AN ANALYSIS OF THE MASSACHUSETTS CONGREGATE HOUSING PROGRAM

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CONGREGATE HOUSING -- A PRELIMINARY ANALYSIS

Summary

Congregate housing is a shared living alternative that began in 1978 as a partnership between the Executive Office of Elder Affairs, the Executive Office of Communities and Development (EOCD), local housing authorities, home care corporations and local service agencies. By June 1989 there were 558 units across the state. By the end of June 1990, the supply will reach a projected 752 units in 54 sites. Since its inception, much has been learned about congregate housing and much has changed.

As the supply grows, interest has increased in the mix of residents, service utilization and costs compared to those of elders living in conventional housing. The preliminary analysis suggests that it is less costly to meet the needs of elders in congregate housing than in conventional housing. However, refinements must be made in the reporting system to accurately measure the differences. The differences in cost are attributed to the adaptive design of congregate units, the shared living features and the authorization of services based on the aggregated service needs of all residents.

Facilities

There are four basic designs of congregate facilities: free standing buildings, small apartments within a larger building, larger apartments, and the housekeeping model.

Free standing sites are usually converted homes or schools in a neighborhood of one and two family houses. Small apartments are usually part of a larger apartment building or a low rise complex. These facilities usually house no more than four or five people. Several four unit models may be sited in one larger conventional building. Large apartments are shared by five or more residents and they are also part of a larger building with conventional units. The housekeeping model is a larger version of the free standing house. The number of units range from 20 to over 60. This model requires more private space than the others.

Small apartments are the most common model, accounting for 45% of the units, primarily because many of these sites have been built in smaller communities. Thirty-six percent of the units were in housekeeping models and larger apartments accounted for 15%. Free standing buildings accounted for 4% of the total number of units in June 1989. Forty-eight percent have a capacity of less than 10 units. The smaller units are more suitable to meeting the needs of frailer residents.

Most of the facilities (63%) are located in suburban or rural areas of the Commonwealth. Sixty-three percent are sponsored by Home Care Corporations, 23% by Human Service agencies, and 10% by

Councils on Aging.

The sponsoring agency is responsible for coordinating the Multi-Disciplinary Assessment Team (MAT), hiring and supervising the coordinator and coordinating all the activities at the site.

The coordinator is the primary ingredient of a successful program. The coordinator is the liaison between the housing manager, the tenants and the service system. The coordinator promotes the project in the community, interviews and assesses prospective residents, determines which services are needed by residents and organizes services from among community agencies and funding sources to meet tenant needs. The coordinator monitors the service plan for each tenant and makes necessary changes.

The MAT includes representatives from home health and mental health providers, social service and other community agencies to review applicants and to make sure that resources will be available to support tenants.

Occupancy

Shared housing requires a thorough presentation to the community at large and prospective residents in particular. Coordinators spend most of their time at the outset of a project explaining the model to applicants to make sure that it meets their expectations. As a result the initial rent up phase takes longer than renting conventional units.

Coordinators must also make sure that the model can meet any functional or other service needs tenants will have upon occupancy. Finally, coordinators are mindful of the unique "culture" that each site develops and the need to recruit tenants that will complement one another.

The average occupancy rate during FY 89 was 72.2%. Occupancy rates are directly affected by the length of operation of the facility and the presence of double units in some facilities. Units reserved for couples are more difficult to lease, and double units reserved for handicapped residents are often vacant.

Most of the facilities with double units were designed over four years ago. Recent designs are less likely to include them and many sites are converting their double units to separate single units.

Sites operating less than 9 months had an average occupancy rate of 47%. It normally takes 6-9 months to reach occupancy levels of 60% or more. Sites operating between 10 and 18 months during the year had a 73.2% occupancy rate and sites operating longer than 18 months had an 83.3% rate.

Among the four models, larger apartments tended to have higher occupancy rates than other models, 81.2% compared to 65.6% for free standing sites, 74.2% for smaller apartments and 65.2% for housekeeping sites. These rates are not adjusted to length of operation and therefore are artificially affected by the number of months of operation among 6 new sites.

Impairment levels

A successful congregate housing program requires a mix of tenants. While a significant majority of tenants are frail and need support services, others seek the companionship and activity that this model offers. Some tenants have recently suffered the death of a spouse and no longer wish to live alone. Others are able to leave a nursing home or rest home because of the support services provided with congregate housing.

The Massachusetts home care program is the primary source of support services for congregate residents. Eligibility for home care services is based on functional impairments. A standardized, statewide tool is used that assesses the level of functional impairments in activities of daily living, instrumental activities of daily living, the cognitive and emotional status of the client, informal supports, and the medical and physical conditions requiring treatment. Elders with the greatest degree of functional impairments receive priority for service. (See appendix for a description of the home care program and the Functional Impairment Levels (FIL).

Because of the adaptive design of these facilities, residents of congregate housing measure less impaired than clients who live in conventional housing. As a result home care corporations are required to give special consideration to congregate housing residents who may not appear to be as frail as other elders. In the absence of this exception, residents needing service would not be able to move into the program without the assurance that services will be available to meet their needs.

Congregate residents were more impaired in FY 89 than during earlier periods. The percentage of residents rated FIL III (6-10 IADL impairments) rose from 29% in June 1986 to 52% in June 1989. The number of residents with two or more ADL impairments (FIL I and II) has remained stable, 10-11%, during the year.

Facilities that are smaller, and newer tended to have frailer residents than larger facilities that have operated for longer periods of time.

Service Utilization

Overall, between 56-65% of congregate residents are home care clients. An additional 10-15% receive home health or day health services. Congregate housing home care clients use less units of

service per month than clients in conventional housing. In FY 89 congregate clients used an average of 15.1 hours of homemaker service per month compared to 18.0 hours for regular clients. Congregate clients used 2.5 fewer hours of personal care service each month than clients receiving personal care in the regular home care program. Again the differences are attributed to the design aspects of congregate housing and the assistance from other residents who are not functionally impaired.

The variations in utilization may be greater than the preliminary analysis suggests. The current monthly report format for congregate housing sites vary from the format for regular home care clients. Current reports of service utilization include services used by residents under 60 years old and older residents whose services are funded from other sources. For example, one handicapped resident with a personal care attendant had nearly one hundred hours of care each month included in the service report.

Homemaker, transportation and congregate meals were the services most frequently used by residents. Thirty-three percent of the residents received congregate meals and 24% used transportation services. A relatively small percentage (10%) used an average of 2.4 hours of personal care per week. Just over 6% of the residents used an average of 1-2 skilled nursing visits a week and 3.0 hours of home health aide care a week.

Other services used included chore, home delivered meals, social day care, day health care, counseling, laundry and companion.

Authorization rates for congregate residents using home care services have dropped steadily over the past three years. Homemaker hours have dropped from an average of 19.6 hours a month in FY 87 to 15.1 hours in FY 89. Utilization of personal care has declined from 16.5 hours a month in FY 86 to 13.5 hours in FY 87 and 10.3 hours in FY 89.

The decline is more apparent comparing data from June 1988 and June 1989. Residents of small and large apartments used 31-33% less service in June 89 than in June 88. The reduction was most noticeable in housekeeping units which received 54% fewer homemaker hours in June 89 than in 1988. Authorizations for residents in free standing units declined by 14%.

The percentage of residents using services has also changed. The percentage of residents using homemaker services has dropped from 67.7% in FY 86 to 62% in FY 89 while the rate for personal care has increased from 7.8% of the residents in FY 86 to 9.5% in FY 89. Yet participation in home health services declined. Over 12% of the residents used skilled nursing and 14.6% used home health aides in FY 86 compared to 5.9% and 6.0% respectively in FY 89.

The highest participation rates were found among residents of small apartments and housekeeping models, 63.3% and 60% in June '89. Participation in the home care program among residents of large apartments was 49% in June '89 compared to 66% in June '88.

It is not clear how much of the decline in participation and utilization is attributed to home care funding shortages, intake policies among home care corporations, tenant selection policies or other factors.

Residents

More men are represented in the congregate housing program than in the regular home care program. Men tend to be younger than women residents. Forty percent of the residents were men and the median age was 74. The median age for women was 78. Twenty-one percent of the residents were over 85 years old and 36% were over 80. The age and sex rates have been stable over the past five years.

Previous Living Arrangements

Thirteen percent of the residents had lived in a rest home, nursing home or a chronic care facility prior to moving to congregate housing. The largest share, 23%, lived with members of their family and 14% lived in their own home.

Less than half of the people who were referred to congregate units actually applied for a unit and 27% of those who applied were accepted.

Discharge

Most residents left congregate housing to enter a nursing home (32%) and 21% died. Another 24% were admitted to a hospital and did not return to the facility. It is not known how many of this group may have died, entered a nursing home or some other housing arrangement. Fourteen percent moved into more independent living arrangements.

Future Directions

Congregate housing offers elders an alternative housing and service system. It is based on an effective partnership between two state agencies and the local housing and service system. That partnership is threatened by continuing budget constraints and the separate budgeting systems. Housing authorities receive a commitment of construction and operating funds from the Executive Office of Communities and Development. The award, design and construction phase may take two years or more before the building is ready for occupancy. When ready, the sponsors turn to Elder Affairs for funding of a housing coordinator and services. Until FY 90, funds for coordinators have been readily available.

Services were also available through the home care program. During an era of budget constraints, funding for new coordinators and services to new residents competes with other priorities. The state's investment in construction is jeopardized if the funds for coordinators and services are not available when the facility is ready for occupancy.

The program could be strengthened by making a commitment of staffing and service funds when the original construction funds are awarded. It could also be strengthened by including funds for services in the appropriation for congregate housing staffing. In this way, an amount of service funds would be earmarked for congregate residents that would stabilize access to services once a building opened. If funds are not available, frail residents may not be able to safely enter the program. If the type of residents for whom the program was designed are not able to enter the program, either the units will remain vacant or they will be rented to less appropriate clients and the program will fail to meet its stated purpose.

Future Housing and Service Models

The economies of providing services to elders in congregate housing may now be applied to the elderly housing facilities in which large percentages of the residents are clients in the Home Care program. In addition, new housing and service models are being designed by the Mass Housing Finance Agency and the Executive Office of Communities and Development that raise new challenges for policy makers, program operators and legislators. These new housing models will be designed and awarded as a combined housing and services package. When construction is completed, funds must be available to serve the residents occupying the units. Applicants, developers and housing agencies will need assurance that funds to provide services will be part of the award process.

The experience serving congregate housing residents will be useful in projecting the service needs and costs for residents in conventional housing and new housing and service or assisted living models.

Short Term Steps

The data analysis has highlighted several aspects of the program that require further refinement. To better understand the trends and dynamics of the program, the record keeping and reporting system must be changed to eliminate differences in reporting among the sites and between congregate housing and the home care program. Further, regular monthly statistical reports must be issued to allow coordinators, sponsors, managers and state agency staff to adjust policies and practices as changes occur.

Elder Affairs will revise the monthly reports in December 1989 and begin issuing regular monthly statistical reports beginning with the January 1990 data.

The data has shown the need to more closely examine and work with sites that are experiencing a decline in occupancy or longer than expected rent up periods.

Finally, the data has shown the need for a more careful examination of the intake, authorization and service delivery policies among the sites to ensure that units are used most effectively to serve appropriate tenants.

Recommendations

- Establish contracting authority for future obligations for services and staffing to congregate facilities when bonds are issued and construction awards are made for facilities.

- Apply the cost efficiencies of service delivery achieved in congregate housing facilities to home care clients residing in conventional public housing buildings.

- Earmark home care service funds for congregate housing clients.

- Review the monthly statistical reporting format with coordinators.

- Revise the monthly congregate housing report.

- Issue monthly statistical reports.

- Develop targeted technical assistance efforts with EOCD to help sites improve rent up and occupancy rates.

- Clarify policy changes needed to facilitate the use of block authorization and coordinated service delivery concepts and implement in congregate and conventional housing sites.

Appendix

Description of the Massachusetts home care program and eligibility process

Cordinators/case managers use the Client Needs Assessment Procedure (CNAP) to rate the elder's ability to perform ADL and IADL activities. Functional status is determined by the client's ability to perform the tasks either without assistance, with assistance, or not at all.

Elders are rated as impaired in an ADL if they need another person to assist with the activity. Coordinators/case managers note whether the client is unable to perform an activity (client assists minimally with less than half the activity) or performs the activity with assistance (client does more than half the activity). These distinctions are necessary to determine the type of service that is appropriate, i.e. home health aide or personal care. Elders are not considered impaired in an activity if they require mechanical assistance or perform the activity with difficulty.

Additional need and service specific modules are used for clients who need home health care, personal care, respite services and home delivered meals.

The assessment tool measures the following activities:

Activities of Daily Living	Instrumental Activities of Daily Living
Bathing	Housework
Dressing	Shopping
Continence	Meal Preparation
Toiletting	Laundry
Eating	Transportation
Mobility (Inside)	Taking Medication
Transferring (Bed/Chair)	Using telephone
	Outside Mobility
	Managing Money

The CNAP also determines if a family member, spouse, or other caregiver is available and willing to help with these activities. If not, home care services are authorized to assist the elder. If others are available to meet the need, services are not authorized.

After completion of the assessment, case managers determine the number of ADL and IADL impairments and assign a Functional

Impairment Level rating. Clients with more than four impairments receive the highest priority for services (see chart).

FIL	Impairments
I	4-7 ADL Impairments
II	2-3 ADL Impairments
III	6-10 ADL/IADL Impairments
IV	4-5 ADL/IADL Impairments
V	2-3 ADL/IADL Impairments