



CALIFORNIA
HEALTHCARE
FOUNDATION



The Right Place: An Overview of Supportive Housing Options for Seniors and People with Disabilities

September 2013

The Right Place: An Overview of Supportive Housing Options for Seniors and People with Disabilities

Prepared for

CALIFORNIA HEALTHCARE FOUNDATION

by

Terri Sult

Chi Partners

About the Author

Terri Sult, MBA, is a principal at **Chi Partners**, a consulting firm focused on innovation in long term care and service-enriched housing for seniors. Chi Partners works with state units of governments and the private sector on public policy, market research, and strategic and business planning. Visit them at www.chipartners.net.

Acknowledgments

The author would like to thank the staff at the following properties, which were highlighted in the report, for their time and for sharing resident stories: Asian Community Center Nursing Home, Caring Hearts Villa, Francis of Assisi, Missy's Guest Home, Potiker Family Senior Residence, the Santa Barbara Village, and Wildwood Canyon Villa. The author also thanks the interview participants at the managed care health plans and state agencies in Arizona, Hawaii, Massachusetts, New Mexico, and Wisconsin for providing valuable feedback. Finally, the author acknowledges Keeta Scholl, who contributed significantly to the research and writing of this report, and Mauro Hernandez and Sherry McKay, who helped research the practices of managed care health plans in other states.

About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Contents

2 I. Introduction

3 II. Licensed Facilities

Residential Care Facilities for the Elderly

Adult Residential Facilities

15 III. Unlicensed Housing Options

Publicly Subsidized Rental Properties

Permanent Supportive Housing

The Village Model

25 IV. The Use of Supportive Housing by Managed Care Plans in Other States

29 V. Health Plans and Housing Partners: Developing Relationships in California

Case Management

Residential Care Facilities for the Elderly

Unlicensed Housing

31 Endnotes

I. Introduction

THE CAL MEDICONNECT PROGRAM launching in 2014 is a partnership between Medi-Cal and Medicare intended to better coordinate the delivery of health care to seniors and people with disabilities in California. Cal MediConnect is a voluntary program that will enable dual-eligible beneficiaries (those eligible for Medi-Cal and Medicare) to receive coordinated medical, behavioral health, long term institutional, and home-based and community-based services through a single organized delivery system. The program will be implemented in eight counties in a three-year demonstration project, with the goals of improving the health of beneficiaries and lowering costs.¹

Managed care health plans will be offered incentives to provide long term services in the most cost-effective setting possible while maintaining quality of care and good patient outcomes, and, ideally, reducing acute-care costs related to hospital admissions and emergency department use. Yet because most of the participating health plans have not previously been involved with the provision of long term services, they may not fully understand the role that various housing options can play in long term care for seniors and persons with disabilities.

This report provides an overview of the supportive housing options available in California to older adults and individuals with disabilities to help health plans find the most appropriate setting in which to provide long term services. The settings discussed include both licensed facilities such as residential care facilities for the elderly, adult residential facilities, and skilled nursing facilities, and unlicensed housing options such as income-restricted apartments, permanent supportive housing, and the village model. In addition, this report summarizes ways managed care plans in other states use supportive housing for the provision of long term services, and offers suggestions for how California plans might engage housing partners to optimize long term care.

II. Licensed Facilities

IN CALIFORNIA, THERE ARE DIFFERENT types of licensed facilities where older adults and individuals with disabilities can live and receive long term care. These include residential care facilities for the elderly and adult residential facilities. Skilled nursing facilities, while not a type of housing, are another option where seniors and people with disabilities can receive long term care. These facilities provide varying levels of services to residents, with oversight by state agencies.

Residential Care Facilities for the Elderly

Residential care facilities for the elderly (RCFEs), also referred to as assisted living facilities or board-and-care homes, are nonmedical facilities that provide 24-hour care, supervision, and assistance with activities of daily living such as bathing, dressing, and grooming. At least 75% of residents in an RCFE must be 60 or older, and residents under 60 must have needs that are compatible with those of other residents. Although not considered medical facilities, RCFEs must meet care and safety standards set by the state, and they are licensed and overseen by the California Department of Social Services Community Care Licensing Division.

Facility features. RCFEs range in size from six or fewer beds to more than 100 beds. Regulations allow for private and semiprivate rooms, but occupancy is limited to two residents per bedroom, and bedrooms must be large enough to accommodate easy passage between beds, furniture, and assistive devices such as wheelchairs or walkers. RCFEs with six or fewer beds, often referred to as board-and-care homes, are commonly single-family homes located in residential neighborhoods. Because these homes typically

Caring Hearts Villa

Caring Hearts Villa is a five-bedroom, single-family home in San Jose that is licensed as a six-bed residential care facility for the elderly. The property offers indoor and outdoor areas for socializing, with trained caregivers to provide meals (including accommodation for special diets prescribed by physicians), medication management, care and supervision, assistance with transportation, and daily social and physical activities. Rates vary based on the needs of residents, with the average rate for current residents \$4,500 per month.

Olivia Velasquez, owner of Caring Hearts, shared a story about a current resident: “He is a retired police officer with a PhD, and he came to us after living in an assisted living facility. They thought he had dementia because he was hallucinating and confused, but it turned out to be an infection. His family members recognized that he needed more hands-on care, so they transferred him here, where we have one staff person caring for every three residents. We don’t provide medical care, but we did make sure he was hydrated and eating well, and we monitored his health conditions and managed his medications. After a few months, his health stabilized and he was able to finish the autobiography that he was writing.”



are not built as RCFEs, residents usually share a bathroom with other residents, and common space for socializing and recreation may be limited.

Most larger RCFEs are built for the purpose; the majority of these properties have an apartment-style design and are referred to as assisted living facilities. Many offer private apartments with private bathrooms, kitchenettes, thermostats, and locking doors. Common areas typically include a commercial kitchen, a dining room, and areas for socializing. Apartments may range in size from small studio units to two-bedroom units.

The majority (80.5%) of RCFEs in California have six or fewer beds. The total number of RCFE beds is evenly spread across facilities of various sizes, with 24.5% of all beds in facilities licensed for six or fewer beds, 19% in facilities with between 100 and 149 beds, and 18.4% in facilities with between 50 and 99 beds. Table 1 shows a breakdown by size of all RCFEs in the state.

Table 1. Number of RCFEs, by Size, California, May 2013

	FACILITIES		BEDS	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Up to 6 beds	6,004	80.5%	35,070	24.5%
7–15 beds	381	5.1%	4,586	3.2%
16–49 beds	309	4.1%	10,298	7.2%
50–99 beds	345	4.6%	26,376	18.4%
100–149 beds	230	3.1%	28,260	19.7%
150–199 beds	116	1.6%	19,348	13.5%
200+ beds	77	1%	19,359	13.5%
Total	7,462	100%	143,297	100%

Resident profile. National research has found that the average age of an assisted living resident is 86.4, with more than half (54%) of residential care facility residents 85 or older. Twenty-seven percent are between 75 and 84, 9% are between 65 and 74, and 11% are under 65.^{2,3} Other studies have shown that 91% of residential care facility residents are non-Hispanic white, 70% are female, and 20% receive financial assistance through Medicaid.⁴

An estimated 38% of residential care facility residents nationwide receive assistance with three or more activities of daily living (ADLs), with an additional 36% receiving assistance with one or two ADLs. Twenty-six percent of residents do not receive any assistance with ADLs.⁵ The most common chronic conditions of residents in residential care facilities are listed in Table 2.

Table 2. Most Common Chronic Conditions at Residential Care Facilities, US, 2010
(percentage of all residents)

High blood pressure	57%
Alzheimer’s disease or other dementias	42%
Heart disease	34%
Depression	28%
Arthritis	27%
Osteoporosis	21%
Diabetes	17%
Chronic obstructive pulmonary disease and allied conditions	15%
Cancer	11%
Stroke	11%
Diagnosed with between four and 10 of the most common chronic conditions	26%
Diagnosed with two or three of the most common chronic conditions ⁶	50%

Services. RCFEs are required to provide the following basic services:⁷

- Safe and healthful living accommodations and services, including needed housekeeping, maintenance, and laundry services
- Three nutritionally balanced meals and snacks daily, including meals that suit modified diets prescribed by a resident's physician
- Personal assistance and care as needed by residents for daily living, such as dressing, eating, bathing, and taking medications
- Regular observation of residents' physical and mental condition
- Arrangements to meet residents' health and transportation needs
- An activities program that includes social and recreational activities appropriate to the interests and capabilities of residents

There is a range in the type of residents served by RCFEs. Some RCFEs target independent residents and may provide less-intensive personal care or medical oversight, while other facilities serve a more frail population with complex functional and health care needs. Today, the residents served by RCFEs are more frail than before, as family members strive to keep their loved ones at home for as long as possible. In fact, today's assisted living resident is frequently compared to the nursing home resident of yesterday.⁸

Staffing. While there are no specific staff-to-resident ratio requirements for RCFEs, regulations do state that facilities must have sufficient staff at all times to provide the services necessary to meet resident needs. Facilities with 15 or fewer residents are required to have one qualified person on call and on the premises at night, while facilities with

Wildwood Canyon Villa

Wildwood Canyon Villa, an 83-unit licensed residential care facility for the elderly with assisted living and memory care units, opened in 2004 in Yucaipa. Wildwood is a 100% private-pay property.

Dorothy, born in 1919, is a longtime resident of Wildwood who came to tour the facility two years after it opened. "Her family ran a popcorn business, and she is well-known in the community," said Lynette Alvarado, Wildwood's executive director. "She is very active and wanted to be in a place where there are lots of things to do and where residents share in the decisionmaking. She was the one who brought up the idea of bringing the outside community into Wildwood. Now we host fundraisers, Chamber of Commerce meetings, and Bible studies. She was very excited about assisted living — she wanted to make it easier for her family. Now she's on hospice care, and she'll say that she's still this strong because of the support she receives from staff and other residents."

Wildwood offers the following services: meals, housekeeping, monitored emergency and life-safety systems, resident assessment and service planning, regular care and supervision, laundry, financial management, incontinence care, and assistance with transferring, eating, bathing, dressing, grooming, walking, medications, and transportation. Rates start at \$2,775 a month for studio units, \$3,240 for one-bedroom units, and \$4,190 for dedicated memory-care units.

more than 16 residents must have awake staff on the premises at all times.

RCFEs with six or fewer beds are often owner-operated, with a live-in owner serving as administrator and primary caregiver. Some RCFEs operated by live-in owners employ additional

caregivers to supplement the services provided by the owner (e.g., on weekends). In other small RCFEs, the owner does not live in the home or serve as primary caregiver, but provides oversight and employs staff on a shift basis to provide needed services. These owners often own and oversee several small RCFEs.

In small RCFEs, there is typically one staff person available per shift, with that person serving as a universal worker and providing assistance to residents with personal care, medications, meal preparation and service, housekeeping, laundry, and activities. The high staff-to-resident ratio (1:5 or 1:6) and the smaller physical size typical of small RCFEs can allow for more personalized attention and oversight than is sometimes possible in larger facilities.

Larger RCFEs typically have more specialized staff positions, which (depending on the size of the facility) may include administrative support staff such as an assistant administrator, receptionist/clerical support staff, a marketing director, and business office staff; dietary personnel such as a food service director, cooks, dietary aides, and servers; housekeeping and maintenance staff; and activity staff. Direct-care staffing ratios are typically lower than at smaller RCFEs, due in large part to the additional staffing positions found at larger facilities.

Many RCFEs also employ licensed nursing staff, typically to provide supervision of resident assistants and to coordinate the medical needs of residents with health care providers. Some small RCFEs are owned and operated by licensed nurses, although a survey of RCFEs conducted for the California HealthCare Foundation in 2008 found that large facilities were more likely to have a nurse on staff or available than were small RCFEs.⁹

Requirements for admission. Before accepting a resident, an RCFE must enter into an admission agreement with the resident and/or the resident's responsible party. The agreement must specify basic

and optional services, rates, payment provisions, refund conditions, and eviction policies.

Residents cannot be admitted or retained in RCFEs if they have any of the following conditions:^{10,11}

- Active communicable tuberculosis
- A condition requiring 24-hour skilled nursing or intermediate care
- An ongoing behavior caused by a mental disorder that would upset the general resident group
- Dementia, unless the RCFE has met the specified regulatory requirements for dementia (see below)
- A stage 3 or 4 pressure ulcer
- A condition requiring gastrostomy care
- A condition requiring naso-gastric tubes
- Staph infection or other serious infection
- A condition requiring dependence on others to perform all activities of daily living
- A tracheotomy

Requirements for residents with specific conditions. Even though large RCFEs are more likely to have a nurse on staff or available than small RCFEs, small RCFEs are often willing to provide a higher level of care than large RCFEs. The 2008 survey of RCFEs found that 94% of the residents in small facilities (one to six beds) were nonambulatory, compared to 45% in facilities of 100 beds or more.^{12,13} In addition, 18% of the residents of small facilities were bedridden, compared to 4% in those with 100 beds or more.¹⁴ This survey also found that while most RCFEs, regardless of size, do not care for

residents who exhibit combative behavior (only 23% accepted these individuals) or who have psychiatric disorders (accepted by only 35% of RCFEs), one-to-six bed facilities do have higher rates of acceptance for people with these two challenging conditions.

RCFEs must follow guidelines when residents have certain conditions and diagnoses.

Nonambulatory. To accept and retain residents who are bedridden or nonambulatory, RCFEs must obtain approval from the local fire marshal and the Community Care Licensing Division. Bedridden is defined by regulation as “requiring assistance turning or repositioning in bed or being unable to independently transfer to and from bed,” while nonambulatory is defined as “unable to leave a building unassisted in an emergency or dependent on mechanical aids such as crutches, walkers, and wheelchairs.”

Infectious disease. RCFE residents suspected of having a contagious or infectious disease must be isolated, and a physician contacted to determine the suitability of continued retention in the facility.

Dementia. Residents who have a primary diagnosis of dementia may be served in RCFEs only if the facility complies with California Department of Social Services requirements for “Care of Persons with Dementia.”¹⁵ These regulations do not apply to residents who have mild cognitive impairment, which is characterized by short-term memory problems but no other symptoms of dementia that affect daily functioning. The dementia-specific requirements include additional training for direct-care staff providing care for dementia residents, an activity program addressing the needs and limitations of residents with dementia, appropriate safety modifications, a secured outdoor space, and monitoring of exits as needed. Many larger RCFEs have separate units designated for the care of persons with dementia, and some smaller RCFEs serve

only persons with dementia. Other facilities serve a mixed population, with residents who have mild to moderate dementia cared for alongside those without a dementia diagnosis.

Terminal illness. To retain terminally ill residents and permit them to receive care from a hospice agency, an RCFE must have a hospice waiver in place and obtain approval from the Community Care Licensing Division to retain a specified number of hospice residents. Specific requirements must also be met by facilities providing care to hospice residents, including the development and implementation of a hospice care plan and ongoing coordination with the hospice agency.¹⁶

Restricted health conditions. RCFE regulations include specific requirements for the delivery of care to residents who have “restricted health conditions,” including: administration of oxygen; catheter care; colostomy/ileostomy care; contracture care; diabetes care; enemas, suppositories, or fecal-impaction removal; care for incontinence of bowel or bladder; injections; use of an intermittent positive pressure breathing machine; care for stage-one or stage-two pressure ulcers; and wound care.¹⁷ Residents with these needs can be served in RCFEs, so long as regulatory requirements are met.

For many of the restricted conditions, the resident must be capable of providing care needed for the condition, or care must be administered by a skilled professional (typically a nurse who is either on staff at the facility or is contracted through a home health agency). Other regulations mandate what types of care unlicensed staff are allowed to provide. For example, unlicensed staff who have been properly instructed by a skilled professional may change a resident’s colostomy bag. Similarly, unlicensed staff may empty a resident’s catheter bag, but insertion and irrigation of the catheter may be performed only by a skilled professional. Other requirements

cover the use of equipment such as oxygen tanks, the disposal of waste such as used colostomy bags, and the provision of privacy when assisting residents.

Prior to the admission of a resident with a restricted health condition, a facility must communicate with all other persons who provide care to that resident to ensure consistency of care for the condition and ensure that staff complete hands-on training in both general and resident-specific procedures with a licensed professional.

Aging in place. The willingness and capacity of RCFEs to support aging in place varies significantly. Some are committed to allowing residents to remain in the facility as long as possible, while others choose to serve a less frail and medically complex population. Aside from a willingness to serve high-acuity residents, other factors that can enter into a facility's ability to accommodate aging in place include the following:

- *Dementia care.* If an RCFE doesn't meet the regulatory requirements for dementia care (described above) residents who have a primary diagnosis of dementia cannot be served. Approximately 85% of RCFEs responding to a 2008 survey reported caring for persons diagnosed with dementia by a physician.¹⁸
- *Hospice care.* An RCFE must have a hospice waiver and obtain approval from the Community Care Licensing Division for the requested number of bedridden beds to care for hospice residents. Seventy-four percent of RCFEs that responded to the 2008 survey reported having a hospice waiver.¹⁹
- *Diabetic care.* Residents with diabetes must be able to self-administer blood glucose monitoring and insulin injections (if needed) or a licensed nurse must be available to perform these tasks.

This requirement means that facilities wishing to serve diabetic residents must have nursing staff available during scheduled times or around the clock if a resident has a sliding scale insulin order.

- *Two-person transfers.* Some residents require more than one person to assist them with transfers to and from a wheelchair. In such cases, a facility needs to have two people on staff and available to provide assistance at any time and/or use a Hoyer lift. As most small board-and-care homes do not have two people on staff at the same time and some larger RCFEs may not be willing to provide this level of care, the need for two-person transfer assistance sometimes precludes the admission or retention of residents in RCFEs.

Oversight. RCFEs are licensed and inspected by the California Department of Social Services Community Care Licensing Division, with licensing visits required every five years. Annual unannounced licensing surveys must be conducted under the following conditions:

- When a facility is on probation
- When the terms of a facility's compliance plan require annual evaluation
- When a facility faces a pending accusation
- When an annual visit is required as a condition for federal funding
- To verify that a resident who has been ordered out of a facility by Community Care Licensing is no longer at the facility²⁰

The infrequency of licensing surveys at most RCFEs means that there is limited public information available to help interested parties understand the quality of care provided at specific

facilities. A number of organizations have developed tools to assist consumers in selecting a facility to meet their needs.²¹

Funding. RCFEs are predominantly paid for privately in California, due to the fact that there is Medi-Cal funding available to residents of RCFEs only in selected counties through the Assisted Living Waiver Program (see page 10 for additional information about this program).

According to the 2012 MetLife “Market Survey of Long-Term Care Costs,” monthly private-pay base rates for assisted living facilities in California ranged from \$1,300 to \$8,973, with an average base rate of \$3,867.²² Base rates typically include at least two meals a day, housekeeping, and some personal-care assistance, with additional needed services charged separately. The MetLife survey found these additional costs to average \$181 per month for bathing assistance; \$236 per month for dressing assistance; \$504 per month for assistance with other personal care such as transferring, toileting, continence care and eating; and \$347 per month for medication management.²³

Research has found that smaller facilities are more likely to have lower private-pay rates and more likely to accept Medicaid residents than larger facilities. One national study found that residents of residential care facilities with 25 or fewer beds paid an average of 16% less than residents in facilities with 26 or more beds, and 23% of residents in smaller facilities were enrolled in Medicaid as opposed to 13% of residents in larger facilities.²⁴ Additionally, 27% of smaller facilities reported that 50% or more of their residents were Medicaid beneficiaries, compared to 13% of larger facilities.²⁵ Reimbursement through Medicaid has been found to average approximately one-third less than rates paid by private-pay residents.²⁶

Table 3. Payment for Stays in Licensed Facilities

Residential Care Facility for the Elderly

- Most fees are paid privately by residents, family members, and/or long term care insurance.
- Medi-Cal pays for services provided to RCFE residents in selected counties and for qualified participants through the Assisted Living Waiver Program, with residents paying for room and board out of SSI/SSP payments.

Adult Residential Facility

- All fees are paid privately, with most residents using SSI/SSP payments.

Skilled Nursing Facility

- Medicare pays for stays of up to 100 days if required after a 3+ day hospital stay, and covers 100% of costs for days 1 to 20. Co-payments may be required for days 21 to 100.
- Medi-Cal covers costs not covered by Medicare for individuals who meet financial eligibility and level-of-care requirements.
- For residents who are not eligible for Medi-Cal, fees not covered by Medicare are paid privately by residents, family members, and/or long term care insurance.

Note: The federal Supplemental Security Income (SSI) program provides monthly cash payments to people with limited incomes who are 65 or older and to people of any age who are blind or who have a disability. SSP, or state supplementary payment, is the state program which supplements SSI payments.

In California, a 2008 survey found that small RCFEs were more likely to accept and retain residents who have exhausted their private resources, although the circumstances of their residency may change (e.g., moving from single to double occupancy). While only 12% of the survey respondents said they would retain residents who exhaust their personal resources and must rely on SSI/SSP, the majority (89%) of those respondents were RCFEs with six or fewer beds. In addition, although only 19% of respondents reported accepting SSI/SSP as full payment, facilities with between one and six beds were more than twice as likely to accept SSI/SSP as those with 50 or more beds.²⁷

Assisted Living Waiver. The Assisted Living Waiver Pilot Project (ALWPP), now called the Assisted Living Waiver Program (ALWP), was created by legislation that directed the California Department of Health Care Services to test the efficiency of offering assisted living as a Medi-Cal benefit. The ALWPP was designed to enable Medi-Cal-eligible seniors and persons 21 or older with disabilities who would otherwise require nursing-facility services to remain in or relocate to the community. The project was initiated in Los Angeles, Sacramento, and San Joaquin counties, with the waiver renewed in March 2009 for another five years and expanded to Fresno, Riverside, San Bernardino, and Sonoma counties. All slots in the ALWP are currently full, with no new applications for the program being accepted.

The ALWP has been carved out of the Cal MediConnect program. As a result, if health plan members want to access the ALWP, they need to first disenroll from their health plan. However, health plans participating in Cal MediConnect can contract directly with RCFEs for the provision of long term services.

Participants in the ALWP have access to four types of services:

1. *Assisted living services* provided in an RCFE or by a licensed home health agency in an unlicensed, publicly subsidized housing setting. These services include help with activities of daily living, intermittent skilled nursing care, medication administration, and social activities.
2. *Care coordination*, which includes identifying, organizing, coordinating, and monitoring services needed by clients.
3. *Nursing facility transition care coordination* to transition participants from a nursing facility to the community.
4. *Consumer education* to help clients take responsibility for their care and services.

To qualify for the ALWP, participants must be eligible for full-scope or share-of-cost Medi-Cal benefits, require nursing-facility level of care as determined by contracted care-coordination agencies, and live in one of the approved counties. Individuals living in other counties can receive services if they are otherwise qualified, willing to relocate to one of the approved counties, and willing to work with an enrolled care-coordination agency.

Current provider rates for the ALWP range from \$52 to \$82 per day, depending on the level of care needed by the resident (there are four payment tiers). Participants pay for room and board. Facilities are allowed to charge residents a maximum of \$936 per month (\$1,055 from SSI/SSP payments less \$119 that residents can keep as a personal-needs allowance).

Adult Residential Facilities

Adult residential facilities (ARFs) provide 24-hour nonmedical care and daily supervision for adults 18 to 59 who are unable to take care of their own daily needs. These facilities serve physically handicapped, developmentally disabled adults (ARF/DD homes), and adults who have mental health or other disabilities that prevent them living independently (ARF/MH homes). Adults 60 or older may reside in an ARF if their needs are compatible with those of the other residents in the facility, if they require the same level of care and supervision as the other residents, and if the facility is able to meet their needs.

According to staff at Community Care Licensing, the majority of adult residential facilities are ARF/DD homes, although a breakdown of ARFs by facility type is not maintained. Agencies in the mental health industry have reported that many ARF/MH homes have closed due to lack of funding or regulatory noncompliance. According to one county-based behavioral health housing office, only half of the ARF/MH homes available 10 years ago in its region are still operating today.

Missy's Guest Home

Missy's Guest Home is an adult residential facility in Garden Grove that provides a home, meals, and some assistance for women with mental health issues. Missy's is a six-bedroom single-family home that was built in 1950 and has been operating as an ARF since 1998. Owner Randy Mendoza and his wife, who helps run the family's two facilities, named both homes after their daughter. He said, "I'm from the Philippines. The elderly and mentally ill don't get the kind of care there that you can get here. Also, I have parents who are 92 and 91. That's why I do this work. These women are like my family — every year I take them on a trip to Las Vegas, and every two years I bring them to my Philippine association's dinner dance." Six women, in their 30s to their 50s, live at Missy's; one woman has lived there for more than 14 years.

Residents are required to work or to participate in a local treatment program or community activity. At Missy's, residents are provided with medication management, meals and snacks, and transportation coordination. Mendoza also operates an RCFE, Missy's Guest Home II, to which residents can transition when they age out of his ARF. Rent at Missy's Guest Home is \$1,013 per month.

A few ARF/MH facilities reportedly receive funding through local mental health services associations, but typically those funds are severely limited. There is a limited number of larger ARF/MH facilities that provide more comprehensive services, with county funding typically providing for specialized services.

Facility features. The vast majority of ARFs are small residential group-home environments. Eighty-nine percent of all ARFs in California have six or fewer beds, and the majority of all ARF beds are located in these small facilities. Following is a breakdown of ARFs statewide by the number of licensed beds.²⁸

Table 4. Number of ARFs, by Size, California, May 2013

	FACILITIES		BEDS	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Up to 6 beds	4,558	89.2%	24,729	62.7%
7–15 beds	300	5.9%	3,563	9%
16–49 beds	190	3.7%	5,824	14.8%
50–99 beds	50	1%	3,628	9.2%
100+ beds	13	0.3%	1,711	4.3%
Total	5,111	100%	39,455	100%

Most ARFs offer semiprivate and private rooms with shared bathrooms and common areas for social activities and meals. ARFs are licensed and inspected by the California Department of Social Services. The Community Care Licensing Division conducts licensing inspections annually at ARD/DD homes and every three years at ARF/MH homes.²⁹

Services. California requires ARFs to prepare and implement a needs and services plan for each resident and “provide those services identified in the client’s

needs and services plan.” These services include, but are not limited to:

- Assistance in meeting residents’ medical and dental needs
- Assistance with activities of daily living such as dressing, eating, and bathing
- Basic laundry services
- Care and supervision
- Meals
- Planned recreational activities

Requirements for admission. Adult residential facilities are prohibited from accepting or retaining individuals:

- With prohibited health conditions
- Who require inpatient care in a health facility
- Who have needs that are in conflict with the needs of other residents or the program of services offered
- Who require more care and supervision than is provided by the facility
- Whose primary need is acute psychiatric care due to a mental disorder

ARFs are permitted to evict residents who engage in behavior that is a threat to their mental or physical health or safety, or to the health or safety of others in the facility.

Staffing. ARFs are required to employ enough staff to ensure the provision of care and supervision to meet resident needs. In addition, ARFs must provide support staff as necessary to perform office work; cook; clean; do laundry; maintain buildings, equipment, and grounds; and meet regulatory requirements for designated staff to organize and provide planned group activities.

When ARFs serve residents who rely on others to perform all activities of daily living, the facility is required to maintain a staff-to-client ratio of at least one direct-care staff person to three such clients. (For clients with developmental disabilities who receive specialized services through a Regional Center, the ARF must maintain staffing as specified by the center.)

ARF employees providing night supervision, from 10 p.m. to 7 a.m., must be available to assist residents in the event of an emergency. Facilities with 15 or fewer residents must maintain at least one person on call on the premises at night, while facilities with 16 or more residents must maintain an awake staff person on the premises during nighttime hours (plus additional available staff, based on the size of the facility).

Funding. Rates for ARF/DD homes can run from about \$900 to over \$5,000 per month, depending on the experience of the operator, staffing levels, and services provided. Rates for ARF/MH homes are generally based on SSI/SSP payments, which are approximately \$900 per month.³⁰

Skilled Nursing Facilities

While not a type of housing, skilled nursing facilities, commonly known as nursing homes, provide long term care to seniors and persons with disabilities who require a high level of medical and personal care. These facilities provide meals, personal care, medication management, nursing care, medical services, and social and recreational activities to residents with chronic conditions requiring long term custodial care and/or individuals needing short-term rehabilitative care. Long term care residents typically require assistance with multiple activities of daily living, including bathing, dressing, eating, toileting, transferring in and out of chairs or beds, and continence. Many have cognitive limitations due to Alzheimer's disease or another form of dementia.

Facility features. The physical environment of nursing facilities have traditionally mirrored that of hospitals, with multiple-bed rooms located on double-loaded corridors, nursing stations, overhead paging, medication carts, and a model designed for the efficient delivery of health care services.

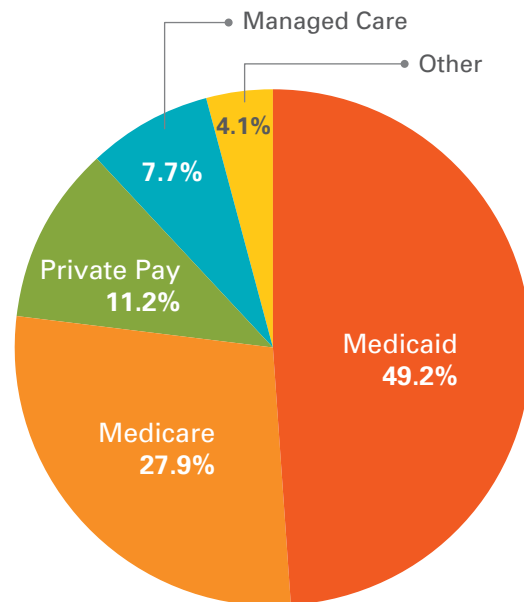
There are an estimated 1,233 nursing facilities in California with a total of 120,715 beds and an average of 98 beds per facility.^{31,32} There are 28 beds per 1,000 seniors 65 or older in California, compared to about 42 beds per 1,000 seniors nationwide.³³

Resident profile. The majority of nursing facility residents are women, and the median age of residents is 82.6.³⁴ Over half of residents need extensive assistance with at least four activities of daily living (such as bed mobility, transferring, dressing, eating, and toileting), with the average level of impairment increasing in recent years.³⁵ Most nursing facility residents have some level of cognitive impairment, with about 10% of residents severely or very severely cognitively impaired.³⁶

Funding. Most nursing facilities receive reimbursement from Medi-Cal, Medicare, private-pay sources, and/or managed care organizations, with the payer mix often varying significantly among facilities. Some nursing facilities serve a high proportion of Medi-Cal residents, while other facilities focus on a short-term rehabilitation Medicare population and/or the private-pay market. Figure 1 shows a breakdown of the average payer mix in California nursing facilities, as reported by the Office of Statewide Health Planning and Development (OSHPD).³⁷

According to OSHPD, even though Medicare provides nearly 28% of skilled nursing revenue, it pays for only 12% of patient days. Medi-Cal pays for nearly two-thirds of all patient days but provides only about

**Figure 1. Average Payer Mix, by Revenue
Skilled Nursing Facilities**



Note: Segments don't add to 100% due to rounding.

Source: Office of Statewide Health Planning and Development, Long-Term Care Facilities Utilization and Financial Trends, 2003–2007 (Spring 2010), www.oshpd.ca.gov.

half of total revenue.³⁸ This disparity is due to the significant difference in reimbursement rates for nursing facilities between Medicare (which pays for short-term rehabilitative care) and Medi-Cal (which covers long term convalescent care).

Oversight. The California Department of Public Health Licensing and Certification Program is responsible for the oversight of skilled nursing facilities, including ensuring that facilities accepting Medicare and Medi-Cal comply with the federal standards mandated by the Centers for Medicare and Medicaid Services.

Culture change. To improve the quality of care and quality of life of nursing facility residents, a growing number of long term care professionals are advocating for culture change at nursing facilities. This movement is working to deinstitutionalize nursing facility care and to transform the nursing facility environment. Culture change aims at a more person-centered approach to care in a more homelike environment, and can involve substantial changes such as remodeling a facility's physical features, restructuring staffing and management patterns to empower frontline workers, and creating a flexible and responsive service-delivery system to better meet the needs and preferences of residents. Culture change initiatives have been shown to have a positive impact on resident satisfaction, worker satisfaction and turnover, and clinical outcomes such as reduced rates of decline, fewer in-house pressure ulcers, and reduced rates of hospitalization.

Additional information about culture change initiatives can be found at the website of the Pioneer Network, a national culture change organization:

www.pioneernetwork.net.

ACC Nursing Home

The Asian Community Center (ACC) Nursing Home, opened in Sacramento in 1987, is a nonprofit skilled nursing facility. The 99-bed property includes a 24-bed unit dedicated to short-term intensive rehabilitative therapy that enables residents to return to their homes. The ACC Nursing Home provides private and semiprivate rooms and nursing, dietary, rehabilitation, and social services in a multicultural, multilingual setting.

Family members of a resident who lived with cancer for 10 years and spent 18 months in hospice care at ACC wrote: "There were things small and large that all added up to excellent care.... Baljit always made sure Mom had lipstick on every day. Rollie always asked which finger Mom wanted him to poke for her blood sugar tests. Hei Ling and Emily spoke Chinese to Mom, which we think Mom enjoyed hearing."

Private-pay rates start at \$254 per day for a semiprivate room.



III. Unlicensed Housing Options

IN ADDITION TO LICENSED FACILITIES, there are a number of unlicensed housing settings where Medi-Cal-eligible older adults or individuals with disabilities may receive long term services. The options include publicly subsidized rental properties and permanent supportive housing, which is typically designed for individuals who are homeless or at risk of being homeless due to chronic conditions or mental health or substance abuse issues.

Publicly Subsidized Rental Properties

Subsidized rental housing enables lower-income individuals to live in housing they otherwise could not afford, with some properties designated specifically for older adults or individuals with disabilities. Because these properties have a concentration of seniors and persons with disabilities not found in other unlicensed settings, they offer an opportunity for health plans to gain efficiencies in the provision of services to dual-eligible beneficiaries.

Unfortunately, there are not enough affordable rental properties to meet the current need. For every 100 extremely low-income households, there are just 30 affordable units.³⁹ As a result, waiting lists for these properties are typically extensive. In some cases, properties give priority to individuals with specific needs, lessening the waiting time for these beneficiaries. In addition, some housing providers are exploring ways to expand the inventory of affordable housing to provide additional housing options for dual-eligible health plan members.

Francis of Assisi

Francis of Assisi is a 110-unit HUD 202 property in San Francisco for low-income seniors. Built in 1980, this property has been owned and operated by Mercy Housing since 1999. Francis of Assisi provides intensive resident service coordination to support residents who wish to age in place. Most residents are 80 or older, and approximately 20% of residents are over 90. Amanda McDade, former services coordinator at Francis of Assisi, shared a story about one resident: “He was an elderly gentleman who was on oxygen and confined to a wheelchair because of his severe emphysema. We made sure he had a hospital bed and necessary supplies. He didn’t have anyone else — we were his system, and Francis of Assisi was his home. He did have a dog that was a huge part of his success. We also coordinated care for the dog! He received hospice care at Francis of Assisi, and died there at home.”

The multilingual staff members at Francis of Assisi mirror its multicultural community, and daily lunches are provided by Project Open Hand. Services coordinated by staff include flu shots, ESL classes, weekly shopping trips and other field trips, weekly foodbank distributions, spiritual programs, cultural events, exercise classes, and social and recreational activities. Residents of Francis of Assisi pay 30% of their adjusted gross income in rent.

Following is a summary of the available programs that provide affordable housing for seniors and individuals with disabilities:

- **HUD Section 202 program – supportive housing for the elderly.** The Section 202 program provides the only federally funded housing specifically for persons 62 or older and targets seniors with very low incomes. Rent is based on 30% of a resident's adjusted gross income (determined by deducting approved medical expenses from the resident's gross income). Residents of US Department of Housing and Urban Development (HUD) 202 properties are typically elderly women living alone, with annual incomes between \$5,000 and \$15,000.⁴⁰

Sponsors of Section 202 housing must demonstrate that services are available through the development or in the community, and most of these properties are designed to accommodate residents who are frail. For example, a 2006 AARP survey found that 74% of Section 202 properties had grab bars in the bathrooms, 88% had emergency call systems, and over 50% had space for congregate meals or other supportive services.⁴¹ In addition, an estimated 56% of Section 202 properties surveyed had a services coordinator on staff, 73% had social and recreational activities arranged or provided by management, and 34% provided or arranged transportation for residents.⁴² National data indicate that many seniors in Section 202 housing have high health care and services needs, with 38% of residents considered frail or near-frail, requiring assistance with basic activities of living, and thus at risk for institutional placement.⁴³

Waiting lists for Section 202 properties are typically very long, although the lists may be prioritized. Some properties give priority to applicants who meet specific criteria such as those who are homeless or living in substandard housing, who pay more than 50% of their income for rent, or who qualify for a Program of All-Inclusive Care for the Elderly (PACE) plan or other managed long term care plan.⁴⁴

- **HUD Section 811 program – supportive housing for persons with disabilities.** Section 811 is the only federal program dedicated to affordable, accessible housing linked with voluntary services for very low-income nonelderly adults with disabilities. The program serves individuals with physical or developmental disabilities or mental illness, allowing them to live as independently as possible in the community. Section 811 rental units are available in a variety of settings, including independent living projects, condo units, and small group homes. Each project must have a supportive services plan, with services provided on or off site.
- **Public housing.** Some public housing authorities own and operate subsidized housing for families and individuals, typically people who have incomes below the poverty level. About half of all public housing sites are designated for seniors, with rent at these properties based on 30% of a resident's adjusted gross income.⁴⁵ As most public housing properties were built more than 30 years ago, many do not have the physical features needed to support the changing needs of residents as they age and become more frail. Service coordinators may be available in some elderly public housing properties to assist residents in accessing needed services.

- **Low-Income Housing Tax Credit program facilities.** The Low Income Housing Tax Credit (LIHTC) program is an indirect federal subsidy used to finance the development of affordable rental housing for low-to-moderate income households. The program awards federal housing tax credits to developers, which reduces the amount of debt the developer incurs on the project and enables the developer to charge more affordable rents.

There are currently 2,985 properties listed in California's LIHTC database, with a total of 253,820 units.⁴⁶ Nationally, an estimated 27% of LIHTC properties are designated for the elderly, 12% for persons with disabilities, and 5% for the homeless population.⁴⁷ According to a 2006 survey, 81% of LIHTC properties for older persons and 67% of other LIHTC properties had waiting lists, with an average of 38 applicants waiting for an LIHTC property for older persons and 45 waiting for other LIHTC properties. In some cases, waiting lists were so long that they were closed to new applications.⁴⁸

The LIHTC program currently finances approximately 90% of all new affordable rental housing.⁴⁹ But very low-income individuals, such as those at or below the federal poverty level, cannot afford LIHTC properties because the LIHTC program does not provide rent subsidies, and low-income individuals typically lack the income to pay the rent without additional rental subsidies. In addition, LIHTC properties are less likely than HUD-subsidized properties to provide or coordinate services that support residents in aging in place. In 2006, only 26% of LIHTC properties had a services coordinator on staff, compared to 56% of HUD Section 202

Rental Assistance Is Helpful, in High Demand

In addition to the various programs that subsidize the development and operation of affordable housing, rental assistance for other housing is also available to qualified individuals.

The Housing Choice Vouchers program (formerly known as Section 8) is the federal government's primary program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Eligibility for the program is determined by local housing authorities based on a household's total annual gross income, with the housing authority receiving federal funds from HUD to administer the program. Participants are responsible for finding housing that meets the requirements of the program. Once the property is approved, the family pays the landlord 30% of their monthly adjusted gross income for rent and utilities. The housing authority then pays a housing subsidy to the landlord to make up the difference between the amount determined by HUD to be a "fair market rent" and the amount paid by the tenant.

As in other housing assistance programs, the demand for Housing Choice vouchers is high and long waiting periods are common. In some cases, housing authorities may establish preference for applicants who are considered to have great need, such as the homeless, those living in substandard housing, those paying more than 50% of their income for rent, or those who have been involuntarily displaced.

A rental assistance program through USDA Rural Development is also available to eligible persons in qualifying rural areas. This program is designed for people with very low and low incomes, the elderly, and people with disabilities who are unable to pay the rent with 30% of their adjusted monthly income. USDA pays the owner of a multifamily property the difference between the tenant's contribution (30% of adjusted income) and the monthly rent.

properties, and 54% of LIHTC properties did not offer any services.⁵⁰

- **USDA Rural Development affordable housing facilities.** The USDA Office of Rural Development offers a number of programs that subsidize the development of affordable rental properties. USDA's multifamily housing programs offer loans to developers to provide affordable rental housing for very low-income, low-income, and moderate-income households; for the elderly; and for persons with disabilities. Properties developed through the USDA Rural Development programs must be located in areas that meet designated criteria for rural communities.

Approximately 57% of those living in rental housing developed through USDA Rural Development are elderly or disabled, and 94% of residents have very low incomes (with an average annual income of \$11,000).⁵¹ Service coordinators are typically not available in properties financed through USDA Rural Development.

Service coordination. Some affordable rental properties have staff available to assist residents in accessing services offered on site and in the community. These service coordinators are trained to work with residents and their families when supportive services are needed, and they link frail or at-risk elderly residents and residents with disabilities to the supportive services they need to live independently. Service coordinators typically provide the following:⁵²

- Case management, and information and referral services

- Resident education in available services and benefits
- Establishment of links with community agencies
- Monitoring the provision of services
- Resident advocacy
- Helping residents set up informal support networks
- Development of volunteer programs

HUD's Service Coordinator Program provides grants to owners of HUD-assisted housing to cover the salary, benefits, and administrative costs associated with employing a service coordinator. HUD-funded service coordinators are prohibited from acting as recreational or activity directors, providing supportive services directly, or assisting with other administrative work associated with housing operations. The grants depend on annual congressional appropriations.

Service-delivery innovations. Innovative housing providers across the country, working with federal, state, and community partners, have developed a variety of models to bring enhanced services to publicly subsidized housing. The goal is to combine affordable housing with health care and long term services to help residents remain in an independent-living setting as they age and as their health declines. In addition, because publicly assisted housing provides a critical mass of elderly or disabled residents living in close proximity, it creates opportunities to achieve economies of scale in organizing, purchasing, and delivering services, thereby increasing efficiency and affordability.⁵³

Innovations in the provision of services in subsidized housing typically build on a property's

employment of resident service-coordination staff and a variety of partnerships with community organizations. The innovations and partnerships implemented by housing properties across the country include the following components, compiled from a literature search of housing-with-services case studies:⁵⁴

- **Partnerships with health care providers.** At some properties, a home care or home health agency provides clustered care where one aide provides care to multiple residents. The agency can then provide care in smaller blocks of time. It sometimes locates an office at the housing site. At some sites, health care providers offer regular on-site primary care, geriatric, and adult psychiatry services, either by colocation of a clinic or physician's practice, or through regularly scheduled visits. Through partnerships with academic health centers, students can carry out clinical rotations and provide needed health services to residents (e.g., nursing, pharmacy, or social work). One site partners with a medical practice that provides physician house calls to minimize the need for transportation and escort assistance to medical appointments.
- **Colocation with service providers.** Having a Program of All-Inclusive Care for the Elderly, adult day health care, or a Federally Qualified Health Center on site facilitates the provision of health care services to residents. Some properties share their site with an assisted living facility or nursing facility to provide nighttime coverage and needed services. A senior nutrition meal site at the subsidized housing property can make centrally prepared meals available to residents. A nursing facility satellite clinic at one property provides physical therapy to residents.
- **On-site health care staff.** On-site nurses or nurse practitioners provide health care services at some sites, including health education and disease prevention; nursing assessment and triage; assistance in navigating the health care system; assistance with transitions to and from acute care and skilled nursing facilities; and care coordination, including the identification of barriers to care, coordination of health care services, and liaison with primary care physicians and other medical providers.
- **Technology solutions.** To help monitor the health of their residents, some facilities use emergency call systems, which are hard-wired, wireless, or via Lifeline-type services. On-site health kiosks allow residents to monitor their vital signs and transmit the information to a health care partner, with the telehealth nurse calling the resident to discuss the alert and sending a report to the resident's doctor as appropriate. Wireless motion-sensing systems installed in resident units detect unusual activity patterns and alert health care providers.
- **Wellness and activity programming.** Comprehensive wellness activities such as educational presentations, exercise and fitness programs, blood pressure checks and weight screenings, and social and recreational activities are offered in many facilities. Some facilities conduct resident assessments to help manage care, and offer evidence-based "healthy aging" programs to address the most prevalent chronic conditions. Some properties also offer to identify and manage the care of residents most at risk, focusing on heart disease, diabetes, and increased risk of falls. Facilities may also offer fall-prevention plans and training for staff in how to

provide assistance in response to resident falls to reduce unnecessary emergency department visits.

- **Enhanced family caregiver involvement.** Some facilities are involving family caregivers in care-consultation meetings and in the development of service plans, and implementing training programs for family caregivers to expand their capacity to assist residents in remaining in affordable properties. Training topics include monitoring health changes, facilitating smooth transitions after hospital stays, and understanding the breadth of services available in the community.

Incorporating enhanced services into an affordable housing property can enable residents to age in place, reducing unnecessary institutionalization. Many of the innovations in the field also provide an increased level of care coordination, communication with medical providers, chronic-disease prevention programs, and facilitation of care transitions. In states such as California, where there is limited or no Medicaid funding for assisted living facilities, the provision or coordination of intensive services in subsidized housing can fill a gap in the continuum of care for lower-income older adults and persons with disabilities.

Permanent Supportive Housing

Permanent supportive housing programs are typically designed to serve chronically homeless individuals and families in which one or more adult household members have a serious long term disability and a history of mental illness and/or substance abuse. These programs link safe and affordable long term rental housing with flexible support services that are available when needed, enabling formerly homeless

Potiker Family Senior Residence

The Potiker Family Senior Residence, opened in 2003, is a Senior Community Centers of San Diego permanent supportive housing development of 200 studio apartment units. Potiker's residents are very and extremely low-income seniors 62 or over, including formerly homeless seniors with special needs. Joe Gavin, support-service case manager, described one resident: "This gentleman came to Potiker about two years ago through our transitional-housing program. In his 70s, he is a veteran, was homeless, and has gone from being on the street to running our computer labs two days a week. He's also active in Potiker's social club, support group, and creative writing class. He was recently selected by the Corporation for Supportive Housing to serve on a panel and then to participate in a lobby day in Sacramento to speak about veterans' housing issues."

Services at Potiker include recreational activities, social services, case management and referral, health care, a peer-led mental health support group, and two meals served each day in a central dining room. An on-site support-services case manager works with residents, and participation in activities and use of services are voluntary. Rent is based on annual income and ranges from \$494 to \$635 per month.



individuals to remain housed and live independently. In permanent supportive housing, the use of available supportive services is not a condition of admission or ongoing tenancy.

According to the US Interagency Council on Homelessness, California is home to approximately one-third of the entire chronically homeless population in the United States.⁵⁵ HUD estimates there are approximately 130,898 homeless people in California, with 33,422 chronically homeless.⁵⁶ In 2012, there were 50,057 permanent supportive housing beds in California, with 12,966 of these beds reserved for the chronically homeless.⁵⁷

Many people who experience chronic homelessness without the additional services offered in supportive housing become frequent users of much more expensive public services and systems, including emergency departments, hospitals, and correctional facilities. Permanent supportive housing decreases the use of these systems and as a result can significantly reduce public costs.⁵⁸

Extensive research has been conducted on the cost of adult homelessness and the savings generated by placement in permanent supportive housing. In a study on the cost of services for the homeless and homeless interventions, it was found that the cost for a formerly homeless individual living in supportive housing was \$31 per day, compared to the daily cost for someone in jail (\$87), a detoxification center (\$256), an emergency department (\$905), or an inpatient hospital room (\$1,940).⁵⁹

Funding. Operating and services costs for permanent supportive housing are funded through a variety of sources, with federal funds such as the Housing Choice Vouchers program and the Shelter Plus Care and Continuum of Care programs the most commonly used. Over half (57.5%) of respondents to the 2012 Supportive Housing Industry Survey reported accessing state and local

Housing First Model Aids the Homeless

Housing First is a nationwide programmatic approach designed to help the chronically homeless access and maintain housing. Housing First addresses the need for housing as a first priority, with treatment services provided after housing has been provided and the individual's trust gained.

Available services typically include crisis intervention, follow-up case management, and support services such as mental health services, substance abuse services, independent living instruction, health care services, peer support, social activities, transportation, referrals, and job training programs. To the extent possible, services are customized to the needs of residents to prevent recurrence of homelessness.

Numerous studies have found the Housing First program to be highly successful in ending homelessness for chronically homeless individuals, particularly those with psychiatric disabilities and co-occurring substance abuse issues.⁶⁰

mental health funding as well. Medicaid funds were used by only 25.9% of projects surveyed, and only 15.5% used funds from the Department of Health and Human Services Temporary Assistance for Needy Families program.⁶¹ Medicaid funds may not be more widely used because many supportive housing residents are not eligible for or not enrolled in Medicaid.⁶²

Another source of funding for permanent supportive housing in California became available in February 2013 when HUD and the Department of Health and Human Services announced an award of \$11.9 million to the California Housing Finance Agency. The agency will use the funding to offer rental assistance to 335 extremely low-

income persons with disabilities, many of whom are transitioning out of institutional settings or are at extreme risk of homelessness.⁶³

The Village Model

Although not a type of housing, “villages” are an increasingly popular approach to allowing residents of neighborhoods to live independently in their homes and avoid institutional care by helping to coordinate and deliver needed services. Villages are consumer-driven, person-centered, and supported by annual membership fees and volunteers, with additional funding often provided through grants and nonmember donations. Village volunteer networks are composed of members and nonmembers using a neighbor-helping-neighbor approach. With over 90% of older adults wishing to remain in their homes and communities, the social and nonmedical support provided by villages make aging in place possible.⁶⁴

One of the first villages was Boston’s Beacon Hill Village, which was established in 2001 by a group of residents wishing to receive services in their homes. The village model has now grown into a worldwide movement, with 89 villages operating in the US, Canada, Australia, and the Netherlands, and another 123 villages under development.⁶⁵ There are currently 41 villages planned or operating in California.⁶⁶

Resident profile. A 2012 nationwide study of villages conducted by the Rutgers School of Social Work found that village size varied substantially, from 13 to 550 members, with a median of 96 members. Members were predominantly over 65, white, and female. Villages reported that approximately half of their members lived alone and one-quarter needed help with household chores. Approximately 40% of respondents indicated that their organization had adopted practices to recruit older adults from underrepresented groups such as marketing the

Santa Barbara Village

The Santa Barbara Village is a nonprofit membership organization that serves as an alternative to a retirement or assisted living facility. Membership in the village is open to adults 50 or over living in south Santa Barbara County. Members pay dues and have access to volunteer-provided and discounted services such as household and home maintenance, transportation, help with errands, and in-home care, as well as social, educational, and cultural activities.

Mae has fibromyalgia, a chronic condition that limits her mobility and energy. When she joined Santa Barbara Village, she asked to be connected with a regular volunteer who could help with errands and household tasks. Mae was paired with Kate, and both women have benefited from the relationship. “[Kate] is a doll,” Mae wrote in an email. “She did four errands for me, which would normally take me several weeks to complete. With Kate’s help, I am hopeful that I can start exercising and focusing more on my health.” And Kate has appreciated having a positive impact on someone’s life.



Ashby Village, Berkeley California

village in lower-income neighborhoods or partnering with organizations that are connected to such groups (e.g., churches).⁶⁷

Services. Villages typically provide or coordinate a variety of services, including information and referrals, home health care, transportation, assistance

with household tasks, and social and educational activities. Villages are not providers and do not have license requirements. Villages are nonprofit organizations governed by a board of directors and operated either by a mix of paid staff and volunteers or solely by volunteers who help coordinate needed services and assist with daily needs (e.g., driving a member to appointments or helping with groceries).

The village model focuses on community-building through social events and activities, integrating formal and informal systems of support, breaking down service-delivery silos, and promoting civic engagement by providing volunteer opportunities for members and involving them on governance boards.⁶⁸

While every organization is unique, each village provides three core services:

1. Concierge or referral to providers or volunteers who help meet members' needs
2. Health and wellness programs and services to allow members to stay in their homes as long as possible (e.g., exercise programs, home health care, or grocery delivery)
3. Social and community-building programs, including seminars, and wellness and prevention activities developed and administered by members

Villages vet service providers (e.g., plumbers, home care agencies, handymen, dog walkers), perform background checks, verify business licenses and bonds, and conduct reference checks and personal interviews. The village maintains a list of vetted providers and adds to the list based on recommendations from members. Similar background checks are conducted on volunteers, and many villages provide volunteer training as a requirement to participate.

Transportation is the most frequently provided service for village members, constituting an average of 60% of service requests, with transportation provided through vetted and trained volunteers, both members and nonmembers.⁶⁹

Membership costs. Villages charge membership fees that range from about \$100 to \$1,000 per year. Some services are included in membership and provided by volunteers and staff of the village, while other services are provided by third parties, often at a discount. Many villages offer reduced-fee or scholarship programs for qualified lower-income residents.

Following are examples of annual fees at villages currently operating in California:

- **Ashby Village, Berkeley (ages 50+)**
\$750 individual; \$1,200 household⁷⁰
- **Monterey Bay Village, Monterey (ages 50+)**
\$360 individual; \$480 household
- **Santa Barbara Village (ages 50+)**
\$853 individual; \$1,285 household
Reduced-fee membership is available for qualified low-income seniors.⁷¹
- **Pasadena Village (ages 55+)**
\$720 individual; \$960 household
Scholarships are available for qualified low-income seniors.

Availability to Medi-Cal beneficiaries. While Medi-Cal does not pay for any portion of village membership, Medi-Cal beneficiaries are welcome. Some villages offer reduced membership rates for qualified low-income residents.

According to AARP, the village movement may have important implications for Medicaid, the largest funder of long term care services, as it can delay the process of spending down assets to qualify

for Medicaid and delay the need for institutional care.⁷² One study showed that older adults who had active social networks decreased their risk of institutionalization by almost one-half.⁷³

Although villages have developed without federal or state funding, state and local interest in villages and other member-driven senior-support models is growing. States are increasingly interested in choice, disease prevention, and healthy living, motivated in part by keeping residents from spending down assets to qualify for Medicaid eligibility. Many states are actively promoting the village model, including Michigan, Ohio, Pennsylvania, and Georgia, as well as Washington, DC.⁷⁴

IV. The Use of Supportive Housing by Managed Care Plans in Other States

HOW MANAGED CARE HEALTH PLANS IN other states use supportive housing can provide lessons for California health plans involved in the MediConnect program. Researchers looked at states with experience providing Medicaid managed care for long term services and/or some form of integrated managed care for dual-eligible beneficiaries and interviewed representatives from health plans, health plan associations, and state agencies that oversee managed long term care services programs.⁷⁵

Researchers investigated managed care plans' approaches to supportive housing in the following states:

- **Arizona.** The Arizona Health Care Cost Containment System provides health care services through a prepaid, capitated managed care delivery model that operates statewide under Medicaid Section 1115 Waivers authority. The program provides coordinated acute and long term care, including behavioral health care, in-home services, and care in alternative residential settings.
- **Hawaii.** The QUEST Expanded Access program provides Medicaid capitated managed care that includes acute and primary care, institutional care, and home-based and community-based long term care to eligible individuals.
- **Massachusetts.** The Senior Care Options program provides eligible individuals 65 or over with primary care, acute care, behavioral care, and community-based and facility-based long term care at a capitated rate.

- **New Mexico.** The Coordination of Long-Term Services program provides institutional and home-based and community-based long term care services to children with long term care needs, adults with physical disabilities, and individuals 65 or over through the State Plan Personal Care Options program and Medicaid Section 1915(c) Home and Community-Based Services Waivers in a capitated managed care program.
- **Wisconsin.** The Family Care Program provides institutional and home-based and community-based long term care services to adults with disabilities and individuals 65 or over who require nursing facility-level care. The Family Care Partnership Program adds primary and acute medical care to the long term services provided through the Family Care Program.

The supportive housing options available are slightly different in each state. All of these states have affordable housing properties such as HUD 202 or Low Income Housing Tax Credit projects, as well as skilled nursing facilities. However, the settings and licensure requirements for residential care settings — assisted living facilities and board-and-care homes — vary by state. For example, some states have a separate licensure category for small facilities, and other states include all residential facilities in the same licensure category, similar to the RCFE regulatory structure in California.

Placement decisions. Many interviewees stressed the importance of monitoring the long term care needs of members to prevent or minimize negative health outcomes and to facilitate placement

decisions. The frequency of visits varied by place of residence: members living at home were visited more frequently, sometimes on a monthly basis for those with complex needs, and members living in skilled nursing facilities were visited less frequently.

Some plans use structured tools to assist with placement decisions. For example, Wisconsin developed a resource-allocation tool for managed care organizations to help identify member goals, outcomes, and preferences, and to evaluate appropriate service options. This tool is used in making placement decisions by balancing a member's desired outcomes, the facility's ability to meet care needs, and cost-effectiveness. In Arizona, a state-based tool is used for level-of-care determinations, and is part of a study conducted to determine whether it would be more cost-effective for a member to be in the community or in a skilled nursing facility.

In-home care. Many interviewees shared the view that relocation from a member's home is a last resort and that the health plan will do "whatever it takes" to keep members at home if that is their desire, regardless of cost. In-home services made available to members include needed home renovation (e.g., bathroom remodeling), meal delivery, Hoyer lifts, and personal care services. One plan representative said that moving is a family decision, with cost not part of the discussion. However, others spoke of the need to balance the desire to remain at home with the associated cost, as it can sometimes cost more to provide care at home than in a skilled nursing facility. In Arizona, cost-effectiveness studies are conducted to evaluate the cost of care in the community versus a nursing facility to ensure that the community-based care is not more expensive than care in a nursing facility.

Many interviewees spoke of the need to conduct in-person assessments and increase the frequency

of visits when members are receiving in-home care. These visits are particularly important when a member experiences a decline in condition or change in status, as a lack of appropriate services can lead to further decline. In-home visits allow case managers to identify potential problems in the environment, observe the member's interaction with family members and caregivers, and observe the provision of care to ensure that tasks performed are safe, appropriate, and meeting the member's needs. In-person visits can reveal issues that are not reported during a phone check-up. One plan representative shared, "Lots of members will say things are fine when they're not."

Additional challenges can arise when members are using self-directed care, or care that allows for individual control in selecting providers and services. A challenging situation can arise when members choose a family member as their care provider and then do not get the care they need, while the family member is reliant on the money received for providing care. In-home visits can help ensure that the care that is authorized is being provided.

Relocation from home. Moves from home to a residential setting are most commonly triggered by a change in care needs or change in the ability of family members to provide care. One plan representative said the need for a move is often necessitated by complex health needs, complex or progressive behavioral issues, an increase in hospital or emergency department visits, or poor staffing patterns. Family members may initiate a move if the level of care increases to the point where they can no longer serve as the primary caregiver (e.g., the member is up at night and is incontinent and the adult children work). The need for round-the-clock care when family support is not available or the need for 24-hour nursing care also typically signal the need for a move to another setting. At times,

however, moves are based on a member's desire to be around more people their own age, to not feel like a burden to family, or to not live alone. One plan representative said that in his experience it is often the member driving the placement, with a preference for residential communities.

Community-based residential facilities. When in-home care no longer meets member needs, and placement in a skilled nursing facility is not yet appropriate, plan representatives work with members to match their needs with available residential facilities. One plan uses a database that includes facility descriptions, locations, prices, and the range of services offered, such as sliding scale insulin, incontinence care, and behavior management. In some instances the available options may be limited due to the number of providers willing to provide care at contracted rates. For example, in Massachusetts there are limited Medicaid slots available in licensed assisted residences, so plans frequently use other approaches such as bringing services into subsidized housing through the state's Group Adult Foster Care Program.

Due diligence conducted as part of the contracting process with residential facilities may include on-site visits and a review of state licensing surveys and complaint reports. One plan reported that contracting with small board-and-care providers is challenging because they are less sophisticated than the medical providers the plan is used to working with. Another factor that enters into the contracting process for some plans is a preference to work with providers that can provide volume, with one plan locating primary care teams at or near those volume-based settings.

Plans use a variety of quality-management approaches to monitor the care provided in contracted facilities, including the following:

- Submitting concerns identified by case managers during member visits to the plan's quality-management team, which then conducts an investigation and initiates any needed follow-up action. Identified concerns are tracked so that patterns of concern that require additional action can be detected.
- Partnering with an agency that uses the state's survey tool and works with the facility to prepare for a successful survey. If issues are identified during this process, the plan's quality-assurance department is notified and, if appropriate, the member is moved and the state notified.
- Conducting additional training for adult foster home providers, including training in nursing tasks and behavior-management issues.
- Conducting visits with members who live in the same location on different days to have an increased level of contact with the facility.

Unlicensed subsidized housing. None of the plans interviewed has contracts directly with subsidized housing providers, but all reported having contracts with in-home care agencies that provide services to members living in affordable rental properties. Plans reported assigning one case manager to all members living in one location to gain efficiencies, and said that one agency may also service multiple clients living at the same property (although it is possible there may also be multiple providers). One plan representative shared that "clustering services is the backbone of community-supported living," as this approach decreases travel time among clients and increases the time available for the provision of services.

Several plans reported that a disadvantage to having members living in subsidized housing is the

lack of oversight compared to licensed facilities that are regulated and surveyed by state agencies. Other drawbacks to subsidized housing are its limited availability and long waiting lists.

Massachusetts' Medicaid benefit through the Group Adult Foster Care Program provides personal care services to elderly or disabled persons at risk of institutional placement in unlicensed housing settings. In these settings, services are provided by organizations such as home care or home health agencies, and include 24-hour supervision, routine assistance with activities of daily living, and assistance with medication management. Caregivers may provide services to multiple clients in one building, but the first priority is meeting client needs.⁷⁶ Use of the Group Adult Foster Care Program can be an option for individuals moving from skilled nursing facilities, as the biggest challenge in relocating from a nursing facility often is securing housing. Even though subsidized housing properties often have lengthy waiting lists, property managers sometimes provide assistance in navigating the lists (e.g., by moving an applicant who has specific needs to the top of the list, or by making referrals to properties with shorter waiting lists). Transition-coordinating agencies for the state's Money Follows the Person Program have housing coordinators who are familiar with the local affordable housing system.

Skilled nursing facilities. Most interviewees said that community-based placements are seen as preferable when appropriate, but recognized that not all members can be adequately served in the community. Community-based care is cost-prohibitive for some members, and other members prefer to live in a nursing facility setting. Some long term nursing facility residents have a difficult time moving back to an independent setting in the community because they are used to the structure and round-the-clock staffing provided in an institutional environment. Interviewees reported that moves from a nursing facility to a community-based facility such as assisted living or an adult foster home were often preferred by members over moving to an independent setting because of the availability of staff. One plan representative reported that the availability of a local support network such as family members was a stronger indicator of a member's successful relocation from a nursing facility than the length of time a member had lived in a facility.

V. Health Plans and Housing Partners: Developing Relationships in California

BASED ON RESEARCH CONDUCTED WITH health plans providing managed long term services in other states, following are ideas for ways plans participating in California's MediConnect demonstration might develop relationships with housing-with-services providers.

Case Management

- Develop a system for monitoring the needs of individuals in long term services, with more frequent in-person visits for members who have more complex care needs or who are in settings with less state oversight.

Residential Care Facilities for the Elderly

- Consider developing a request for proposal (RFP) for RCFEs to identify facilities interested in serving health plan members. The RFP would include questions related to the facility's size; physical features (e.g., private versus semiprivate rooms and bathrooms, available common-area space, handicapped accessibility); rate structure; admission and discharge criteria; staffing levels; availability of a nurse on site or on call; and service capacity in key areas such as dementia care, hospice care, diabetes care, and transfer assistance.

Contractual agreements with RCFEs would cover the provision of needed services, with room and board covered directly by the resident out of SSI/SSP funds. These contracts could be structured in a variety of ways. For example, a plan might provide higher payments to residents who have higher-acuity care needs or to facilities that

provide more intensive services, such as behavior management or end-of-life care. Provisions to address the management of Medicare costs could also be included, such as implementation of policies and procedures designed to minimize rehospitalization and use of the emergency department.

- Focus on providers that have the capacity to accept and retain residents with high-acuity care needs, including the availability of a licensed nurse who can do blood glucose monitoring and injections for diabetic residents; a hospice waiver, with sufficient beds approved for bedridden residents; and the ability to provide care for residents diagnosed with dementia.
- Screen interested providers by conducting on-site visits and reviews of state survey and complaint data.
- Develop an oversight program to monitor the quality of care provided in contracted RCFEs, which currently see visits by state agency staff only every five years. An oversight program might include a contract with a third party familiar with RCFE regulations and requirements.
- Consider a training or mentoring program for contracted facilities, particularly smaller RCFEs that may have fewer resources, to improve service capacity and quality of care.
- Determine how to gain efficiencies in scale and volume to minimize oversight and quality-assurance measures such as contracting with providers that are able to care for multiple

members and contracting with several small homes that have the same ownership structure.

Unlicensed Housing

- Develop relationships with home care agencies that can provide services to multiple clients living in unlicensed housing settings to gain efficiencies around the provision of care, and explore the provision and coordination of enhanced services in affordable housing settings.
- Work with a care-transition agency that has staff who understand the local affordable housing system and who are familiar with available properties to facilitate the timely placement of members in these settings.
- Explore the provision of enhanced services in unlicensed housing settings to retain residents in this setting for as long as possible and provide another option for residents who can no longer live at home or who wish to relocate from a skilled nursing facility.

Endnotes

1. Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino Counties
2. MetLife Mature Market Institute, *Market Survey of Long-Term Care Costs: The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs* (November 2012), www.metlife.com.
3. Christine Caffrey et al., *Residents Living in Residential Care Facilities: United States, 2010* (National Center for Health Statistics, Centers for Disease Control and Prevention, Number 91, April 2012).
4. Ibid.
5. Ibid.
6. Ibid.
7. CA Code of Regulations, Title 22CA Code of Regulations, CA Code of Regulations, Title 22, Article 8, Section 87464, Basic Services.
8. Paul R. Willging, "Assisted Living Also Has a Future," *Long-Term Living Magazine* (April 30, 2007), www.ltlmagazine.com.
9. NCB Capital Impact, *Residential Care Facilities for the Elderly in California – a 2008 Snapshot* (prepared for the California HealthCare Foundation, 2008).
10. CA Code of Regulations, CA Code of Regulations, Title 22, Article 8, Section 87452, Acceptance and Retention Limitations.
11. CA Code of Regulations, Title 22, Article 8, Section 87615, Prohibited Health Conditions.
12. See note 9.
13. Nonambulatory is defined by regulation as being unable to leave a building unassisted under emergency conditions. This includes persons who are unable or likely to be unable to respond physically or mentally to oral instructions relating to fire danger and take appropriate action. The definition of a nonambulatory person also includes individuals who depend on ambulation aids such as crutches, walkers, and wheelchairs.
14. Bedridden is defined by regulation as requiring assistance in turning and repositioning in bed or being unable to transfer independently to and from bed.
15. CA Code of Regulations, Title 22, Article 12, Section 87705.
16. CA Code of Regulations, Title 22, Article 11, Section 87632.
17. CA Code of Regulations, Title 22, Article 11, Section 87612.
18. See note 9.
19. Ibid.
20. CA Code of Regulations, Title 22, Article 13, Section 87755.
21. For example, www.alfa.org or www.caassistedliving.org.
22. See note 2.
23. The additional service fees are based on national-versus state-specific data.
24. Prudential, *Long-Term Care Cost Study: Including Consumer Perceptions and Cost Trends by State and Key Metropolitan Areas* (2010).
25. The SCAN Foundation, *DataBrief: Residential Care Facilities and Medicaid* (October 2012), www.thescanfoundation.org.
26. Avalere Health, *Analysis of the 2010 National Survey of Residential Care Facilities* (2010).
27. See note 9.
28. California Department of Social Services - Community Care Licensing Division (CCLD), "CCLD Facility Search Form," secure.dss.cahwnet.gov.
29. According to staff at Community Care Licensing.

30. Community Training Connection, *Frequently Asked Questions about Opening a Residential Facility*, www.communitytrainingonline.com.
31. The SCAN Foundation, analysis of the State of California Office of Statewide Health Planning & Development's Long-Term Care Facility Annual Utilization Data, 2009, www.oshpd.ca.gov, accessed November 4, 2010.
32. American Health Care Association, *LTC Stats: Nursing Facility Operational Characteristics Report* (September 2011 Update), www.ahcancal.org, accessed November 15, 2011.
33. The SCAN Foundation, *Long-Term Care Fundamentals, Technical Brief Series* (January 2012, No. 10), www.aging.org.
34. See note 2.
35. Centers for Medicare and Medicaid Services, *Nursing Home Data Compendium, 2010 Edition* (2010).
36. Ibid.
37. Office of Statewide Health Planning and Development, *Long-Term Care Facilities Utilization and Financial Trends, 2003–2007* (Spring 2010), www.oshpd.ca.gov.
38. Ibid.
39. Elina Bravve et al., *Out of Reach 2013* (National Low Income Housing Coalition, 2003), www.nlihc.org.
40. Barbara Haley and Robert Gray, *Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement* (US Department of Housing and Urban Development, Office of Policy Development and Research, June 2008), www.huduser.org.
41. The Lewin Group, *The 'Value Added' of Linking Publicly Assisted Housing for Low-Income Older Adults with Enhanced Services: A Literature Syntheses and Environmental Scan* (prepared for the Office of Disability, Aging, and Long-Term Care Policy, Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, January 31, 2012), www.aspe.hhs.gov.
42. Ibid.
43. See note 40.
44. LeadingAge, *Senior Housing in New York State* (New York, February 2013).
45. Jill Khadduri and Gretchen Locke, *Making Subsidized Rental Housing a Platform for Improved Health for Vulnerable Populations*, www.abtassociates.com.
46. US Department of Housing and Urban Development Low-Income Housing Tax Credit Database, lihtc.huduser.org.
47. See note 45.
48. Los Angeles Housing Development, "Building Healthy Communities 101," www.lahd.lacity.org.
49. Enterprise Community Partners, *Issue Background: Low-Income Housing Tax Credit* (last updated July 10, 2013), www.enterprisecommunity.com.
50. See note 41.
51. National Rural Housing Coalition, *Fast Facts! Section 515: Ensuring Affordable Housing in Rural America* (Washington, DC), www.ruralhousingcoalition.org.
52. US Department of Housing and Urban Development, *Multifamily Housing – Service Coordinator Grants*, portal.hud.gov.
53. See note 41.
54. Including: "The 'Value Added' of Linking Publicly Assisted Housing for Low-Income Older Adults with Enhanced Services: A Literature Syntheses and Environmental Scan," prepared by the Lewin Group for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, January 2012; "Senior Housing in New York State," prepared by LeadingAge New York, February 2013; "Affordable Senior Housing with

- Services Programs and Models” and “Research on Affordable Senior Housing with Service Strategies,” prepared by the American Association of Homes and Services for the Aging for the National Summit on Affordable Senior Housing with Services, May 2010; “Supporting Aging in Place in Subsidized Housing: An Evaluation of the WellElder Program,” prepared by LeadingAge, January 2011; and housing with services case studies as identified at www.leadingage.org.
55. US Interagency Council on Homelessness, “Chronic Homelessness in Focus,” www.usich.gov.
 56. US Department of Housing and Urban Development, “HUD reports slight decline in nation’s homelessness in 2012,” news release, December 10, 2012, portal.hud.gov.
 57. OneCPD Resource Exchange, *2012 Point-in-Time Estimates of Homelessness: Volume I of the 2012 Annual Homeless Assessment Report* (December 2012), www.onecpd.info.
 58. Zack Olmstead, *Effective, Cost-Saving Solutions to Homelessness: Why ‘Supportive Homes’ Work* (Housing California Fact Sheet), www.housingca.org.
 59. These data were based on research conducted in multiple locations including Atlanta, Ga.; Chicago, Ill.; Columbus, Ohio; Denver, Colo.; Los Angeles, Calif.; Portland, Maine; Massachusetts; New York, N.Y.; Phoenix, Ariz.; Portland, Ore.; Rhode Island; San Francisco, Calif.; and Seattle, Wash. Office of the Comptroller of the Currency, US Department of the Treasury, [www.occ.gov](http://www OCC.gov).
 60. Colorado Coalition for the Homeless, *Housing First Works* (March 2012).
 61. Ibid.
 62. Patricia A. Post, *Defining and Funding the Support in Permanent Supportive Housing* (National Health Care for the Homeless Council for the Corporation for Supportive Housing, February 2008), www.csh.org.
 63. US Department of Housing and Urban Development, “HUD and HHS team up to provide permanent supportive housing to extremely low-income persons with disabilities in California,” news release, February 12, 2013, portal.hud.gov.
 64. AARP, *Aging in Place: A State Survey of Livability Policies and Practices, A Research Report by the National Conference of State Legislatures and the AARP Public Policy Institute* (AARP in Brief 190, December 2011), assets.aarp.org.
 65. Village to Village Network, “About VtV Network,” www.vtvnetwork.clubexpress.com.
 66. Village to Village Network, “Membership Directory,” www.vtvnetwork.org.
 67. Emily A. Greenfield et al., *A National Overview of Villages: Results from a 2012 Organizational Survey* (Rutgers School of Social Work, December 1, 2012).
 68. Emily A. Greenfield et al., “A Conceptual Framework for Examining the Promise of the NORC Program and Village Models to Promote Aging in Place,” *Journal of Aging Studies* 26(3), 273–84 (2012).
 69. Candace Baldwin et al., *With a Little Help from Our Neighbors: How the Village Model Is Transforming How We Age* (Village to Village Network, January 2013).
 70. A household consists of two or more qualifying members living together as a family unit.
 71. Charter members pay for a full year of membership up front and receive a discount. Regular members pay the annual membership fee on a monthly basis.
 72. AARP Policy Institute, *Fact Sheet — The Village: A Growing Option for Aging in Place* (March 2010), assets.aarp.org.
 73. Ulrike Steinbach, “Social Networks, Institutionalization, and Mortality Among Elderly People in the United States,” *Journal of Gerontology Social Sciences* 47(4): 183–90 (July 1992).
 74. Susan Poor, “Villages: A New Take on an Old Idea,” Leading Age California, www.aging.org.

75. To aid in the selection process, a review of current literature summarizing the status of state programs for the provision of managed care long term care services was conducted. The literature review included: “State Medicaid Integration Tracker, Tenth Edition,” published by the National Association of States United for Aging and Disabilities (NASUAD), February 2013; Herman, Michelle, and Ensslin, Brianna, “Innovations in Integration: State Approaches to Improving Care for Medicare-Medicaid Enrollees,” published by the Center for Health Care Strategies, February 2013; Gifford, K., et al, “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,” published by the Kaiser Commission on Medicaid and the Uninsured, September 2011; “Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider,” published by the Kaiser Commission on Medicaid and the Uninsured, October 2011.
76. According to the Director of MassHealth’s Office of Long-Term Services and Supports.



**CALIFORNIA
HEALTHCARE
FOUNDATION**

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org