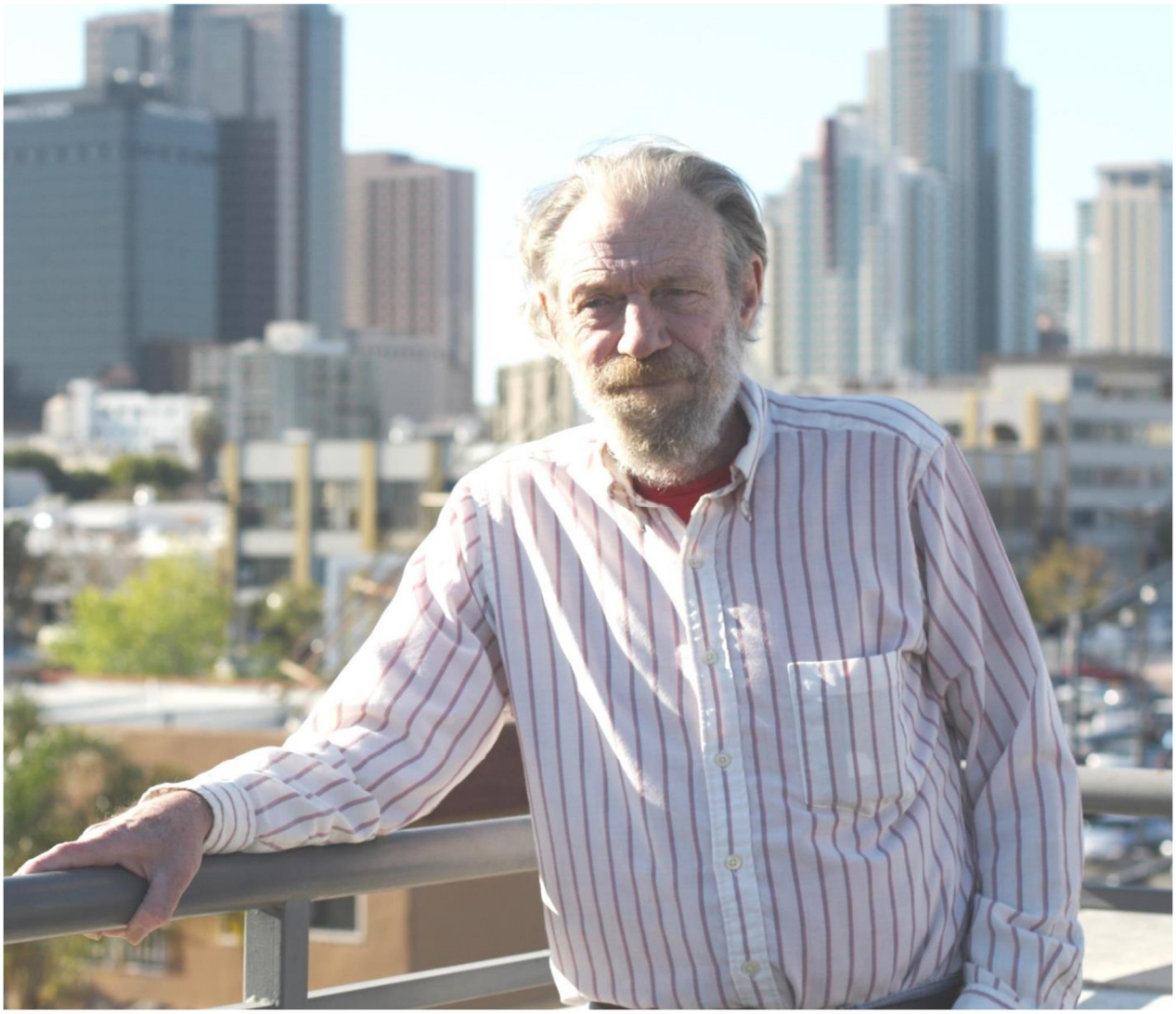
Home to Stay: Creating Quality Supportive Housing for Aging Tenants

New York City's Supportive Housing Aging Learning Collaborative
Core Competencies Checklist & Resource Guide



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About this Guide

Very little is known about the homeless aging population, referred to as the "invisible population"[1] and even less is known about those aging in place within supportive housing and older/elderly adults in institutions who, if provided with long-term supportive services, would be able to return to the community. Historically, the phenomena of homelessness amongst the elderly have not received the same attention from researchers as homeless youth and families; nor have efforts to stem the tide of chronic homelessness among older adults been sufficiently chronicled.

This guide calls attention to the unique needs experienced by aging formerly homeless adults and briefly examines the chronic health, geriatric syndromes and social challenges faced by older and elderly adults in supportive housing, as well as some promising approaches for improving providers' capacity to deliver and coordinate flexible and responsive services to aging residents with complex health and social support needs. This guide serves as a 3-in-1 resource for New York City supportive housing providers:

- A self-assessment guide for agencies to assess their readiness to respond to the needs of aging adults, from both physical space and program design aspects.
- A compilation of accumulated promising practices for serving aging tenants, including effective socialization strategies, care coordination, staffing models, and other issues/areas important to aging tenants and the providers who serve them.
- A guide to NYC-specific resources to promote healthy aging in place in supportive housing.

The Graying of America's Homeless: The Invisible Population

As evidenced by the increase in national average life span and decline in national birth rates, the US population is living longer with less family and social supports than its previous generation.[2] The percentage of people over the age of 64 is expected to increase to 19.6% or 71 million by the year 2030 and the number of people over 80 is also expected to reach 19.5million by 2030.[3] According to 2014 Census data, by 2033, for the first time, the population 65+ will outnumber people younger than 18 in the US.[4] There is also troubling evidence to suggest that homelessness is increasing among this aging demographic. The median age of homeless individuals has risen. Nationwide, nearly half of single homeless adults are aged 50 and older, compared to 11% in 1990.[5] Projections suggest that the number of homeless elderly will also double by 2050, from 44,172 in 2010 to 95,000 in 2050.[6]

Not only are those on the streets getting older, but their health is deteriorating at rates much faster than the general population. Pressing, chronic, physical and behavioral health challenges and geriatric conditions exacerbate the housing crisis for thousands of unsheltered individuals over 50. Without access to safe, affordable and accessible housing coupled with appropriate support services, many of the homeless older adults (those 50-64) will not live long enough to make it to their elderly years (65+). Homelessness and health are interwoven as poor health is both a cause and result of homelessness. Research suggests that homeless adults suffer premature mortality and age-related medical conditions compared to the general population. Homeless persons have age-adjusted mortality rates 3–4 times higher than domiciled adults, and the proportion of homeless adults in their 50s with chronic diseases (e.g., hypertension) is similar to housed adults aged ≥65.3.[7]

One marker of optimism is that it is possible for individuals to safely age in place, and the majority of Americans wish to remain in their homes (78%) as they grow older rather than moving to an institutional care setting.[8] As individuals are living longer than ever before, largely due to better nutrition and health care, the rate of age-related illnesses such as Alzheimer's disease also has increased, becoming the sixth leading cause of death in America.[9] However, as age increases, so do the health and geriatric conditions of the aging – especially those with histories of homelessness and chronic physical and behavioral health conditions. Researchers have found that homeless older adults over 50 have higher prevalence of geriatric conditions than that seen in housed adults 20 years older; suggesting that housing and services addressing geriatric conditions are needed for older homeless adults living across varied environments.[10] Fortunately, supportive housing – which combines affordable housing with supportive services that help people facing the most complex challenges live with stability, autonomy, and dignity – is a model that works to address homelessness among older and elderly adults, and can prevent premature placement into costly nursing homes or other institutions.

Aging in Place within Supportive Housing

The average age of those living in supportive housing is rising. Nationally, the share of people age 62 and older living in supportive housing grew from 6.4% in 2013 to 7.2% in 2014 (1,749 more people), and the share of supportive housing residents aged 51 to 61 grew from 25.1% to 26.4% (2,144 more people).[11] The population that now resides in supportive housing experiences high rates of chronic health conditions and a baseline of early mortality.[12] In 2010, close to 80% of supportive housing tenants had diagnosed disabilities due to mental health and substance use disorders. Most also have co-occurring medical conditions such as diabetes, hypertension, and heart disease.[13]

The Graying of a City

New York City's senior population is growing faster than ever, living longer and getting poorer. By 2030, New York City's 60+ population will increase by 47% to a projected 1.84 million, comprising 20% of the total population compared to 15% in 2000.[14] The Baby Boom Generation – those born between 1946 and 1964 – will dramatically shift the City's composition, with the last of the boomer generation having turned 50 in 2014. As this generation continues to mature, so will the need to efficiently plan, develop and deliver appropriate supportive services to meet their increasing needs.

Although national poverty rates for seniors declined from 12.8% to 9.5% from 1990 to 2012, the poverty rate among older adults in New York City increased by 15% during the same period (16.5% to 19.1%), according to the NYC Department for the Aging (DFTA).[15] Of all New York City renters, 55.6% have a housing cost burden greater than 30% and 32.1% pay more than 50% of income for gross rent, but one of the most severely impacted populations are elderly headed households who pay a high percentage of their income for housing.[16] The widening trends in income disparities and severe housing cost burden due to lower incomes put elderly New Yorkers at higher risk of premature displacement from their homes.

CSH's Aging Learning Collaborative (ALC)

By 2030, at least 1 in 5 New Yorkers will be over the age of 60

With generous support from the Fan Fox and Leslie R. Samuels Foundation and the Mizuho USA Foundation, CSH embarked on an initiative to better define quality supportive housing for residents aging place. Recognizing the need for more supportive housing and service providers with specialized expertise around serving aging tenants in supportive housing, CSH initiated the Aging Learning Collaborative (ALC). This group brought together nine supportive housing providers in New York City to exchange resources and information on evidence-based models for serving aging supportive housing tenants. The ALC addressed topics ranging from program design and service delivery best practices to identifying potential funding streams for supportive housing. The ALC convenings focused on housing homeless older and elderly adults, identifying and problem solving issues facing aging tenants in supportive housing, and sharing resources for this population. The goal of the collaborative is to foster uniformity around quality services provided to aging tenants, develop replicable best practices in serving aging tenants, and increase the capacity of supportive housing and service providers currently not serving this demographic to begin to implement programs tailored to the unique geriatric needs of aging tenants.

The ALC specifically addressed issues pertaining to five critical domains for safe and healthy aging in place:

- **Domain 1: Coordination of Medical & Behavioral Health Services**
- **Domain 2: Building Staff Capacity**
- **Domain 3: Activities of Daily Living (ADLs)/ Instrumental Activities of Daily Living (IADLs)**
- **Domain 4: Social Services**
- **Domain 5: Physical Space**

Coordinating Medical and Behavioral Health Services

As aging individuals with complex health needs attempt to navigate the health care system, they often encounter a very complex, fragmented, and confusing system that leads to gaps in care and reduced quality of life. While supportive housing is prepared to meet the needs of homeless individuals with special needs, current programming falls short in meeting the physical and behavioral health needs of those wishing to age in place and prevent premature displacement into costly institutions like nursing homes. As such, more focus is needed on the special services required by older adults to safely age in place in supportive housing.

Challenges Identified by the ALC:

- Fragmented Care Coordination with Home Health Care Agencies. Whereas supportive housing is independent housing with access to supportive services, increasingly the allowed hours for home health care are diminishing. In some instances, home health aides do not see themselves as part of the social service team and do not participate in case conferencing, severely impacting care coordination efforts. There are perceived and real restrictions on what can be shared with supportive housing case managers. Improved communication among home health agencies and supportive housing providers, as well as meaningfully-integrated care coordination is essential for quality service delivery.
- Medication-Related Problems. For older adults, medication non-adherence accounts for 26% of hospital admissions, almost 25% of nursing home admissions, and 20% of preventable adverse drug events in community settings.[17] While most supportive housing providers do not provide medication management, they can assist in identifying discrepancies in drug regimens prescribed by different healthcare providers to prevent medication-related problems due to fragmented communication across the continuum of care. Strategies shown to reduce medication errors include pharmacist medication reviews and medication reconciliation upon discharge from a hospital or other institution. Assistance with mediations can increase treatment effectiveness and decreases in avoidable emergency department visits and hospitalizations.
- Ineffective Discharge Planning. Ineffective discharge plans can lead to harmful and even grave breaks in services. Current Medicaid Redesign reforms should incentivize improved care coordination between hospitals/ long-term care facilities and supportive housing to prevent dangerous lapses in care. Supportive housing providers should make every effort to educate hospitals on the services provided in supportive housing and to make clear that it is not assisted living or a nursing home.
- Disruptions to Housing Stability Due to Medical Complexities. Elderly and medically-frail supportive housing residents are at increased risk for losing vital housing subsidies due to long stays in medical facilities. Policies should be in place that permit stays in hospitals, rehabilitation and convalescent care without elderly tenants losing their housing.

Programs and services provided to aging adults in supportive housing must be comprehensive, age-appropriate and made available onsite or close to housing and include: specialized elderly outreach services, assistance with activities of daily living, 24-hour crisis assistance, physical health care, mental health care, substance use treatment, transportation services, representative payee services, care coordination with community providers, nutrition and meal services, and community building activities aimed at reducing isolation.[18] Self-directed care plans must take into account the interplay of chronic, often co-occurring, health conditions with the normal physical and psychological changes

that come with accelerated aging as a result of years of hard living on the street or in shelters and unattended health needs.[19] Ongoing Medicaid redesign efforts must effectively plan for and deliver integrated coordinated care for vulnerable aging individuals with co-morbid physical and behavioral health conditions.

Building Staff Capacity to Better Serve Aging Residents

Key to successful aging in place within supportive housing is having professional staff that possesses knowledge of geriatric syndromes and are attuned with the fears and concerns of older formerly homeless and vulnerable aging adults in supportive housing. It is essential for staff, particularly newer staff, to build a comfort level with aging and an appropriate understanding of their aging tenants' needs to promote a healthy culture of aging where growing older is celebrated. Supportive housing agencies must provide their staff with essential trainings and resources on common geriatric issues and the emotional and professional support to deal with end-of-life issues.

Assisting with Activities of Daily Living

Formerly homeless older adults may have significant challenges in completing activities of daily living (ADLs), such as cooking, cleaning, doing laundry and bathing as well as instrumental activities of daily living (IADLs), such as travelling to medical and other appointments, taking medications, and paying bills. Such challenges are often due to limited mobility or cognitive impairments, and aging tenants may benefit from living in housing that has been thoughtfully designed with their safety and independence in mind. Staff in supportive housing must be properly equipped through training and staff development to assess any indication of physical and/or cognitive decline of a tenant that may require arranging for additional services such as in-home care, visiting nurse services, housekeeping services or even hospice care in order to prevent or delay a person from having to move into an institution in their final days.

Social Service Programs

As the population in supportive housing ages, social engagement is critical to ensuring that residents can safely age at home. The ability to connect with people and places is essential to overall well-being, and access to social networks and religious institutions help lower the risk of isolation.[20] Robust social programs aimed at decreasing social isolation and malnutrition as well as wellness groups that focus on chronic disease and end of life care issues for aging tenants should be targeted to older residents and sufficiently financed. Supportive housing providers must create a culture of healthy aging among their tenants and help build positive relationships and increased community support.

Physical Space: Environmental Challenges to Aging Safely in Place

The ability to safely age in place requires housing that is adaptable for individuals for as long as they live. Housing presents a unique challenge for the senior population with its higher prevalence of fixed income, physical disability and limited mobility. Some existing supportive housing requires only modest environmental modifications, but in a scattered-site model, significant rehabilitation is often needed to make buildings and units accessible. Modest capital improvements may include: distinct entryways to apartments, ramps, accessible kitchens and bathrooms, grab bars, emergency communication and adaptive technologies. Adherence to universal design principles and the creation of dementia-friendly spaces are key examples of how providers are improving accessibility to help maintain independence.

Supportive Housing Agency Self-assessment

What follows are a set of core competencies identified under each domain deemed by agencies serving a growing number of aging residents as either "Must Have", "Should Have" or "Nice-to-Have" to meet the unique needs of their aging residents. Supportive housing providers are encouraged to self-assess their efficacy in meeting these core competencies and identify areas in need of improvement. Competencies are deemed as "**Must-Haves**" if they are programs, policies, procedures, services, linkages, and/or physical design specifications that must be in place to meet existing requirements as well as provide basic support to those who are becoming frailer. Competencies listed as "**Should Haves**" are the enhanced programs, policies, and/or design specifications that are seen as critical for effectively serving aging residents in supportive housing. Competencies listed as "**Nice-to-Haves**" include innovations that, while important, are considered desirable for this population and complement existing requirements. Providers are encouraged to use this checklist to assess whether they are excelling in the listed competency (**Going Beyond**!), meeting the required standard (**Meets the Mark**) or require improvement (**Needs Work**).

Domain 1: Medical and Behavioral Health Care Coordination

***Must-Haves**: Programs, policies, procedures, services, linkages, and/or physical design specifications that must be in place to meet existing requirements as well as provide basic support to those who are becoming frailer.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Case Management	Staff manage a mixed caseload with client to case manager ration no larger than 40:1 (14:1 for medically frail/complex individuals) in addition to providing program supervision based on team structure level and level of service needs.			
	Staff conduct resident assessments (e.g. food security) and create consumer-directed individualized wellness plans in consultation with the resident.			
	Staff have HIPAA release forms signed at intake. Once trust is established, staff are able to obtain information on wills and health care proxies and Advanced Directives.			
	Staff are able to provide referrals for other community- or borough-based services (e.g. Department for the Aging).			
	Staff are able to evaluate residents' income benefit/entitlement needs and assist with applications and recertification processes (or has agreement with other agencies to provide these services).			
	Staff understand how to manage spend-downs.			
	Staff are able to monitor, coach and support chronic disease management.			
	Staff are able to counsel on long-term care issues.			
	Staff maintain regular contact to ensure service needs are being met and resident is satisfied.			
	Staff accompany residents to appointments, grocery shopping, etc. and/or provide escorts.			
Service Provision	Onsite nurse practitioner one day a week to assist with acute medical needs, preventive services, psycho-social or at least a linkage to a primary care provider.			
	Behavioral health provider onsite.			
	Behavioral health case manager and/or Rehabilitation specialist onsite.			
Medication Assistance – depending on need/disability	Medication assistance is client-centered and based on needs.			
	Staff have access to basic information on drug			

	interactions.			
Discharge Planning	Agency executive staff develop proactive outreach with local hospital discharge staff.			
	Protocols are in place for residents coming out of crisis so there are no gaps in care (e.g. food security, linkage to home health aide, access to required medications).			
	Executive staff advocate for discharge coordination with hospitals and other systems to ensure appropriate in-home services (wound care, aftercare).			
***Should-Haves**: Enhanced programs, policies, procedures, services, linkages, and/or physical design specifications that are critical for supporting healthy aging in place.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Service Provision	Agency coordinates access to occupational therapy services.			
	Agency coordinates access to Home Health Services. All release of information forms are consistently updated.			
	Agency coordinates access to a psychiatrist and/or psychiatric services.			
Medication Assistance – depending on need/disability	An onsite wellness nurse who can assist in reviewing medications and communicate with providers on any identified drug complications.			
	Agency has an onsite nurse that can educate residents about the purpose of their medications and the most effective way to take them.			
	Agency provides information on drug interactions including an accessible list of current or frequently used medications to case management staff.			
	Agency has a case manager that can help identify potential medication management assistance mechanisms.			
***Nice-To-Haves**: Programs and innovations that are considered desirable for this population and complement existing requirements but program success does not necessarily rely on it.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Service Provision	Co-location of, or close proximity to health center.			
	On-site access to integrated Primary Medical Care for highest risk tenants.			
	Access to palliative care services.			

Here's What Worked!

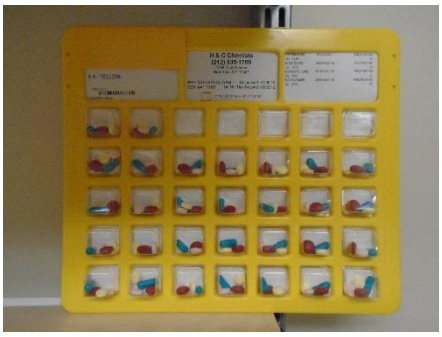
Healthy Aging at The Oak Hall SRO

Brooklyn Community Housing and Services (BCHS) is a supportive housing provider founded in 1978 that serves nearly 1,000 formerly homeless individuals every year. Oak Hall is a single room occupancy residence opened in 1991 providing permanent housing for 74 formerly homeless individuals, most of whom have a mental illness. Many moved in during the early 1990's and by 2006 more than 1/3 of the population was over age 55. Tenants were experiencing new physical and mental health needs, including emotional difficulties adjusting to the aging process. In response, BCHS staff met to discuss the additional challenges of serving their aging tenants and to create a plan to foster a culture of healthy aging. BCHS' Healthy Aging program established a Healthy Aging Case Manager with a smaller caseload focused specifically on the needs of older residents, brought on a part-time Nurse, and utilized a Clinical Coordinator with an expertise in mental health issues specific to the aging population. Daily socialization and wellness activities were developed, including a peer led morning "coffee and news" discussion group, weekly wellness groups on topics like reconnecting with family, coping with loss, relationships after 60, and nutrition, and movie and game nights. Regular in-service trainings for residents and staff were also held. As a result of these and other changes, inpatient hospitalizations decreased by 87% and resulted in estimated annual Medicaid savings of over $400,000. When the program first started in 2007, there were 415 days of in-patient medical stays; in 2016 there were only 54 days of in-patient medical stays.

Breaking Ground's Elder Care Health Outreach (ECHO) Program

Recognizing that a growing number of existing permanent supportive housing tenants (27%) and new move-ins (35%) were 62 and older, Breaking Ground and its long-term service partner at congregate residences, the Center for Urban Community Services (CUCS), launched the Elder Care Health Outreach (ECHO) initiative in 2013. This two-year pilot at three trial locations sought to provide complimentary service enhancements that would strengthen aging in place capabilities. Specifically, ECHO offered on-site, integrated primary medical care and specialized tenant activities that promote mental and physical wellness for individuals 62 years of age and older. The medical services were targeted towards formerly homeless elderly tenants who were among the most vulnerable, as evidenced by higher rates of early geriatric syndromes and illnesses, high co-morbidities, high-risk for serious health conditions and grave outcomes, and significant obstacles to utilizing mainstream quality health care. The tenant activities were offered to all senior tenants, aiming to facilitate safety, healthier lifestyle choices and to minimize isolation. Evaluation data demonstrated significant qualitative benefits of these services alongside reduced reliance on costly institutionalized care. Pre- and post- ECHO data showed 12 fewer ER days and 66 fewer inpatient hospital days, translating into potential cost savings of $177,000, which offset double the annual cost of a day of medical service per week. Moreover, these results suggested increased housing stability for elder tenants wishing to remain in their own home.

Meds-On-Time: Goddard Riverside Community Center H&C Chemists



Goddard Riverside is a supportive housing provider founded in 1959. Goddard has had a long-standing relationship with H&C Chemists pharmacy which provided medication monitoring at The Senate, Goddard's 135 single-room occupancy permanent supportive housing residence for formerly homeless adults, many with mental illness. At Goddard's other housing site, Capitol Hall, a 10-story building, 201 unit single-room occupancy where residents are more independent and do not require monitoring assistance, Goddard made use of H&C's Medicine-on-time to make medication adherence easier for residents. Medications are delivered to a resident's door which is especially helpful for those with mobility issues or recently discharged from a hospital. The medications are bubble-packaged; color coded for AM or PM, and dated allowing staff to see if a resident has taken his/her medication on a regular basis. This simple tool helps with opening dialogue on compliance with residence.

Resources:

- Age-friendly NYC Resource Guide http://www.agefriendlyneighborhoods.nyc/resources/
- Breaking Ground's ECHO Pilot Report and ECHO Activity Guide & Toolkit
  http://www.breakingground.org/files/ECHO-Pilot-Report.pdf
  http://www.breakingground.org/files/ECHO_Toolkit.pdf
- Enterprise's Affordable Senior Housing A Guide to Conducting Resident Assessments
  https://s3.amazonaws.com/KSPProd/cache/documents/677/67766.pdf
- MedicAlert® NYC Wanderer's Safety Program http://www.caringkindnyc.org/wandersafety/
- Potentially Inappropriate Over-The-Counter Medications for the Elderly
  http://agefriendlynyc.org/docs/OTC-list-for-patients-NYAM.pdf

Domain 2: Building Staff Capacity

Must-Haves: *Programs, policies, procedures, services, linkages, and/or physical design specifications that must be in place to meet existing requirements as well as provide basic support to those who are becoming frailer.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Continuous Staff Training & Access to Resources	Agency provides ongoing training on geriatric and co-occurring conditions – including the emotional issues and physical sensitivity that come with aging.			
	Agency provides ongoing training on universal precautions, e.g. incontinence vs hygienic issues.			
	Agency provides ongoing training to improve basic understanding and respect for cultural norms and cultural sensitivity/ stigma to aging and health care.			
	Agency provides training on certain cultural beliefs around Western medicine and respect for cultural sensitivities to health care.			
	Agency provides training on positive engagement approaches including harm reduction and motivational interviewing.			
	Staff are knowledgeable of and have access to resources that specialize in eldercare in New York City.			
	Staff understand veterans system and services available through the local VA.			
	Staff are aware of and have access to elder abuse resources, including DFTA's Elderly Crime Victims Resource Center, Safe Horizons Hotline and other community based providers.			
	Staff know how to access to Silver Alert system in the event a tenant with dementia goes missing.			
End-of-Life Care	Protocols are in place for when a resident passes. Examples include immediately contacting family, convening building meeting and memorial service. Appropriate services are on-hand to assist residents with loss. Efforts are made to reduce trauma and preserve privacy.			
	Emotional support services are available for staff serving elderly residents who may be dying.			
Care Coordination	Coordination between property management and support services.			
	Staff conduct in-room visits and employ other engagement approaches to address isolation.			
	Weekly case conferencing among support			

	service, property management and case management staff.			
	Conduct occupational therapy fall assessments to identify at-risk tenants.			
	Appropriate referrals are made to senior centers/ specialized care.			
***Should-Haves**: Enhanced programs, policies, procedures, services, linkages, and/or physical design specifications that are critical for supporting healthy aging in place.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Legal	Access to landlord/ resident attorneys that are sensitive to the issues of elderly individuals in supportive housing.			
	Access to immigrant services (translation services, advocacy and community groups and resources).			
***Nice-To-Haves**: Programs and innovations that are considered desirable for this population and complement existing requirements but program success does not necessarily rely on it.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Care Coordination	Health care navigator to accompany tenants to health appointments (clinical benefit).			
End of Life	Access to pastoral care to help families prepare for loss.			
	Employee Assistance Program (EAP) to help staff cope with loss, especially in the rare events that there are a cluster of losses in one building.			

Here's What Worked!

Case Conferencing: Goddard's Hot Button Issues

Staff at Goddard Riverside convene weekly "Hot Button Issues" team meetings. While focused on case conferencing on their most vulnerable clients as a team, these multi-functional meetings also serve as an opportunity for in-service training, an opportunity for general programmatic announcements and tenant updates. The meetings include all social service team members including expected participants, such as case managers and building management to discuss maintenance, rental arrears and other issues, as well as the nutritionist/cook, who is able to observe and provide distinct input on the well-being of residents.

SAMPLE: Oak Hall Health Aging Staffing Plan

Health Aging Case Manager F/T:

- Bachelor's Degree and 3+ years relevant experience, including with older adults
- Caseload of 15 – 22 (keep to 15 in program's first year or two)
- Receives on-going training on issues related aging

Supervisor/Program Director F/T:

- MSW or other graduate degree in relevant field, and 5+ years relevant experience
- Provides oversight and support, supervises HA Case Manager on a daily basis

- Ensures that Healthy Aging approach and curriculum is implemented building-wide, and that all staff are educated about issues related to the aging population
- Oversees clinical case reviews
- Supervises on-site nurse

On-site Nurse P/T:

- RN or LPN with experience with both the aging and mental health populations
- Present 1-2 days a week (6-12 hours / week)
- Provides 1 on 1 consultation with residents, including administering health screenings, checking blood pressure, heart beat, breathing, and blood sugar levels
- Provides consultation with staff on all relevant cases; provides some medical case management by following-up on medical and treatment issues with residents' physicians and pharmacies
- Conducts periodic in-service trainings around aging issues for staff

Clinical Coordinator P/T:

- Consulting mental health expert, either psychologist or doctorate level clinical social worker with experience working with at-risk aging populations
- 5 hours / week
- Provides clinical consultation to HA Case Manager and the program, reviewing interventions in cases with significant mental health/behavioral/substance abuse challenges, with a particular focus on issues related to aging such as onset of depressions and recognizing early signs of dementia
- Provides 1 on 1 consultation with residents, including crisis intervention and conducting psycho-social evaluations
- Conducts periodic in-service trainings around aging and mental health issues for staff

Resources

- New York City's Department for the Aging's Elder Abuse and Crime Victims Services http://www.nyc.gov/html/dfta/html/services/crime-victims.shtml
- Access to resources on Falls Prevention (NYC Fall Prevention Coalition) https://www1.nyc.gov/site/doh/health/health-topics/healthy-aging-preventing-falls-in-older-adults.page
- CDC Falls Prevention Checklist http://www.cdc.gov/HomeandRecreationalSafety/pubs/English/booklet_Eng_desktop-a.pdf
- NYC DOHMH Falls Prevention Checklist https://www.cdc.gov/steadi/pdf/check_for_safety_brochure-a.pdf

Domain 3: Activities of Daily Living (ADLs)/ Instrumental Activities of Daily Living (IADLs)

Must-Haves: *Programs, policies, procedures, services, linkages, and/or physical design specifications that must be in place to meet existing requirements as well as provide basic support to those who are becoming frailer.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Assistance with ADLs	For residents who require assistance with bathing, toileting, eating, and dressing, home care services are accessible.			
	Residents have access to assistance with money management. Could include representative payee services.			
	Residents have access to housekeeping services to assist with laundry, cleaning (for those who need it /have no home health care).			
	Residents have access to meal services.			
	Residents have help with shopping for groceries or personal items.			
	Residents have assistance with performing light or heavy housework.			
	Residents have access to and assistance with using the telephone.			
Should-Haves: *Enhanced programs, policies, procedures, services, linkages, and/or physical design specifications that are critical for supporting healthy aging in place.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Skills-building	Staff convene building-based activities and programs that promote self-sufficiency and socialization through a mix of onsite and offsite events and workshops.			
	Staff engage residents with cognitive exercises (e.g. puzzles) and memory games.			
Nice-To-Haves: *Programs and innovations that are considered desirable for this population and complement existing requirements but program success does not necessarily rely on it.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Skills-building	Staff encourage building skills of residents as well as peer-based learnings.			
	Residents have access to motion sensitive burners and other assistive technologies.			

Here's What Worked!

Project FIND's Housekeeping Program to Assist Individuals Who Need it

Recognizing the importance of housekeeping services, Project FIND included housekeeping services in their maintenance budget at the Woodstock SRO. The Woodstock, formerly a hotel in the heart of NYC's Times Square, has 280 residents of which two-thirds do not have home health aides or supports. All of the Woodstock residents are 55 years of age and older with the median age of 70. As a former hotel, a key feature was housekeeping and linen services. All tenants are eligible for free housekeeping services. Housekeepers provide a necessary supplement when a person's ability to maintain their home is compromised. The housekeepers work on two floors a day and see residents on a consistent weekly basis. "Oftentimes they see residents more than staff do", says David Gillcrist, Executive Director at Project FIND. "They're usually the first line of defense in identifying bed bugs, seeing signs of decompensation and serve as gate-keepers for social work staff when they notice a medical issue, a hoarding problem or other indication of something more serious." David provided an example of one resident who was super fastidious with paying his rent on time and keeping his apartment clean, but his cognitive health was deteriorating and was becoming forgetful. The housekeepers noticed this and his inability to care for his cat which was leading to tensions with his neighbors. The house-keeper worked with this resident for over 2 hours to help him clean his apartment and develop a routine schedule for maintaining a clean and safe living environment for him and his pet.

Laundry Taskforce Taking Charge!

With limited laundry facilities on the premises of Goddard's Capitol Hall Residence, social service team members lead a bi-weekly laundry group for residents. Flyers are posted in the building's main lobby and interested residents meet every two weeks in the lobby and walk over to the local laundromat, escorted by staff. Funds for soap and one load of laundry are provided by the program, and staff assist frail residents with getting clothes into and out of the machines and provide guidance on how to use them. The group, named the "Laundry Taskforce", focuses on the strengths of aging residents who want to perform these duties. A part-time house keeper was brought on board to do the laundry for elderly tenants (approximately 15) who are unable to do their own laundry; these residents are only responsible for the cost of the laundry, not the service itself. The house-keeper also provides education on maintaining cleanliness and other hygienic support.

Resources

- Department for the Aging (DFTA) home care services are available for individuals in need of assistance performing activities of daily living in the home such as bathing, transferring, feeding, and/or housekeeping. Eligibility must be determined by a DFTA-funded case management agency. http://www.nyc.gov/html/dfta/html/services/case-management.shtml
- Partners in Care finds the right home care professional for your needs, matching New Yorkers in all five boroughs, as well as Nassau, Westchester, Suffolk and Rockland Counties, with certified home health aides and nurses. http://www.partnersincareny.org/
- Visiting Nurse Service of NY has the resources, the knowledge, and the expertise to deliver home care services for seniors, assistance making dietary and lifestyle changes after a diagnosis of diabetes or congestive heart failure, help with changing surgical dressings and caring for wounds and physical therapy. http://www.vnsny.org/

Domain 4: Social Services

Must-Haves: *Programs, policies, procedures, services, linkages, and/or physical design specifications that must be in place to meet existing requirements as well as provide basic support to those who are becoming frailer.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Fostering Community	Staff works to build community and connectedness among residents.			
Supporting Healthy Aging	Residents have access to onsite recreation that promotes healthy aging/ builds comfort to address health issues.			
	Residents have access to delivered meals as necessary.			
Addressing Isolation	Residents have access to senior centers, psychosocial clubhouses, parks libraries, etc.			
	Linkages to socialization activities (e.g. classes and groups, senior centers) to combat isolation behaviors.			
	Protocols are in place to assess residents' propensity for isolating behaviors and the means to address them.			
Should-Haves: *Enhanced programs, policies, procedures, services, linkages, and/or physical design specifications that are critical for supporting healthy aging in place.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Wellness and Nutrition	Residents have access to onsite wellness groups.			
	Nutritionist (or linkage to a nutritionist) is available to counsel residents on nutrition/ help prepare meals.			
Access to Off-site Recreation	Funding is available for off-site recreation (e.g. movie groups for mobile individuals).			
	Staff have access to a van for group grocery shopping and offsite activities.			
	Onsite meals are available to residents.			
	Residents are engaged in building-wide cleaning activities and are provided with assistance as needed.			
Transportation	Residents have access to Access-A-Ride/ DFTA Project Cart.			
	Residents are able to sign up for reduced fare Metro Cards.			
Nice-To-Haves: *Programs and innovations that are considered desirable for this population and complement existing requirements but program success does not necessarily rely on it.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Wellness and Nutrition	Residents are engaged in nutrition groups/workshops.			

Wellness and Nutrition	Linkages to a diabetic counselor to coach residents on healthy meals (microwave-friendly).			

Here's What Worked!

Project Renewal's Occupational Therapist Intern Programs

Project Renewal brings on onsite occupational therapists (OTs) and occupational therapist interns from SUNY Downstate Medical Center, Touro College and New York University to convene classes for residents 2-3 days a week. Classes range from leisure exploration to music groups to nutrition groups. These classes help residents develop skills in areas of deficit, e.g. time-management, communication and use of support services. Project Renewal staff see the importance of the OTs as "gateways", particularly for residents with histories of disengagement and view the OTs not as clinical staff to the residents. "They've been great with assisting with socialization." says India Wright, Tools for Aging in Place Program (TAP) Nurse Coordinator.

Breakfast Club at Capitol Hall

In 2016, Goddard Riverside expanded its onsite meal services, adding on a lunch program to their existing breakfast program. Capitol Hall has been providing breakfast three times a week as a free service intended to increase socialization. As part of the social engagement, staff put on the local news and a pot of coffee, while providing a continental breakfast, and encourage socialization. On Wednesdays, the breakfast club blends into a current events group that has been extended an extra hour. Capitol Hall expanded to add a lunch program which includes bringing on a cook/nutritionist. In addition to preparing meals, the nutritionist provides cooking workshops for the residents on healthy cooking and nutritious microwaveable meals. Unlike the free breakfast program, the agency charges a nominal fee for this weekday lunch service, which helps residents feel self-sufficient. In addition, residents are paid a small stipend for helping to serve both breakfast and lunch. Through these programs, food is used to bring folks together and increase socialization as well as address nutritional needs. To date, the meal programs have been flourishing, with high attendance and steady participation.

Annual Spring Cleaning at Breaking Ground's Prince George

What started as an internal office organization day has become a building-wide annual tradition with deep impact and affection at the Prince George, one of Breaking Ground's oldest and largest permanent supportive housing sites. Spring Cleaning day kicks off in the lobby with breakfast and a raffle with cleaning supplies and other pertinent giveaways. Throughout the day, both tenants and staff work to clean out their apartments and office spaces. Breaking Ground sponsors dumpsters for professional trash removal and shredding. Staff wear informal clothes, ready to be hands-on in assisting tenants as needed and as appropriate. Some tenant engagement is impromptu, while some staff schedule in advance to work closely with tenants who need assistance, or may have hoarding-like tendencies. Activities staff promote the event at least one month prior with flyers and with related workshops about home organization and fall prevention to contextualize the value of the event and to help tenants prepare. Spring Cleaning has entered into its fifth year at the Prince George and been adapted at other locations with growing success – many tenants report planning and looking forward to it months in advance.

Resources

- Adult Protective Services Program (APS) provides services for physically and/or mentally impaired adults. APS works to help at-risk clients live safely in their homes. APS clients can be referred by anyone. Find more information on referrals or make a referral here or call 212-630-1853. If an individual is eligible, a home visit will be made in three business days or in 24 hours if the situation is life-threatening. http://www1.nyc.gov/site/hra/help/adult-protective-services.page
- Department for the Aging (DFTA) Senior Centers: https://a125-egovt.nyc.gov/egovt/services/service_query.cfm
- Department for the Aging (DFTA) home-delivered meals is a resource available for individuals aged 60+ that have difficulty preparing their own meals. Eligibility must be determined by a DFTA-funded case management agency. https://a125-egovt.nyc.gov/egovt/services/service_query.cfm
- God's Love We Deliver prepares and delivers nutritious, high-quality meals to people who, because of their illness, are unable to provide or prepare meals for themselves. This resource also provides illness-specific nutrition education and counseling to our clients, families, care providers and other service organizations. All of our services are provided free of charge without regard to income. https://www.glwd.org/
- HITE is a free online resource directory for social workers, caseworkers, discharge planners, and other information and referral professionals http://www.hitesite.org/
- TEN (Tiered Engagement Network) Food Bank For New York City's TEN program links member programs—each playing different roles in providing services—to refer clients to each other and together provide a full range of needed benefits, from emergency food to SNAP benefits (food stamps) to income tax assistance and more. http://www.foodbanknyc.org/index.cfm?objectid=8D698E30-BBEB-11E2-83D000304864E324
- The Supplemental Nutrition Assistance Program (SNAP) and Food Program provides food assistance for nearly 1.8 million low-income New Yorkers including families, the elderly and the disabled. The program helps families and individuals supplement the cost of their diet with nutritious foods. You can apply online on ACCESS NYC. You can call the Infoline at 718-557-1399 to have an application mailed to you. You can pick up an application at one of our SNAP centers. You can print out an application and drop off at a SNAP center

Domain 5: Physical Space

Must-Haves: *Programs, policies, procedures, services, linkages, and/or physical design specifications that must be in place to meet existing requirements as well as provide basic support to those who are becoming frailer.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Residential Safety	Staff engage in regular inspections to address hoarding and other risks and hazards including fall risk.			
	Staff test appliance during inspections.			
	Each apartment contains an emergency pull/ Life alert or other an in-house communication device to support 24-hour emergency response if no other 24-hour way to assess danger.			
	Staff are aware of Universal Design principles.			
	Units are equipped with grab bars and raised toilet seats.			
	Buildings and units are equipped with adequate lighting.			
	Staff conduct routine home visits to check for clutter and other hoarding tendencies.			
Accessibility	Units are wheelchair accessible and buildings have areas to "park" wheelchairs to prevent theft.			
	Buildings are ADA compliant/meet ADA accessibility standards.			
Pest Management	Property management effectively manage pests and mold throughout the building to reduce health risks for older adults.			
Emergency Preparedness	Staff are informed of the emergency preparedness protocol in case of a disaster.			
Should-Haves: *Enhanced programs, policies, procedures, services, linkages, and/or physical design specifications that are critical for supporting healthy aging in place.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Accessibility	Building have accessible entryways and portable wheelchair ramps that are ADA-certified. Older buildings that don't meet current ADA guidelines should make modifications to ensure easy accessibility in public areas, such as ADA-compliant ramps at entrances.			
	Agency has the ability to accommodate unit transfers for those with mobility challenges requiring them to be on the first floor.			
Design	Residents have access to gardens and raised planting beds.			
	Apartment door peepholes are lowered for residents in wheelchairs.			

	Buildings include open communal spaces, such as social cooking facilities for residents to congregate, decrease social isolation and increase participation in social activities.			
	Agency utilizes rooftop (with appropriate fencing) for communal space.			
Residential Safety	Buildings are equipped to accommodate Wi-Fi to aide staff doing in-home inspections/ engagement.			
***Nice-To-Haves**: Programs and innovations that are considered desirable for this population and complement existing requirements but program success does not necessarily rely on it.*				
Area	**Competency**	**Going Beyond!**	**Meets the Mark**	**Needs Work**
Residential Safety	Assistive technology (e.g. motion sensors/ detectors) to promote safety and independence.			
Design	Working with an experienced Universal Design consultant to assist with the programming and design process, cost effective incorporation of minimum required elements, and construction administration.			

Here's What Worked!

Improving Access for the Residents at Capitol Hall

The Capitol Hall Residences, owned and operated by Goddard Riverside Community Center, provides housing to formerly homeless men and women as well as social service case management to keep tenants housed. The site recently underwent major renovations to its 201 single-room occupancy apartments to make them more age-friendly. The renovations were funded by NYC Department of Housing Preservation & Development (HPD). All 201 apartments are now ADA- accessible. "The HPD funded improvements at Capitol Hall have greatly improved the accessibility for those clients with mobility issues and allowed them to continue to live independently," says Ashley Arner, Assistant Program Director at Capitol Hall Social Services/Senior Supportive Housing Pilot Program. "Furthermore, renovations included the conversion of underutilized space into a community space. This has allowed us to augment programming capabilities with an eye toward limiting client isolation by fostering engagement. With the addition of the Senior Pilot Staff, much needed social services have increased particularly at Capitol Hall, as well as at other GRCC supportive housing sites."

Utilizing the Gerontological Environmental Modifications (GEM) Home Assessment

As part of their Tools for Aging in Place (TAP) program, the staff at Project Renewal began utilizing this comprehensive home assessment tool that works to identify both problems and potential solutions for each room of a dwelling unit and the immediate outdoor area. The Gerontological Environmental Modifications (GEM) assessment covers a broad range of environmental features, including accessibility, furniture, flooring, lighting, etc. Project Renewal started utilizing this tool in November in 2015 to assess clients' units for any potential home hazards and amend existing care plans to address those areas. When presented with a cluttered unit, staff at Project Renewal help to organize items to clear pathways and reduce preventable falls. The GEM home assessment is done upon enrollment, along with a Patient Review Instrument (PRI) assessment (a medical evaluation tool that

identifies whether or not an individual is eligible for skilled nursing care placement) by a nurse; both are re-assessed annually. Wellness and other assessments are done at least quarterly and are streamlined so as not to overwhelm clients.

Resources

- AIA New York Chapter, Urban Design and Architectural Guidelines for an Age-Friendly New York City http://agefriendlynyc.org/docs/Archtl-Guide-FINAL-2BAFD9-cwk-WP.pdf
- Gerontological Environmental Modifications (GEM) Home Assessment http://www.environmentalgeriatrics.com/pdf/enviro_assessment.pdf
- Integrated Pest Management (IPM) best practices to reduce health risks for older adults. IPM uses non-chemical strategies and less toxic pesticides to minimize health risks. For more information, see the New York City Health Homes Guide: How to Control Pests Safely http://www1.nyc.gov/nyc-resources/service/2199/pest-control-brochure, https://www1.nyc.gov/site/doh/health/health-topics/pests-and-pesticides.page and the US Environmental Protection Agency Guidance on Pesticides https://www.epa.gov/pesticides
- New York Academy of Medicine's Resilient Communities: Empowering Older Adults in Disasters and Daily Life. New York City requires emergency plans for buildings located in flood zones. http://agefriendlynyc.org/docs/Resilient_Communities_Report_Final.pdf
- New York City Home Repair Assistance for Seniors. There are two non-profit organizations that provide free minor home repairs to income-eligible homeowners or tenants ages 60 and older. http://www1.nyc.gov/nyc-resources/service/1848/home-repair-assistance-for-seniors
- New York City Department for the Aging and the American Institute of Architects New York Design for Aging Committee Aging in Place Guide for Building Owners http://www.nyc.gov/html/dfta/downloads/pdf/publications/AIPGuide2016.pdf

CSH DIMENSIONS OF QUALITY SUPPORTIVE HOUSING SUMMARY MATRIX – PERSPECTIVES FROM THE GERIATRIC LENS

The following matrix summarizes each component and dimension of a quality supportive housing project with perspectives from the NYC Aging Learning Collaborative with a geriatric lens. Visit csh.org/quality for additional resources on planning for or operating quality supportive housing.

Project Components

CSH Dimensions of Quality

	Project Design & Administration	Property & Housing Management	Supportive Services	Community
Tenant-Centered	Tenants play an active role in planning the supportive housing project and all partners share a common commitment to helping tenants thrive.	Staff educates tenants on their rights and responsibilities as leaseholders, actively soliciting tenant feedback.	Services are voluntary, customized and comprehensive, reflecting the needs of all household members.	Tenants have meaningful opportunities for leadership through avenues such as tenant associations and board positions.
Accessible	The housing is affordable and in a location that meets tenants' needs and accommodates persons with special needs.	Tenants move into housing quickly, and the process accommodates their varying backgrounds and cultural needs.	Staff actively works to ensure that tenants are aware of available services, which are at convenient hours and locations.	The housing application and screening process is part of a larger community strategy to coordinate access to housing.
Coordinated	Roles, responsibilities and communication strategies are clearly established among the supportive housing partners, codified in written agreements and revisited regularly.	Staff works closely with service providers and landlords to ensure tenants sustain stable housing.	The primary service provider has established connections to mainstream and community-based resources.	Tenants who have high service needs or who are high utilizers of existing systems are given priority for available units.
Integrated	The supportive housing project meets or exceeds community standards, and the partners actively engage in community dialogue.	All tenants are offered a choice of housing unit and have a lease identical to tenants not in supportive housing.	Staff supports tenants in developing and strengthening connections to their community.	There is an overall strategy promoting the ability of tenants to choose from a variety of housing models and neighborhoods.
Sustainable	The supportive housing project has funding that is adequate for its ongoing operations and allows it to target its intended tenants.	While respecting tenant rights and privacy, staff regularly checks to ensure that the unit remains in good condition and receives any needed maintenance.	The supportive housing project has funding that is sufficient to provide services to tenants on an ongoing basis and flexible enough to address changing tenant needs.	Goals outlined in community planning efforts, such as Plans to End Homelessness and Consolidated Plans, are furthered as a result of supportive housing.

Services must address the evolving needs of individuals as they age

Efforts must be made to deliver services in the home

Ensure that applicants do not feel rushed into making decisions they do not fully understand

Critical to build community among aging population & healthy culture of aging

Ensure that housing itself is not isolated and residents have convenient access to critical services

Budget flexibility to utilize contingency funding for unit modifications to allow aging tenants to remain in their homes

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[1] Gonyea, J. G., Mills-Dick, K., & Bachman, S. S. (2010). The complexities of elder homelessness, a supportive housing shifting political landscape and emerging community responses. Journal of Gerontological Social Work, 53(7), 575-590.

[2] Chapman DP, Williams SM, Strine TW, Anda RF, Moore MJ. Dementia and its implications for public health. Prev Chronic Dis. 2006;3(2):A34. Available at https://www.cdc.gov/pcd/issues/2006/apr/05_0167.htm

[3] Ibid.

[4] U.S. Census Bureau, Population Projections http://www.census.gov/population/projections/data/national/2014.html

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

[6] Sermons W & Henry M 2010 National Alliance to End Homelessness Demographics of Homelessness Series: The Rising Elderly Population April 2010. In Research Matters: Homeless Research Institute. http://www.endhomelessness.org/page/-/files/2698_file_Aging_Report.pdf

[7] Brown RT, Kiely DK, Bharel M, et al. Geriatric syndromes in older homeless adults. J Gen Intern Med. 2012 Jan;27(1):16–22. Epub 2011 Aug 31 Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250555/

[8] Katz PR 2011 An international perspective on long term care: focus on nursing homes. Journal of the American Medical Directors Association 12 487-492 e481.

[9] Alzheimer's Association. 2015 Alzheimer's disease facts and figures. Retrieved from https://www.alz.org/facts/downloads/facts_figures_2015.pdf

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

[11] Part 2 of the 2014 Annual Homeless Assessment Report. https://www.hudexchange.info/onecpd/assets/File/2014-AHAR-Part-2.pdf

[12] Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prev Chronic Dis [serial online] 2006 Apr [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

[13] Henwood BF, Katz ML, Gilmer TP. Aging in place within permanent supportive housing. Int J Geriatr Psychiatry. 2015 Jan; 30(1):80-7. PMID: 24737594. Accessed from: http://www.academia.edu/21012286/Aging_in_place_within_permanent_supportive_housing

[14] *U.S. Census Bureau. 2010 Census.*

[15] N.Y.C. Department for the Aging, Annual Plan Summary: April 1, 2015-March31, (Sept. 2014), available at http://www.nyc.gov/html/dfta/downloads/pdf/dfta_aps_0914.pdf

[16] New York City Five Year Agency Consolidated Plan for Fiscal Years 2015-2019 Retrieved from http://www1.nyc.gov/assets/planning/download/pdf/about/consolidated-plan/2015-conplan-needs-assessment.pdf

[17] Polypharmacy: Strategies for Reducing the Consequences of Multiple Medications. *Today's Geriatric Medicine.* Vol. 9 No. 3 P. 24 Available at: http://www.todaysgeriatricmedicine.com/archive/MJ16p24.shtml

[18] National Leadership Initiative to End Elder Homelessness. Ending homelessness among older adults and elders through permanent supportive housing. 2011 Available at: http://www.csh.org/wp-content/uploads/2012/01/Report_EndingHomelessnessAmongOlderAdultsandSeniorsThroughSupportiveHousing_112.pdf

[19] Ibid

[20] Joint Center for Housing Studies of Harvard University, Housing America's Older Adults: Meeting the Needs of an Aging Population, 2014. Available at: http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_americas_older_adults_2014.pdf

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