facilities, hospice care and long-term care facilities. The next section, Transitions to Higher Levels of Care, discusses these options in greater detail.

Case Scenario – **Hospital Discharge Intervention**

Tenant Profile: 66-year-old female

Primary health issues known at time of decompensation: major depression and history of alcohol abuse.

Behavior Change and Decompensation
Staff noticed the tenant had lost a lot of weight and approached the tenant to ask how she was feeling. The tenant explained she was having difficulty swallowing and had been suffering from a cough for several weeks.

Intervention
The case manager met with the tenant to encourage her to see her physician. The tenant's next appointment wasn't for three months so staff obtain a release of information form from the tenant and called the doctor to share her observations. The doctor scheduled an appointment that week.

After evaluating the tenant the doctor ordered a chest X-ray and referred the tenant to a specialist who diagnosed the tenant with cancer of the esophagus. The tenant elected to have surgery and was admitted to the hospital. The tenant notified onsite staff and asked staff to contact her friend to see if the friend would care for her dog until she returned. The friend agreed.

While in the hospital the tenant signed a release of information for the discharge planner to discuss her plan of care with onsite staff. The doctor ordered the tenant to follow a liquid diet during her recovery. The tenant elected to begin radiation treatments immediately and required help getting to and from her appointments. The discharge planner discussed the tenant's level of functioning with the case manager and arranged for home health services.

Outcome
Prior to hospitalization the tenant was not a candidate for In-Home Supportive Services. She prepared her own meals and kept her apartment organized and clean. After the surgery, the tenant required daily assistance with ADLs. The case manager requested an IHSS application and identified a worker for her. The IHSS worker began aiding with meals, medication reminders, grooming, and transportation to and from radiation treatment. These services complemented the support being provided by the home health agency (3 visits/week) and the case manager.

The tenant has since regained some strength but requires daily assistance from her IHSS worker. Onsite staff deliver ongoing counseling to help the tenant process her diagnosis and offer referrals to support groups in the area.

Transition to Higher Level of Care

RESOURCES

- **Types of Skilled Care Facilities**
- **CSH** PACE Fact Sheet

When given a choice, many seniors prefer to remain living in their homes. The goal of supporting someone to age at home instead of transitioning to an institutional setting is attainable in many, but not all, situations, but often not for an indefinite period. For this reason, staff must have tools for transitioning seniors to a higher level of care. This requires knowledge of the terminology, types of care settings, and alternative community-based programs that can safely prolong a senior's independence in supportive housing.

Resources to Preserve Independence

Some common issues that initially threaten seniors' independence and ability to age in place typically involve a loss in the ability to perform:

- Activities of Daily Living (ADLs): self-care tasks such as eating, bathing, dressing, toileting, transferring (walking) and continence.
- Instrumental Activities of Daily Living (IADLs): includes shopping, preparing meals, managing medications, managing finances, housekeeping, and transportation.

Initially, difficulty performing one or more ADLs or IADLs may be mitigated by in-home care and other physical supports.

If a tenant is exhibiting signs of confusion and memory loss, staff should refer the tenant to the doctor for a medical examination to rule out treatable medical issues. Medical problems such as urinary tract infections and medication interactions are sometimes produce symptoms of delirium and confusion that can be mistaken for cognitive decline. After ruling out a treatable medical condition, doctors can order additional screenings to assess the senior's cognitive functioning.

Adult Day Care

Adult day care allows memory-impaired and/or socially isolated elderly tenants to spend their days in a caring, supportive environment. Daily activities include lunch and snacks, arts and crafts, and group therapy. Many service providers in supportive housing enter written agreements with adult day care facilities, recognizing that tenants aging in place ultimately will need and choose this intervention.

Program of All-inclusive Care for the Elderly (PACE)
PACE's interdisciplinary team delivers in-home care, therapies, rehab, social services, transportation, and medical care to seniors over the age of 55 who require a nursing home level of care. PACE providers contract with mental health specialists to deliver behavioral health treatment. To see if PACE is available in your Zip Code, visit the California PACE website. For dual eligible seniors in Los Angeles County the PACE Health Plan is an alternative to Cal Mediconnect. The steps for accessing the PACE Program include:

- Visit the website to find out if your community lies within a PACE-covered Zip Code or service area;
- Contact the PACE Provider in your area (AltaMed or Brandman Centers for Senior Care) to ask about enrollment;
- Schedule an assessment with the tenant and the PACE team; and
- Tour the site.

Adult Day Health Centers (ADHC)
ADHCs offer a less intensive model than PACE but similarly provide a safe and secure location for seniors to access social and health services delivered by health care professionals. ADHCs accept PACE participants who are Medi/Medi but neither Medicare nor Medi-Cal fund ADHC as a specific benefit unless through a Medicaid waiver. In some instances, Medicare pays for certain services offered by an ADHC when prescribed by a doctor. Barriers to participation in Medi-Cal waiver programs include enrollment caps, narrowly defined service areas, and other eligibility requirements.

Assisted Living Waiver (ALW) in California
In part, the ALW is designed to help eligible seniors who are at risk of being institutionalized to remain living in the community by using ALW services to meet a variety of housing services. The ALW is also used to transition people out of nursing homes and into a community setting. Examples of ALW services include:

- Assistance with ADLs and IADLs;
- Skilled nursing and other health services (e.g., medication management);
- Social and recreational services;
- Meals, housekeeping, laundry; and
- Transportation services.

When Supportive Housing isn't Enough

The combination of supportive housing and Medi-cal waiver services may allow a senior to live independently into old age. However, some seniors will require a living environment with more intensive services. The need for skilled care can trigger a senior's transition from living in an

apartment to living in a setting with additional staffing, supervision, and structure, such as a rehabilitation center or assisted living facility.

There is a natural tension between what a tenant wants or needs and what supportive housing staff can facilitate. On-site staff must balance an individual's preferences with the level of services staff and partner agencies can reasonably provide. A tenant's safety – their risk to self and others – must be considered in these situations.

When on-site care is not enough to handle the side effects of severe memory loss, decreased cognitive function, frailty, and/or frequent falls, the senior's home environment becomes too challenging to navigate. Service staff must talk with the tenant about options for transitioning to a higher level of care. Steps for how to approach the topic with tenants:

1) Talk to the tenant. Share your observations and concerns.
2) Ask if the tenant has noticed the same things and if they are willing to consider moving to a place that can offer a higher level of care.
3) Recommend what you think are possible options.
4) Talk with the tenant's geriatrician or doctor to share your observations and concerns.
5) If the tenant agrees to cooperate, then coordinate the transition as necessary.
6) If a tenant refuses to relocate to a care facility, then continue to monitor the situation and advocate with the doctor.
7) If it appears a tenant will stay onsite, then do as much as possible to keep the tenant safe. A health crisis and subsequent change in functioning may force a tenant and the tenant's medical team to make the transition.

There are options for tenants who require a higher level of care. Some common care settings include:

- **Residential Care Facilities for the Elderly** (RCFE): these can be Board-and-Care Facilities or Assisted Living Facilities, and are designed to imitate community housing situations and preserve the independence of senior residents while simultaneously meeting their needs.
- **Skilled Care Facilities**: commonly known as a Nursing Facility (NF) or a Skilled Nursing Facility (SNF), these facilities provide tenants with skilled nursing care, health services or rehabilitation services that meet their needs.
- **Hospice**: can provide palliative care and management of the tenant's terminal illness and can treat the associated symptoms.

Facilities can provide tenants with three meals a day and access to a medical doctor onsite. Seniors who are struggling to live independently may respond well to this type of structure and supervision. Facilities are either locked or unlocked per the facility's license and type of residents. Tenants living in supportive housing often tend to resist moving to a facility because a larger

portion of their monthly check will go to pay the facility. Facilities issue seniors a monthly allowance after covering room and board expenses.

Barriers to Outplacement

- Tenant refusal; loss of freedom and less money to spend;
- Medical and/or behavioral problems limit which facilities that will accept the senior;
- SSI rate too low for the level of service the senior will require; or
- No availability of beds in the facilities that will accept the lower SSI rate.

These challenges require staff devote significant time to identifying outplacement opportunities because many facilities will not accept hard-to-serve referrals. Staff should work closely with a tenant's medical team to gain their buy-in by explaining the limitations of supportive housing and specific concerns related to the tenant's safety.

If outplacement from housing is not possible, then staff should assemble appropriate services to mitigate safety risks for the tenant until a better solution or relocation can occur. Staff can file a report with Adult Protective Services if the tenant is a risk to themselves or others. An APS report is helpful for documenting staff efforts to monitor the tenant and manage risk.

Case Scenario – **Transition to Higher Level of Care Intervention**

Tenant Profile – 74-year-old male

Primary health issues known at the time of decompensation: alcohol abuse, hypertension, and arthritis.

Behavior Change and Decompensation
Tenant displayed poor hygiene and poor housekeeping and staff noticed he had become more forgetful. The tenant failed a unit inspection because he had repeatedly defecated on his bedroom floor.

Intervention
Staff scheduled deep cleaning services and replaced the carpet with easy-to-clean linoleum flooring. Staff increased the intensity of services for the tenant by checking on him several times a week and scheduling and transporting him to doctor appointments. His geriatrician was becoming increasingly worried about his health because he was losing weight and was more forgetful.

After a few weeks of continued decline the tenant fell in his apartment. Onsite staff scheduled another doctor's appointment for the tenant. At this visit staff went into the exam room ahead of the tenant and spoke with the geriatrician about the recent fall and her growing concerns.

Outcome
The geriatrician examined the tenant and decided to admit him to the hospital for a medical workup and evaluation. During the hospital stay a neurologist, psychiatrist, and orthopedic doctor saw him. He had fractured his ankle when he fell and it was determined he had dementia secondary to his alcohol abuse. The tenant had multiple infections and was unable to walk on his own. Hospital staff determined that the tenant could not safely return to his apartment.

The hospital discharged the tenant to a skilled nursing facility to recuperate. The geriatrician spoke with the tenant and explained to him that she felt he needed to live somewhere that offered more help for his own safety and well-being. The tenant agreed and voluntarily gave up his apartment knowing he would be referred to a board and care home after he stabilized.

Staff contacted the tenant's sister and informed her of the doctor's recommendations and the tenant's decision. Staff gave the sister contact information for the skilled nursing facility where she could contact her brother. During the tenant's stay, the supportive housing staff visited him to deliver clothes and to have him sign the 30-day notice to vacate his apartment. His sister came to the apartment to pack the rest of his belongings. After three months in the skilled care facility the senior was discharged to a board and care home where he now resides.

End of Life Care

RESOURCES

- **Checklist – Managing a Deceased Tenant's Affairs**
- **Bet Tzedek –** Advanced Health Directives

Seniors often experience anxiety or fear of aging and end-of-life. Therefore, it is crucial to have staff with geriatric training that can help guide seniors through this process and plan for end-of-life care. Additional training and support for all staff is necessary for supportive housing that includes senior tenants.

Because formerly homeless seniors experience higher rates of both morbidity and premature mortality, death and dying services must be incorporated into supportive housing that serves formerly homeless seniors. Some examples include:

- Wellness groups that focus on chronic disease, terminal illnesses, end of life care and other issues that impact senior tenants;
- Training that prepares staff for dealing with tenants who are dying or do die;
- End of life counseling and referrals for tenants with terminal or life-threatening medical conditions and/or who are of advanced age. (N. B.: end of life counseling is also part of the care offered by health care agencies, but case managers often must assist tenants in accessing this care);
- Clear procedures for handling deaths that happen on the premises;
- Assistance for funeral and memorials, as needed; and
- Services for tenants and staff to process depression and stress that accompany death and dying.

Community Connections

Service provision need not be limited to clinical interventions, skill development and improvement of financial status. Developing a program of social and recreational activities has become standard for supportive housing projects, and is especially critical for those serving formerly homeless seniors. Social and recreational programming serves many purposes and is a vehicle for:

- Encouraging socialization;
- Providing educational opportunities;
- Orienting residents to the neighborhood;
- Increasing service engagement among tenants who isolate;
- Reducing rates of depression by offering opportunities to engage in enjoyable activities;

- Improving rapport among tenants and staff as they interact in other settings and contexts;
- Encouraging tenants to lead activities that will give them a sense of purpose; and
- Inviting tenant's family and friends to events to support family reunification

Recreational programming is particularly relevant for seniors whose social networks are small and shrinking. Once stabilized in housing, seniors will have idle time. Some will pursue interests and hobbies and others will benefit from assistance connecting to activities. Opportunities to engage in purposeful activities can give seniors a chance to discover new interests that are meaningful to them.

Options for On-site Programming:

- Movie screenings, game nights, karaoke or "open mic" nights
- Classes and workshops, such as on cooking, exercise, storytelling/writing, and gardening
- Discussion groups based on common interests, such as books, current events, and music
- Clubs: coffee club, sewing, walking group, or knitting club
- Communal meals

Local Innovation **– Winnetka Senior Housing and a Meal Site for the Community**

Meta Housing completed the Winnetka project in the San Fernando Valley in 2016. PATH's delivery of services is innovative because of their nascent partnership with ONEgeneration, a nonprofit that has been providing services to seniors since 1978.

Initially, PATH contacted ONEgeneration to access their evidence-based memory workshops. This was a critical first step in the partnership as the two organizations began working together. As ONEgeneration became more familiar with the Winnetka community, they identified an opportunity to expand the partnership with PATH.

ONEgeneration applied to the Department of Aging on behalf of PATH to start a dining site at Winnetka for tenants and members of the broader community. The Department of Aging toured Winnetka and granted approval and funding for a new meal site because they felt the neighborhood and tenants were underserved by existing resources.

Winnetka is equipped with a kitchen and dining area that can accommodate tenants and guests at meal time. PATH case managers encourage tenant participation and work closely with the property manager to implement appropriate security measures. ONEgeneration manages the operation of the dining service by preparing the food off-site, conducting final food preparations in Winnetka's kitchen, and cleaning up after the meal. Communal meals provide access to nutrition and opportunities for tenants to form social bonds with neighbors.

Off-site Programming

Staff should help tenants avail themselves of recreational amenities nearby, such as exercise options in municipal parks, sporting matches, music or theatrical performances, and cultural events. Off-site events typically include:

- Outings to cultural institutions, such as museums and libraries
- Physical activities, such as to parks and bowling alleys

- Referrals to skill development programs; examples: CSH Speak UP! Program, classes at Adult Schools for continuing education

TIP Ask your city council member if they provide free transportation for community groups and request an application to reserve a driver and bus.

The Aging Services Network offers friendly visitor programs for seniors who prefer one-on-one interactions or who could benefit from more socialization. Seniors may also wish to apply as a volunteer for these programs to keep others company.

Other Considerations

Tenants should be included in the planning of social activities. Staff can host monthly community meetings, circulate a survey, or use a suggestion box to give tenants opportunities for suggesting activities and providing feedback about past programming. Request tenants' help for set-up and clean up during events and assign special projects as needed. Tenants who can help with events appreciate feeling useful and involved.

Individual tenants may choose to organize their own events, groups or workshops. Staff should encourage this and provide support as needed. Organizing activities can also be an appropriate avenue for Tenant Council involvement. Working together to coordinate activities fosters pride and responsibility for the housing community among tenants and staff.

Attendance sign-in sheets allow staff to track participation and understand tenants' patterns and preferences. Satisfaction surveys are also a useful tool for evaluating the success of an activity. Distribute a monthly calendar that lists activities happening on and off-site. Send personal invitations and post reminders. Promote nearby volunteer opportunities and encourage tenants to do what interests them.

Project Design

RESOURCES

- ❖ Aging-in-Place Design Guidelines, Enterprise resource
- ❖ Seven Principles of Universal Design
- ❖ Taking Action to Prevent Falls: A Home Environmental Assessment

Common conditions associated with aging (e.g., hearing loss, vision loss, frailty, mobility issues) must be reflected in the housing design for seniors. Ideally, these factors are considered before a project is built, however, modifications can also be made to facilitate aging-in-place. Universal

Healthy Aging in Supportive Housing

Los Angeles Edition

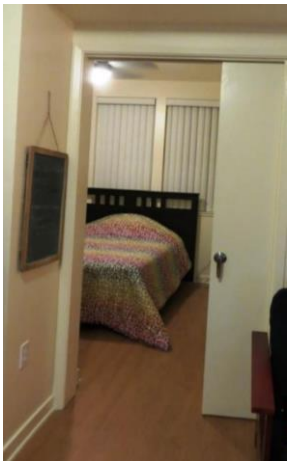
Design features provide a comprehensive framework for addressing housing accommodations. Smart design will eliminate barriers and promote safety and prevent falls among seniors.

The building's physical features are critical to making successful social and recreational programming possible. The presence of common areas fosters informal socializing and gathering of tenants. Examples of common areas include community rooms, computer labs, exercise rooms, libraries, cooking facilities, dining rooms, raised gardens and patios. The location of these spaces should encourage tenant participation, by having them located on the ground floor or near the elevator where people frequently walk.

Local Innovation – **Janet L. Witkin Senior Housing**

Located on a main thoroughfare in West Hollywood, the Janet L. Witkin site is Affordable Living for the Aging's first project to incorporate universal design in 100% of the apartments. Every apartment has physical features that anticipate how tenants' needs will change as they age. ALA hired a universal design consultant to collaborate with the architects, the Killefer Flammang team. Key design features include:

- Curb less shower with two shower heads for when a caregiver assists with bathing
- Hard-wired night lights installed along the bedroom to bathroom pathway
- Wall oven with a shelf underneath
- Reachable cabinets and refrigerator space
- Pocket doors with lever door handles
- Adequate overhead lighting and rocker light switches
- Raised planters on wheels for the rooftop garden
- Stairs adjacent to the elevator



VI. Resources

Directory of Senior Services in Los Angeles County

Adult Protective Services

Mandated Reporter Hotline……...(888) 202-4248
Main Office……...(213) 351-5401

Aging Services Network

Los Angeles City Department of Aging……...(213) 482-7252
County of Los Angeles Community and Senior Services……(213) 738-2600

Benefits Enrollment

Benefits Enrollment Center, Wise and Health Aging……...(855) 636-7655
- Medicare Part D and Medi-Cal enrollment

Center for Healthcare Rights……(213) 383-4519
- Medicare and Medi-Cal assistance and advocacy

Bet Tzedek……(323) 939-0506
- Medicare Part A, B, and C; Medi-Cal (share of cost issues and denials)
  SSI, SS, SDI, IHSS, and Advanced Health Care Directives

Department of Mental Health for Older Adults (60+)

Full Service Partnership (FSP)……(213) 738-2327…(213) 738-2663
Field Capable Clinical Services (FCCS)……. (800) 854-7771
Genesis Older Adults Program……(213) 351-7284
Prevention and Early Interview (PEI)……..……..(213) 738-2305
Service Area Navigator for Older Adults……..…(213) 738-2327

Emergency / Psychiatric Evaluation

ACCESS / PMRT (countywide; available 24/7)...……...(800) 854-7771
Verdugo Hills Hospital Psychiatric Crisis Evaluation (geriatric psych unit). …….(818) 952-2270
Suicide Hotline……..(800) 999-9999

Friendly Visitor Program / Companionship for Seniors

Friendly Visitor Program, Volunteer Action for Aging…….. (562) 637-7175
- Weekly visits and phone calls; multilingual companions available

Friendly Visitor Program, Wise and Healthy Aging…… (310) 394-9871 x 552
- For seniors living on the Westside

Senior Health and Wellness Program, Jewish Family Services (JFS)…….…….(213) 260-7919
- 5-10 hrs./week
- English/Spanish
- JFS matches seniors who are 65+ with a volunteer wellness coach who is 50+

Home Care, Home Safety, and Assistive Devices

City of LA Handy Worker Program ……(213) 808-8803…...(866) 557-7368
In-Home Supportive Services – application request hotline…….(888) 944-4477
Personal Assistance Services Council – request IHSS provider candidates…..... .(877) 565-4477
Veterans Administration – call for home care eligibility……..(877) 222-8387

PACE Providers in Los Angeles County

AltaMed Senior Buena Care……...…..(877) 462-2582
Brandman Center for Senior Care (San Fernando Valley)……...(818) 774-3065

Substance Abuse

Community Assessment Service Centers (CASC)……...(800) 564-6600
- 19 sites throughout the County; funded by the Department of Public Health

Volunteer and Advocacy Opportunities

Corporation for Supportive Housing's Speak UP! Program
- Public speaking and advocacy training to promote supportive housing.....(213) 623-4342
- The interview and application process is done once a year

Jumpstart Program ……...(213) 387-5505
- Part of the Foster Grandparent Program through Senior Corp
- For seniors 55+ who want to work with children

Evidence Based Practices

Please consult these additional resources for EBPs in a wide variety of topic areas:

- Administration for Community Living, Aging and Disability Evidence-Based Programs and Practices: http://www.acl.gov/Programs/CPE/OPE/ADEPP.aspx

- CHAMP Geriatric Falls Prevention Toolkit: http://www.champ-program.org/page/99/geriatric-falls-prevention-toolkit

- City of Los Angeles, Department of Aging, Los Angeles Wellness Center Network Evidence- Based Programs: http://aging.lacity.org/pdf/programs/EvidenceBasedPrograms.pdf

- Community Research Center for Senior Health, Toolkit on Evidence-Based Programming for Seniors: http://www.evidencetoprograms.com/

- National Council on Aging, About Evidence Based Programs: https://www.ncoa.org/center-for-healthy-aging/basics-of-evidence-based-programs/about-evidence-based-programs/

- National Cancer Institute, Research-Tested Intervention Programs: http://rtips.cancer.gov/rtips/programSearch.do

- Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices (NREPP): http://www.samhsa.gov/nrepp

- Substance Abuse and Mental Health Services Administration Report on Housing Services: discusses Housing First, Motivational Interviewing, Integrated Dual Diagnosis Treatment and offers the basic mechanics for delivering permanent support housing for chronically homeless adults.

- Substance Abuse and Mental Health Services Administration, Trauma-Informed Care. This site offers information on the principles of trauma-specific interventions are designed to address the consequences of trauma in the individual and to facilitate healing: http://www.samhsa.gov/nctic/trauma-interventions

- United States Interagency Council on Homelessness, Solutions Database: http://usich.gov/usich_resources/solutions/explore

Benefit Programs for Seniors

Benefit programs often come from federal sources and are passed through the state social services department and/or county welfare system. The following benefits programs most impact the senior population.

Social Security

https://www.ssa.gov/retire/

Eligibility for Social Security requires a work history - 40 quarters of credit in covered employment. Seniors are eligible for reduced benefits at age 62 or full benefits at age 66. A spouse age 62 or older who has been married to the wage earner for at least 12 months can receive half of the spouse's benefits. Survivors benefits based on age are payable to a spouse any time after age 60 and full retirement age. The marriage must have lasted at least 9 months or 10 consecutive years for divorced couples. A worker who becomes disabled but worked 20 of the last 40 quarters before not being able to work is eligible for SSDI.

Supplemental Security Income (SSI)

https://www.ssa.gov/ssi/

The federal SSI program provides cash assistance to low-income individuals who are disabled, blind, or 65+. To qualify based on disability, must meet Social Security Act definition of disability. Benefits can be used to pay for basic needs such as housing, household and medical needs. SSI can also help connect recipients to the workforce and healthcare resources.

Social Security Disability Insurance (SSDI)

https://www.ssa.gov/planners/disability/

The federal SSDI program provides cash assistance to low-income individuals who are blind or disabled under the Social Security Act definition of disability. In order to qualify, individuals must have an employment history that is long and recent enough to have "insured status" or be a "SSDI beneficiary" through parents or a spouse Benefits can be used to pay for basic needs such as housing, household and medical needs. SSDI can also help connect recipients to workforce and healthcare resources.

General Relief (GR)

http://www.cdss.ca.gov/cdssweb/pg132.htm
http://ladpss.org/dpss/gr/default.cfm

The State General Relief (GR) program is administered through the County welfare system. The Los Angeles County GR program provides cash assistance to individuals who are ineligible for state or federal programs, and often have no other sources of income. For recipients who are employable, participation in employment activities are required in order to receive aid.

Supplemental Nutrition Assistance Program (SNAP)/CalFresh

http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap
http://www.dss.cahwnet.gov/foodstamps/
The federal SNAP program is passed through the state (called CalFresh in California) and is administered through the County welfare system. CalFresh provides low-income households with funds to supplement their food budget and meet nutritional needs. SSI recipients are ineligible for SNAP.

Medicare

https://www.medicare.gov/
The federal Medicare program provides health insurance that is primarily targeted at individuals older than 65 or people younger than 65 who have certain eligible disabilities. Depending on the level of coverage, Medicare may cover hospital care, medical care, care in other medical settings, medical supplies and/or prescription medications.

Medicaid/Medi-Cal

http://www.medicaid.gov/
https://www.medi-cal.ca.gov/
Medicaid is established and administered at the state level (called Medi-Cal in California). Because California expanded Medicaid coverage under the Affordable Care Act, low-income (below 138% of Federal Poverty Level) families, individuals, children, pregnant women, seniors and those with disabilities are all now eligible for Medi-Cal. Medi-Cal covers a range of primary health care, mental health, substance abuse, prescriptions and other essential health services.

Veterans Affairs (VA) Benefits

http://www.benefits.va.gov/benefits/
VA benefits are available to current Service members, Veterans, or the spouse/child/parent of a deceased or disabled Service member or Veteran (with other than dishonorable discharge status). VA benefits are varied but cover disability compensation, pension, education and training, vocational rehab and employment, life insurance, home loans, health care, burials and dependents of survivors. VA benefits offered specifically to homeless veterans include health care, housing assistance, employment assistance and foreclosure assistance.

To find out if a veteran is eligible for VA Aid and Attendance benefits, review this fact sheet and call (877) 222-8387.

List of Services for Aging in Place

Minimum Services

- Intensive Case Management, including:
  - Individualized Service Planning
  - Transportation Planning
- Physical Health Care
- Behavioral Health Care
- Substance Use Services
- Housing Outplacement for Higher Level of Care

Ideal Services

- Independent Living Skills, including:
  - Personal Care Attendant Services (IHSS)
  - Money Management
  - Food and Nutrition
  - Household Maintenance
  - Neighborhood Orientation
- Benefits Assistance
- Representative Payee
- Legal Assistance
- Peer Advocacy
- Medication Management
- Adult Day Care
- End of Life Counseling
- Employment and Volunteer Opportunities
- Community Connections: Social/Recreational Activities

Sample Job Descriptions

Job Title: Program Director/Supervisor

JOB DESCRIPTION: "Agency" is seeking a Program Supervisor to lead a team of social service staff providing services in permanent supportive housing. Tenants living in permanent supportive housing are seniors over the age of 62 who have mental health and substance abuse diagnoses as well as personal care needs related to declining health. The goal of the Social Service Program is to provide intensive case management that allows vulnerable, formerly homeless seniors with a mental health diagnosis to maintain the highest degree of independence, mental and physical health, and emotional well-being.

Permanent supportive housing provides services with a *whatever it takes for as long as it takes* attitude. Participation in services is voluntary; however, staff are responsible for finding ways to engage the most service-resistant tenants. The Program Supervisor will advocate on behalf of tenants and coordinate with the property management team to support long-term tenancies for all individuals.

RESPONSIBILITIES:

Supervision and Staff Development
- Supervise a team of case managers, mental health practitioners, and MSW interns
- Provide weekly supervision hours in accordance with the CA Board of Behavioral Sciences for MSW staff who are fulfilling licensing requirements
- Participate in monthly site meetings with onsite property management and social services staff to discuss issues impacting the building's community and individual tenants
- Prepare annual calendar of in-service trainings with input from social services staff

Service Delivery
- Manage a caseload of 5-10 individuals in addition to providing program supervision
- Conduct tenant assessments and develop individualized service plans
- Coordinate seamless delivery of services among mental health providers, medical specialists, and personal care attendants by managing communication among all members of a tenant's care team
- Oversee a monthly activities calendar with input from tenants and staff to provide social, recreational and leadership opportunities for tenants
- Develop outreach and engagement strategies with staff aimed at serving the most service-resistant tenants
- Collaborate with partner agencies and hold providers accountable for supporting tenants in housing
- Sustain existing community partnerships and identify new partnership opportunities

- Provide crisis intervention support to staff and tenants

Reporting and Compliance

- Manage monthly reporting and compliance procedures for funding agencies
- Implement tenant-level data collection in preparation for third party evaluations

Policies and Procedures

- Review and update the policy and procedures manual
- Educate property management and building security staff about procedures for responding to tenant emergencies and crisis situations

REQUIREMENTS:

- Ten years' clinical experience as a Licensed Clinical Social Worker
- Licensed by State of CA Board of Behavioral Sciences
- Minimum of five years of supervisory experience
- Personal commitment and sensitivity to working with the homeless population, many of whom have co-occurring mental health and substance abuse disorders
- Demonstrated ability to work with the senior population and seniors who have experienced homelessness
- Experience providing services to seniors exposed to trauma
- Knowledge of geriatric health principles and conditions that impact seniors' overall level of functioning within the community
- Proficient knowledge of managed care organizations, Medicare, and Medi-Cal
- Knowledge of community resources within the Aging Services Network including, but not limited to public benefits, education and employment services (including volunteer services), self-help, peer support, caregiver support groups, alcohol and other substance abuse treatment, and mental health services
- Ability to resolve conflicts and motivate staff
- Ability to remain calm, with patient demeanor
- Team leader with a strong sense of self-motivation and good judgment
- Detail-oriented and able to comply with the necessary documentation and reporting requirements, including to the Los Angeles County Department of Mental Health and in compliance with HIPAA guidelines
- Experience with HMIS software preferred but not required
- Insert language preference/requirement

"Agency" is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to their race, religion, ancestry, national origin, gender, sexual orientation, age, disability or other protected class per federal and state law. "Agency" encourages individuals in recovery to apply, including those that have been homeless or have histories of mental illness and substance abuse disorders.

Job Title: Mental Health Practitioner

JOB DESCRIPTION: "Agency" is seeking a Mental Health Practitioner to be part of a team that implements consumer-directed Individualized Services Plans for very low-income and formerly homeless seniors (62+) who are living in permanent supportive housing. Tenants living in permanent supportive housing have mental health and substance abuse diagnoses as well as personal care needs related to declining health. The goal of the Social Services Program is to provide intensive case management, which allows individuals with a mental health diagnosis to maintain the highest degree of independence, mental and physical health, and emotional well-being.

Permanent supportive housing provides services with a *whatever it takes for as long as it takes* attitude. Participation in services is voluntary; however, staff are responsible for finding ways to engage the most service-resistant tenants. The role of the Mental Health Practitioner is to support case managers by providing tenants with access to mental health services and therapeutic activities both on and off-site.

RESPONSIBILITIES:
- Participate in tenant assessments and the development of individualized service plans
- Deliver individual or group counseling/therapy
- Conduct support groups onsite and refer tenants to nearby support groups; encourage peer mentorship and facilitate peer-run support groups
- Coordinate psychiatric appointments and other mental health services
- Hold providers accountable for supporting tenants in housing
- Participate in monthly reporting requirements as necessary
- Provide crisis intervention support
- Educate property management about procedures for responding to tenant emergencies

REQUIREMENTS:
- Master's degree in social work required
- Master's degree in social work with a concentration in aging/gerontology preferred
- At least five years of experience serving adults with chronic and persistent mental illness
- Personal commitment and sensitivity to working with the homeless population, many of whom have co-occurring mental health and substance abuse disorders, and health conditions
- Experience providing services to individuals exposed to trauma
- Proficient understanding of geriatric health principles and conditions that impact individuals' overall level of functioning within the community
- Knowledge of community resources within the Aging Services Network including, but not limited to public benefits, education and employment services (including volunteer services), self-help, peer support, caregiver support groups, alcohol and other substance abuse treatment, and mental health services

Job Title: Case Manager

JOB DESCRIPTION: "Agency" is seeking a social worker to be part of a team that develops consumer-directed Individualized Services Plans for formerly homeless seniors (62+) who are living in permanent supportive housing. Tenants living in permanent supportive housing have mental health and substance abuse diagnoses as well as personal care needs related to declining health. The goal of the Social Services Program is to provide intensive case management that allows individuals with a mental health diagnosis to maintain the highest degree of independence, mental and physical health, and emotional well-being.

This position will deliver case management services to assist seniors in achieving the highest degree of independence and mental, physical, and emotional well-being. Permanent supportive housing provides services with a *whatever it takes for as long as it takes* attitude. Participation in services is voluntary; however, staff are responsible for finding ways to engage the most service-resistant tenants.

This position is located at "X site" and is part of a larger social services team that supports tenants in housing across "X number of" sites. The case manager will work collaboratively with the onsite property management team to mitigate tenant problems and proactively address issues that put tenants at-risk for eviction.

RESPONSIBILITIES:

- Deliver case management for formerly homeless seniors with mental health and substance abuse issues; average caseload size: 20
- Conduct tenant assessments and create consumer-directed individualized service plans
- Encourage tenant involvement in community activities
- Educate individuals on tenants' rights and responsibilities
- Assist individuals to access: mental health services, psychiatric services, substance abuse treatment, income and benefits, in-home care giving, assistance with activities of daily living, and support to improve independent living skills
- Coordinate seamless delivery of services among mental health providers, medical specialists, and personal care attendants by managing communication between the tenant's care team
- Facilitate a monthly Community Advisory Group or Tenant Council to solicit input from tenants about onsite recreational and social programs
- Produce a monthly activities calendar to provide social, recreational and leadership opportunities for tenants
- Maintain an updated listing of community resources for use by tenants
- Assist with production and collection of annual tenant satisfaction surveys
- Complete monthly reports documenting service utilization and tenants' progress toward goals
- Implement eviction prevention activities and provide crisis intervention

- Educate property management and building security staff about procedures for responding to tenant emergencies and crisis situations
- Participate in semi-monthly meetings with onsite property management to discuss issues impacting the building community and individual tenants

REQUIREMENTS:

- Master's degree in social work preferred
- A four-year degree from an accredited university in a human services related field required
- Experience working with older adults
- Experience working with individuals who have histories of homelessness
- Personal commitment and sensitivity to working with the homeless population, many of whom have co-occurring mental health and substance abuse disorders
- Knowledge of geriatric health principles and conditions that impact individuals' overall level of functioning within the community
- Proficient knowledge of managed care organizations, Medicare, and Medi-Cal
- Excellent interpersonal skills and sensitivity to working with culturally diverse populations
- Well-organized and able to comply with documentation and reporting requirements
- Ability to maintain professional boundaries with clients and effectively manage time
- Insert language preference/requirement

Trainings for Staff

This table can help supportive housing staff determine gaps in knowledge where additional training is needed (adapted from CSH's *Working with Aging Tenants In Supportive Housing: Connecticut Providers*).

Training Area	Staff are Competent	Training Needed
Physical Health		
1. A training on physical health specific to chronic health conditions, dementia, and other geriatric health concerns		
2. How to engage tenants to talk about health and preventative care via Motivational Interviewing		
3. Geriatric nutrition and resources for low-cost food and meals		
4. Awareness of increasing physical fragility and range of motion or low-mobility exercise		
5. General training on medication and specific training on senior issues, including common side-effects, medication interactions, effects of skipped dosage, reasons elderly tenants might abuse pain medications or alcohol to self-medicate, dangers of weaning off pain medications, and side-effects when a tenant is overmedicated		
Behavioral Health		
1. Basic mental health issues and symptoms		
2. Motivational Interviewing and other therapeutic interventions		
3. How to prevent isolation through promoting healthy social networks, helping tenants stay connected through technology, and addressing root causes and issues		
4. How to use education and engagement to encourage follow through on referrals/appointments		
5. Techniques for advocating for tenants with behavioral health providers		
6. How symptoms may be affected by the aging process		
Activities of Daily Living		
1. How to teach individuals to compensate for declining abilities, including self-awareness and how to request assistance		

Training Area	Staff are Competent	Training Needed
2. Approaches for addressing hoarding		
Housing		
1. Procedure for requesting reasonable accommodations		
2. Unit safety assessment		
End of Life Issues		
1. Advance directives		
2. Access to counseling resources (for tenants and for staff)		
3. Steps to take following the death of a tenant including responsibilities for notifying and providing documentation to outside agencies		
4. Rules for interacting with friends and family of a tenant who has died		
Coordination with Other Systems		
1. Use of 211 and government websites to locate elder services		
2. Agency policy regarding making connections and assisting tenants in making connections with family, and friends		
3. Policies regarding tenant return home from community placement, such as from a physical or behavioral healthcare facility, including timing of discharge, transportation, and resources needed, and follow-up on discharge instructions		
4. Techniques for training tenants to advocate		
Income and Benefits		
1. Knowledge of local social, medical, and nutritional resources		
2. Knowledge of current health insurance information including types of coverage and benefits and the process for resolving disputes or gaps in coverage		

Wellness Planning Policy

<Agency name> makes every effort to promote the health and safety of our residents. Because many of the tenants living in <agency name> supportive housing are frail and managing several chronic conditions while living alone, <agency> developed the following wellness procedures to respond to the needs of residents who may be experiencing distress in their apartments.

The efficacy of this wellness procedure depends on the cultivation of positive relationships between the resident and supportive service staff. Through maintaining a working relationship with the tenant, supportive service staff will have strong insight of how each resident copes with health and mental health challenges, uses on-site and neighborhood resources, relates with friends and family, and maintains his/her apartment. The supportive service staff will use observed changes in their behavior to implement an appropriate wellness intervention, including safety planning and wellness checks.

The following process will guide supportive service staff to proactively determine the resident's preferred health plan, identify potential health challenges, implement safety plans, and conduct wellness checks to promote personal and community safety.

Documents that Promote Wellness

At intake, staff will complete the following documents with residents:

- A Wellness Check Policy Acknowledgement – this form explains the policy and solicits consent from the residents
- A biopsychosocial assessment – the assessment includes emergency contact information and grants permission for staff to contact this person(s) in the event of a crisis

At intake, annually and periodically as appropriate, staff will invite residents to complete the following documents:

- **Wellness and Recovery Action Plan** (WRAP): a mental health action plan for residents to identify signs of wellness, recognize triggers that may cause a health decline, create plans for how to address symptoms, and determine a course of action in the event of a mental health crisis
- **Vial of Life**: to detail a resident's current health and mental health conditions, medications, and health care provider information. A copy of this information is kept in the apartment with a placard in plain sight alerting emergency responders to its presence
- **5 Wishes**: instructions for end of life care

Wellness Check Criteria

A wellness check is a visit to a resident's apartment to re-engage with a resident and identify if the person needs assistance. When service staff have noted health or mental health concerns or abrupt changes in a resident's typical behaviors, a wellness check can be used to confirm a resident's safety. The following criteria can help guide the determination if a wellness check is appropriate:

- The resident has not been seen or heard from for an unusual amount of time; this will be determined and tracked by a weekly check-in sheet
- The resident has been having acute health or mental health issues
- The resident has recently experienced a traumatic event or trigger
- Service staff has been unable to contact the resident via phone or knocking on the resident's door
- Posted notices on the door have not been responded to or moved for over 72 hours
- Neither property management or maintenance staff have seen the resident
- Staff observes the resident has not picked up mail for an amount of time that is unusual for the resident

If at least two of these conditions have been met, service staff should first do the following:

- Knock on the resident's door to attempt visual contact
- Call the resident to attempt verbal contact
- Contact local hospitals to learn if the resident has been admitted for medical treatment
- Review the sheriff's department webpage to see if the resident has been incarcerated
- Contact emergency contact to verify if resident has been seen/is safe
- Contact other health providers who treat the resident to see if they can be located

If these steps have been taken with no success in locating the resident, staff should conduct a wellness check

Conducting a Wellness Check

During a wellness check, the case manager and property manager will first knock on the resident's door. If the resident does not answer, staff will enter the resident's apartment.

If staff determine the resident is not in an immediate crisis, staff will review reasons for concern to strategize proper interventions to ensure resident safety. If the resident is confirmed as not home, the service staff will leave a note indicating a wellness check was performed and requesting the resident make contact within 24 hours. **Important note:** Wellness checks should always ensure a resident's privacy is not violated. A wellness check is not an opportunity to investigate a resident's belongings.

During a wellness check, staff may encounter a resident who is unresponsive and in need of emergency attention. In this situation, service staff will coordinate the following:

- Call 911, or direct other staff to make the call
- Provide emergency assistance such as CPR, if certified to do so
- Ensure personal safety by giving an agitated resident space or keeping a clear distance from bio hazardous substances
- Assist emergency personnel to locate the resident's apartment
- Remain onsite and available for emergency personnel and other tenants until EMS has left or the crisis has stabilized
- Ensure no one moves the resident or his/her belongings
- Notify supervisor as soon as possible
- Collaborate with the property manager to notify the resident's emergency contact
- Complete an incident report within 24 hours or the first work day after the incident

Self-Care

Once the crisis is stabilized, staff should take time for personal reflection and processing. Processing looks different for each person but may include taking a break, debriefing with teammates, discussing with a supervisor, or potentially requesting time off to engage in personal wellness activities.

Follow Up Items

The site supervisor will debrief with staff and determine any additional plans of action for the resident, the community, and the onsite services team's wellness.

If a person has passed away in his/her unit, the social service staff will assess how to notify other residents. The service staff will closely monitor how the resident community is responding by observing any related health, mental health or trauma symptoms. The service staff will assist residents to process feelings of grief or loss. The service team should work with the community to plan a Celebration of Life event.

**Special thanks to PATH Ventures for sharing a copy of their Wellness Planning Policy with CSH*

Types of Skilled Care Facilities

Individuals who cannot live safely in supportive housing can benefit from an environment with supervision and more intensive care. Long-term care facilities provide a higher level of care with attention to an individual's safety and quality of life.

Assisted Living and Residential Care Facilities for the Elderly

Definition

Assisted Living Facilities (ALF) and Residential Care Facilities for the Elderly (RCFE) also known as "Board and Care" are options for individuals who can no longer live alone but who do not require a nursing level of care. These facilities are all licensed the same in California and vary in size from less than 20 beds to 200 beds. These settings are non-medical facilities that provide some supervision and assistance with activities of daily living, transportation, shopping, meals, cleaning, laundry services, management of incontinency care (both bladder and bowel incontinency) and special dietary requirements. These facilities support individuals with functional and/or cognitive impairments.

Limitations

ALFs, RCFEs, and Board and Cares cannot accept individuals who require feeding tubes, treatment for open bedsores, stage 3 bedsores or 24-hour nursing care. Not all facilities will accept someone who cannot walk (non-ambulatory). Facilities may accept someone who uses a walker or a cane but not an electric wheelchair. Assisted living facilities may also refuse admission based on an individual's diagnosis (i.e., HIV/AIDS) if it triggers additional licensing requirements.

With a waiver from the licensing agency, facilities are able to provide care for individuals on hospice. RCFEs will accept individuals with certain health conditions if the person can demonstrate the ability to perform self-care (i.e., changing a colostomy bag). Smaller RCFEs or Board and Cares will not have the capacity to provide social or recreational activities.

Payer Source

Most individuals pay privately to live in assisted living. Individuals in California enrolled in the Assisted Living Waiver Program can use Medi-Cal to pay for care. The SSI rate for RCFEs is so low that it is difficult to find a facility that will accept individuals on SSI. RCFEs are not required by law to admit SSI recipients. Larger RCFEs are more likely to accept an individual on SSI if the individual has fewer personal care needs. Veterans who receive Aid and Attendance can qualify for help paying an assisted living facility or a nursing home.

Nursing Home (licensed as Skilled Nursing Facility (SNF) in CA)

Definition

California broadly defines SNFs as a health facility that provides skilled nursing and supportive care to persons who need this care on an extended basis. SNFs in California are licensed by the California Department of Public Health. Facilities that want to participate in the Medicare and Medicaid program must also receive certification from the federal government. Most, but not all, licensed skilled nursing facilities in California are certified to participate in Medicare and Medi–Cal.

Limitations

SNFs are heavily regulated health care environments that feel institutional rather than residential. Individuals may not experience the same level of freedom they would in an assisted living facility.

Payer Source

Medi-Cal pays for nursing home costs for individuals who require skilled care for an extended period of time.

Medicare Part A covers the first 20 days in a nursing home after a qualifying hospital stay. Individuals must pay a copay for days 21-100 and Medicare can deny payment if it is determined the individual is no longer responding to treatment. After the 100th day, the full cost of the nursing home is the responsibility of the individual. Medi-Cal will cover the cost for individuals who are financially and physically eligible.

California Advocates for Nursing Home Reform

The California Advocates for Nursing Home Reform (CANHR) offer a directory of residential care facilities searchable by county or city. The information comes from the Community Care Licensing Division of the Department of Social Services and from facility questionnaires returned to CANHR.

RESOURCE Directory of Residential Care Facilities in California

California's Health Facilities Consumer Information website has a tool for finding skilled care facilities by zip code, city, county or name. The federal government also operates a Nursing Home Compare tool through its Medicare.gov website.

RESOURCE California Health Facilities Search Tool and Nursing Home Compare

CHECKLIST – MANAGING A DECEASED TENANT'S AFFAIRS

Date completed	Task	Any follow up needed? If 'yes,' please list	Responsible Staff Member
	Notify property manager[1]		
	Host a debriefing meeting with property manager/management team; discuss disposition of belongings and contacting family		
	Complete HMIS Housing Exit form		
	Complete internal Incident Report		
	Update tenant case file		
	Notify the bank if the tenant had automatic payment set up		
	Contact Meals on Wheels to discontinue this and other community services		
	Make arrangements for grief counseling for staff, if needed		
	Plan and hold memorial event for tenants in the building and staff [internal and external] that worked with the deceased individual		
	Be available to tenants to provide supportive counseling for those who seek assistance		
	Host an internal debriefing with appropriate agency staff		
	Notify cable company to discontinue service – (provide letter, if needed)		

Adapted from CSH's Working with Aging Tenants in Support Housing: CT Providers

[1] The Property Manager is responsible for conducting a walk-through of the unit with the next of kin to collect the keys, coordinate pick-up or disposal of belongings and assess damages. If there is no next of kin and the tenant's belongings exceed $300 in value, then the property manager must store personal belongings for 30 days before disposing of items.

Additional Readings

California Department of Social Services. (2007). *In-Home Supportive Services (IHSS) Program*. http://www.cdss.ca.gov/agedblinddisabled/pg1296.htm

Centers for Medicare and Medicaid Services. (2015). *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*, prepared by Vikki Wachino. Retrieved from http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

CSH. (2013). *Best Practices in Serving Older Adults*. http://www.csh.org/wp-content/uploads/2014/02/OlderAdults_T.pdf

CSH. (2011). *Ending Homelessness among Older Adults and Elders through Permanent Supportive Housing*. http://www.csh.org/wp-content/uploads/2012/01/Report_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing_112.pdf

CSH. (2016). S*upportive Services*. http://www.csh.org/toolkit/public-housing-agencies-toolkit/primer-on-homelessness-and-supportive-housing/supportive-services/

Kassenbrock, R. (2016). *Downtown Women's Needs Assessment.* Retrieved from http://www.downtownwomenscenter.org/needsassessment

LeadingAge Center for Applied Research. (2014). *Housing and Health Care: A Toolkit for Building Partnerships*. http://www.leadingage.org/housinghealth/

LeadingAge Center for Applied Research. (2015, April 2). *Center for Housing Plus Services: Making it Easier to Age in Place,* prepared by Robyn I. Stone. http://www.leadingage.org/Center_for_Housing_Plus_Services_Making_it_Easier_to_Age_in_Place.aspx

Mental Health America. (2015). A Peer Driven Solution to Isolation and Social Exclusion, Part I, II and III [Webinars]. In *It's My Life: Social Self-Directed Care* series. www.mentalhealthamerica.net/it's-my-life-social-self-directed-care

National Health Care for the Homeless Council. (2010). *Harm Reduction: Preparing People for Change*. http://www.nhchc.org/wp-content/uploads/2011/09/harmreductionFS_Apr10.pdf

Shelter Partnership, Inc. (2008). *Homeless Older Adults Strategic Plan*. http://shelterpartnership.org/Common/Documents/studies/HOAPlanCompiled.pdf

Stanford Patient Education Research Center. (2016). *Chronic Disease Self-Management Program (Better Choices, Better Health® Workshop).* http://patienteducation.stanford.edu/programs/cdsmp.html

Substance Abuse and Mental Health Services Administration (2011). *Depression and Older Adults: Key Issues.* https://store.samhsa.gov/shin/content/SMA11-4631CD-DVD/SMA11-4631CD-DVD-KeyIssues.pdf

Substance Abuse and Mental Health Services Administration. (2011). *MedTEAM (Medication Treatment, Evaluation, and Management) Evidence-Based Practices (EBP) KIT*. http://store.samhsa.gov/product/MedTEAM-Medication-Treatment-Evaluation-and-Management-Evidence-Based-Practices-EBP-KIT/SMA10-4549

Substance Abuse and Mental Health Services Administration. *Substance Abuse and Addiction: Harm Reduction*. http://homeless.samhsa.gov/channel/harm-reduction-273.aspx

U.S. Department of Housing and Urban Development. (n.d.). *Case Management Services. Curriculum: Supportive Housing Training Series*. https://www.hudexchange.info/resources/documents/SHPCaseManagement.pdf

U.S. Department of Housing and Urban Development, *Crisis and Conflict. Curriculum: Supportive Housing Training Series*. https://www.hudexchange.info/resources/documents/SHPCaseManagement.pdf

U.S. Department of Housing and Urban Development. (n.d.). *Strategies to Support Homeless or at-Risk Clients with Effectively Utilizing the Healthcare System* [Webinar]. https://www.hudexchange.info/training-events/courses/strategies-to-support-homeless-or-at-risk-clients-with-effectively-utilizing-the-healthcare-system/?utm

U.S. Interagency Council on Homelessness. (n.d.). *Critical Time Intervention*. http://usich.gov/usich_resources/solutions/explore/critical_time_intervention_cti

U.S. Interagency Council on Homelessness. (n.d.). *Motivational Interviewing*. Retrieved from http://usich.gov/usich_resources/solutions/explore/motivational_interviewing

Wilkins, C. (2015). *Medicaid Strategies: Serving People Experiencing Homelessness and Supportive Housing Tenants*. http://www.endhomelessness.org/page/-/files/Medicaid%20Strategies%20by%20Carol%20Wilkins.pdf