Promoting Healthy Aging in Supportive Housing: A Review of the MRT Senior Supportive Housing Pilot

2018 presents a unique moment for supportive housing in New York. The state faces unprecedented challenges and opportunities as homelessness reaches record levels statewide; new federal policy requires homeless service prioritization based on vulnerability level; state and local initiatives promise to fund 35,000 new units of supportive housing over the next 15 years; and the health care industry moves toward innovative strategies to improve health outcomes and reduce cost. With these initiatives, policy-makers, developers and service providers will need to meet the complex and specific needs of newly prioritized subpopulations of people in need of supportive housing. Older adults (age 50-61) and seniors/elderly (age 62 or older) constitute a growing proportion of people at risk of or experiencing homelessness and supportive housing residents, yet the unique health and behavioral challenges associated with aging often go unaddressed, resulting in avoidable, high-cost interventions such as hospitalizations or institutionalization.[1] Safe, affordable housing with targeted services, supportive housing, is proven by research as a superior alternative intervention that promotes independence, improves health outcomes, and reduces public expenditures.[2]

Governor Andrew Cuomo's Medicaid Redesign Team (MRT) is the state's leading-edge effort to transform how health care is delivered and paid for under Medicaid. The initiative has included an unparalleled half-billion dollar investment in supportive housing to address the social drivers of preventable utilization and disparate health outcomes. In 2014, the State released several RFPs for pilot projects to test innovative supportive housing models of care. One project, the Senior Supportive Housing Services Pilot Program, provided funding for unit modifications and supportive services to seniors experiencing homelessness, living in an institutional setting, or precariously

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[1] 2016 AHAR Report, HUD Exchange.
[2] CSH," Housing is the Best Medicine," July 2014.

housed. This pilot initiative was designed to assist low-income seniors remain housed in their current apartments for as long as possible. Eight providers were awarded a maximum of $500,000 for a two-year contract.[3] The programs developed throughout this pilot show how effective staffing and services may best meet the needs of medically-frail aging adults in supportive housing. This paper explores the staffing plans, services offered, successes, and challenges of three of those pilot programs, with an eye toward how these case studies can inform senior-specific policy and programming to ensure that the future of supportive housing in NY is inclusive of the unique needs of vulnerable, aging adults.

Aging in Supportive Housing

Meeting the complex and often evolving needs of aging tenants is essential to New York's initiative to expand the supply and quality of its supportive housing. Between 2010 and 2016, the share of elderly supportive housing tenants more than doubled across the United States; in New York alone, the number of seniors experiencing homelessness and residing in shelters increased by 55% between 2002 and 2012.[4] Nearly half of all adults ages 65+ experience difficulty or require assistance with activities of daily living skills regardless of housing status, and those with a history of homelessness experience even higher rates of geriatric symptoms, including functional and cognitive impairment, frailty, depression, and others.[5] Years of poor living conditions, lack of access to nutritional meals and healthcare, and high rates of physical and behavioral health conditions among persons experiencing homelessness lead to a mortality rate three to four times higher than the general population.[6] Furthermore, research shows that adults with experiences of homelessness or trauma begin experiencing geriatric symptoms nearly 20 years before their housed peers and continue aging at an accelerated rate.[7]

Given the rising age of supportive housing tenants and the fact that 80% have experienced homelessness, supportive housing programs must offer flexible, nimble services to allow tenants to safely age in place.[8] Conditions associated with aging, such as difficulty with activities of daily living skills, memory impairment, and limited mobility or stability issues, result in a poor quality of life and often lead to extremely expensive interventions, such as hospitalization or placement in nursing homes. Specifically, individuals with memory issues may experience difficulty accessing or following medical advice, benefit programs, or housing opportunities, but could live independently if flexible supportive services were available. Residing in a nursing home for one year in New York State costs between $111,184 and $151,596, whereas the estimated yearly cost of supportive housing ranges

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[3] Providers included Goddard Riverside Community Center in NYC; Westchester Independent Living in Westchester and Putnam Counties; Family Services Society of Yonkers in Westchester; Ithaca Housing Authority in Ithaca; Rural Ulster Preservation Company (RUPCO) in Ulster County; Acacia Network and Promesa Inc. in South Bronx; Catholic Charities in Long Island, United Helpers in St. Lawrence and Jefferson Counties, and Project Renewal in Manhattan.

[4] 2016 AHAR Report, HUD Exchange, pg. 7-5; CSH, "Best Practices for Serving Aging Tenants in Supportive Housing," pg. 4.

[5] Rebecca T. Brown, Kaveh Hemati, Elise D. Riley, Christopher T. Lee, Claudia Ponath, Lina Tieu, David Guzman, and Margot B. Kushel, "Geriatric Conditions in a Population-Based Sample of Older Homeless Adults," The Gerontologist, Feb. 2016, DOI Retrieved http://gerontologist.oxfordjournals.org/content/early/2016/02/17/geront.gnw011.full

[6] CSH, "Best Practices for Serving Aging Tenants in Supportive Housing," pg. 4.

[7] Rebecca T. Brown, Kaveh Hemati, Elise D. Riley, Christopher T. Lee, Claudia Ponath, Lina Tieu, David Guzman, and Margot B. Kushel, "Geriatric Conditions in a Population-Based Sample of Older Homeless Adults," The Gerontologist, Feb. 2016, DOI Retrieved http://gerontologist.oxfordjournals.org/content/early/2016/02/17/geront.gnw011.full

[8] 2016 AHAR Report, HUD Exchange, pg. 7-2.

between $15,000 and $25,000.[9] Not only does supportive housing improve health and offer a cost-effective alternative to institutional care, but studies show that older adults prefer to continue living in their own homes and communities.[10]

Deep Dive: A Review of Three Supportive Housing Pilot Programs in New York State

An expanding body of evidence demonstrates that supportive housing can decrease the use of crisis Medicaid-funded care as people stabilize in their housing. Many individuals experiencing chronic homelessness make frequent and potentially avoidable use of emergency departments and inpatient hospital treatment. Additionally, frail, older adults residing in nursing homes, adult homes, and long-term rehabilitation who do not require such high levels of care remain institutionalized because they would otherwise fall into homelessness. The inefficient use of these high-cost public services has been a major motivator for supportive housing, which has been shown to help tenants reduce service cost while improving tenant outcomes.[11] As part of this strategy, in 2014 the NYS Department of Health made funds available for a Senior Supportive Housing Pilot program. The Pilot Program would fund up to eight innovative projects to make capital improvements and provide supportive services for low-income, Medicaid-eligible seniors aged 65+ for two years.[12] The care models and program design of three of those pilots, explored below, demonstrate the effectiveness of flexible, targeted services and physical modifications and further elucidate outstanding barriers to quality care for an aging supportive housing population.

Image Courtesy of Brooklyn Community Housing and Services' Aging Program

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[9] Estimated Average NYS Nursing Home Rates, New York State Department of Health 2015, https://www.health.ny.gov/facilities/nursing/estimated_average_rates.htm; "Best Practices For Serving Aging Tenants in Supportive Housing," pg. 5.
[10] Nicholas Farber, J.a. (2011). Aging in Place: A State Survey of Livability Policies and Practices. AARP, National Conference of State Legislatures, Public Policy Institute. Washington, DC: NCSL.
[11] CSH, "Achieving New York's Medicaid Redesign Goals through Supportive Housing," June 2015, pg. 3.
[12] Ibid.

Case Study: Goddard Riverside Community Center

Goddard Riverside Community Center's Senior Supportive Housing pilot focused primarily on decreasing emergency department use and improving tenant health and stability. Through unit modifications and an integrated medical and case management team, the program served a total of 54 Medicaid-enrolled seniors aged 65+ living in three of GRCC's SH buildings. A team of two Case Managers, a Clinical Coordinator, and a part-time Registered Nurse (RN) worked in tandem with the onsite management to conduct frequent assessments of tenants' safety and wellbeing. The pilot program received additional funding from the John H. and Ethel G. Noble Charitable Trust, administered by Deutsche Bank Trust Company New York.

About GRCC

Located on the Upper West Side of Manhattan, Goddard Riverside Community Center was founded in 1959 and now operates 26 diverse programs that serve 17,000 people each year. GRCC's devotion to creating "a fair and just society where all people have the opportunity to make choices that lead to better lives for themselves and their families" has lead the organization to embrace innovative, collaborative approaches to tackling everyday issues facing the community.

The GRCC care team worked closely with tenants to connect them with services appropriate for each tenant's needs. Case Managers conducted monthly home visits to evaluate barriers to physical safety, and met regularly with tenants to assess activities of daily living skills and access to daily nutritious meals. The RN assessed each client's health and stability on a monthly basis and conducted yearly "Staying Healthy" evaluations, and provided a host of services to help triage health concerns and minimize ED visits and hospitalizations. Case Managers also connected tenants to social and educational opportunities onsite and provided referrals to services in the wider community as needed.

GRCC applied to NYSDOH to fund a total of 155 unit modifications and purchase of technology-assisted devises on the basis of monthly assessments of client risk and impediments to independent living. Physical modifications included installation of hollow-core metal doors, non-slip tape on stairs, grab bars and poles, motion sensor lights, and adjustable EZ bed rails, and technology-assisted devises included in-unit cameras, MedicAlert bracelets, Life Alert medical alert system, digital alarm clocks, molding stock aids to assist clients with putting on socks, motion sensor lights, Range Minder alerts on stoves, and folder reachers to assist with reaching for items at a distance.

Overall, the pilot led to an increase of primary care utilization from 82% to 96%, a 38% reduction in hospitalizations, and a jump in SNAP enrollment from 78% to 89% in a pre-post examination. The care management team delivered nearly 4,000 services over the two-year period.[13]

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[13] All pilot program data and information provided by Goddard Riverside Community Center.

Case Study: RUPCO

RUPCO's Senior Supportive Housing Pilot Program aimed to reduce emergency department use and hospitalizations by addressing tenant needs and barriers to living independently for tenants aged 65+ with Medicaid.

A Care Management Team, consisting of a Program Services Supervisor and two Care Managers, served a total of 60 seniors throughout the course of the two year pilot. Care Managers assisted tenants with navigating the Medicaid system, increasing stability, and improving quality of life.

Care Managers conducted biannual assessments of clients' health and quality of life, including an evaluation looking back six months prior to enrollment as a baseline for measuring changes to clients' health. Care Managers worked closely with clients to evaluate risks and impediments to independent living, and clients reported on any falls, emergency department usage, and visits to primary care providers.

About RUPCO

Located in Kingston, NY, RUPCO's mission is to "create homes, support people and improve communities, with a vision to build strong, vibrant communities with opportunity and a home for everyone." RUPCO serves approximately 560 low-income individuals and families with case management services and through development and management of affordable housing properties.

Based on the assessments of clients' risks and overall health, Care Managers recommended unit modifications to those clients with stability issues and those who used canes or walkers, had a history of falls, or who'd had recent injuries resulting in emergency department visits or hospitalizations. RUPCO applied for NYSDOH funds for 41 unit modifications, which included tub-to-shower conversions and installation of grab bars, front-control stoves, and ADA-compliant high-rise toilets.

In order to decrease isolation and improve health, Care Managers connected each client with supportive services offered either through the pilot program or that were available in the wider community. These included healthy, educational activities such as bingo nights, a Tai Chi group, and technology and diabetes management classes, as well as referrals to healthcare in the community such as managed long-term care services and chronic disease self-management education.

In total, tenant-reported falls dropped from 23 in the year prior to admission to 9 in the program's second year, and hospitalizations and emergency department use fell by 35% and 58%, respectively. Additionally, among tenants who initially reported "Poor Health," 66% saw an improvement over the course of the pilot, and 63% of tenants who initially reported "Fair Health" also felt their health had improved.[14]

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[14] All pilot program data and information provided by RUPCO.

Case Study: Acacia Network/Promesa

About Acacia Network

Acacia Network, the leading Latino led integrated care organization, operates across New York State to transform Latino and other communities through culturally responsive housing, social services, and health care systems. Founded 48 years ago, Acacia Network strives to "partner with our communities, lead change, and promote healthy and prosperous individuals and families in a HEALTH NEIGHBORHOOD environment."

Through the Acacia Network's affiliate agency Promesa Inc. in the South Bronx, Acacia's pilot program served 46 seniors living in Section 8 affordable housing. At the outset, 75% of the housing complex's elderly tenants were monolingual Spanish speakers facing isolation and at risk of nursing home placement. The program focused specifically on improving health and stability, reconnecting tenants with family and community, and reducing hospitalizations, emergency department use, and nursing home enrollment.

A team of two Case Managers and a Program Director worked closely with building management to assess client health and safety risks and to provide necessary supports to ensure stability and community integration. Case Managers conducted bi-weekly home visits to assess tenants' overall health, activities of daily living skills, and any barriers to safety and independence. The case management team provided escorts to medical appointments, referrals to community services, translation, benefit enrollment assistance, and provided educational and recreational fairs to build trust between Case Managers and clients and reduce isolation. Additionally, the Case Managers provided culturally responsive family counseling for seniors found to be excessively burdened by family concerns, who did not receive adequate support from children or grandchildren, or those in abusive or violent relationships.

Acacia/Promesa's pilot won additional funding from the Deutsche Bank Noble Trust Fund, which enabled the case managers to secure a total of 129 unit modifications, including 14 ADA-compliant high-rise toilets, sinks, and faucets, 15 tub-to-shower conversions, 30 portable bathlifts, handrails in 22 bathrooms and 3 full apartments, 14 entryway renovations, 25 stove safety-shut-off systems, and new ADA-compliant front entrances for 5 buildings. Over the course of the program, the two oldest tenants were able to remain in their units through the end of their lives without nursing home admission, ten tenants successfully reconnected with family as part of their care plan, and no tenants were admitted to nursing homes in the year since the pilot ended.[15]

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[15] All pilot program data and information provided by Acacia Network.

Discussion: Successes and Outstanding Challenges

In all three case studies, supportive care models coupled with physical unit modifications resulted in an apparent reduction of expensive medical interventions, including emergency department utilization, hospitalization, and nursing home placements, and ultimately bolstered tenant stability and independence. While these programs clearly demonstrate the benefits of flexible service models dedicated to meeting the needs of aging adults, the challenges faced by program administrators at all three sites offer guidance on how to further strengthen the supportive housing programs on the horizon.

- **Services and Case Management**
  All three programs administered successful care management models, but Case Managers faced challenges in addressing complex geriatric conditions, including how to best assist tenants experiencing memory loss, compulsive hoarding disorder, and social or cultural isolation. Additional case manager training in geriatric care and best practices would provide staff with necessary resources to meet client needs.

- **Unit and Facility Design**
  All three programs reported that unit modifications and technology assisted devises, when available, significantly reduced barriers to independent living. Several Case Managers felt that the application process for unit modifications was lengthy and unclear, sometimes resulting in long wait times and denials of recommended modifications/devises. At all three sites, program administrators reported that in-unit modifications were insufficient in securing tenant safety and stability because hallways, stairs, and entrances throughout the buildings continued to pose significant risks. Modifying existing buildings or constructing new developments in accordance with ADA-approved Universal Design features would enable tenants to age-in-place safely and without disruption; meanwhile, flexible funding to secure additional health and safety equipment as necessary would reduce the burden of extended application processes.

- **Program Eligibility**
  The MRT funding for this pilot specified that all participants be ages 65+ and Medicaid-eligible or enrolled. The care teams at all three sites found the minimum age requirement of 65 to be a barrier to serving the aging population effectively at their respective supportive housing sites. Given many SH tenants' history of trauma, years on the streets, and scant or inconsistent access to treatment, these tenants often begin experiencing geriatric conditions earlier and continue aging at an accelerated rate. Both providers found need for senior-specific services for tenants ages 50+.[16]

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[16] Due to the prevalence of early-onset geriatric conditions within the SH population, CSH defines "aging tenants" as those SH tenants aged 50+. See "Ending Homelessness among Older Adults and Elders through Supportive Housing," pg. 3, http://www.csh.org/wp-content/uploads/2012/01/Report_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing_112.pdf .

Looking Forward

Given the changing landscape of homeless services, health care, and supportive housing across the state, GRCC, RUPCO, and Acacia Network/Promesa's experience with the Senior Supportive Housing Pilot contributes valuable insight into how to replicate and scale promising policy and advocate for additional programmatic changes to meet the needs of older adults. Pre-post evaluation suggests that the exemplar supportive care models coupled with physical modifications resulted in a reduction of expensive medical interventions such as hospital and nursing home stays, and tenants also reported feeling more secure, independent, and healthy. Throughout the pilot, Case Managers addressed the complex set of health and social needs faced by the aging population in supportive housing, including mental health issues, frailty, isolation, and chronic health conditions; they also demonstrated how targeted trainings and additional resources could assist care management teams moving forward. These programs illustrated the importance of physical design features in determining an individual's ability to safely age in place, such as embracing Universal Design features throughout newly constructed buildings and lowering the age restrictions to 50 for access to senior or geriatric services as needed. As the population continues to age and newly-implemented Coordinated Entry systems prioritize more vulnerable populations for supportive housing, this paper reveals critical opportunities for improving and advancing quality supportive housing for tenants as they age.