CONGREGATE HOUSING

for

OLDER MINNESOTANS:

A Discussion Summary

Minnesota Housing Finance Agency

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Introduction

The housing programs in Minnesota for the independent and well elderly are not adequate for a large but relatively unrecognized group of older citizens who require some services to live independently. These persons are not sick, but may experience some chronic physical impairment associated with the aging process which limits their mobility in daily living. They do not require the services of a nursing home. However, shelter with services for this older population may only be available in an institutional environment.

Congregate housing or shelter with services is one alternative to institutionalization for the frail elderly. However, the lack of a central subsidy for nutritional, health and social services is a major obstacle to the development of congregate housing for older citizens of low or moderate income.

The 1977-79 biennial report of the Minnesota Housing Finance Agency lists as a major purpose: "to provide a variety of housing alternatives for persons and families of low and moderate income". One area in which stronger efforts should be made is the provision of housing choices for the frail elderly who require housing between independent living and nursing homes. This report will discuss some of the issues involved in developing congregate housing for the elderly.

Definition

Several different definitions and terms are being used for the shelter/services concept. The 1974 Housing and Community Development Act terms "congregate housing" as "low cost housing in which some or all of the units have no kitchens and a central dining facility is provided". Congregate housing must also include other essential services to support those who need some assistance to continue living independently.

While congregate housing may follow different models, this report will define the minimum requirements for congregate housing as providing access as needed to the following:

- private living unit, with or without a kitchen,
- some shared living areas,
- congregate meal service,
- health maintenance service,
- emergency call service,
- access or transportation to medical/dental care,
- homemaker and chore services,
- personal care, and
- social/recreational/educational activities.

Since the service "bundle" for each individual will differ, providing and subsidizing services may be complex and require innovative approaches.

Need and Demand

Population projections for Minnesota up to the year 2000 indicate that the most rapid increases in the over 65 age group will be among those age 80 and over. A high proportion of this group are potential congregate housing residents. Their activity may be limited due to chronic conditions such as arthritis, heart disease, or vision problems, although they can function independently with some assistance. The table in Appendix 2 provides more detailed population projections.

No specific data are available on the number of elderly persons needing congregate housing. Various studies estimate percentages of those elderly persons physically impaired, inappropriately institutionalized or presently living in boarding houses. From these estimates, it is appropriate to suggest that 6% of those Minnesotans over 65 or approximately 25,000 could not live independently without some assistance. Many cannot afford the retirement, "life care" centers planned for higher income persons.

The long waiting lists at those developments which offer some services such as Ebenezer Towers in Minneapolis is indicative of the demand for shelter and

services for older citizens. The availability of congregate housing may decrease inappropriate placements in nursing homes. This could reduce health care costs and provide a more suitable environment for many older citizens.

Services

Older persons who need congregate housing find that services are as important as the shelter and must be available on a continuous and assured basis. Meal service, assistance with homemaking, health maintenance and personal care are the services related to the major needs of these semi-dependent elderly. As the residents age, the need for these services will increase. It is inadvisable to provide services not yet needed as it may encourage unnecessary dependence among the residents.

The congregate meal is an assured source of nutrition for elderly persons who may neglect their nutritional needs because shopping and meal preparation are too difficult. Central dining instead of meals in their apartments serves to reduce the social isolation of the elderly. The mealtime can also provide the management a chance to unobtrusively monitor the functional health of the residents. Food service is a highly specialized business and requires appropriate expertise.

Homemaker, chore and personal care services need to be accessible to the elderly in congregate housing. Various community agencies now provide these services as part of "in-home care" in housing for the elderly, but the sources are diverse and the supply is inadequate.

The availability of health care services ranks first among those desired by elderly persons according to various studies. Health problems increase in frequency as aging progresses. Regular on-site health care is desirable, but difficult to deliver. Extensive rules and regulations for federal health and medical care subsidies act as a restraint to development of health care services in congregate housing. A waiver of federal regulations for use of Medicare and

Medicaid payments could be sought for a pilot project in congregate housing.

Models of Congregate Housing Developments

Design of congregate apartment developments for the elderly can follow a variety of models according to community needs and resources. Major types are:

- Independent apartments in a multi-unit development. A central kitchen and dining facility is included. A minimum of 30 and maximum of 200 units are recommended with 100-125 being cost effective. Other services are available as needed.

- An apartment development in which one floor of units or several scattered units exclude kitchens. Meals and other services are provided.

- A "life care" facility including independent apartments, residential units with congregate dining and a nursing home.

- Residential units only, without kitchens and a complete meal service in a central dining room is provided.

- A rehabilitated hotel with kitchens omitted in the living units, but shared areas such as a snack kitchen for each four or five units.

- Cooperative apartment development with private apartments and central dining with other services.

- Shared housing in a converted single family home with private bed-sitting room and bath and a shared living and dining area.

The size of a congregate housing development is not a subject on which there is clear agreement. Experience does indicate that a maximum of 200 units is probably advisable. A development of this size would need to be in an urban area. Some managers feel that 100 to 125 units is acceptable for cost effectiveness. The needs of the elderly and available community resources will affect size considerations.

European countries have been providing sheltered housing for their elderly much longer than we have and their experience strongly indicates the desirability of small developments. In England a number of large houses have been remodeled into "bed-sitting room flats" with a housekeeper preparing meals for the 10 or 12 residents in a shared kitchen.

Design

The design of congregate housing developments is affected by the space needs for services. A central meal service requires appropriate kitchen and dining areas. Private rooms for other needs such as health care or personal counseling are needed. The limited mobility of semi-dependent residents increases the importance of pleasant and flexible surroundings.

Management and staff may require more room than is now provided in conventional housing for the elderly. The higher proportion of shared and community space in congregate housing raises questions of how this space should be supported, since the total rentable area may be reduced.

The issue of including or excluding kitchens in congregate housing developments requires further analysis and discussion. HUD regulations now permit developments without kitchens for the elderly and handicapped if a full central meal service is provided. However, specific guidelines are lacking on the use of Section 8 Housing Assistance Payments for this type of development.

It is generally agreed that full kitchens in apartments are important as a means of maintaining the independence of the elderly. There are issues related to the economy of providing a meal service and complete kitchens in subsidized housing. Construction specialists indicate there is probably minimal cost savings achieved by excluding kitchens in some apartments in a development because the basic wiring, plumbing and exhaust system requirements still exist. Marketing of a development without kitchens is based on limited experience in this state, but elsewhere, this model for retirement communities of upper income persons has wide acceptance.

Site and Location

Site selection of congregate housing requires consideration of the specific needs of the impaired elderly. Reasonable proximity to a hospital/medical care and other services is important, but these persons also benefit from the social

stimulation of observing the activities of others from their secure environment.

Locating a congregate housing development adjacent to a nursing home has several advantages for sharing of staff and service facilities. However, health department regulations may limit this option. The disadvantages of attaching a congregate facility to a nursing home are related to the social/psychological well-being of the residents who benefit from a more active and non-institutional environment.

Those communities having a high proportion of elderly persons are an appropriate location for congregate housing. In those urban areas, where subsidized housing for the elderly is concentrated, it may be more practical to develop congregate housing than to continue expanding services to the elderly in their houses and apartments. Small communities may be able to support smaller congregate housing models if adequate community resources are available from which to secure services.

Regulatory Requirements

State regulatory agencies do not now have specific requirements for construction and operation of congregate housing. Existing licensing for food service or boarding houses would be applied by the state or local health agency.

The provision of health care services on-site, where several residents may be receiving health maintenance service from the Public Health Nursing Service, may raise questions as to the need for licensing as a health care facility. Congregate housing is residential with emphasis on maintaining the independence of the residents instead of the emphasis on "care" implied in nursing homes. Therefore, licensing as a health facility is inappropriate.

The State of Maryland has passed specific legislation relating to the development, certification and operation of "sheltered" or congregate housing for the elderly and excluding this housing alternative from the definition of "hospitals and related institutions". Other states are considering legislation

intended to clearly designate congregate housing as residential for licensing and zoning purposes.

Management

The management of independent housing for the elderly funded by the MHFA has limited responsibility for services to the residents. Congregate housing management must be responsible for a well run physical facility as well as fostering the delicate balance of providing needed services to residents without encouraging dependency. Staff and management are needed who are sensitive to needs of the elderly, knowledgable of community resources, experienced in handling health emergencies and skilled in business organization. The additional time and responsibility required for managing this type of housing will certainly increase management costs above that now allowed in independent apartment developments financed by this Agency. There may also be a need for staff training programs if congregate housing development is expanded.

Financing a Congregate Housing Development

Enabling legislation permitting limited development of congregate housing for low and middle income elderly and handicapped persons was included in the Housing Act of 1959 and reenacted in the Housing and Community Development Act of 1974. The HUD Section 202 program provides direct long term, low-interest loans by the federal government to non-profit groups and allows amortization of the kitchen and dining facility. No subsidy is included for meals and other services. Several developments have been financed under this program in Minnesota. (See Appendix 1)

The Section 8 Housing Assistance Payments Program established in the 1974 Housing and Community Development Act subsidizes rent payments to 15-25% of the income of qualifying households. The HUD Section 202 program can be successfully combined with the Section 8 program in a congregate housing development. Sponsors may require residents to purchase one meal daily though

no subsidies are included in the Section 8 payments for food and other services.

Guidelines for use of Section 8 funds in congregate housing have not been developed by HUD, but action on this subject is proceeding. Sponsors may submit innovative applications which will be considered on an individual basis regarding the portion of Section 8 funds which may support the service structure.

The Section 515 rural rental housing program administered by the Farmers Home Administration permits the financing of congregate housing for the elderly and handicapped in rural communities. No provision for services is included in this program.

There is no existing program for renovation of subsidized housing for the elderly to include services and congregate meals for the aging tenants. Some remaining public housing funds are being used by the Duluth Public Housing Authority to include a "care floor" in a development now being constructed. This experience will aid other developers using HUD funds.

Financing Services in Congregate Housing

A major deterrent to the development of congregate housing with services for the semi-dependent elderly is the lack of a single specific subsidy for supporting the cost of services. There are many agencies and subsidized programs for providing nutrition, health and social services to the elderly. However, sources of funding are diverse, coordination is lacking, subsidies for services are uncertain, and their availability varies throughout the state.

The food service is the major expense in congregate housing above the rent costs. Costs for meals now being served in housing developments vary widely from $1.06 to $2.45 per meal. One full meal daily is usually sufficient if the residents have kitchens in their apartments.

The Title VII nutrition program funded through the Administration on Aging and implemented at a local level provides meals to elderly persons at nutrition centers across the state. Financial need is not a requirement for participants.

Several other public and nonprofit groups bring prepared meals to the elderly in their homes.

Existing nutrition programs for the elderly require a more assured funding source to be implemented in congregate housing for low and moderate income persons. There is also a duplication of effort in subsidized nutrition programs and minimal direction of resources towards elderly with the greatest need.

Title XX of the Social Security Act provides federal funding to states for provision of social services for all age groups. This program is administered through the County Social Service Agencies with additional funds from state appropriations and local tax levies. A variety of services is now being provided to elderly persons in their homes through this program. If funds were available, sponsors of congregate housing could enact a "purchase-of-services" contract with the County Department of Social Services to provide required services on a scale based on ability to pay.

There is substantial variance of opinion in the literature and among professionals working with the elderly on the best approach to providing and subsidizing health/medical services in congregate housing. Payments for health care from Medicare and Medicaid are subject to stringent regulations and are not presently structured for use in congregate housing developments.

Most congregate housing developments will use community health facilities since maintaining a health care staff is costly and health department regulations restrict the provision of nursing care except in a licensed nursing home. The Public Health Nursing Service/Community Health Service is a function of the counties using federal, state and local funds. These county agencies have considerable autonomy in administering these funds and would determine the basis on which residents of a local congregate housing development are served.

Other sources for subsidizing services are Title III of the Older Americans Act which is coordinated regionally by the Area Agencies on Aging. Community Development Block Grants and general revenue sharing may be used for services to

the elderly. Numerous non-profit agencies provide services also. While a 1972 HUD-HEW agreement confirms cooperation of these two federal agencies in providing shelter with services for the elderly, no significant implementation of this agreement has occurred.

State Coordination of Services to the Elderly

The State Department of Public Welfare, the Governor's Citizens Council on Aging and the State Board of Health are the major state agencies responsible for coordinating services to the elderly with federal and state funds. County or area agencies are delegated much of the planning, policy making and implementation function by statute or agency policy.

Minimal coordination of the policy development and program planning among state agencies with regard to the needs of the impaired elderly occurs. Local and regional planning and policy development is emphasized in Minnesota under this decentralized approach, a state appropriation to be used for services in congregate housing through the above agencies would be implemented on a local basis. No state agency is structured to coordinate the delivery of services in congregate housing.

Since the provision of services to residents in congregate housing requires a long term commitment of funds to support services for those unable to afford it, an appropriate program will need to be developed, or existing programs modified to support services in congregate housing for the semi-dependent elderly. The need for a federal, state and local policy relating to the needs of the impaired elderly is implied.

For several years, there have been Congressional hearings and federal conferences on the need for congregate housing. More recently, state housing finance agencies have been requesting HUD/HEW to clarify guidelines and designate subsidies for this alternative to institutionalization.

Maryland and Delaware have developed "sheltered" housing programs by

coordinating the resources of the various state agencies. Private developers have been brought into the process. The decentralized service delivery system in Minnesota requires a different approach from those states, but we can learn from their experiences.

Role of the Minnesota Housing Finance Agency

The MHFA has provided financing for over 3,600 apartments for the elderly of which most have been combined with Section 8 rental assistance subsidies. Applications for 2,200 more units are being processed. The developments and units are generally designed for the well and ambulatory so the inclusion of services has received minimal consideration. Policies or guidelines have not been developed for service provision. However, this need will increase.

Some developments financed by MHFA will have a limited food service. A Title VII Nutrition Site has been established in Alice Nettell Towers in Virginia for residents of the building and the larger community. Trinity Housing for the Elderly in Minneapolis will include a central kitchen and dining room at which one meal daily will be served to residents. Other proposals for MHFA financing which include a central kitchen or other services are now being considered. The inclusion of these services assists some older residents to continue living independently, but is not a substitute for congregate housing.

The MHFA is authorized to make loans to limited dividend, nonprofit or cooperative corporations to finance construction of congregate housing and Section 8 housing assistance payments can be used for rent subsidies. The MHFA is not authorized to finance the operating costs of providing food and other services in Agency developments. However construction costs of a central kitchen and dining facility and other community spaces may be amortized. Marketing expenses of developments are a mortgageable item and the Agency has considerable latitude in determining what expenses may be included in this category. For example, the mortgage could include funds for preparing a grant application to attract services.

Several important policy considerations will be confronted by this Agency

if its role as a major provider of housing for older Minnesotans evolves to include housing with services for the semi-dependent elderly. These include:

- A determination of MHFA's role in financing congregate housing.
- A determination of MHFA's role in providing services in congregate housing.
- The impact of service provision in housing on the MHFA financing structure.
- The role and responsibility of management and staff in congregate housing.
- The need for legislative action in defining congregate housing as a residential use.

Conclusion and Recommendations

This report has reviewed some of the basic issues related to congregate housing for the elderly and the role of the Minnesota Housing Finance Agency in developing this housing option. The need for congregate housing exists and will increase and current programs do not adequately address this need.

It is recommended that the MHFA take the following action to implement the findings of this report:

1. Proceed with further study on specific issues and policies related to congregate housing through development of a model apartment development proposal to which HUD and state/local service providers can respond. Details of this proposal should be outlined as soon as possible. Consideration may be given to seeking a federal grant for assisting with this activity.

2. Communicate with other appropriate state agencies regarding the need for a state policy to coordinate delivery of services to the elderly in subsidized housing and focus available resources to the impaired elderly. A state level task force or conference on congregate housing may be considered.

3. Examine the advisability of establishing a state appropriation for services designated specifically for low and moderate income impaired elderly in congregate housing as a source of long term funding.

4. Propose legislation defining congregate housing as "residential" and excluding this housing alternative from consideration as a "group home" or institution.

Appendix 1: Existing and Proposed Congregate Housing Developments in Minnesota

Congregate housing developments or apartment developments with supportive services are not centrally listed in this state so it is difficult to establish a complete inventory. Following are the major "congregate type" residences:

These congregate housing developments were built in the 60's under HUD Section 202 program , for 766 residents:

Minneapolis, Ebenezer Towers, 2523 Portland, 200 residents

Duluth, St. Ann's Residence, 200 units, bed-sitting rooms, a former hotel.

Montevideo, Brookside Manor, 83 units, 52 units have no kitchens.

St. Paul, Central Towers, 20 East Exchange, 283 residents

These privately funded residences provide single rooms, congregate meals and other services for 247 older persons.

Minneapolis, Soul's Harbor, 161 units, formerly the Nicollet Hotel.

Rochester, Samaritan Bethany Manor, 86 rooms in a remodeled nursing home.

These retirement centers provide on-site services to the residents.

Edina, Rembrandt, Heritage and Roybet, 225 apartment units.

Edina, 7500 York, a cooperative apartment development under construction for middle and upper income persons, sponsored by Ebenezer Society under HUD Section 213 program, 338 units with services for residents.

These public housing projects provide services for the semi-dependent elderly.

Ely, HRA Public Housing, 40 units, modified kitchens, adjacent to independent housing and a nursing home.

Duluth, HRA, a development under construction in downtown Duluth has one floor designated as a "care floor" of 20 apartments (40 residents) in which meals and other services will be provided by the St. Louis County Department of Social Services.

St. Paul, HRA, three developments have congregate dining facilities, 300 residents receive extensive services to remain independent.

These MHFA developments will have a meal service, but are not intended to be congregate housing.

Virginia, Alice Nettell Tower, 160 units, with Title VII Nutrition Program

Minneapolis, Trinity housing for the elderly, 120 units (150 residents).

These residences have independent apartments and are affiliated with nursing homes which offer meals and other services:

St. Paul, Wilder Residence at 508 Humboldt, 150 units.
St. Paul, Presbyterian Homes, 3220 Lake Johanna Blvd., 108 units.
Minneapolis, Bethany Apartments, 2309 Northeast Hayes, 16 apartments.
Minneapolis, Walker Methodist Home, 3701 Bryant Ave. S., 300 units.
Winona, Watkins Methodist Home, 55 units
Rochester, Madonna Towers, 150 apartments.

Several proposed congregate housing developments are awaiting final loan commitment under HUD 202 Section 8 financing. These developments will have complete apartments and a central dining facility in addition to other services:

Minneapolis, Ebenezer Park Apartments, 200 units.
St. Paul, Lyngblomsten Care Center, 100 units.
Hastings, Oak Ridge Manor, 109 units.
Morris, Pioneer Plaza, 60 units.

Other proposed developments will have private financing. They are:

New Hope, North Ridge Care Center, 60 units.
New Hope, St. Theresa Nursing Home, 220 units.
Bayport, Croixdale, 48 units.

Plans are underway for the development of "life care" centers for upper income persons who wish to retire in an apartment with services. Proposed are:

Eden Prairie, Tudor Oaks, 240 apartments.
Bloomington, Friendship Village, 348 apartments.

Appendix 2: Estimates of 1975 Population of Minnesotans over 65 by Age and Sex; Population Projections of Elderly Minnesotans; Percent of Increase by Age Groups From 1975

1975 Population Estimates

Age Sub-Group	Males	Females	Totals by Age Grouping	Totals
65-69	63,899	75,612	139,511	
70-74	48,331	63,614	111,915	251,456
75-79	35,316	51,178	86,494	
80-84	22,706	35,551	58,257	144,751
85+	11,985	22,249	34,234	34,234
TOTAL	182,237	248,204		430,441

Population Projections

1980

Age Sub-Group	Males	Females	Totals by Age Grouping	Totals	Percent of increase in Elderly Population From 1975
65-69	67,444	80,849	148,293		
70-74	51,826	68,180	120,006	268,299	6.6
75-79	34,978	52,987	87,965		
80-84	22,178	38,460	60,638	148,603	2.6
85+	13,073	25,922	38,995	38,995	13.9
TOTAL	189,499	266,398		455,897	

1985

65-69	69,705	85,575	155,280		
70-74	54,710	72,872	127,582	282,862	12.4
75-79	37,497	56,781	94,278		
80-84	21,963	39,807	61,770	156,048	7.8
85+	12,798	28,021	40,819	40,819	19.2
TOTAL	196,673	283,056		479,729	11.4

1990

65-69	71,327	86,278	157,605		
70-74	56,539	77,131	133,670	291,275	15.8
75-79	39,573	60,704	100,277		
80-84	23,541	42,667	66,208	166,485	15.0
85+	12,649	29,029	41,678	41,678	21.7
TOTAL	203,629	295,809		499,438	16.0

1995

Age Sub-Group	Males	Females	Totals by Age Grouping	Totals	Percent of increase in Elderly Population From 1975
65-69	69,773	84,545	154,318		
70-74	57,854	77,785	135,639	289,957	15.3
75-79	40,890	64,258	105,148		
80-84	24,864	45,597	70,461	175,609	21.3
85+	13,578	31,115	44,693	44,693	30.5
TOTAL	206,959	303,300		510,259	18.5

2000

65-69	65,551	79,825	145,376		
70-74	56,580	76,203	132,783	278,159	10.6
75-79	41,861	64,804	106,665		
80-84	25,690	48,284	73,974	180,639	24.7
85+	14,329	33,257	47,586	47,586	39.0
TOTAL	204,011	302,373		506,384	17.6