



CREATING AFFORDABLE RURAL HOUSING
WITH SERVICES:
OPTIONS AND STRATEGIES



MUSKIE
SCHOOL

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Executive Summary

In an effort both to save money and meet consumers' preferences, many state governments are moving public long term care dollars away from nursing facilities and into community-based alternatives that provide comprehensive care in an environment that is more home-like than the typical nursing home. Long term care alternatives to nursing facilities tend to be less available for consumers in rural areas, where demographic and economic features – such as lower population density and a smaller proportion of high income consumers – make certain care models more expensive to develop and operate. The same challenges, however, also force the development of new models that suit the realities of rural life.

This study explored the challenges and opportunities for developing and operating housing with services in rural areas of Maine, New Hampshire, Vermont and Massachusetts. The study is based on visits to more than a dozen housing with services sites, and interviews with about twenty-five informants in state government, non-profit organizations and providers. The findings demonstrate that developers and operators of housing with services have adopted new and creative strategies for designing, financing, constructing, marketing, and operating facilities in rural areas, but that greater flexibility in state regulations are needed to allow providers to adapt housing with services models to fit small communities and expand the options available for rural consumers.

MAJOR FINDINGS

Rural Challenges and Advantages: The lower population density and smaller proportion of high-income consumers found in rural areas generally make it difficult to develop housing with services facilities that are large enough to take advantage of economies of scale in construction and service delivery or to use rent-skewing approaches to subsidize low-income tenants with the rents of higher income tenants. Facilities in rural areas tend to be smaller than their urban counterparts – typically serving from five to twenty residents – and must adopt different financing and operating strategies to be successful. At the same time, small facilities also have special advantages to offer consumers: They are often more home-like in appearance and character, and more easily integrated into a residential area or town center. Tenants in small facilities also tend to form close bonds with both staff members and other tenants, reducing social isolation and the risk of health problems or other needs going unnoticed.

Financing Strategies: As mentioned, developers of small rural facilities must use aggressive and creative financing strategies to develop new housing with services, in some cases combining funding from ten or more different sources, such as state, local and federal housing and community development grants and loans, tax credit financing, and state or local preservation or conservation trusts. Developers must plan carefully to maximize the capital infusion these funds provide, by making design, materials, and construction decisions for the long term, investing in quality capital improvements that can help reduce operating expenses and avoid the need to seek additional funding later for costly repairs and needed improvements. The renovation of an older building may keep development costs down (compared to new construction), help revitalize a community by giving new life to abandoned buildings, and open the door to local historical preservation funds. Given the complexity of these financing arrangements, obtaining housing finance expertise is especially important in rural areas, because many developers of rural facilities are small local organizations inexperienced in housing development. Expertise may be found in state housing finance agencies or private for-

profit or non-profit consultants; the latter's services may be paid for through the construction financing package or planning grants.

Funding for Services: The greatest challenge to rural housing with services projects may lie in funding the services, rather than the housing. Funding sources for services tend to be more limited in variety and scope than available housing finance programs. Many states rely heavily on Medicaid waiver programs, with medical and financial eligibility requirements that exclude many consumers with moderate levels of impairment, create oversight and licensing burdens too costly for small facilities, and may unintentionally preclude the development of cost-effective, preventive measures designed to prevent institutionalization. Regular Medicaid programs (as opposed to waiver programs) may have less restrictive medical eligibility requirements, but they also have very low income and asset limits which exclude many low income consumers, and all moderate income consumers. States may heavily subsidize services through SSI supplement or other programs which allow for greater flexibility in eligibility requirements, but these programs do not permit states to benefit from federal matching funds.

Affordability: "Affordability" may mean the model is inexpensive to develop and operate, so the housing and services fees are within the private means of tenants with low or moderate incomes, or it may mean that the model is only "affordable" because states have provided generous housing and service subsidies. For the latter, dependence on the state's continued willingness to provide the subsidies can create uncertainties for developers, even non-profits, whose business plans must provide for an adequate revenue stream to service debt on the building and pay operating expenses, which is especially critical for rural facilities with a small tenant population. The affordability advantage most housing with services options have, however, is that they are less expensive than nursing facilities and so, for consumers who would otherwise be in nursing facilities, these alternatives almost always represent a cost savings for state government. Savings are not assured, however, for consumers who desire to live in an assisted living-style residence or other housing with services facility, but who need less intensive services.

Aging in Place: The goal of "aging in place" is generally shared by consumers as well as developers, operators, and regulators of housing with services, and this goal is particularly important for residents of rural areas who may face moving to a distant city if long term care options in their local area are limited. But the goal is in competition with maintaining affordability, because it depends upon a facility's ability to provide an array of services adequate to meet residents' needs, which may increase as they age. Twenty-four hour staffing is one of the services which seems especially important to allowing residents to age in place, and may be especially expensive to provide in smaller rural facilities. Although trained overnight staff may be required in some types of facilities by state regulations, in others live-in managers may provide an adequate level of security and peace of mind, and the cost is often limited to the manager's room and board.

Local Involvement and Support: Successful housing with services facilities in small rural communities have found that community support for and involvement with the project is crucial. Local residents and organizations can provide much-needed financial contributions and volunteer services, and can help market a new facility through word of mouth. In some cases, developers have affiliated themselves with other local healthcare providers who have an established position in the community. Even with community support, developers and operators have found that achieving full occupancy and financial stability usually took longer in rural areas than they expected. This may be a result of having to draw upon a relatively small population of consumers, or with potential tenants' unfamiliarity with housing with services options in general.

Location and Transportation: The location of a housing with services facility is important because it impacts how the facility and its residents interact with the community. In contrast to nursing homes and larger institutional facilities that are typically located far from a city center, in rural areas it is usually an advantage to locate a housing with services facility in or near the town center. This can facilitate residents' involvement with members of the larger community, and vice versa, and make it possible for tenants to walk to restaurants, the bank or a pharmacy, or to entertainment and activity centers. Where these amenities are not within a short walking distance, facilities need to provide or make arrangements for some kind of transportation services. For larger facilities, this might be in the form of a vehicle owned by the facility or, more commonly, through public transportation programs.

Successful Development Strategies: Some of the successful strategies adopted by providers in rural areas include the use of subcontractors for providing services, sharing management and services staff with other facilities, operating as an area meals site or an adult day program, and employing live-in managers who receive room and board as part or all of their compensation. Developers and operators who participated in the study also shared the following advice:

- Be creative in putting a package of funding sources together, but recognize that all funding comes with strings attached. Weigh the benefits of each funding source against the burdens it may impose on either construction or operations.
- Maximize the initial infusion of capital to invest in systems that will minimize future operating costs. Invest capital for the long term because future repairs may have to be paid for from operating funds. Special funds (gifts or grants) may be available for major repairs or renovations.
- Get help from the experts, especially on financial issues.
- Be involved in the community and create support through interaction. Locating a facility in or near the town center may provide many benefits to the facility and its tenants.
- Be prepared for a difficult start-up period. It may take several months or close to a year to reach full occupancy.
- Screen tenants to make sure they are physically able to cope with the living environment and are socially suited to group living. Also, make sure that the tenants and their families have realistic expectations about the level of services the facility does and does not offer.
- Consider what number of tenants will be required for "critical mass," for purposes of covering operating costs as well as ensuring tenants' social compatibility.

STATE POLICIES AND PROGRAMS

Policy Goals vs. Regulatory Reality: All of the states we studied are in one stage or another of reforming their long term care financing and delivery systems to respond to recent trends in long term care philosophies and to control spending. However, these states' housing and services regulations sometimes thwart efforts to meet these goals in rural communities. Building and service regulations and licensing requirements often make current care models too expensive to build and operate on a scale small enough for rural communities to support. Inconsistencies between licensing regulations, fire codes and other regulations may also inhibit development. In addition, programs and policies that address the needs of the nursing home eligible population may have the unintended consequence of discouraging development of housing with services that could ultimately help avoid or delay nursing home placement. One way for state government to avoid some of these problems is to ensure that its housing development agency and its human services agency carefully coordinate their priorities and planning for older and disabled populations.

The Need for Targeted Rural Policies: Although we discovered a variety of creative and innovative ways that rural challenges are being addressed by facility developers and operators, many program requirements, eligibility criteria, and licensing regulations continue to hinder the development of a wider array of affordable options that can be implemented in rural areas. State policies and programs consistently fail to address directly the special challenges rural communities face in meeting the need for affordable housing with services and, with few exceptions, policy makers appear to assume that one size fits all when it comes to long term care. Since few states have undertaken specific efforts to develop rural housing with services, continued analysis of policies and programs that will influence the development of these types of facilities in rural areas is needed.

SECTION ONE

Introduction

Long term care is evolving as consumers, their families, health care providers and payors search for alternatives to traditional institutional models of care. In an effort both to save money and meet consumers' preferences, many states are moving public long term care dollars away from nursing facilities and into community-based alternatives that provide comprehensive, quality care in an environment much more home-like than the typical nursing home, if not in the consumer's very own home. In most states, these community-based alternatives include expanded home care and other community-based supportive services as well as non-medical residential care homes or facilities, such as board and care homes, adult foster care homes, assisted living residences¹ and, for privately paying consumers, continuing care retirement communities.

Making sense out of this spectrum of alternative long term care options can be difficult, particularly for consumers in rural areas. The demographic and economic features of rural areas – such as lower income levels and reduced population density - create special challenges for consumers, providers and payors. These challenges may limit the number and kinds of alternatives available, or make certain care models more expensive to develop and operate. The same challenges, however, also force the development of new models that suit the realities of rural life.

This working paper examines housing with services in Maine, New Hampshire, Vermont and Massachusetts. We define “housing with services” as any multi-unit housing offered in conjunction with the provision or coordination of daily supportive services. Though we are interested in the whole range of housing with services options for older adults or physically disabled younger adults, our focus is on those which offer new and innovative models that are applicable in rural areas and affordable for persons with low or moderate income (with or without subsidies). The paper has three sections. The first section reviews the literature on housing with services, with attention to issues surrounding the delivery of housing with services in rural communities. The second section is a description, for each of the four states studied, of the policies and programs shaping the state's housing with services environment. The second section also briefly identifies and discusses specific housing with services facilities that have been successful in meeting the needs of rural residents. A full profile of each facility can be found in Appendix A. These profiles contain information obtained through visits to the facilities and written surveys and personal interviews with the operators and/or developers of the facilities

(more detailed site descriptions are available from the researchers upon request). The third section is a discussion of the common themes and policy issues encountered in the development and operation of these housing with services facilities. In this section, we also identify the lessons that can be learned from the operators and developers who participated in this study.

Literature/Background

The literature on housing with services suggests a number of different ways in which facilities may be categorized to define alternative models of housing with services. Mollica (1998) has identified four regulatory models for housing with services:

- 1) Institutional models based on older board and care regulations,
- 2) A new model which licenses facilities and sets requirements for the housing and services, which may allow some or all nursing home level needs to be met;
- 3) A service model which regulates only the provision of services and allows the housing to be controlled by existing building codes and requirements; and
- 4) An umbrella model under which regulations are issued which cover a variety of types of housing with services facilities, including residential care facilities, congregate housing, conventional senior housing, adult family care, and assisted living.

For unregulated housing with services models, including several that we examine in this paper, other classification schemes may be more helpful. Hawes, Rose, and Phillips (1999) suggest that facilities may be classified as self-defined assisted living facilities vs. those that call themselves by other names, as free-standing facilities vs. those located on campuses offering different levels of service, or in groups defined by combined levels of service and privacy.ⁱⁱ MacDonald, Remus, and Laing (1994) suggest that facilities can be classified as “constant” or “accommodating” based on whether they see themselves as offering a specified level of service, so that they must discharge residents whose requirements exceed what the facility provides, or whether they adjust the level of services provided to meet resident requirements. An architect interviewed by Manard & Cameron (1997) suggested that there are two models commonly accepted among developers of assisted living facilities: an “active management” model, “reminiscent of summer camp” which emphasizes common spaces and activities to encourage socialization among residents vs. a “passive management” model which emphasizes private space at the expense of common areas.

Facilities providing housing with services have traditionally been developed by persons coming from a social services, nursing home, or senior housing background, but with the advent of new types of assisted living facilities, private real estate developers have increasingly become involved in the business. Manard and Cameron (1997) identify five types of developers: Former nursing home providers, other senior health and housing providers (exclusive of nursing homes), other health and housing providers (for example, substance abuse rehabilitation), specialized assisted living providers, and entrepreneurs (most with real estate backgrounds). Based on their interviews, the authors report that some entrepreneurs have found both that developing assisted living facilities is more complicated than they expected and that success is difficult to achieve without making more of a commitment to the long term welfare of residents than is required by other kinds of real estate development. They also note an increasing tendency for assisted living developers to establish joint ventures and other relationships with hospitals, nursing facilities, and continuing care retirement communities.

For consumers in rural areas, the absence of a strong market for private pay facilities, as discussed below, means that private developers are less likely to build or operate housing with services facilities, particularly the newer assisted living-type residences.

Housing with Services Market

The literature on assisted living and other forms of housing with services indicates that the population served by and in need of these services is dominated by single women (widowed, unmarried, or divorced) in their early 80s (Lewin-VHI, 1996). Recent studies of assisted living in particular reported that residents are on average age 82 to 85, that 75% to 81% of them are female, and that 97% are single or widowed. Prior to entering a facility, most residents lived in their own homes or with their family; smaller numbers entered from retirement communities or nursing homes. Many of the residents in these facilities have significant limitations in their activities of daily living (ADLs) and/or cognitive impairments. One study (Coopers & Lybrand, 1993) found that typical assisted living residents had three ADL impairments and that 42% had some cognitive impairment.ⁱⁱⁱ The majority of people discharged from assisted living go to a nursing facility or to a hospital, although there is evidence that some facilities are able and willing to keep residents until they die or shortly before (Lewin-VHI, 1993). In housing models providing less intensive or comprehensive support services than assisted living, however, we might expect to find resident populations that are somewhat less frail.

A recent survey of assisted living developers notes a tendency for acuity levels within individual facilities to rise over time with resulting increases in the level of services required and

a corresponding “cost creep” (Manard & Cameron, 1997). This reflects the fact that the relatively healthy residents who enter a facility when it opens will inevitably deteriorate over time, and that facilities with a sicker and more impaired resident population find it more difficult to recruit healthier residents. Facilities can limit the services they provide and discharge patients who require more services, but this deprives them of a major selling point in an increasingly competitive and consumer-driven market where individuals facing a decision to enter a facility want to know that they will be able to remain there as long as possible. The result is that operators of assisted living facilities have found it much more difficult to control the level and cost of services than they anticipated.

The newer models of assisted living have been developed primarily for the upper-income market, and except for those using a rent-skewing^{iv} approach to provide a limited number of affordable units within generally high-cost facilities, they are not affordable for low and moderate income elders without substantial public subsidies. The developers interviewed by Manard & Cameron (1997) describe this market as highly competitive and even over-saturated in many suburban areas. This may lead to the conclusion that future opportunities for development will be found only by expanding the market to serve low and moderate income consumers and currently underserved populations, such as those in rural areas. As one commented, "The future challenge of the industry will be to use capital/investment and staffing strategies to make assisted living more affordable to a wider range of people while preserving the core residential quality of the product."

Risks of Non-Institutional Care

States have an incentive to encourage the development of housing with services facilities that can avoid or delay the point at which older persons enter nursing homes, which are generally the most expensive long term care option. As Mollica (1998) comments, however, this requires policy makers to balance the risks and benefits of non-institutional long term care options. Non-institutional housing with services facilities usually operate with fewer and less trained staff than nursing facilities, and some may be unlicensed and unregulated. This usually makes them less expensive than institutional models, but may put the personal safety of residents at risk, particularly as residents become older, frailer and sicker. Also, newer non-institutional models often have a philosophy of maximizing the dignity and autonomy of residents, which is what consumers prefer, but which means that residents assume the risks associated with their own independence. Thus, policy makers must weigh government interest

in protecting residents' personal safety against the benefits of reducing costs and conforming with residents' preferences.

Services and Staffing Issues

There is wide variation in the types and levels of services provided to residents in housing with services facilities, as well as in how these services are delivered. Some states tightly regulate certain forms of housing with services, mandating specific services and establishing minimum staffing patterns and ratios for facilities, while others regulate service delivery separately from the facility (Mollica, 1998). Some states regulate only certain types of housing with services, allowing other models to remain unlicensed.

Many facilities offer a graduated range of services to meet individual needs (Kane and Kane, 1995). In some facilities, services are "bundled," allowing residents to choose service packages for different levels of care, and to change the service package as their needs change over time. Other facilities provide unbundled services as "a la carte" or "cafeteria-style" options. In this case, residents pay a base price for their living unit and a basic service package, purchasing additional individualized services or supplies at an extra charge. Not surprisingly, the financial status of residents was found to be a strong determinant of the kind and amount of services they receive (Lewin-VHI, 1996).

Services may be delivered by in-house staff, shared staff, or outside contractors. Delivery models depend upon facility type and size and category of service. Almost all facilities use outside providers for some services, such as physician or podiatrist consults. Larger institutions are more likely than smaller ones to have in-house staff, and facilities that are part of a nursing home or extended care facility are more likely to share administrative or nursing personnel, especially for night call. Freestanding and housing complex units usually do not have their own personal care or medical services, but contract out for these services (Kane and Kane, 1995).^v Food service, housekeeping, transportation, and case management are other services frequently supplied by outside contractors. Facilities choose a specific model of service delivery for reasons that include cost, availability, quality control, and state regulations (Yee, 1993).

Few housing with services facilities employ staff that is medically skilled. Even service-intensive assisted living facilities tend to use nurses aides or personal care staff in place of licensed nurses, and it has been found that fewer than 25% have either an RN or LPN on staff (Lewin-VHI, 1996). The trend is to delegate nursing duties like administering medications and injections to non-medical personnel, and lack of knowledge and training is therefore an issue in

maintaining quality of care. Due to concerns about quality, some states have implemented regulations or guidelines for the qualifications and training of care staff.^{vi} Hiring and retention of staff is another operational and quality issue surrounding service delivery. High staff vacancy levels and turnover are common, since much of the work force is largely unskilled and receives low wages.

In rural areas, where population density is low and where facilities tend to be smaller, providing affordable supportive services may be an even greater challenge because there are fewer opportunities to take advantage of economies of scale. It is difficult for smaller facilities, with their correspondingly lower operating income, to provide 24-hour staffing or adequate staff for intensive services without significant public subsidies. Similarly, outside contractors, such as home health agencies, that serve a more geographically dispersed population, often encounter transportation issues and a shortage of labor that urban providers may not.

Payment and Public Subsidies

In most housing with services models, residents pay a fixed monthly fee which covers both rent for the living space and the cost of services. The payment varies depending on the size and characteristics of the individual unit and on the level of support services required.^{vii} Residents may pay rent and service fees with their own funds, while low-income residents may rely on public funds to subsidize room and board costs. Some states offer SSI supplemental payments to cover such costs, and most states have or are planning to offer Medicaid assistance with the cost of some services, either through community Medicaid benefits or a waiver program (Mollica, 1998; Citro and Hermanson, 1999). In rural states, however, where per capita income is generally lower, more residents live in poverty, and the tax base is smaller, it may be more difficult to allocate adequate funds to SSI and Medicaid programs to make some housing with services models – particularly assisted living – available to poorer residents.

Facility Design

Design characteristics of many of the newer housing with services models have been driven both by consumer demand for less institutional alternatives to traditional nursing homes and by a philosophy that emphasizes providing a more homelike environment, with features like locking doors, private bathrooms, and kitchen facilities, which are believed to enhance and support the personal autonomy of residents (Lewin-VHI, 1996). Change in facility design has been limited by the large pre-existing stock of older facilities, such as board and care homes, which were built in accordance with more traditional institutional models.^{viii} Change has also

been restricted by licensing and building code regulations intended to insure resident safety, such as fire codes, and by handicapped access regulations, which tend to require more institutional design features, particularly in hallways and bathrooms (Manard & Cameron,1997). Facilities designed for residents with Alzheimer's disease, who cannot be allowed to leave freely, have had particular problems with building code regulations intended to facilitate egress in case of fire (Mollica,1998). Design issues are a particular challenge for facilities in rural areas, which can only support smaller facilities.

Construction Financing

Much of the early financing for development of the newer models of assisted living facilities was private, coming from local banks and savings and loan associations, and more recently from real estate investment trusts (REITs), commercial banks, and insurance companies (Lewin-VHI, 1996). Although there is evidence that the lending community is becoming more comfortable with and interested in financing supportive housing and other kinds of long term care facilities, the increasing competitiveness of the market for upper income assisted living, along with a reluctance on the part of lenders to become involved with management-intense facilities which are seen as likely to become subject to increasing regulation, may continue to present a barrier to private financing (Lewin-VHI, 1996; Manard and Cameron, 1997). On the other hand, there is evidence that public-private partnerships and joint ventures are becoming more common (Lewin-VHI, 1996). These mechanisms provide developers with a way of expanding the market by making facilities more affordable while at the same time facilitating access to public sources of financing. Such partnerships may be particularly important in rural areas, where the private market is not well developed.

Public funding for the construction of housing with services comes primarily from the federal government, although in recent years state funding has become increasingly important (Lewin-VHI, 1996). Types of public funding include federal, state and local grants, such as federal Housing and Urban Development (HUD) grants, community development block grants, and housing and conservation board grants; incentive funding, such as low-income housing tax credits; and housing development loans, such as state housing finance authority loans and USDA rural development funds. Rent payments may be subsidized by HUD Section 8 programs or through individual entitlements, such as SSI and state SSI supplements. State governments may supplement federal construction funding in a variety of ways using money

from general revenue appropriations, state-levied fees or trust funds, and general obligation bonds.

Affordability and Applicability to Rural Areas

In the United States as a whole, the newer assisted living models have not been affordable for low and moderate income elders, and as a result they do not yet account for a large share of housing with services in general (Hawes, Rose, and Phillips, 1999). If such facilities are to become more than a private-pay-only option within the broader supportive housing market, they must be able to obtain more public funding and also reduce the costs of building and operating facilities in order to make themselves affordable. There is considerable economic incentive for this to happen. The development of assisted living facilities has been described as a consumer-driven phenomenon, and the evidence is clear that most older adults prefer them to the traditional alternatives of nursing homes and residential care facilities, when their financial resources give them the choice (Lewin-VHI, 1996). At the same time, there is considerable incentive for states to facilitate the development of facilities which are both less expensive than nursing homes and potentially capable of retaining residents longer than traditional residential or board and care facilities. And interviews with developers indicate that most agree that assisted living facilities can be developed less expensively and still retain the “core values” which have proved attractive to older adults (Manard and Cameron, 1997).

The literature suggests a number of ways in which housing with services, and assisted living facilities in particular, can be made more affordable (Lewin-VHI, 1996; Manard & Cameron, 1997). Specific ways of holding down costs, many of which work together to reduce capital and operating costs, include the following:

- Creating non-profit joint venture organizations to qualify for real estate tax exemptions;
- Minimizing the use of debt;
- Raising donations of money and land in the community;
- Using grant funding, including federal Community Development Block Grants (CDBGs) and HUD’s Home Investment Partnership Program (HOME) grants, along with tax-exempt financing;
- Renovating existing buildings instead of constructing new ones;
- Designing facilities with smaller units and common areas and removing superficial features that do not enhance quality or safety;
- Negotiating low-cost developer and architect fees; and

- Hiring and cross-training staff to perform multiple tasks in order to limit the number of staff needed.

Some developers surveyed by Manard and Cameron (1997) thought that the biggest source of cost savings would come from providing dual occupancy units, although some might question whether dual occupancy is consistent with the current emphasis on consumer preference, when most consumers prefer private units. It could be argued that single occupancy might still be less expensive than nursing homes. Another strategy mentioned by some developers was mixing upper and lower income residents, and charging higher rents for the wealthier residents in order to reduce rents for those with lower incomes, a rent-skewing approach. This has the advantage of avoiding or decreasing the segmentation of housing with services into separate tiers for upper and lower income groups, a tendency anticipated by some developers (Manard & Cameron, 1997). To the extent that this approach provides for a broader scaling of rents based on ability to pay, it also responds to another problem, that of providing assistance to moderate as well as low income consumers. It may be hardest for those with moderate incomes to pay for housing with services, because they are not usually eligible for the programs available to help the very poor but still cannot afford the high rates charged by many facilities.

The literature on housing with supportive services has relatively little to say about issues concerning the development of facilities in rural areas. To a large extent, the challenge of making more alternatives available in rural areas is one of making them less expensive, given that per capita income in rural areas is generally lower than in more heavily populated areas, and the lower population density may prevent developers and operators from taking advantage of economies of scale. Thus, in rural areas some of the affordability strategies mentioned above are applicable, while those that rely on having large numbers of residents in a facility or a certain number of high income residents, are of little help. In some cases, state regulation may prevent or interfere with certain strategies.

In the states we studied, a number of housing with services models have been developed to meet the challenge of providing affordable long term care alternatives to rural residents. Many of these models have put into practice a creative combination of the cost-saving strategies described above, or have developed their own strategies.

Methodology

This study examines housing with services in four New England states, Maine, New Hampshire, Vermont, and Massachusetts. Our primary sources of information about the housing with services policies and programs in each of the states were administrators in state

housing finance agencies, state human services agencies, private non-profit human services organizations, Area Agencies on Aging, housing development agencies, housing with services providers, and independent living programs. We conducted semi-structured telephone interviews, and some in-person interviews, with our primary sources. These sources also referred us to others knowledgeable about housing with services policies and programs. From these primary and secondary sources we identified a set of housing with services facilities for further study.

We conducted preliminary telephone interviews with the developers and operators of the housing with services facilities identified by our primary and secondary informants, to help us narrow the list of case study candidates to those which offered housing and daily support services (at a minimum, daily meals and some housekeeping), served older adults and/or younger adults with physical disabilities, were affordable to low or middle income consumers, were located in rural areas (defined as communities with a population less than 20,000), and were willing to participate in a personal interview and site visit. From these potential sites, we selected facilities that appeared to have some unique or innovative feature that would be instructive to long term care policy makers or providers. This selection process yielded three sites each in Massachusetts, New Hampshire and Vermont, and four sites in Maine.

Each of the facilities we selected was visited and toured by one or more researchers who conducted in-person, semi-structured interviews with the developer and/or operator of the facility. The on-site interviews covered the facility's ownership structure, planning and development history (including financing strategies), regulatory issues, public subsidies, and operational issues such as the rent and fee structure, hiring difficulties, services, and admission and discharge policies. The facility tour was designed to provide an opportunity for the researcher to observe and describe the facility's location, overall condition, and amenities, as well as resident activities and interactions between staff and residents. Researchers also gathered and reviewed the application and marketing materials the facility typically makes available to prospective tenants. An administrator of each facility also completed a written survey containing questions about licensure status, design features, services and staffing levels.^{ix}

The next section of this report contains a discussion of each state's policies and programs regarding housing with services, identifies the facilities that participated in this study, and summarizes our findings with respect to housing with services in the state. Readers who are interested in learning more about the specific facilities that participated in the study may contact the researchers and request our detailed site descriptions.

SECTION TWO

This section of the report contains a subsection for each state we studied that discusses the state's general housing with services environment, policy issues influencing housing with services, and state programs supporting or promoting housing with services. These subsections also contain brief descriptions of the housing with services facilities that participated in the study and discussion and findings specific to each state. Full profiles of the sites are contained in Appendix A.

MAINE

General Housing with Services Environment

In Maine during the early 1990's, the Governor, Legislature, state policy makers, and advocates for the elderly and disabled made a concerted effort to redirect state policy from providing long term care services in nursing homes to developing a community-based long term care service system. The goal was to reduce reliance on expensive institutional care and to offer consumers more home and community care choices, including residential care options. This change in policy had broad support because it proposed community-based services that consumers prefer, and it promised to reduce expenditures for consumers and the state, because community-based care would be less costly than institutional care for many consumers.

While traditional boarding homes and congregate housing programs have existed in Maine for many years, the laws and licensing regulations were reviewed and updated in 1998 as part of the state's long term care reform initiatives. A task force was formed to review and evaluate state law and rules on housing and supportive services for adults outside of nursing facilities and to examine housing and supportive services for adults. The task force agreed that the term "assisted living" should be the umbrella under which a range of services would be provided in group residential settings consisting of private apartments, called congregate housing, as well as facilities with single or double occupancy rooms, called residential care facilities. Regulations were developed to prescribe the minimum requirements for the operation and licensing of assisted living facilities and to specify application and inspection procedures, fire safety standards, provider qualifications, resident rights, and requirements for nutrition and health, clothing and possessions, medication management, resident records, living areas and

sleeping accommodations, sanitation, and safety, with special provisions for the care of residents with Alzheimer's disease.

Under Maine's assisted living regulations, all residential care facilities (traditionally known as "boarding homes" or "board and care homes") that provide assisted living services must be licensed. Congregate housing services programs that provide personal care and administration of medication, with or without nursing services, must also be licensed. For congregate housing services programs that only provide personal care assistance, a license is optional.

State Programs and Policy Issues

Maine's Bureau of Elderly and Adult Services (BEAS) within the Department of Human Services has several programs that support housing with services. The Congregate Housing Services Program funds services for tenants in traditional senior housing and is part of BEAS' effort to provide in-home supportive services that allow individuals to age in place. Tenant eligibility is determined using a standardized assessment tool, and the overall funding level for all eligible tenants at a single housing site is set through a contractual arrangement with BEAS for a fixed amount for the year (as a consequence, tenants needing services after the start of a contract year may be placed on a waiting list until the next contract year begins). Currently, 45 housing units receive congregate housing service funds through BEAS. Generally, congregate housing services are provided only to a few people at each site. State funding has been available for congregate housing services since the 1980's.

As part of the state's long term care reform initiatives, there was also a recognition of the need for assisted living that is affordable. The private sector has been developing assisted living projects, but they are generally too expensive for moderate and low income consumers. As a consequence, the State legislature appropriated funds to pay for a higher level of services in three assisted living demonstration projects using a cooperative approach between the Bureau of Elder and Adult Services and the Maine State Housing Authority. One of these sites is profiled in this report. These demonstrations have been so well received that the 1999 legislative session made funds available to support services at three additional sites, which are now in various stages of the planning and development process. Two of the new sites are expected to be in rural areas.

Maine programs have also encouraged the development of Adult Family Care Homes, which may be licensed for up to six individuals and are designed to provide a home-like atmosphere in which residents may age in place. Medicaid pays the cost of services depending

on the level of care needed, as identified through the state's standardized assessment tool. Reimbursement rates range from \$32 to \$36 per day, and the state will also provide funds to supplement room and board costs up to \$681 per month. Services are individualized and emphasis is placed on maintaining a resident's independence and participation in decision-making.

The Maine State Housing Authority (MSHA) also has a number of programs to encourage the development of affordable rental housing for low income seniors. The Rental Loan Program is MSHA's program for developing affordable rental housing in projects of 20 or more units. The program provides long term mortgage financing at reduced interest rates. This financing is generally linked with the subsidy available from federal low income housing tax credits, and developers who use the Rental Loan Program and/or the tax credit must reserve a portion of the units for low or very low-income renters. The tax credits are allocated to developers, who sell (or syndicate) them to corporate investors. The Maine Housing Investment Fund helps developers market the credits.

The Maine State Housing Authority's New Lease Program offers reduced interest rate loans to finance the acquisition and renovation of housing with 4 to 19 units. The program's purpose is to create more affordable units and to upgrade existing substandard units, and it requires that a percentage of units be rented to tenants with incomes at various levels of the area medium income. Projects in communities that have a demonstrated need are encouraged to assure geographic diversity. MSHA uses state grant funds and the agency's own bonds to fund this program. In addition, the Supportive Housing Program provides reduced interest rate mortgage financing and subsidy funding to eligible nonprofit sponsors to create housing for persons with special needs. The program targets low income tenants, with special emphasis on those with incomes at or below 30% of the area median income. The program may be used for the purchase, purchase and rehabilitation, or new construction of facilities.

Maine's Housing with Services Models

In Maine, we visited an assisted living demonstration project, Merry Gardens, which is a "Type III Congregate Housing Program" licensed under Maine's assisted living regulations and located in a town of about 5,000 residents. It was developed as one of the three assisted living demonstration projects under the cooperative venture between MSHA, which financed the construction costs, and BEAS, which provides state subsidies for rents and services. It has 30 single-occupancy units with private bathrooms and kitchenettes. Two service packages are

available at a cost of \$1,023 or \$1,526 per month and tenants pay 30 to 40 percent of their income as a co-payment, with the remainder paid for through state subsidies.

We also visited Island Commons, an adult family care home on an island with a very small year-round population. It has five residents and is staffed by live-in managers and two full-time personal care aides. The home in which it is located was a gift to a community organization, and renovations were financed by the Maine State Housing Authority and a Community Development Block Grant. Other state agencies and many private individuals and organizations provided financial or in-kind support for the project. The building is completely debt free, so rent is only \$312 per month for a single room. Services cost \$2,400 per month and may be paid for by Medicaid for eligible residents.

A licensed residential care facility we visited, called Three North Pleasant Street, is located in a town of about 3,000 people widely known for its large concentration of older Russian immigrants, whose needs the facility was designed to meet. Construction and renovations were funded primarily through MSHA. Additional funds were provided by a community loan fund and the Maine Homestead Land Owners Alliance, and the facility receives some on-going operating funds from the Johnson and Johnson Foundation. Medicaid pays for room, board and services for most tenants, at a rate of \$90 per day.

To study a congregate housing services program we visited Knox Hotel Apartments, a traditional senior housing development. Services for four tenants are provided through contract arrangements made by the housing provider and paid for through a lump-sum contract with the state Bureau of Elder and Adult Services.

Discussion and Findings

Several examples of housing with services are operating successfully in rural areas of Maine. The state's licensure options are generally flexible enough to meet the needs of rural communities and the state is providing some funds to support the development of new options for providing needed services. Following the demonstrated success of the first three assisted living demonstration projects, including Merry Gardens, the legislature allocated funds to develop three additional demonstration sites. The Maine State Housing Authority and Bureau of Elderly and Adult Services are in the process of determining where these demonstration sites should be located, and it is likely that two of the three new sites will be located in rural areas.

The operators of the sites we studied feel they offer a valuable option for individuals, one that offers older adults privacy and choice, rather than viewing tenants as people to be taken care of. At the same time, they recognize that there is some risk for people who choose more

independent housing models. Some believe that traditional health care providers, such as hospitals and nursing homes, find it difficult to understand that residents want to and can maintain their independence and protect their dignity of choice.

Providing needed services is a serious challenge, since the facilities we studied in Maine serve a relatively frail population. One operator reported having underestimated the extent of medication assistance their tenants would need as well as the resources such assistance would require. Record keeping was also found to be a heavier burden than expected.

The managers of Island Commons expressed their strong conviction that adult family care homes are an extremely valuable residential option, because many older people can receive adequate assistance and thrive in non-medical, home-like facilities. However, they feel the state currently reimburses adult family care homes at too low a level to provide adequate housing, care and management. Island Commons is fortunate because it is a non-profit organization and received a great deal of foundation, grant, and private support. One other island community in Maine is in the process of developing a housing with services project and has benefited greatly from the experience gained by the developers of Island Commons.

The Three North Pleasant Street project represents an interesting adaptation of a very traditional residential care model to meet a community's need to provide support for members of a specific ethnic community. The concept of creating a housing option for aging Russians was promoted by a group of visionaries who had little experience on a non-profit Board or with running an organization. Board members also had little direct experience supervising staff and relied heavily on one staff person. In spite of these challenges, they successfully created and implemented a residential care model molded to meet a unique community need.

The development of additional affordable housing with services in Maine will depend largely on the presence of additional state funding. There is a pervasive feeling among providers and observers that sufficient funds are not currently available for new projects and that providers must await legislative approval in order to expand the number of developments beyond the current demonstration sites. This reflects the perception that the need for these facilities is much greater than the available resources.

The Maine State Housing Authority is consistently praised for its assistance in putting together financing packages as well as for the technical assistance and support that its staff provides during the development process. While our contacts were not overtly critical of the "service" side – the Department of Human Services (DHS) – their experience with DHS contrasts with their experience with MSHA. DHS is characterized as more "bureaucratic" and somewhat slower to act. Delays were attributed to understaffing in licensing and reimbursement

offices within DHS, and frustrations sometimes arose from getting inconsistent answers from different departmental staff about new rules and program requirements. Policy makers have recognized regulatory inconsistencies and convened a task force in 1998 to look at these issues and improve consistency among programs, including coordination with the Fire Marshall's office and local code officers.

Overall, it can be said that Maine has successfully expanded housing with services options in rural areas, and that several existing housing models demonstrate flexibility in meeting community needs. At the same time, there is general agreement that these options should be available to even more of Maine's older and disabled residents.

NEW HAMPSHIRE

General Housing with Services Environment

Long term care policy in New Hampshire was in the midst of a transitional period at the time of this report. The New Hampshire Housing Finance Authority recently completed a study of elderly housing residents, and a number of demonstration projects were underway to explore ways to meet their needs for supportive services. Also, New Hampshire has been engaged in a public debate regarding nursing facilities and community-based care. Recent legislation proposes to divert Medicaid dollars from nursing facilities to residential care options, which would parallel a trend observed in neighboring states.

Currently, long term care consumers in New Hampshire can choose from among private-pay assisted living facilities located in many areas of the state, approximately 80 licensed residential care facilities, and 95 licensed nursing facilities, all of which are regulated by the Bureau of Health Facilities. Observers in New Hampshire anticipate that as the state's new policies are phased in over the next several years, the state's consumers will have an expanded set of housing with services options.

State Programs and Policy Issues

Although New Hampshire's long term care policies are in transition, the state has programs to support affordable housing with services and to explore new options. For example, the Health Care Transition Program, created with the interest earned on Medicaid dollars, supports pilot projects for providing supportive services for older adults and adults with disabilities. One such project is the Co-Location Project, a joint effort of the New Hampshire

Housing Finance Authority and the New Hampshire Office of Family Services. The Co-Location Project has completed a survey of 1,010 elderly housing residents to determine what services are needed in rural areas of the state, to learn about the coordination of services in existing public housing, and to determine the feasibility of developing four “assisted living clusters” in rural areas of the state.

The Congregate Housing Services Program is administered by the New Hampshire Department of Health and Human Services and provides services to frail elderly and younger adults with disabilities who live in public housing, helping them remain independent. Funding for the Congregate Housing Services Program comes primarily from the federal Department of Housing and Urban Development (HUD), but it also receives support from the state and from participant contributions.

The Home and Community-Based Care for the Elderly and Chronically Ill is another program run by the New Hampshire Department of Health and Human Services, Division of Elderly and Adult Services. The program is a Medicaid waiver program designed to provide home care as an alternative to nursing facility care. Individuals who meet Medicaid nursing facility medical eligibility criteria and income guidelines may be eligible under this program to live at an approved assisted living facility as part of a pilot program.

County government in New Hampshire is particularly interested in alternatives to nursing facility care, because county government pays for a county nursing facility through its property tax revenues and the nursing facility costs are usually the largest single item in the county’s budget.

Several programs available to housing with services developers are offered through the New Hampshire Housing Finance Authority, which was established by the state’s legislature in 1981 and operates a broad range of programs to assist low-income persons, families and older adults to obtain decent, safe and affordable housing. The New Hampshire Housing Finance Authority is a quasi-governmental agency which generates funds from the sale of tax-exempt bonds, fees and grants. Each of the three New Hampshire housing with services facilities profiled in this section of the report received assistance from the Authority.

New Hampshire’s Housing with Services Models

In New Hampshire we studied two congregate housing services programs and an assisted living facility. The services programs are located in traditional senior housing and modeled after the U.S. Department of Housing and Urban Development’s Congregate Housing Services Programs. Program participants must have limitations in at least three ADLs and pay

20% of their income for the services, with the remaining cost subsidized through a grant from the New Hampshire Health Care Transition Program or federal funds. Services are provided by facility staff and include housekeeping, IADL assistance, care planning, and activities. Medication and personal care services are available under contract with a private home health agency.

The assisted living facility, Summercrest Assisted Living, LLC, is located in a town of about 6,000. It is an unlicensed model, with clinical services provided by a licensed home health agency. Financing was obtained from private investors, a New Hampshire Community Reinvestment Corporation loan, and the federal Department of Housing and Urban Development. The New Hampshire Housing Financing Authority provided assistance to the project as a pilot program. The facility has 24 assisted living studios and 10 independent living apartments. Market rates for rent and services are \$1,980 to \$2,450 per month, which is subsidized for those who meet the medical and financial eligibility criteria for New Hampshire's Medicaid waiver program.

Discussion and Findings

The models represented by the congregate housing services program have been operating now for a number of years and are successfully providing services that allow residents to maintain independence and avoid placement in a nursing facility. Adequate funding, along with the hard work and dedication of the program managers, have been critical to the success of both programs. Managers of the programs, however, expressed concerns about the possibility of needing to seek alternative funding in the future that would require them to meet the state's licensing standards, an option they feel would make these programs less affordable, or less widely available.

The collaboration demonstrated between Summercrest Assisted Living and New Hampshire's HCBC-EI is innovative and exciting. Eligible individuals can stay in their community and receive needed services in a modern facility at an affordable rate. However, this facility is still in its infancy. Rent-up was not yet complete at the time of our visit, despite a great deal of outreach and marketing, although this is not considered unusual for the first assisted living facility in a rural area. Others who have experienced slow rent-up have attributed it to the local residents' unfamiliarity with this type of housing with services option. Time, word-of-mouth and continued outreach efforts are expected to achieve full occupancy.

Many in New Hampshire believe that the state should make more housing with services options available to enable consumers to age in place. One perceived problem with current

Medicaid-funded programs is that they have a medical focus. Some observers believe the Medicaid programs should make money available for non-medical models; as one person said, “We have to get over the feeling that if a nurse is not involved you are not getting really good care.” A related suggestion is to modify Medicaid programs to provide services in mid-level or residential care facilities.

Other concerns among those who are developing or operating housing with services include the expiration of HUD mortgage funding for older facilities. When the 20-year HUD subsidy is gone, some facilities will become private pay facilities, which will be unaffordable for low income consumers. Also, observers believe that middle income consumers are falling into the gap between housing with services options that are available for low income consumers, who qualify for Medicaid programs, and those developed for high income consumers, who are able to pay privately. For all facilities, we were told, transportation for residents is an important consideration. In rural areas and smaller communities, locating in or near town centers or public transportation services may alleviate this problem.

There is a clear sense that long term care in New Hampshire is in a transitional period. At present, the creation of new housing with services models depends largely on the efforts of individuals. One observer in New Hampshire who was personally involved in the process stated, “[It] is a matter of encouraging it to bubble up . . . [getting] it going informally,” and this is likely to remain true until the state’s long term care policies are more fully developed. Some see the problem as a need for more legislative support through increased funding. Others see the problem as a matter of priorities. New Hampshire only recently completed a public debate about nursing facilities and long term care in general and new state policy on these issues is still in development, to be phased in over the next several years. It is expected and hoped that the new policy initiatives will re-balance Medicaid and lead to the development of a broader array of services. However, one observer noted that while recent legislation addressed the issue of alternative housing, it did not go far enough.

New Hampshire also has a new Health and Human Services Director, which further contributes to uncertainty about what direction the department will take. One person involved with housing with services hopes that the department will at least be able to streamline the process for recipients to qualify for the state’s HCBC-ECI Medicaid waiver program. This observer questions why the process now takes three months, while consumers can be qualified for Medicare coverage of nursing facility costs practically overnight.

Part of the transition the state is going through has to do with consumers’ lack of familiarity with housing with services options. Some consumers are reluctant to try a new living

arrangement, fearing the unknown and unfamiliar. An observer suggested that social workers can help greatly in this regard and can ease the personal transition required when an older person is making decisions about new housing with services options.

There is clear evidence of support for such programs in rural areas, as indicated by the positive commentary from one of those interviewed, who also offers suggestions for developers and policy makers: “This type of option is a win-win for families and consumers. It’s what consumers and families want once they are aware of it. It’s easily packaged as family support. Give families and consumers the option of picking the services [and] get good, strong community support.”

VERMONT

General Housing with Services Environment

In 1996 the Vermont legislature instituted long term care reform by passing Act 160, which mandated a shift in long term care spending away from institutional care and towards community-based options. Specifically, the state’s Department of Aging and Disabilities (DAD) was directed to re-allocate \$20 million of Medicaid expenditures over four years from nursing facilities to community-based services. The state is seeking to accomplish this through a number of strategies: Expanding community-based support services such as adult day services, personal care attendant services, and homemaker and respite services; increasing funding for Medicaid waiver programs for home and community-based care, traumatic brain injury, and residential care homes; targeting applicants for the home and community-based waiver who are at high risk for nursing home placement; revising nursing facility admission and reimbursement policies; more aggressively pursuing federal matching funds; and providing funds for demonstration projects to explore and test residential alternatives. Act 160 also created regional long term care coalitions. These organizations represent consumers, providers and advocates, and are charged with assessing regional long term care needs, setting priorities for meeting them, and developing innovative programs to reduce nursing facility use and promote community-based care options.

Under Act 160, Vermont’s long term care environment is changing. More Vermonters are receiving home and community-based services and nursing home utilization is declining (Vermont DAD, 1999). State government is exploring new ways to deliver supportive services in consumers’ own homes or apartments and to provide quality care in less expensive, non-

institutional settings. There is a special emphasis on responding to consumer preferences in long term care.

State Programs and Policies

Vermont's Department of Aging and Disabilities is funding a demonstration project to deliver services to older Vermonters in traditional senior housing. "Hope in Housing" is an \$80,000 project which has the goal of increasing residents' independence and prolonging their ability to avoid nursing home placement. The program is modeled after HUD's Hope in Housing program and is operated in partnership with local housing authorities, Area Agencies on Aging, and home health agencies. The two locations where the program is operating, Brattleboro and Rutland, have a higher than expected number of residents moving to nursing facilities, and residents who receive services through the program were targeted because of their risk of needing more intensive services or nursing facility placement. The program funds a part-time service coordinator at each site who assesses residents' needs and arranges services for them, including occasional congregate meals, housekeeping and shopping, preventive health services, and companions. Participation is voluntary and residents are not required to pay for the services, but may make a donation to the program.

At another senior housing site, the Department of Aging and Disabilities is funding a second demonstration project, the Wellness Program. This program provides an on-site registered nurse or nurse practitioner to perform assessments and screening of residents for their social and medical needs and make appropriate referrals to primary care physicians or Area Agency on Aging case managers. The Wellness Program was developed through the efforts of the Champlain Valley Long Term Care Coalition, one of the regional coalitions created by Act 160.

Home sharing is also available in Vermont. It has been implemented and promoted by a private non-profit organization called Project Home, a matching service that works to connect home owners who need assistance to continue living at home with tenants who can provide companionship or caregiving in exchange for room and board. Project Home is a program of Cathedral Square Corporation, a private non-profit concerned with the development and management of senior and other special needs housing in Vermont.

For Vermonters who need personal care and 24-hour supervision, and who are unable or unwilling to live in their own home or apartment, Vermont has about 100 licensed residential care homes. Most residential care homes are less expensive than nursing facilities and offer a more home-like environment, but do not generally provide nursing services. Approximately 30

residential care facilities provide more intensive medical supervision and personal care to eligible residents through the state's Enhanced Residential Care (ERC) Medicaid waiver program, which was designed to allow residents to receive nursing home level care in a more home-like environment. The ERC program increases by more than 100% the reimbursement level for providers and requires them to deliver additional nursing services and individualized activities for participating residents. The program also requires that ERC residents have at least semi-private rooms; about two-thirds of ERC providers offer these residents private rooms (Vermont DAD, 1998).

Traditional residential care is struggling in Vermont. There is wide agreement among observers that the state's residential care subsidies are too low, and a recent Department of Disabilities and Aging report stated that "chronic under-funding has contributed to [the closure]" of nearly twenty residential care homes in the past two years (Vermont DAD, 1999). Although state payments for residential care have recently been raised, they are still too low to cover many providers' average per diem costs. In addition, while state government seems committed to residential care homes as part of the long term care continuum in Vermont, the development of licensed assisted living residences appears to pose a competitive threat to traditional residential care.

Vermont is in the process of adding assisted living to its licensed housing with services options. Although a number of residential care homes in the state now call themselves "assisted living," until recently there had been no legislation governing the use of that term in the state. In 1997, legislation was passed that broadly defined assisted living and directed the Department of Aging and Disabilities to establish licensing standards for assisted living residences.* The state is also amending its Medicaid waiver program to include assisted living as a residential option.

New assisted living regulations are expected to govern unit size and require kitchenettes, private bathrooms and twenty-four hour personal care staff. Some existing residential care homes or other group housing facilities that want to market themselves as assisted living may be able to take advantage of a proposed exception to the unit size and kitchenette requirements for pre-existing structures which allows smaller living spaces and a community resident kitchen to substitute for in-room kitchen capacity. These exceptions could

* The recent legislation defines an assisted living residence as one which, "combines housing, health and supportive services for the support of resident independence and aging in place. Within a homelike setting, assisted living units offer, at a minimum, a private bedroom, private bath, living space, kitchen capacity, and a lockable door. Assisted living promotes resident self-direction and active participation in decision-making while emphasizing individuality, privacy and dignity" (Vermont Statutes, Title 33, Section 7102(11)).

make it much easier for existing facilities, at least those already offering private rooms with private baths, to become licensed as assisted living.

Shared housing

Shared housing is an unlicensed model of housing with services that offers an affordable alternative for those who do not want, or are no longer able, to live alone, and who need some supportive services, but who do not have serious enough nursing or personal care needs to qualify them for Medicaid assistance in licensed facilities or for Medicaid waiver programs. Typically, shared housing consists of a large dwelling having several private bedrooms with locking doors, private or semi-private bathrooms, and shared common areas such as a living room, kitchen, and activities room. The housing is available to tenants for a modest rent, while in-house staff provide three congregate meals a day, housekeeping services, and usually some planned activities, for an additional monthly fee. Shared housing is often located in a renovated building, such as a large private residence or former inn, and provides housing for 10 to 20 low or middle income tenants. The cost of rent and services in two shared housing developments we visited is about \$750 per month, and some tenants may pay even less if they are eligible for state or federal housing subsidies.

In the absence of state service programs to subsidize the cost of services delivered by in-house staff in unlicensed facilities, shared housing depends on a complicated financial strategy of piecing together a collection of public and private funding mechanisms that maximize subsidies for capital improvements and minimize the debt burden, so rents can remain low. Some of the funding sources shared housing developers have tapped include:

- Vermont Housing and Conservation Board, which makes state money grants and administers federal housing development grants;
- Housing and Urban Development funds, through the HOME program and other special purpose funds;
- Community Development Block Grants, administered through municipalities;
- Municipal or regional community development loans;
- Non-profit sponsor contributions;
- Private community development or housing conservation trust loans or grants;
- Mortgages from private parties or local area banks, sometimes at below-market interest rates;
- Historical preservation trust grants;
- Private donations from organizations or individuals; and
- Sales of tax credits to private investors.

In Vermont, non-profit developers may obtain expert advice and assistance in the financing process from the SHARE Program, which provides housing development consulting services to non-profit developers or community organizations. SHARE is a non-profit organization devoted to the development of affordable special needs housing in rural Vermont, and the organization (and its predecessor) is largely responsible for the successful development of the shared housing model. SHARE is sponsored by the non-profit Cathedral Square Corporation, which owns and manages senior and special needs housing mostly in central and southern Vermont, the more populous part of the state. Although the SHARE Program receives some funding from the Vermont Housing and Conservation Board, most of its consulting services are paid for through development fees written into the grant applications it submits on behalf of housing developers.

Vermont's Housing with Services Models

We visited three examples of shared housing in Vermont. Park House is in a town of about 1,100 people and occupies a renovated building with private rooms for 17 tenants. Funding sources included a Vermont Housing and Conservation Board grant, a community development block grant, and a mortgage loan from a local bank. Tenants pay \$400 to \$425 per month, and for an additional \$300 per month, they are provided with three meals a day, monthly housekeeping, weekly bathroom cleaning, and some service coordination and planned activities. Some tenants receive state housing assistance and may receive home health care paid for Medicaid or Medicare, but there are no specific state subsidies for the services fee.

Joslyn House is a twenty-bedroom shared home in a town of about 4,800 people. It is owned by a non-profit community reinvestment organization, and was financed with a mortgage from the seller (a charitable organization), a community development block grant, funds from the Vermont Housing and Conservation Board, and HUD funds from the local housing authority. The combined cost of rents and services is similar to Park House.

Our third site, Evarts House, is located in a renovated historical building and is home for ten tenants. The project was financed through a complex assortment of private, federal, state and local funding sources. Tenants must meet income eligibility requirements and rents are set according to formulas based on the area's median income. Tenants may also be eligible for Section 8 subsidies paid directly to the tenant. Services at Evarts House are provided "cafeteria style" and moderately priced for all tenants, regardless of income.

Discussion and Findings

The developers and operators of shared housing who participated in this study, as well as other observers, believe strongly that they are successfully meeting a critical need among older adults for a housing alternative somewhere along the spectrum from living alone to residential and nursing home care. The housing and services are affordable to lower and middle income tenants, without any publicly-funded operating subsidies, other than rent subsidies. Moreover, at least two shared homes have been operating for several years in very small towns located in rural areas and at least two more shared homes are currently being developed in other small towns. Because the shared housing model is an unlicensed model, does not require state service subsidies, and relies on development funds generally available in many states, the model could probably be successfully replicated in other states.

Shared housing developers and operators face several challenges in light of Vermont's long term care policy priorities. The state's decision to make home-based care its highest priority engenders mixed feelings among shared housing developers and operators. No one disagrees that promoting independence at home is a worthy goal, and some study participants also recognize that there seems to be a stigma associated with group living that suggests dependence and poverty. Also, programs that provide services in an individual's own home or apartment are more consistent with many survey results showing consumers' overwhelming preference to remain in their own homes as they age. But shared housing proponents point out that living alone has disadvantages for some people, and that delivering services in individual homes may prevent providers and consumers from taking advantage of economies of scale. Many older adults do not want to live entirely alone, either because they are physically frail and worry about accidents or sudden illnesses, or because they feel socially isolated. Shared housing provides the security of others' constant presence in the house, together with many opportunities to socialize, while still offering tenants privacy in their own bedrooms. In addition, shared housing developers and operators note that many older adults are very happy to give up cooking and housekeeping responsibilities, and that in any event, shared housing tenants have access to full kitchen facilities. They also point out that congregate meals eliminate social isolation and may provide improved nutrition for those who find meal preparation difficult.

Shared housing developers and operators also have concerns about the state's emphasis on assisted living and its apparent commitment to making assisted living affordable for low and middle income Vermonters. Shared housing, as well as traditional residential care, may face stiff competition from assisted living facilities. Many believe that assisted living housing models, with completely private apartment-like units, are preferable to shared housing

arrangements, where units generally do not have in-room stove-tops or refrigerators and some do not have private or in-room bathrooms. Assisted living is believed to offer tenants more privacy and independence, and to promote aging in place more readily because more intensive services are usually available in such facilities. The level of services available to shared housing tenants is limited, so that as tenants age and become more frail or cognitively impaired, a move may become necessary for many of them. One operator predicts some families will reason that if their family member will eventually need a move to more intensive services, it would make more sense to move directly from home to an assisted living residence rather than to a shared home, because of the risk with shared housing that a second move would be needed later if their loved one becomes more frail.

Some observers in Vermont have perceived a “disconnect” between the state’s housing development agency and its human services agency, which is impeding the development of more housing with services alternatives. As demonstrated by shared housing developments, money is available from the housing agency to create multi-unit special needs housing, which is a priority of the agency. But the human services agency is focused instead on delivering services either in consumers’ own single-family homes or in licensed facilities, relying heavily on Medicaid waiver funding. One observer noted that if operating costs in shared housing rise beyond the means of consumers to pay for them, even a debt-free shared home will not be viable without service subsidies.

Most operators would like to see some state support for services provided in shared homes, so that shared housing could be expanded to more communities, made more readily available to low-income tenants, and offer more services. However, state government does not seem inclined to become more directly involved in shared housing development, in light of state policy priorities that favor the development of assisted living facilities and in-home service delivery programs. While this means shared housing will probably not benefit from state funding for services, it also means the state is unlikely to perceive the need to regulate shared housing. Shared homes now enjoy relative freedom from building codes and other regulations that make residential care facilities, for example, more expensive to build and operate. Two shared housing operators mentioned that state regulators had paid “unofficial” visits to tour their homes and that the regulators seemed to be very pleased with the conditions there. So long as quality of care problems do not arise, the lack of regulation should help to keep shared housing affordable.

Even in the absence of state service subsidies, shared housing is providing a very affordable housing with services option for small communities struggling to deal with long term

care issues, and it appears to be successfully meeting the needs of a growing number of older Vermonters in rural areas. It may be that whatever happens with respect to assisted living or in-home services, shared housing will continue to provide a desirable housing alternative.

MASSACHUSETTS

General Housing with Services Environment

The environment for affordable rural housing with services in Massachusetts differs in several significant ways from that in its northern neighbors. With more than 6 million people, the state's population is about double that of the other three states combined, and a much larger proportion of the state is urban. Only two of the state's ten counties can be considered rural in the usual sense, although there are rural parts of some other counties. Per capita income and general state revenue per capita in 1996 were significantly higher in Massachusetts than in the other states we studied.

The long term care and supportive housing environment shows similar contrasts. In 1995-96, Massachusetts had more nursing home beds but fewer traditionally licensed residential care beds in relation to its older population than the other states. However, Massachusetts has a large number of congregate housing facilities, as well as assisted living and other retirement communities, that are not considered in the count of residential care beds.

Since 1995, Massachusetts has seen a rapid growth in the number of new assisted living facilities, which increased from 44 in 1995 to 107 in 1998 and are projected to reach 130 in 1999 (MassAlfa, 1999). This growth is being driven partly by demographic and economic factors, which have attracted many real estate developers into assisted living, and partly by state policies and programs which are described below. Most of the new facilities have been built to conform with the state's new assisted living regulations, have between 20 and 150 units, and provide a relatively high level of service and privacy. A smaller number of new facilities have fewer than 20 units, usually consisting of single bedrooms with or without private bathrooms and tubs or showers, and typically are converted private residences managed by a proprietor who lives in the home. These small facilities are hard to distinguish from traditional residential care homes and can qualify as assisted living residences under the regulations only because some of the requirements are waived for buildings that do not involve new construction.

Some of the newly constructed facilities are entirely for high-income consumers, some use rent-skewing to reserve a proportion of the units for persons with low and moderate incomes, and a few have tried to keep their fees for all or most units at a level that is affordable for elders with moderate incomes, and for those with low incomes who receive help through Medicaid, the state's Group Adult Foster Care program, or SSI state supplements to cover the costs. Monthly fees for rent and services usually fall between \$1,500 and \$2,500 in facilities targeting moderate and lower income individuals, and between \$2,500 and \$4,000 in those targeting higher income persons. Most of the newly constructed assisted living facilities are located in urban or suburban areas, although some are found in more rural areas with large summer populations, such as Cape Cod and the islands, and the Lenox area in the Berkshires. Those few assisted living facilities which exist in rural communities are almost all of the small, more traditional residential care variety.

State Programs and Policies

Massachusetts has made a major commitment to the assisted living model of housing with services and has provided substantial resources to implement it. For many years the state has funneled money to home care providers to deliver supportive services to elders living in their own homes or apartments through a limited number of Aging Services Access Points, local home care corporations which often are also Area Agencies on Aging. The state's Executive Office of Elder Affairs (EOEA) has a history of collaborating with the Department of Housing and Community Development (DHCD) to plan and implement programs to provide supportive services in public housing projects, and in many cases this has filtered down to the local level, encouraging more collaboration between the local housing authorities and home care corporations.

The state also has older board and care facilities known as rest homes which provide personal care services to residents but cannot serve those who require skilled nursing services (Mollica, 1998). In addition, there are a number of congregate housing facilities, built in the 1980s under a joint EOEA-DHCD program with money from HUD, which funded construction by local housing authorities and provided money for service coordinators to manage daily operations and provide case management services for residents. Other options include adult family care programs, under which persons willing to provide a room and personal care assistance for elders receive a monthly tax-exempt stipend paid by the Medicaid program. In some areas, there are also home sharing programs which provide a mechanism for elders in their own homes to offer living space in exchange for support services and companionship.

In 1994, the legislature created a process for the certification of assisted living facilities by EOEA (Mollica, 1998), and regulations for Assisted Living Residences (ALRs) were issued in January of 1996. These regulations require that all ALRs provide units with lockable doors and either a kitchenette or access to cooking capacity (defined as refrigerator, sink, and heating element) in each unit. All newly constructed ALRs have to provide private bathrooms with a tub or shower for each unit. ALRs that are not newly constructed are required to provide at least a private half-bathroom (lavatory and toilet) for each unit with a tub or shower for every three residents, although these bathroom requirements can be waived if required by public necessity and convenience and to avoid undue economic hardship.

ALR staff must conduct individual assessments, develop individual service plans for each resident, and provide services specified in the plan. ALRs are also required to provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed; self-administered medication management; 24-hour on-site staff coverage for urgent or emergency needs; and from one to three regularly scheduled daily meals. In addition, ALRs may provide or arrange for optional services, including local transportation, barber/beauty services, and money management. Nursing care and other skilled health services can only be delivered by certified providers of ancillary health services (visiting nurse associations and home health agencies); if ALR staff do provide such services, they must be working as employees of such certified providers.

The new assisted living regulations provided a framework for the development of new assisted living residences, but additional funding was needed to insure that these residences were available to low and moderate income consumers. Such funding was provided in the form of state Medicaid payments and a special state supplement to SSI payments for eligible low income individuals. Through the Group Adult Foster Care Program (GAFC), Medicaid recipients can receive up to \$33.70 per day to pay the service component of assisted living fees. In addition, the state has a special category of SSI benefits for assisted living residents, funded through a legislative appropriation, which pays \$920 a month toward the room and board component of assisted living fees (Mollica, 1998; MassAlfa, 1999). Since SSI beneficiaries automatically qualify for Medicaid and GAFC, this combination of subsidies has made it possible for many low income consumers to access assisted living in Massachusetts.

To support the construction of new ALR facilities, the state supplemented federal funding (such as low income housing tax credits, HUD's HOME program, and community development block grant programs) with the Massachusetts Housing Finance Agency's (MHFA) Elder Choice Program. This program provides financing that can be used with tax credits and FHA mortgage

insurance for the construction of assisted living facilities with 30 to 100 units in which 20% of the units must be available to individuals whose income does not exceed 50% of area median income. To obtain Elder Choice funding, applicants must document market demand for the proposed unit mix and must meet certain design criteria. The agency explicitly discourages shared occupancy and does not consider rental revenue attributable to shared units in loan underwriting. Applicants must also demonstrate their ability “to accommodate the increasing or changing needs of the very frail in a manner that facilitates the resident’s dignity, privacy, and ability to choose care or services” (MHFA, Elder Choice Program Guide, 1999). As of April 1998, the agency had committed \$128 million for fourteen projects with 1,207 units (about 15% of units available or in development in the state at the end of 1998) and hoped to continue producing several hundred units annually (MHFA Press Release, 4/15/98).

Early in 1999, EOEA and DHCD announced a new Supportive Senior Housing program designed to bring “assisted living like” services to public senior housing projects, to allow residents to age in place and avoid institutionalization. The program will provide funding for 24-hour on-site response services, service coordination, medication monitoring, and one congregate meal a day for those who are clinically eligible for home care services, as well as construction funding to build or upgrade kitchens and provide office space where needed. Scheduled personal care services will continue to be provided through the Aging Services Access Points (local home care corporations) as before. The new program has been piloted in three sites, one of which we visited for this study. The state has included \$800,000 in the budget for the next fiscal year to expand the program to 12 new sites (EOEA Press Release, 2/4/99).

Massachusetts’ Housing with Services Models

Because Massachusetts policies and programs are geared toward the development of relatively large facilities, we were not able to find any single housing with services model serving an entirely rural population. We selected three facilities which together suggest some models that might work in rural areas. One is a traditional congregate housing facility called the Winslow-Wentworth House, which is located in a town with a population of 8,300. It is new construction financed through HUD, with 17 studio apartments. Residents pay 30 percent of their income as rent, and the difference between this amount and fair market rent (about \$450 a month for studio apartments) is paid from state funds. Services are provided under a contract between vendor agencies and the local home care corporation, and residents pay for them on a sliding fee scale.

The second facility is a new licensed assisted living residence located in a small town adjacent to several metropolitan areas. The Corcoran House has forty-two units in a renovated 1890 brick school house. The financing package for the project included a private mortgage, low income housing tax credits, historic rehabilitation tax credits, HUD's HOME program, tax increment financing, and a community block development grant. The facility has also been approved for Medicaid GAFC funding. The private pay rate for rent and services range from \$1,950 to \$2,850 per month.

The third facility is a housing project in Gardner, population 20,000, which is one of the three pilot locations for the state's new Supportive Housing program. The Church Street Housing Project is a traditional senior housing project in a high-rise building with a congregate housing section attached to the main building which was completed in 1996. Initiative for the project came from the Executive Office of Elder Affairs, which has provided funding for services, and Department of Housing Community Development, which has provided funding for upgrading kitchen facilities. Tenants who qualify to receive regular state-funded home care services receive an array of supportive services. The area home care corporation receives fixed monthly payment per client and contracts the services out to local vendor agencies, billing Medicaid and EOEA for services covered by those programs and clients for their share of costs.

Discussion and Findings

Massachusetts has a highly developed and well-funded system of supportive housing, but due to assisted living regulations and financing programs (like the Elder Choice Program) which tend to favor more expensive models, most of the recent development activity has taken place in urbanized parts of the state. It is doubtful whether the Massachusetts approach is applicable to more rural states, since state program requirements appear to be mainly targeted to larger facilities. Although the Program Guide for the Elder Choice program says that it is for facilities with 30 to 100 units, in fact only one of their projects has had fewer than 60 units, a new ALR with 45 units located in the wealthy Boston suburb of Sudbury.

The assisted living regulations are not as restrictive as the Elder Choice program, but it is still doubtful that facilities meeting all the requirements for newly constructed ALRs are feasible in rural areas, although waiving some requirements makes it possible for some facilities that are more like traditional residential care to qualify as assisted living. The Supportive Senior Housing program seems to have more potential for rural applicability, though even here it has not been demonstrated that it can be applied to housing projects on a rural scale. EOEA staff

suggest that a “critical mass” of people requiring the services is necessary and the Gardner site is a 15-story high rise with 177 units.

In addition, although the state’s programs have made assisted living accessible to low-income consumers, it is not clear whether they have been successful in making this housing available to elders with moderate incomes who cannot afford current market rate fees for assisted living but are not eligible for state SSI supplements and Medicaid subsidies.

Taken together, the three sites we visited suggest ways in which models might be adapted to make them more suitable for rural areas, particularly if mechanisms were in place to allow SSI and Medicaid funds to be used for different models of supportive housing. The Corcoran House provides a model for private development of affordable assisted living facilities that may be applicable in more rural areas. At 42 units, it is at the smaller end of the scale for the new assisted living facilities that have been built in the state, and its reliance on a mixture of financing sources, including low income and historic rehabilitation tax credits, to renovate an older building with minimal debt makes it seem suitable for larger rural towns. A similar approach might work to create somewhat smaller facilities in older buildings located in traditional hub towns and drawing their residents from a somewhat larger area. The model seems particularly appropriate for joint ventures between towns or nonprofit organizations, which may be better able to obtain grant funding or raise money locally, and private developers, who can take advantage of the tax credits.

The Gardner model for providing supportive services to residents in traditional public senior housing projects also may be applicable to more rural areas, although the smaller size of rural projects combined with the need for a critical mass of residents requiring services presents some difficulties. The Franklin County Home Care Corporation, which manages the services for the Winslow-Wentworth House, is interested in becoming one of the new sites for the state’s Supportive Senior Housing program, but the housing projects in the area range from 8 to 45 units, with most of them having fewer than 20 units. Since not all the residents need supportive services, making these services available at any one site for 24 hours a day is probably not feasible. In addition, it may not be easy or very helpful to provide congregate meals within a small housing project, particularly when there is already a larger congregate meal site nearby.

The Franklin County Home Care Corporation has considered a number of ways to meet the intent of the program by combining housing projects in several different towns into a single “site” for the purposes of the program. It has discussed several of these with EOEA staff, who have expressed an interest in coming up with models that are applicable in rural areas and a willingness to consider possible alternatives. Under most of these alternatives, the service

coordinator and overnight service provider would have to be “circuit riders,” spending certain days or nights at each project but available by phone from the others. Their availability could be supplemented through an emergency response system and perhaps by volunteers living in the project or nearby. The state already has funded a model for this kind of approach in the Managed Care in Housing and Neighborhood Initiative, which combines the clustering of service delivery with 24-hour assistance in a housing project or in their own homes nearby for older adults who are at risk of losing their independence. The program provides scheduled personal care assistance on a daily basis, on-call nursing services through the local VNA, and an emergency response system, along with other optional services, and has been implemented in the Cape Ann area on the coast north of Boston (Pynoos et al., 1994). This kind of approach depends heavily on the network of regional home care corporations which exists in Massachusetts, but may not be found in many other states. In order to work elsewhere, some kind of regional or local coordinating organization for home care services would probably have to exist or be created.

The congregate housing model represented by the Winslow-Wentworth House is not a new one, but is clearly one that can be applied in rural areas. Given the existence of adequate home care services in the community, it shows that this type of facility is capable of serving people with high levels of need for ADL assistance. The missing piece is the availability of 24-hour support services to meet unscheduled needs, for which funding has not been readily available and which has been too expensive for smaller facilities to provide on their own. If mechanisms can be found to provide such services to several clustered housing projects and to others living independently nearby, congregate facilities might provide a more effective and affordable alternative to the high-end assisted living facilities.

SECTION THREE – DISCUSSION AND LESSONS LEARNED

This section of the report discusses the common themes and policy issues encountered in our study of rural, affordable housing with services models and present the lessons to be learned from the operators and developers of affordable housing with services in rural areas. We pay special attention to the particularly unique or innovative ways in which developers and operators in the four study states have met the challenges presented within their own policy environment.

RURAL CHALLENGES

While state efforts to promote newer service delivery models may promote the development of affordable housing with services in general, recent trends in state policy and long term care philosophies as expressed in state regulatory schemes, may hinder such development in rural areas. For reasons discussed more fully below, state strategies to deliver services in a cost-effective way are often more difficult to implement in sparsely populated areas. In addition, regulations of assisted living style facilities typically impose facility design and service requirements – such as large rooms with private baths and kitchenettes, and 24-hour staffing – that make these models expensive to build and operate. Although not intended by state regulators, the impact of these requirements is probably hardest on small facilities in rural areas, where per unit costs are generally greater than in large facilities and there is not a large market of consumers. To avoid this disproportionate burden on facilities in rural areas, state regulators must pay special attention to these rural issues and avoid the assumption that one size or type of facility will fit urban and rural areas alike. Some regulatory flexibility is often required to adapt housing with services models to small communities.

Other challenges that apply to housing with services in general are particularly critical to the development and operation of housing with services in rural areas. The demographics of rural areas – including lower population density and a smaller proportion of high-income consumers – generally will support only smaller facilities, and this in turn limits the opportunities to take advantage of economies of scale in construction and service delivery, or to use a rent-skewing approach to make facilities more affordable. Some states are overcoming these obstacles through programs that provide services to residents of existing housing complexes, thereby creating economies of scale that are absent in traditional home-based programs, or

through housing models that manage to combine public housing development funds with service subsidies in a non-institutional setting that is less expensive than nursing facility care.

One of the challenges presented by smaller facilities is the need to ensure a workable tenant “mix.” Where certain numbers of units are allocated to tenants with narrowly defined income categories, for example, the inflexibility of these allocations can make it difficult to find the right tenant for the available unit. In other cases, a unit’s size or accessibility may present barriers to potential tenants. In Vermont’s shared housing model, some operators have found that the social mix among tenants is important as well, because there is somewhat less privacy in shared homes than in some other housing models, and tenants must be amenable to shared living space. This also means that tenants and their families must have realistic expectations about the living arrangement and the level of services available in the facility.

Rural areas may also present special challenges in hiring qualified staff. In some small communities, housing with services operators found it difficult to hire aides, kitchen help and/or housekeepers. This was not a universal problem among participants in our study, however. In two very small Vermont communities, shared housing operators reported that their staff of cooks and housekeepers was very stable. It may be that in very small or isolated communities, employment is more stable in general, and local residents tend to maintain a position of employment over longer periods of time. In Massachusetts, some observers believed there was no general problem in hiring qualified staff, but that the current job market offered better paying opportunities for people normally interested in these kinds of jobs. A different staffing issue may arise for small facilities, however, when they find themselves too heavily dependent on a single staff person or manager. In one Maine facility, the departure of one key staff person, who had been there from the facility’s beginning, left the facility somewhat adrift and in danger of straying from its original mission.

Small facilities have developed several innovations to meet the special challenges of operating in a rural community. One strategy is to subcontract for services or to share staff with other facilities. In facilities we studied in Massachusetts and New Hampshire, tenant services are provided almost entirely by vendor agencies under contract with the housing operator or local home care corporation, while in a Vermont facility, service staff are shared with a residential care facility. In Massachusetts, subcontracting is not an issue of facility strategy but rather a matter of how the state regulates and funds the provision of home care services. Sharing staff was an important strategy for the two congregate projects in Massachusetts, and one of the central issues in the Supportive Senior Housing program’s efforts to develop small rural housing projects. In several instances, facilities have created additional economies of

scale in service delivery by operating as the area meals site or offering an adult day program. In Maine, one project is developing a plan to link five small adult family care homes and provide central management and shared nursing staff. Several smaller facilities we studied were able to provide a 24-hour staff presence for tenants' security and peace of mind by employing live-in managers who receive room and board as part or all of their compensation.

While presenting challenges in some respects, smaller facilities in rural areas present special opportunities in others. Often they can more easily be made home-like in appearance and character, and more easily integrated into a residential area or town center. Tenants in small facilities also tend to form close bonds with both staff members and other tenants, reducing social isolation and the risk of health problems or other needs being overlooked. In two facilities we studied, tenants bonded together in rather unique ways. In a senior housing facility in Thomaston, Maine, a tenant cooperative operates an on-site meals program, while in a shared home in Rochester, Vermont, the tenants earn money for special activities through piecework contracts with local businesses. These projects demonstrate the sort of innovation that a closely-knit group can facilitate. Small facilities are also able to focus on the needs of a special population, as in the case of the residential care facility in Richmond, Maine, serving the needs of the community's older Russian-speaking residents, or Chebeague Island's adult family care home enabling islanders to stay in their own community.

FINANCING STRATEGIES

Facilities in rural areas have developed a variety of strategies to obtain funding for construction costs. Many of the facilities we studied are housed in older buildings, such as former inns or retirement homes, which keeps development costs down and helps revitalize a community by giving new life to unused or abandoned buildings. Renovating an older building also opens the door to additional financing sources, such as historical preservation funds, and may provide greater opportunities for the facility to be made home-like and less institutional looking.

Historical preservation funds, however, like many other housing development funds, generally come with strings attached. For example, historical preservation funds usually restrict construction methods or materials that may be used in the renovation, which may increase construction or repair costs. Housing and Urban Development HOME program funds impose a rigid set of tenant income-eligibility requirements and rent limits. In addition, most funders require that the borrower or grant recipient be a non-profit organization, and many funding sources require a significant investment of administrative resources to complete the application

process and, later, to ensure compliance with all the conditions of each funding source. The benefits of each funding source must be balanced against the burdens it imposes on the project, both during construction and in operation.

Taking advantage of these funding sources also requires that developers have access to some source of financing expertise. In most states, the state's housing finance agency is providing assistance in this regard. In Vermont, the SHARE Program, sponsored by the non-profit Cathedral Square Corporation, offers consulting services to meet this need. There may also be private consulting services available in some states.

Developers who rely heavily on housing development funds must consider how they can maximize the capital infusion these funds provide. Developers and operators have discovered that making the most of the available capital means making design, materials, and construction decisions for the long term, by investing in quality capital improvements that can help reduce operating expenses and avoid the need to seek additional funding later for costly repairs and needed improvements.

In some areas, housing with services development may be spurred by the Balanced Budget Act's definition of expectations for "Critical Access Hospitals." The BBA requires Critical Access Hospitals to conduct community needs assessments and participate in community development of a spectrum of health care services. This obligation may provide a valuable opportunity for rural communities, their hospitals, and local entrepreneurs to partner in the development of affordable housing with services. This potential may be found in the independent and assisted living facility in New Hampshire that was developed in partnership with the regional hospital. Also, in Vermont, at least one rural hospital has considered developing shared housing.

LOCAL INVOLVEMENT AND SUPPORT

Successful housing with services facilities in small communities have found that the community's support for and involvement with the project is critical both to its development and successful operation. Many of the rural facilities that participated in this study were developed as a direct result of the efforts of specific individuals or small local organizations with an interest in providing housing options for their community's older or disabled residents. Community acceptance of a project has proved important in several instances. For one Vermont facility, initial hostility to the project contributed to a slow rent-up period. When that hostility later turned to enthusiastic support, local residents and organizations began providing much-needed financial contributions, as well as volunteer services that enhance the housing environment for

tenants. Developers and operators have found that this kind of support can be generated by involving area residents in the project's earliest stages, as one New Hampshire facility did by staffing planning committees with community members. In other cases, developers have affiliated themselves with other local healthcare providers who have an established position in the community.

Even with community support, a number of developers and operators told us that achieving full occupancy and financial stability usually took longer than they expected. They would warn operators of new facilities to plan on a long and difficult rent-up period, when revenues will be low. Slow rent-up may be a result of having to draw upon a relatively small population of consumers, or potential tenants' lack of familiarity with housing with services options in general. Some observers believe that some types of group living are associated with a stigma of dependence or poverty, and this may also be a factor in prolonging the rent-up period for some facilities. As a consequence, local efforts to attract tenants are critical, as are efforts to meet the need among consumers, and those who may be helping them with long term care decisions, for information about housing with services options. It may be that in smaller communities, "word-of-mouth" is especially important in increasing potential tenants' interest in new housing with services options.

SERVICES VS. HOUSING

In the housing with services arena in the states studied, the greatest challenge seems to lie in funding the services, rather than the housing. Many of the models we studied utilized well-established housing development financing mechanisms, such as community development block grants, housing conservation board financing, tax credit financing, HUD's HOME program funds, and other community development and historical preservation funding in the form of grants or low-interest loans. Although many of these funds come with strings attached (see below), and there is sometimes very stiff competition for some grants, a variety of sources of capital funding are available in all of the four states studied.

On the services side, however, funding sources tend to be more limited in variety and scope. Many states, such as Vermont, rely heavily on Medicaid waiver programs to fund services in housing with services facilities. However, these programs have medical and financial eligibility requirements that exclude many consumers and create substantial oversight and licensing burdens. Some older or disabled adults who need supportive services will not have extensive enough nursing or personal care needs to be medically eligible for Medicaid home and community-based care waiver services coverage. Others will be over-income or

required to spend down their assets in order to qualify financially. Also, by serving only consumers with relatively high levels of impairment, Medicaid waiver programs preclude the development of cost-effective, preventive measures designed to intervene with services and prevent institutionalization. Some states, such as Massachusetts, heavily subsidize supportive services through the state's SSI supplement or other state spending programs. These programs allow for greater flexibility in eligibility requirements, but do not permit states to benefit from federal matching funds. At least for the present, Maine has made the decision to use non-Medicaid funds for its assisted living demonstration projects, partly to avoid the regulatory burden imposed by the Medicaid program and partly because most individuals who live in these developments are not Medicaid eligible.

Regular Medicaid – as opposed to Medicaid waiver – has less restrictive medical eligibility requirements and often may be used to pay for supportive services for low-income consumers, whether they live in single-family or multi-unit housing. However, community Medicaid's income and asset limits are very low. To receive full benefits, a beneficiary living in a one-person household must generally have an income at or below 100 percent of poverty and countable assets (excluding the value of a residence) of \$2,000 or less. These financial eligibility requirements exclude many low income consumers, and all moderate income consumers, who generally cannot afford to pay privately for an array of daily support services.

In some states, the housing vs. services funding disparity may be the result of what one observer called a “disconnect” between a state's housing development agency and its human services agency. For example, in Vermont the housing development agency has made financing for special needs housing a priority, with special funding mechanisms for multi-unit housing development, yet the human services agency's priority is on community-based services delivered mostly in single-family homes. In Maine, the housing development agency is perceived as having a more customer-friendly approach, while the human services agency has struggled to be responsive to developers' and providers' needs, although the two agencies have recently been collaborating on assisted living development projects. It may be that among the states in this study, Massachusetts is doing the best job of integrating development funding with services programs, with special efforts underway to establish effective collaborations between the agencies involved. This advantage is probably due to Massachusetts' longer involvement in housing and services development and more affluent tax base.

AFFORDABILITY

In discussing housing with services models, “affordability” may have more than one meaning. It may mean that the model is relatively inexpensive to develop and operate, so that the housing and services fees are within the private means of tenants with low or moderate incomes. Vermont’s shared housing models and some limited congregate housing services programs are affordable in this sense of the word. “Affordable” may also mean that housing with services models are accessible to low and middle income tenants only because states have provided generous housing and service subsidies to reduce charges to tenants. Subsidized assisted living models in all four states are affordable in this sense of the word, but they are still expensive for the state to provide. Massachusetts’ rent-skewing approach to making assisted living affordable relies on producing expensive, high-end assisted living facilities that can attract sufficient numbers of wealthy private pay tenants. For heavily subsidized models, affordability depends on whether the state will continue the subsidies in the future. This dependence can create uncertainties for developers, even non-profits, whose business plans must provide for an adequate revenue stream to service debt on the building and pay operating expenses.

The affordability advantage most housing with services options have, however, is that they are less expensive than nursing facilities. For consumers who would otherwise be in nursing facilities, these alternatives almost always represent a cost savings for state government. Savings are not assured, however, for consumers who desire to live in an assisted living-style residence or other housing with services facility, but who need less intensive services and are not eligible for nursing home care. Although it is generally assumed that economies of scale can be achieved by delivering services in multi-unit housing rather than single-family homes, this is probably true only if the level of services provided corresponds closely to residents’ service needs.

AGING IN PLACE

Many of the housing with services providers we interviewed, as well as our state program and policy contacts, expressed their interest in promoting consumers’ ability to age in place. This goal, which is generally shared by consumers themselves, depends upon a facility’s ability to provide an array of services adequate to meet residents’ needs, which may increase as they age. Naturally, though, providing higher levels of services will have a big impact on the facility’s affordability. Thus, the goal of aging in place is in direct competition with maintaining affordability.

Twenty-four hour staffing is one of the services which seems especially important to allowing residents to age in place. For certain types of facilities, such as residential care or assisted living facilities, 24-hour coverage by trained personal care staff is mandated by state regulations to respond to unscheduled personal care needs or medical emergencies. In other facilities, such as Vermont's unlicensed shared homes, the overnight presence of staff is provided in response to consumer wishes and serves more to provide a sense of security and peace of mind for residents and families than to meet unscheduled needs. These facilities may have live-in managers on the premises overnight, who can be called by residents when they need assistance, so the cost of this type of overnight coverage is often limited to the manager's room and board. In these arrangements, the managers are not expected to provide direct care services, and their presence offers only a somewhat more supportive environment than that provided by the telephone emergency response systems described in the congregate housing programs in New Hampshire. As with many other features of housing and services options, developers and operators face a trade-off. The presence of on-site, direct care staff 24-hours a day may contribute more to a resident's ability to age in place, but will be more expensive to provide.

POLICY GOALS VS. REGULATORY REALITY

All of the states we studied are in one stage or another of the process of reforming their long term care financing and delivery systems. New Hampshire is just beginning to explore new service delivery options, while Maine, Massachusetts and Vermont are somewhat further along, having implemented several new programs. The changes these states are seeking to make are driven both by recent trends in long term care philosophies and by states' efforts to control their spending on long term care in general and nursing facility care in particular. Many consumers and providers are embracing principles of privacy, choice, aging in place, and home-like environments. States are seeking to provide quality care through less expensive delivery models, and many have expressly identified the goal of shifting state funding from institutional care to home and community-based care.

However, these states' housing and services regulations sometimes thwart efforts to meet this goal in rural communities. State regulations often impose extensive facility design and service requirements that make certain housing with services models too expensive to build and operate on a small scale. These may include fire safety regulations, as well as facility licensing requirements, that may govern building materials, room size, means of ingress and egress, staffing levels, and more. Developers and providers both expressed a need for greater flexibility

in building and service regulations and licensing requirements if they are to make current models viable on a scale small enough for rural communities to support. In some cases, these regulations also need to be modified to eliminate inconsistent facility requirements.

In addition, as discussed above, Medicaid eligibility criteria often limit the availability of long term care funds to those with care needs great enough to require nursing home level care, or to those who have very low incomes, leaving a funding gap for consumers with more moderate needs and a more moderate income. Legislators and other policy makers have the challenge of addressing the needs of the nursing home eligible population, while still promoting the development of housing with services that may help avoid or delay nursing home placement.

Several informants and providers also pointed out that state government needs to ensure that its housing development agency and its human services agency carefully coordinate their priorities and planning for older and disabled populations. Failing to do so may result in the creation of affordable housing that older or disabled persons cannot use because they cannot afford the supportive services they need to live there independently.

ADVICE FROM DEVELOPERS AND PROVIDERS

Developers and providers who participated in the study were eager to offer their advice to others who might be interested in developing or operating housing with services in rural areas:

- Be creative in putting a package of funding sources together, but recognize that all funding comes with strings attached. Weigh the benefits of each funding source against the burdens it may impose on either construction or operations.
- Maximize the initial infusion of capital to invest in systems that will minimize future operating costs. Invest capital for the long term because future repairs may have to be paid for from operating funds. Special funds (gifts or grants) may be available for major repairs or renovations.
- Get help from the experts, especially on financial issues.
- Be involved in the community and create support through interaction. Locating a facility in or near the town center may provide many benefits to the facility and its tenants.
- Be prepared for a difficult start-up period. It may take several months or close to a year to be reach full occupancy.

- Screen tenants to make sure they are physically able to cope with the living environment and are socially suited to group living. Also, make sure that the tenants and their families have realistic expectations about the level of services the facility does and does not offer.
- Consider what number of tenants will be required for “critical mass,” for purposes of covering operating costs as well a workable tenant mix.

ISSUES FOR FURTHER STUDY

Although we discovered a variety of creative and innovative ways these challenges are being addressed by facility developers and operators, many program requirements, eligibility criteria, and licensing regulations continue to hinder the development of a wider array of affordable options that can be implemented in smaller facilities. State policies and programs consistently fail to address directly the special challenges rural communities face in meeting the need for affordable housing with services; with few exceptions, policy makers appear to assume that one size fits all. Continued analysis of policies and programs that will influence the development of these types of facilities in rural areas appears warranted in the absence of specific rural development initiatives. As states seek uniformity in long term care policy and service delivery, continued vigilance will be necessary to assure that rural residents with varying levels of housing with service needs and their preferences are not forgotten. Educational programs targeted to increase policy makers' awareness of these rural housing with services challenges and opportunities, and guidelines for the review of policies to assure sensitivity to affordable rural development issues, may be necessary.

ENDNOTES

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1. A recent review of the literature, for instance, examines current definitions of assisted living and finds wide variations in how the term is used (Lewin-VHI, 1996). Some use the term to refer to the whole range of housing with services options, including traditional residential care and congregate housing, while others restrict it to newer assisted living facilities which are characterized by 24-hour staffing, a home-like setting, and a philosophy of maximizing the independence and dignity of residents.
 2. In this latter classification, high privacy means having at least 80% of units private, and high service means having a full-time RN on staff and providing nursing care as needed with facility staff. The study identifies the following four major categories of facilities within their nationwide sample:
 - Facilities with minimal privacy or services, or with both low privacy and services, which are basically indistinguishable from traditional board and care facilities (59%)
 - High privacy/low service facilities, which provide a “cruise ship” approach to supportive housing, but without the ability to allow residents to “age in place” (18%)
 - High service/low privacy facilities, where most residents live in single rooms and more than 20% of units are shared, but which offer more services and are better able to retain residents who need specialized nursing care (12%)
 - High service/high privacy facilities in which more than 80% of units are private, almost evenly divided between rooms and apartments, and which provide services which allow them to retain sicker and more impaired residents.
 3. A more recent study based on a survey of facility administrators found that almost a quarter of residents received help with three or more ADLs, and that about a third had moderate to severe cognitive impairment (Hawes, Rose, and Phillips, 1999).
 4. “Rent-skewing” reduces the rents on some units at an assisted living facility, for example, by charging higher rents for other units in the facility to individuals who are able to afford them. The higher rents subsidize the lower-rent units.
 5. One study found that over 70% of facilities contract with a home health or home care agency for personal care, while another study of more than 500 board and care facilities found that at least half used outside agencies for temporary nursing care (Kane and Kane, 1995; Hawes et al., 1995).
 6. The level and pattern of staffing are also related to quality of care. It has been shown that higher levels of staff result in higher quality of care, but determining the adequacy of staffing levels is problematic. Labor ratios in this case are not always meaningful because of the differences in services provided, differences in levels of care needed at various times of the day and night, and differences in the categories and qualifications of employees (Kane and Kane, 1995). Studies have found staffing levels in assisted living facilities from 0.1 to 1.4 per resident, and patterns of staff coverage that are not consistent across programs. Around-the-clock assistance to meet unscheduled needs is highly desirable, but not all facilities have on-site coverage. Some states have vaguely defined requirements for staffing levels, while others stipulate fixed standards. More states are beginning to specify concrete ratios and staff qualifications, and many states are requiring 24-hour staff (Lewin-

VHI, 1996). In 1995, it was found that 6 out of 19 states had nursing requirements, 5 had aide requirements and 6 specified orientation or on-going training (Lewin-VHI, 1996).

7. Mollica (1998) lists five approaches for establishing rates: flat rates, flat rates that vary by the type of setting, tiered rates, case-mix related rates, and care plan or fee for service rates, and he concludes that flat rates are the most common. In some cases, a facility may provide a basic level of service with additional services offered on an “a la carte” basis, or the resident may contract directly with a separate service provider for additional services. Recent industry estimates suggest that average fees nationwide approximate \$2,000 per month, which is more expensive than traditional board and care homes but less expensive than nursing homes (Citro and Hermanson, 1999).
8. Hawes, Rose, and Phillips (1999) found that almost 60% of the facilities in their nationwide sample were providing little privacy and limited services and were basically indistinguishable from traditional board and care homes, while another 12% were low privacy/high service facilities, most of whose units were single rooms with a significant proportion of them being shared.
9. The site visit, written survey, and personal interview instruments are available from the researchers upon request. An administrator of the facility completed a written survey, which contained questions about the facility’s licensure status, design features, services, and staffing levels.

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CREATING AFFORDABLE RURAL HOUSING WITH SERVICES: OPTIONS AND STRATEGIES

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APPENDIX A – Facility Descriptions

MAINE

The four sites we visited in Maine included an assisted living demonstration project in a small coastal community, an adult family care home located on an island in Casco Bay, a residential care facility designed to serve a specific ethnic group, and a traditional subsidized housing project with a supportive services program.

Merry Gardens, Camden

Merry Gardens is a Type III Congregate Housing Program licensed under Maine's assisted living regulations and was developed in 1997 as one of the three assisted living demonstration projects under the MSHA and BEAS cooperative venture described above. Realty Resources of Rockport, and the Eastern Area Agency on Aging based in Bangor responded jointly to the state's request for proposal and received the award in mid-1996. Realty Resources is a for-profit company that created a non-profit subsidiary to take advantage of the financing available from MSHA, which included the Rental Loan Program, low income housing tax credits, and HOME program funds. The facility is managed by Realty Management.

Merry Gardens is located in a residential neighborhood in Camden, a mid-coast community with about 5,000 residents. The home is a two-story structure with 30 single units with approximately 350 square feet of living space. Each unit has its own bathroom, a kitchenette with a stove, and a door that locks. All units are wheelchair accessible and are furnished by the tenants. Common areas include a living room, sun room, dining room, sitting areas, and outdoor gardens. The base market rental rate is \$395, with lower rents for income qualified tenants subsidized by the Bureau of Elder and Adult Services. All of the tenants have low to middle incomes, and about 21 of the 28 tenants receive rental subsidies.

About half of the tenants at Merry Gardens need medications, more than half need assistance with bathing and/or mobility, and about forty percent of them are memory impaired. Services for tenants are provided by the Eastern Area Agency on Aging and may include

service coordination and care planning, personal care (most often bathing assistance), apartment cleaning, transportation, medication administration, meals, emergency call system, 24 hour staffing, activities, and pharmacy consultation. A key feature of the services program is that it must meet residents' scheduled and unscheduled needs around the clock.

Ten full time equivalent staff are employed by Merry Gardens. Hiring qualified staff has been difficult because Camden is the home of a large credit card service center and telemarketing site, which offers substantial signing bonuses to new employees, as well as competitive wages and benefits.

A "basic" service package provides seven hours of service a week for \$1,023 a month, and an "enhanced" package provides an average of fourteen hours of services a week for \$1,526 a month. The state subsidizes the cost of services based on the tenant's income, with residents responsible for paying either 30 or 40 percent of their income, depending on which service package they choose, as a co-payment. In contrast with Medicaid programs, however, residents are not subject to asset limits. Residents may also receive services they would be eligible to receive in the community through Medicaid, Medicaid waiver, Medicare home health services, or state-funded care programs, provided they do not duplicate services the facility is paid to provide.

Island Commons, Chebeague Island

Island Commons is an Adult Family Care Home located on Chebeague Island in Casco Bay, part of the town of Cumberland. There are 300 year round residents on the island, though the population swells to more than 1,800 during the summer. Island Commons is owned by the non-profit Chebeague Care Resource and had been in operation for six months at the time of this study. Located in a residential area in the middle of the island, it has four single rooms with 126 square feet each and one double room with 170 square feet. Common areas include a living room, a large vestibule with chairs, a sitting room, outside deck, kitchen and dining room, all of which were decorated and furnished as gifts or with family donations. Twenty-four hour staffing is provided by the Resident Care Managers, a couple with a child who live upstairs, and two full-time equivalent personal care aides. The multi-generation environment is very home-like.

Island Commons was conceived by Chebeague Care Resource, a non-profit corporation concerned with home health and long term care for the island's older residents. Chebeague Care Resource (CCR) began pre-development planning for an adult family care home in 1996, receiving financial support for planning activities from the town of Cumberland and The Island

Institute. In 1997, a donor deeded a home to CCR and renovations began with financing from the Maine State Housing Authority and a Community Development Block Grant. Other state agencies and many private individuals and organizations provided financial or in-kind support for the project. Island Commons clearly represents a community effort.

Because the building is completely debt free, the rent is only \$312 per month for a single room, and double that for a two-person room. Services include three meals a day, housekeeping, transportation, service coordination, medication monitoring and assistance with activities of daily living, for a monthly cost of \$2,400. One tenant is currently receiving Medicaid reimbursement for services. Public assistance for room and board is available for some residents through the SSI state supplement at a rate of \$659 per month.

Island Commons serves a frail population, including some residents who are nursing home eligible.

Three North Pleasant Street, Richmond

Three North Pleasant Street is a licensed Residential Care Facility located in Richmond, a town of about 3,000 people in central Maine that is widely known for its large concentration of older Russian immigrants. Three North Pleasant Street is a newly constructed building attached to a rehabilitated older house in a residential neighborhood. The facility is owned and operated by Richmond Eldercare, which is a non-profit community organization created specifically to develop programs and services for older Russian residents and other eligible individuals in Richmond and surrounding communities. In 1994 the organization began exploring housing options to meet the needs of this population, and submitted a proposal in response to a Department of Human Services announcement of the availability of Medicaid funds for residential care. Construction and renovations were funded primarily through Maine State Housing Authority programs, with technical assistance from the Genesis Foundation, some additional funds provided by the Maine Community Loan Fund and the Maine Homestead Land Owners Alliance, and on-going operating funds from the Johnson and Johnson Foundation to pay for community outreach and an activities director.

Three North Pleasant Street has twelve beds in total, half of which are in single rooms, and the other half in three double rooms. One single room and two double rooms have private baths, while the remaining rooms have shared baths. Residents furnish the rooms with their own belongings. Tenants range in age from 66 to 92 years old. Ten of the twelve current residents are supported by the Medicaid program and two pay \$90 a day from personal funds for their room, board and services. The facility has eight full-time equivalent staff positions,

including part-time RN consultants, and provides 24-hour on-site staff coverage. Services include three meals a day, daily housekeeping, service coordination, medication reminders/monitoring, assistance with activities of daily living, handling personal finances, care planning, and transportation to medical services, grocery stores and recreational and other social events.

Knox Hotel Apartments, Thomaston

Knox Hotel Apartments is a traditional senior housing project with independent living apartments, but which has an unlicensed limited Congregate Housing Services Program for four of its tenants. The housing is owned by a for-profit corporation and managed by a subsidiary of the Methodist Conference Home called ElderServ. Thomaston has a population of about 3,300 persons and is located in the mid-coast area of Maine.

The Hotel is located in the town's business district and has 29 apartments (25 single apartments and four two-bedroom apartments). All units have a private bath, a kitchen with a stove, and a locking door. Residents furnish the apartments with their own belongings. The building has several large common areas including a large dining area, and a very large living room divided into two large sections. Off of the living room, tenants have created a cooking area where meals are prepared for those who choose to participate in the meals program.

Knox Hotel Apartments employs a part-time housing coordinator and a part-time service coordinator, as well as a maintenance person, though staff is not available during the evening or at night. Four residents receive congregate housing services funded by the Bureau of Elder and Adult Services. They hire their own service providers, who are paid for through a contractual relationship valued at about \$9,000 per year between the Methodist Conference Home and the Bureau of Elder and Adult Services.

The meals program is unique in that it is run by a tenant cooperative. Tenants do the meal planning, cooking, shopping, and bookkeeping. The program provides three meals a week to other tenants for a requested \$3.00 donation per meal. Food costs are kept low through participation in the food stamp program, and the Congregate Housing Services Program can buy meals from the cooperative for participants in that program. The meals program has been an empowering experience for tenants and demonstrates a creative way to provide services in a traditional senior housing environment.

Village Care Project, Lincoln County

In addition to the sites already profiled, it is worth noting another project that is still in the developmental stage. The Village Care Project, planned by the non-profit ElderCare Network of Lincoln County, is conceived as a model supported housing program for the rural elderly. It will link together five small family-like eldercare homes (each with six residents for a total of 30). All will be licensed Adult Family Care Homes, eligible for Medicaid reimbursement. These will be scattered around Lincoln County in the villages of Boothbay, Waldoboro, Round Pound, Wiscasset, and Jefferson. By dividing the 30 residents among five villages, Village Care will provide a homelike atmosphere and improved quality of life for frail elders in their own villages, while taking advantage of economies of scale through central management. Economies are anticipated through menu planning, purchasing of food and supplies, financial management, billing and bookkeeping, staff training, and provision of respite care, maintenance and repairs. For example, the same registered nurse will supervise all five homes. It is planned that the homes will be occupied by spring 2001.

NEW HAMPSHIRE

For New Hampshire, we profile two congregate housing services programs – one federally funded and one state funded. We also discuss a combined independent and assisted living facility recently developed in a smaller community of about 6,000 residents.

The Tavern Project at Stafford House, Laconia

The Tavern Project is an alternative housing program serving 15 residents of the Stafford House, which is a 50-unit public housing complex for people age 62 or older and younger people with disabilities. Stafford House is located on a main street in the downtown section of Laconia, a community of approximately 17,000 year-round residents. Attached to Stafford House is a converted “mini-mall,” where a medical-model adult day center, the local Meals-on-Wheels distribution site, and a senior center are located.

The Tavern Project was modeled after the U.S. Department of Housing and Urban Development’s Congregate Housing Services Programs. Staff from the public housing authority began pre-development planning in 1993 and responded to a Request for Proposals issued by the New Hampshire Health Care Transition program. Other participants in the program’s development were the community action agency and Meals-on Wheels located in the adjacent mini-mall, a regional hospital, the New Hampshire Housing and Finance Authority, and the Bank of New Hampshire.

Stafford House consists of private single apartments of 200 square feet each. Each unit contains a living area, separate bedroom, efficiency kitchen or kitchenette and private bath. All of the units have locking doors. None are fully wheelchair accessible. A common dining area for the Tavern Project participants and a resident lounge are located just outside the manager's office. The building is within walking distance of the library, post office, various stores, churches and restaurants. Public transportation is available and there is a bus stop with benches at the front door.

Approximately twenty of the building's tenants are under age 65, and three-quarters of these have some form of mental illness, four have a physical disability, and one is a wheelchair user. Five tenants have probable Alzheimer's disease or other dementia with mild to moderate cognitive impairment. Twenty of the tenants who are age 65 and older require assistance with instrumental activities of daily living (IADLs), and five also need help with activities of daily living (ADLs).

To be eligible for Tavern Project services, participants must have limitations in at least three ADLs or IADLs. Participants pay 20% of their adjusted gross income for the services package, regardless of the number of services required. The remaining cost for services is subsidized through a grant from the New Hampshire Health Care Transition Program. Other services in the package provided by staff include weekly housekeeping, service coordination, IADL assistance, care planning, and planned activities. A local bank provides assistance on a monthly basis to tenants who need help handling their personal finances. Medication assistance and personal care services are available under contract with a private home health agency. Stafford House employs three and one-half full time equivalent staff, including a full-time resident/program manager, a kitchen aide, a meals coordinator, a housekeeper, and maintenance staff. Although the facility does not have 24-hour staff on site, there is a Lifeline Emergency Response system provided under a contract with New Hampshire Emergency Response.

Sunrise Towers, Laconia

Sunrise Towers is a traditional 98-unit high-rise public housing complex with a federally funded HUD Congregate Housing Services Program (CHSP) that serves 30 tenants. Sunrise Towers is located in downtown Laconia, a town of about 17,000 residents, within walking distance of the library, post office, various stores, churches, restaurants, an adult day program and a senior center.

Most of the units at Sunrise Towers are single units with separate bedrooms, but there are 12 studio apartments and 12 two-bedroom units. All units are wheelchair accessible and 2 are specially designed for individuals with physical disabilities. All have kitchens with stoves, locking doors, and private baths. Tenants decorate their individual units and are required to provide their own furniture. Each floor has a small common area that tenants have customized and use for informal social gatherings.

At the time of our visit Sunrise Towers had 117 tenants. There is a waiting list of 40 and it is estimated that the next tenant will have to wait 8 to 10 months for an available unit. The oldest tenant is 93 years old and the youngest is 42. Tenants include five people with Alzheimer's disease or other dementia and four younger people with physical disabilities. All 30 of the Congregate Housing Services Program participants require some level of ADL and IADL support services. The service package provided to participants is the same as at the Tavern Project. In addition to meals, the CHSP service package includes one hour of weekly housekeeping, transportation to medical appointments, service coordination and care planning, and assistance with ADLs and IADLs. Transportation and ADL/IADL assistance is delivered through contracts with outside agencies. As at Stafford House, there is no 24-hour staff coverage, but there is an emergency response system available. There are sixteen employees at Sunrise Towers, including the housing authority staff who work in the building, as well as housekeepers, kitchen workers, and maintenance workers.

The services program is a joint project of the local housing authority, HUD, and the State of New Hampshire. It is a non-licensed program which has been in operation for 6 years, but the HUD grant is ending in 1999 and the program's future is uncertain. Program administrators anticipate that to gain continued funding, the program may need to become licensed under state regulations.

Summercrest Assisted Living, LLC

Summercrest Assisted Living is located in a small, rural community of approximately 6,000 residents and opened in March 1998. It is an unlicensed independent and assisted living

facility, owned by a for-profit limited liability corporation. The corporate partners are a realty company (65% participation) made up of four local businessmen who developed the original concept for the facility, and a regional hospital (35% participation). The hospital also owns and operates a community health center, an adult day program, and a community mental health program for adults. Although Summercrest itself is not licensed, all on-site clinical services are provided by a licensed home health agency.

It was a local businessman who first conceived of developing an assisted living facility for area residents. He recruited three other investors and began pre-development planning in 1997, with construction beginning soon after. A building committee with members from the regional hospital and municipal government assisted in the planning. Financing was obtained from the private investors, a New Hampshire Community Reinvestment Corporation loan, and the federal Department of Housing and Urban Development. The New Hampshire Housing Finance Authority provided assistance to the project as a pilot program and plans to encourage two similar developments in rural New Hampshire.

Summercrest is a two-story structure designed to look like a New England style inn and is located one-half mile from the downtown area and within walking distance of the local medical center. It has 24 studio apartments for individuals using assisted living services, and 10 one-bedroom and 2 two-bedroom independent living units. The assisted living studios are 374 square feet and consist of a living area, bedroom area, kitchenette with refrigerator and microwave oven and a bathroom. The independent living one-bedroom and two-bedroom apartments are somewhat larger but have similar accommodations, with the addition of a complete kitchen.

Individuals in assisted living receive the following services, through various contractors, as part of their monthly fee: Three meals a day, housekeeping, service coordination, care planning, medication monitoring, ADL and IADL assistance, mental health and counseling services, planned activities, preventive health programs, and assistance with nursing home placement, if needed. The local community transportation service makes 4 stops each day at Summercrest. The facility has 24-hour staff on site, and also provides an emergency response system. Technically, Summercrest does not employ any staff. A residence manager, who coordinates activities and services, and maintenance personnel are employed by the partnering regional hospital, and all other services are provided by independent contractors such as a home health agency and food service provider.

Market rates for rent and services at the facility start at \$1,980 per month for a single-occupancy independent living one-bedroom, \$2,440 for a double-occupancy independent living

one-bedroom, \$2,750 for an independent living two-bedroom, and \$2,450 for assisted living studios. All services and amenities are included in the monthly fee. Of the 24 assisted living studios, 12 are set aside for individuals who meet the medical and financial eligibility criteria for New Hampshire's Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI), a Medicaid waiver program run by the Division of Human Services. To be eligible for HCBC-ECI an individual must be a Medicaid recipient, medically eligible for nursing facility level of care, and meet income eligibility requirements.

VERMONT

The following sections contain descriptions of three shared homes in central and southern Vermont, including two of the first shared homes developed in the state and one which opened more recently. The homes range in size from ten to twenty tenants and are located in communities with fewer than 5,000 residents.

Park House, Rochester

Park House is a shared home located in Rochester, a town of about 1,100 people. Built in approximately 1915 as a private home and later operated as an inn, it was renovated in 1990 to provide 17 individual rooms, with private or semi-private bathrooms, and a number of common areas for shared use. The house is adjacent to the town park on a double lot just one block from the town center and has been operating since August 1991.

Park House is owned by a local non-profit corporation, Rochester Community Care Home, Inc., which originally wanted to develop a nursing facility but found the cost prohibitive. Shared housing was an alternative presented by the National Shared Housing Resource Center, predecessor of the SHARE program. Park House is the first example of shared housing developed in Vermont using the financing and operating strategies previously described. Pierce Property Partnership was the project developer, putting together the financing package and overseeing the renovations. Funding sources included a Vermont Housing and Conservation Board grant, a community development block grant, and a mortgage loan from a local bank.

Bedrooms are located on all three floors of the building. Although an elevator is available, tenants living on the upper floors must be able to use the stairs in an emergency, a requirement of the applicable fire regulations. All the rooms have locking doors. None have in-room kitchen facilities, but tenants are allowed full access to the central kitchen. Seven rooms have private baths, two of which are wheelchair accessible; the remaining ten rooms share five

bathrooms. Rooms are rented unfurnished and tenants furnish them with their own belongings. Most rooms have space enough for a bed and for a sitting area.

Tenants pay \$400 per month for a room with shared bath, or \$425 for a room with private bath. For an additional \$300 per month, tenants are provided with three meals a day, monthly housekeeping, weekly bathroom cleaning, and some service coordination and planned activities. These services are provided by in-house staff, including an executive director, food services director, a live-in resident manager couple, and part-time kitchen and housekeeping staff. Additional services, such as personal care and medical services, must be obtained from outside providers or from family members. Some tenants receive state housing assistance and may receive home health care paid for Medicaid or Medicare, but there are no specific state subsidies for the services fee.

Tenants at Park House range in age from 75 to 91 years. One resident is a wheelchair user, some need the assistance of home health aides for personal care and medication monitoring, and several have mild or moderate cognitive impairment. All tenants are able to transfer without assistance from bed and toilet, which is a condition of continued residence.

Joslyn House, Randolph

Joslyn House is a twenty-bedroom shared home in Randolph, a town of about 4,800 people in central Vermont. It is located in a residential area one block away from the local hospital and several blocks from the town center. Joslyn House is owned by a non-profit community reinvestment organization, Randolph Neighborhood Housing Services. The house is run by a house manager couple who live and work full time at the house and has a staff of several part-time cooks and housekeepers; altogether, there are four and one-half full time equivalent staff positions.

Joslyn House resulted from the combined efforts of Randolph Neighborhood Housing, which wanted to develop housing for older adults in the community, and Arlene Wright, now one of the house managers, who was retiring and interested in developing a day program or other service program to meet the needs of older adults. Other individuals and organizations became involved in the planning and development process, including the SHARE program's predecessor agency. Primary sources of financing for the project were a mortgage from the seller (a charitable organization), a community development block grant, funds from the Vermont Housing and Conservation Board, and HUD funds from the local housing authority.

Joslyn House has twenty bedrooms and nine bathrooms (three rooms originally designed as space to lease as offices were later converted to bedrooms). Sixteen tenants

share semi-private bathrooms; half of these are adjoining bathrooms and half are in the hall. Four tenants share a single bathroom. Tenants' rooms are of modest size, averaging about 170 square feet, and have locking doors. Tenants furnish the rooms with their own furniture and other belongings. Common areas include a kitchen, dining room, two living rooms, alcoves and sitting areas, sun porch, activities room, workshop, laundry room, outside porch and yard.

Joslyn House tenants are generally able-bodied and range in age from 77 to 94 years old. Two or three tenants have mild cognitive impairment and ten to twelve tenants have non-Alzheimer's dementia. Nine need assistance with instrumental activities of daily living and seven need assistance with activities of daily living.

All tenants at Joslyn House pay the same base rent of \$500 per month, although some tenants are eligible for state housing assistance vouchers. Tenants also pay a monthly service fee of \$225, which purchases three meals a day served family-style in the dining room, monthly room cleaning and weekly bathroom cleaning. Joslyn House staff also provide service coordination and planned activities. Transportation services are provided through a contract with the local rural transportation service, for which Joslyn House pays. There are no state or federal subsidies for other services.

Evarts House, Windsor

Evarts House is a former private home of some historical significance, recently renovated to provide shared living for ten tenants. It is one of three restored buildings owned by Stoughton House Inc., a private non-profit organization which also owns and operates a licensed residential care facility in one of the buildings and is developing independent living apartments in the other. Stoughton House Inc. is formally affiliated with the Mount Ascutney Hospital and Health Center, which operates a hospital, nursing facility and rehabilitation center in Windsor.

Evarts House was conceived following a community housing needs evaluation in 1994, when the SHARE program proposed the idea of shared housing to the Mount Ascutney Hospital and Health Center and Stoughton House. The project was financed through a package of ten major funding sources, which included a mortgage loan from the Hitchcock Alliance, a HUD special purpose grant, a community development block grant, the town's revolving loan fund, Vermont Housing and Conservation Board funds, state and local historical preservation and land trust grants, and contributions from the principal partners in the development.

Evarts House is located one block from the center of Windsor, a town in southern Vermont with a population of about 3,700 people. It opened in August 1998 and is fully

occupied with ten tenants. Tenant rooms range in size from 200 to 400 square feet, and all are large enough to include a bed as well as a sitting area. Each bedroom has a private in-room bathroom. Eight rooms are fully wheelchair accessible. Rooms are rented unfurnished and tenants provide their own furniture and personal items. Common areas include a dining room, wheelchair accessible kitchen, and several other sitting areas.

Tenants range in age from 75 to 92 years old. Two tenants have mild cognitive impairment and two have moderate cognitive impairment. No tenants at present are wheelchair users, incontinent, or confined to bed, and none need help transferring or eating. Tenants must also meet income eligibility requirements and rents are set according to formulas based on the area's median income. State and federal development funding programs require a specified number of rooms to be allocated for tenants at or below 30 percent, 50 percent, 60 percent and 80 percent of median income, and rents are calculated as a percentage of income. Tenants may also be eligible for Section 8 subsidies, which are paid directly to the tenant.

Services at Evarts House are provided "cafeteria style" and priced the same for all tenants, regardless of income. The meals package of three meals a day costs \$250 per month and the housekeeping service, consisting of daily bath linen service and weekly cleaning, costs an additional \$100 per month. Staff provide some assistance with medication reminders and personal finances, and organize activities and transportation to recreational or social events. These in-house services are provided by staff that are shared with the residential care facility next door. Tenants may also arrange for personal care and medication monitoring through the local visiting nurses association.

MASSACHUSETTS

Because Massachusetts policies and programs are geared toward the development of relatively large facilities, we were not able to find any new housing with services models in the state that are serving an entirely rural population. We selected three facilities for this study, however, which taken together allowed us to suggest some models that might work in rural areas, though none of them taken alone fully met our criteria. One is a traditional congregate housing facility located in a town that is unquestionably rural, with a population of 8,300. The second is a new assisted living residence located in a town which, though relatively small (population 13,800), is located 35 miles west of Boston and within a short distance of several metropolitan areas. The last is a housing project in Gardner (population 20,000) which is one of the three pilot locations for the state's new Supportive Housing program.

Winslow-Wentworth House, Turners Falls

The Winslow-Wentworth House is a small congregate residence originally built in 1990 with Funding from HUD obtained through the state's Department of Housing and Community Development. Turners Falls (township of Montague) is an old mill town on the Connecticut River in western Massachusetts with a 1990 population of about 8,300. The house is located in a residential area one block off the main street with a small shopping plaza and super market within a block and several churches and a library within easy walking distance. The Winslow-Wentworth House was built and is owned by the Franklin County Regional Housing Authority. The project was financed with federal Housing and Urban Development funds administered through the Massachusetts Department of Housing and Community Development and the Executive Office of Elder Affairs. The planning process took several years and involved a citizens' advisory group, the housing authority, the Franklin County Home Care Corporation (which services as the local Aging Services Access Point), and the local council on aging.

The house is a two-story building with eleven units on the first level and six on the second. Of the 17 units, 16 are singles with an average of 390 square feet each and one is a double. All units have a bedroom, kitchenette, and a half bath that is shared in a mirror configuration between each pair of units. Several larger public bathrooms with showers or bathtubs are accessible from the hallways and shared by all residents. There are thirteen current residents ranging in age from 47 to 86, of whom nine are 65 or over, two are younger adults with physical disabilities, and two are younger adults with mental illness. None of the older group are seriously impaired or require intensive support services, although one of the younger physically-disabled adults is only partly ambulatory and requires help with transfers and eating, which is provided by a personal care attendant. Residents pay 30 percent of their income as rent and the difference between this amount and fair market rent (about \$450 a month for studio apartments) is paid from state funds.

There is no state licensing for congregate housing, and Winslow-Wentworth House operates under guidelines and regulations from EOE, DHCD, HUD, and state and local boards of health. Services are delivered by vendor agencies under contract with the home care corporation, and are paid for in the same way as services for individuals living in their own homes, using a sliding fee scale. Residents receive three congregate meals a day, housekeeping services as needed, and assistance with ADLs and IADLs. Medication monitoring and other skilled nursing services can be provided by certified home health agencies for individuals who qualify for skilled management through Medicare or Medicaid. Mental health

services are available through referral to a local counseling agency and paid for by Medicare, Medicaid, or private insurance.

The home care corporation employs a part-time congregate coordinator for the facility, but contracts with a homemaker service agency for cooking and housekeeping services. The housing authority provides property management and maintenance services. Winslow-Wentworth House does not offer round-the-clock staff coverage.

Corcoran House, Clinton

The Corcoran House is a newly established, forty-two unit “assisted living community” housed in a renovated 1890 brick school house. Clinton, an old mill and manufacturing town with a growing population of about 13,800, is located in central Massachusetts. Corcoran House is one block from the revitalized center of town, close to a drug store, banks, a café, and numerous other small shops and businesses. The primary entrance of the Corcoran House is now at the basement level on the side of the building, since the impressive granite staircase leading to the old front door is not wheelchair accessible. The basement is considered the first floor and has three floors above it. A new elevator connects all floors, but the main staircase has been left in place and creates a focal point for the entire building.

Corcoran House was developed and is owned and operated by a private for-profit corporation which responded to an RFP from the town of Clinton for alternative uses for the old school building. The financing package for the project included a private mortgage, low income housing tax credits, historic rehabilitation tax credits, HUD’s HOME program, tax increment financing, and a community block development grant.

Corcoran House has been certified as an Assisted Living Residence under the EOEIA assisted living regulations and has also been approved for Medicaid GAFC funding. More than half of the current residents come from Clinton and the rest from neighboring towns, confirming the developer’s belief that the market for assisted living facilities is basically local. Residents range in age from 67 to 98 with most being in their middle 70s. A few residents have mild cognitive impairment.

Individual units in Corcoran House are all studio apartments ranging in size from 325 to 450 square feet. Each unit has a kitchenette containing a sink, counter, microwave oven, small refrigerator, and a few cabinets, but no oven or range top. There is a living/sleeping room with a closet and private bathroom. Residents bring their own furnishings and may have family and guests in for meals and gatherings.

Rent and services are included in a single monthly fee. The service package includes a personalized health needs assessment and service plan, three meals a day, laundry and housekeeping services, medication monitoring, and limited transportation. Residents can choose from three service levels and are charged from \$1,950 to \$2,850 per month. The monthly fee is paid from some mixture of residents' personal funds, family contributions, and state SSI supplements and GAFC payments for those who are eligible. Staff consist of twenty to twenty-five full and part-time employees, including an executive director, an administrative assistant, an activities director, a registered nurse, a social worker, an on-call dietitian, a security guard, housekeepers, and personal care attendants. Corcoran House provides 24-hour on-site staffing and has a universal worker philosophy, so that most workers are able to do multiple jobs.

Church Street Housing Project, Gardner

The Church Street Housing Project is a traditional senior housing project in a high-rise building originally constructed in 1972, with a congregate housing section attached to the main building which was completed in 1996. Gardner is a town of about 20,000 located in the rural north-central part of the state. The project is owned and managed by the Gardner-Westminster Housing Authority, and is one of three pilot sites for the state's new Supportive Senior Housing Program. Initiative for the project came from the Executive Office of Elder Affairs, which has provided funding for services, and the Department of Housing Community Development.

The Church Street Housing Project has a total of 177 units. The average size of a unit is 470 square feet, and except in the congregate section, all units have kitchens and full private baths. The congregate section is essentially a congregate residence located within the larger housing project. It occupies three floors and appears newer, more nicely finished, and much more home-like than the older building. Common areas include a sitting area on the first floor and a kitchen-dining room on the second. Individual units have a half-bath, with no tub or shower and a kitchenette with a sink, stove top, and refrigerator but no oven.

State home care clients (tenants who qualify to receive regular state-funded home care services) at the Church Street Housing Project receive an array of supportive services, including service coordination, a daily meal, and scheduled personal care or homemaker services provided by the local home care corporation. A full-time service coordinator (who was previously the coordinator for the congregate section) is funded through the Supportive Senior Housing Program, which is also providing demonstration funds for 24-hour staffing to meet unscheduled needs of home care clients. Regularly scheduled services for tenants are

provided by the home care corporation on the same basis as services delivered in the community. The home care corporation receives fixed monthly payment per client and contracts the services out to local vendor agencies, billing Medicaid and EOEAs for services covered by those programs and clients for their share of costs. Home care clients, and other project residents who wish to participate, receive a congregate meal at noon five days a week (the project is a congregate meal site and serves some meals to non-residents), a continental breakfast on weekdays, and a breakfast cooked on-site Saturday and Sunday.



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