

*Adult Care Homes in Public Housing: A
Feasibility Study*

UNC Center on Poverty, Work and Opportunity

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Demographic Background and Aging Trends, 2010-2050¹

As a nation, we are graying. Driven principally by the baby boomers—the first wave of which will turn 65 in 2011—the rapid growth of the older population will continue to surge up the age ladder for the next forty years.² The elderly³ will constitute a larger portion of the overall population, climbing from 13 to 19 percent by 2030.⁴ The majority of the country’s older population will be on the younger side of old age until about 2034, when all the boomers reach 70. By 2050, the 65 and over population is projected to total 88.5 million, more than double 2010’s number.⁵ And the oldest of the old—those 85 and over—will have more than tripled to 19 million⁶: more than 21 percent of the older population⁷ or almost 5 percent of all Americans.⁸

While the elderly are not as racially and ethnically diverse as those under 65, they are projected to become substantially more so in the coming years. By 2050, minorities will comprise 42 percent of the 65 and over group, compared to 20 percent now.⁹ Women will continue to have a longer life expectancy than men, but that gap is expected to narrow, particularly for those 85 and over: 61 percent of that group are projected to be female in 2050, down 6 percentage points from 2010.¹⁰

The demand for long-term care, and the government programs that pay for it, will escalate with the aging population. Long-term care is expensive, ranging upward of \$70,000 per year, yet nationally only a small percentage of adults over age 65 have purchased long-term care insurance.¹¹ Approximately half of the boomer generation, experts say, “will have difficulty paying out-of-pocket costs for health and long-term care as well as meeting their minimum need for food, housing, and essential transportation.”¹²

North Carolina will face similar pressures as its own population—including its 2.3 million baby boomers—ages.¹³ North Carolinians are living longer. Those who are 60 today are expected to live, on average, an additional 22.5 years.¹⁴ Additionally, the state’s allure as a retirement destination will add to the numbers of elderly in the state.¹⁵ By 2030, the state is predicted to have one million more residents 65 or older than it does currently—nearly doubling from 1.1 million to 2.1 million.¹⁶ Not all counties will experience this growth equally: the North Carolina Commission on Aging estimates that by 2030, twenty Tar Heel counties will have an older population of 25 percent or more.¹⁷

This older population will exhibit considerable variation in health status and economic security. Despite a slight decline in recent disability rates, a significant portion of seniors will grapple with infirmities that impede their day-to-day functions. The most recent American Community Survey reports that 38 percent of men and 41 percent of women 65 and over have at least one disability.¹⁸ Experts forecast that the number of people with disabilities will double, along with the state’s older population, over the next twenty years.¹⁹ Sixty percent of persons over the age of 65 will need long-term care services, either in their home or a residential setting, sometime in their lives.²⁰

Of North Carolinians 65 and up, 11.3 percent fall below the poverty line.²¹ Although this rate is lower than the overall poverty rate of 14.3 percent, thanks in large part to Social Security, it ignores those on the cusp of poverty: fully one in four older residents lives below 150 percent of poverty.²² North Carolina's minority residents are generally poorer: 24 percent of older African Americans, 17 percent of older Hispanics and 28 percent of older Native Americans are impoverished. Women are poor at twice the rate of men.²³ Moreover, a broad consensus of researchers contends the official poverty measure undercounts poverty for older persons—actual levels of deprivation in North Carolina are undoubtedly higher.²⁴

Poverty and disability are closely linked. In 2009, an annual state health survey found that while 31.1 percent of respondents overall reported a disability, that rate was 53.7 percent for those with incomes under \$15,000 and 41.1 percent for those earning between \$15,000 and \$24,999.²⁵

Safe and affordable housing for the elderly is another looming challenge in North Carolina. For renters 65 and over, 46 percent spend more than 30 percent of their gross annual income (the level deemed “affordable” by the U.S. Department of Housing and Urban Development (HUD)) on housing costs; for older homeowners, 27 percent pay more than 30 percent.²⁶ Almost 62,000—one in four—residents of subsidized housing in North Carolina are 62 and over; 41 percent of this group have a disability.²⁷ Subsidized housing clearly plays a “crucial role” in the lives of a substantial number of older adults in the state.²⁸

While an aging population presents many opportunities—a lifetime of accumulated experience, social and human capital; ability and the time to “give back”—it will also tax already-strained programs. The projected growth of older North Carolinians, along with “their increasing ethnic and racial diversity, rural living and poverty, the aging of individuals with physical and mental disabilities, and the slowed economy all create major challenges” that call for innovative solutions, cross-agency collaboration and new initiatives.²⁹

Issue #1:

Is the model of an adult care home in public housing needed to complement the care options currently available to older adults in North Carolina?

For years North Carolina's policymakers, agencies and consumer advocates have been aware of, and preparing for, these demographic transformations and their impact on long-term care. Among the state's accomplishments are the adoption of a long-term care policy that prioritizes in-home and community care over institutionalization and the subsequent expansion of programs providing in-home care,³⁰ the creation of the Office of Long-Term Services and Supports and the Long Term Care Ombudsman Program, the development of a voluntary state licensure program for long-term care providers, increased coordination between departments and agencies, improved consumer access, regularly published state aging plans, the establishment of pilot aging and disability resource centers and the participation in a number of promising demonstration projects.

As a result of these and other initiatives, the state offers a continuum of long-term care options to North Carolina's older citizens.

A. In-home Care

The preponderance of in-home care for older disabled adults is provided by volunteers, usually friends and family. Some studies estimate that as much as 85 percent of the care received at home is informal and unpaid.³¹ According to a study commissioned for the North Carolina Institute of Medicine's Task Force on Long-Term Care, 57 percent of older adults who have problems with one to two activities of daily living (ADLs), and 49 percent of those who have problems with three or more ADLs, rely exclusively on unpaid support.³² Nevertheless, current trends—women working outside the home, families with fewer children, more single women, greater mobility and distance between family members—along with the growth of the elderly population, suggest that demand for paid in-home assistance will increase substantially in coming years.³³

Public sentiment and current health care best practices favor helping people to stay in their homes³⁴, and the state expends considerable funds on home and community-based services.³⁵ These services include home management (cooking, cleaning, laundry, shopping, bill paying); personal care (dressing, grooming, bathing, toileting and moving); transportation; case management; skilled medical care and therapies; home-delivered meals; home repair; respite care; adult day care and adult day health care; volunteer companionship; and case assistance. The amount of in-home care a person receives is a function of both need and availability.

For low-income elderly in North Carolina, the primary sources of public funding for in-home care are North Carolina Medicaid waivers (Community Alternatives Program for Disabled Adults (CAP/DA)), Medicaid Personal Care Services, and Home and Community Care Block Grants. Other funding sources include State-County Special Assistance-In Home, the Family Caregiver Support Program and a smattering of demonstration projects and smaller programs.

B. Assisted Living Facilities and Planned Communities

This category encompasses a wide range of residential facilities that may also provide services. Many are assisted living facilities, which in North Carolina are defined as providing housing, at least one meal per day, and housekeeping and personal care services to two or more adults.³⁶ The two types of assisted living facilities that serve the elderly are adult care homes and multiunit assisted housing with services.

Adult care homes are licensed facilities that provide 24-hour in-house custodial care (including meals, housing and housekeeping), health monitoring, and some assistance with medication administration. Adult care homes are primarily for people who might need unscheduled supervision, assistance or help with personal care, but not ongoing medical treatment for chronic conditions.³⁷

Multiunit assisted housing with services (MAHS) combine independent apartment settings with optional services arranged by the housing management.³⁸ This type of

housing is not licensed; instead, housing managers work with licensed home care agencies to develop a care plan based on individual resident's needs.³⁹ Tenants can use the home care agency selected by the housing management or select their own. This flexibility, and the ability to customize care plans, make MAHS appealing to relatively independent seniors. Nursing services may be available, but tenants cannot be in need of regular 24-hour supervision.

As with conventional apartments, MAHS tenants sign lease agreements and pay monthly rent. Housing providers must register with the North Carolina Division of Health Service Regulation and submit a disclosure statement identifying charges, limitations on service and tenancy, the nature of the relationship between the housing management and the home care agency and other details with the annual rental contract.⁴⁰

A consumer advocate in North Carolina described the fundamental difference between adult care homes and MAHS in this manner: "...in an adult care home, you can't lock your door and be really private. You're getting institutional care and... they're supposedly monitoring you for 24 hours, whereas in a MAHS it's much closer to independent living, and you presumably can schedule your appointments and the rest of the time you're free to be whoever and do whatever you want...."⁴¹

Other unlicensed residential settings are available to older persons who want the security and convenience of a planned community setting. Independent/congregate housing, of which MAHS are a variation, may or may not provide supportive services, meals and amenities. Such housing may be privately owned with market rate rentals only, or it may be subsidized housing for persons who qualify based on income.

Continuing Care Retirement Communities (CCRCs) offer a range of accommodations and services, from purely independent housing to assisted living to 24-hour nursing care.⁴² Care is controlled by contractual agreements and as a result CCRCs are regulated by the North Carolina Department of Insurance. CCRCs are required by law to provide prospective tenants with a disclosure statement that identifies services provided, fees charged, circumstances under which a resident may remain and other specified terms and conditions.⁴³

Some unlicensed residential facilities may accept low-income tenants, but most such facilities are out of the reach of the elderly poor. Entry fees alone can range from \$20,000 (on the low end) to upward of \$400,000.⁴⁴ Assistance in the form of North Carolina State/County Special Assistance is available, however, to eligible poor seniors to pay for room and board in adult care homes. Special Assistance is a state supplement to Supplemental Security Income (SSI), the federal program for aged, blind and disabled persons who have very little income. The state funds half the program; counties fund the other half. The General Assembly sets the adult care home reimbursement rate. SA/ACH does not cover personal care services, but recipients are automatically eligible for Medicaid.

C. Nursing Homes

Nursing homes are facilities licensed by the North Carolina Division of Health Service Regulation that provide nursing or convalescent care for three or more persons. Care can be short-term and rehabilitative in nature, but most residents are older adults who suffer from long term ailments for which medical and nursing care are indicated. Nursing homes that receive Medicaid and Medicare reimbursements must be certified in accordance with federal law.

Medicaid is the main source of public financing for nursing home care. For state fiscal year 2008, Medicaid expenditures for nursing facilities for the aged were \$898,236,766— at over 45 percent, this is by far the largest category of expenditures for the elderly.⁴⁵

Despite this broad array of long-term care options, the reality is that limitations on public assistance mean that many older adults cannot access an adequate level of care. Medicaid, the single largest source of assistance for long-term care services,⁴⁶ imposes categorical, financial and functional criteria, including a stringent assets test, lookback provision and spend-down requirement. Although Medicaid benefits are an entitlement, states can set coverage limits, including caps on hours of personal care assistance or individual spending.⁴⁷

Older adults seeking in-home help face another set of obstacles. Medicaid's outsized presence in the state budget (\$3.6 billion in 2008) regularly draws the attention of lawmakers searching for fat to trim.⁴⁸ Because federal money is conditioned on the provision of mandatory services, so-called "optional services," which are extended by the state, become frequent targets of cutbacks. Optional services (such as vision care, prosthetics, podiatry, prescription drugs or personal care services) "make up the vast majority of all Medicaid spending for long-term care (85 percent)" nationwide⁴⁹ and are disproportionately used by older adults.⁵⁰ The most recent state budget slashed "\$50.7 million for in-home care for Medicaid recipients, meaning 18,000 people would lose benefits."⁵¹ Cutting payments to health care providers—another common cost saving measure—creates a financial disincentive to accept or retain Medicaid patients. This is especially problematic in rural and underserved areas where providers are few and scattered, and transportation may be scarce.

An older adult who receives assistance in one county may not in another. Slots for the CAP/DA program, which funds a large portion of in-home services in North Carolina, are allocated to each county based on a formula. As a result of variations in utilization rates between counties, some "have lengthy waiting lists while others have vacancies."⁵² The home and community care block grant (HCCBG) program, which also pays for in-home care, comes with similar limitations. An April 2010 survey of service providers estimates that approximately 12,600 seniors statewide have unmet needs for home and community services through HCCBG providers.⁵³

Differences among counties in terms of facilities and resources also affect access to services. Assisted living facilities in one place may restrict the number of non-private pay beds. The closest facilities—and many rural counties may only have one or two—may be undesirable or even hazardous to older adults.⁵⁴ Due to failures in communication, misunderstandings or insufficient outreach, individuals eligible for in-home care services may not be aware of existing

programs. County commissioners, who have “maximum discretion” to decide how funds will be spent, may prioritize some services over others.⁵⁵ The fragmentation of the long-term care system, the welter of eligibility criteria, differing definitions of covered services and application hurdles mean that without an experienced guide, many people may simply fall through the cracks.

In addition, program eligibility is meaningless if the program does not cover services that individual older adults need, to the degree and duration that they need them. Funding for housekeeping services, for example, may be irrelevant if not accompanied by the wherewithal to install grab bars in the bathroom or to widen doorways for wheelchair access. A recipient of personal care services in the home may not be able to “make do” on ten hours of care a week if they need twenty. A mismatch between available programs and an individual’s needs accelerates institutionalization and increases costs in the long run.⁵⁶

Calculating unmet need is difficult. Nonetheless, the “general finding is that access to the needed services and resources to meet current demand is falling short, and the gap is only likely to grow larger in the years to come given the constraints of the current economic environment.”⁵⁷ The challenges facing poor older adults in North Carolina are many, according to the Office of Healthy Carolinians and Health Education:

Low-income older adults have access to fewer services than those with financial resources. Poor people in rural counties have few, if any, home and community-based services. Low-wealth counties face particular challenges in meeting service needs. Lack of resources, financial and human, is a major reason for inadequate services. Funding may not be sufficient to develop or sustain services at the needed level. Many funding sources are biased toward the funding of institutional care services.⁵⁸

The model under consideration by this study—that of an adult care home (ACH) operating in public housing—has the potential to fill an important gap in long-term care services. Older public housing residents with unmet care needs are likely to be institutionalized.⁵⁹ This runs contrary to the wishes of an overwhelming majority of older Americans, long-term care policy and, possibly, the state’s fiscal self-interest. This approach would allow public housing tenants who are residents of an ACH to receive a heightened level of care without having to leave their homes. Seniors in public housing are often very low income, making them good candidates for Special Assistance. SA/ACH, which is available to anyone who qualifies, covers room and board and guarantees Medicaid eligibility. In an optimal situation, an ACH in public housing would give tenants the best of all worlds: the comfort of their own home, the critical support services of an ACH and a monthly allowance provided by Special Assistance.

An ACH in public housing offers other significant benefits. Elderly tenants of public housing are more likely than the general older population to be frail and require assisted living services.⁶⁰ They are “overwhelming female; report more disabilities than older persons who do not live in subsidized housing; have very low incomes; and tend to have no one to turn to if they become sick or disabled.”⁶¹ Due to higher acuity levels, older public housing tenants may especially benefit from round-the-clock supervision. As one study observed:

An assisted living program that provides twenty-four-hour staff and nursing oversight is beneficial to tenants for many reasons. [They] may routinely need certain services at odd hours and in small increments, like “as needed” medications, cueing and reminders, and assistance with transfers and walking. They may also need occasional assistance in incontinence management; behavioral interventions (such as training or using other means to interrupt actions that can harm a patient or others); or skin and wound care, which cannot easily be given by care providers who make scheduled visits.⁶²

Studies indicate that care delivered in an ACH can prevent or delay entry into a nursing home.⁶³ Not only is this usually a happier outcome for the tenant, it may be thriftier for the state.⁶⁴ A 2010 cost of care survey found that the median annual rate of an assisted living facility in North Carolina was \$31,950; the median annual rate for nursing homes was more than double that amount at \$65,700.⁶⁵ Furthermore, evidence suggests that the cost of assisted living services in subsidized housing is substantially less than most market-rate assisted living facilities.⁶⁶ Due to the critical mass of older adults living in one place, personal care services such as transportation, on-site meals, scheduled activities and health checks can be provided more efficiently than to individuals dispersed throughout the community.⁶⁷

Housing authorities are uniquely positioned to manage adult care homes. Their staff have regular interactions with tenants and know their backgrounds, habits and impairments. Guided by a social mission, housing authority personnel may feel a moral commitment to ensuring and preserving tenants’ wellbeing. Housing authorities are familiar with HUD regulations and subsidies. Freed from the yoke of the bottom line and shareholder demands for profit, housing authorities can deliver services at cost.⁶⁸ And some lenders and investors may welcome a housing authority’s political and financial stability, ready market for assisted living facilities and extant housing stock, as well as the cost savings associated with conversion (as opposed to new construction).⁶⁹

This model also accomplishes important housing-related goals. The lack of safe, affordable and accessible housing remains a “significant challenge” to older adults who wish to remain in the community.⁷⁰ An ACH in public housing, designed with the physical limitations of aging tenants in mind, expands housing alternatives for older adults in the community. Subsidized housing avoids some of the drawbacks of home and community-based care: housing is both affordable and safe, offering amenities that minimize the risk of injury and allow greater independence. An ACH presents an opportunity for housing authorities to use existing housing stock creatively.⁷¹ Finally, linking services with housing benefits the housing authority by ameliorating the health and safety concerns of all residents, reducing maintenance problems, easing pressure on property managers to respond to emergency calls and laying the groundwork for fewer turnovers and a more stable population.⁷²

Notwithstanding these selling points, the challenges awaiting a public housing authority that wants to implement this model should not be underestimated. Untested in North Carolina, this model represents a risky departure from a housing authority’s traditional activities and realm of expertise. Before moving ahead, a public housing authority must conduct a searching appraisal of its own capacity and infrastructure, tenant concerns and local conditions. While the feasibility of the project is the sum of many factors, some considerations that must be addressed are:⁷³

- Local need and market:*
After identifying the population it aims to serve, a public housing authority must survey tenants and gather input. It must assess tenant familiarity with, demand for, and opinion of, ACHs; gauge tenant expectations and concerns; identify current and future impairments, cognitive functioning ability and other health conditions; and determine familial concerns. The housing authority must take the temperature of the larger community, including that of local providers and agencies. Market studies are useful but frequently fall short of conveying a complete picture; on-the-ground discussions with key stakeholders are far more revealing.⁷⁴ The housing authority must work with local providers to identify gaps in service and to determine the housing authority's role, if any, in filling these gaps.
- Infrastructure and facility design/location:*
The housing authority must evaluate the safety and accessibility of the physical plant, identify necessary changes, navigate between competing demands and do it all within budget. Do units contain features requested by or required for tenants? Will an existing facility suffice? Will it have to be modified, renovated or retrofitted? Does it need new amenities such as commercial kitchens or common areas? Does the building meet codes and zoning laws? Will units be scattered or concentrated?

The neighborhood's location, its proximity to shops, hospitals and other conveniences, and its security and accessibility must be taken into account. Finally, will the recharacterization, modification or construction of an ACH unit disrupt or dislocate current residents? By law, housing authorities cannot evict tenants in public housing in order to redesignate housing as being for the elderly or disabled,⁷⁵ and the ill will created by inconvenience or imposition would not be in the best interest of the project, its future tenants or the housing authority.

- Financial feasibility:*
Unsurprisingly, securing funding is one of the most difficult issues a housing authority faces.⁷⁶ Funding must be found to underwrite the entire process: from the soft costs associated with project development, to expenses associated with construction and ongoing operation and maintenance. Public housing authorities lack the financing options available to private developers and frequently have to rely on multiple funding streams. Managing finances and their accompanying conditions (meeting accounting or reporting requirements, submitting updates to funders, applying for grants) can become a headache. Trying to weave together housing and health care funds—with divergent qualifications, definitions, services and service specifications—presents housing authorities with an “organizational puzzle where the pieces do not match up.”⁷⁷ Other funding concerns are the availability of specific programs at any given time and the ongoing reliability of funding sources.⁷⁸
- Licensing and regulatory concerns:*
The housing authority must consider the impact of regulatory demands on its ACH plans. Regulations can dictate the services offered or conflict with tenant assumptions. The

“rigidity” of many regulatory frameworks is often in tension with the flexibility required to respond to residents’ changing needs.⁷⁹ Complying with all relevant licensing and regulatory guidelines, many of which may be convoluted and unfamiliar, adds new responsibilities and increases the size and complexity of the housing authority’s workload.

- *Services and staff coordination:*

The housing authority must formulate service plans and make operational decisions that will define the ACH. What services should or must be offered? Which services are most essential? Which ones are affordable? Who will provide them? Will they be available on an a la carte or bundled basis? Are meal plans mandatory or voluntary? Each of these decisions has personnel, physical design, financial and legal consequences.

The compatibility of housing and health care providers is fundamental to the success of the project. Professionals from both fields must “adjust to the unique hybrid environment of assisted living in subsidized housing,” a process that entails clearly defining roles and substantial retraining.⁸⁰ Staff must accept and adopt changes in their positions and in the facility’s mission. The housing authority must be adept at navigating two disjointed sets of terms, regulations, performance measurements and implementation guidelines.

- *Suitability of alternate models of care:*

Even if conditions are favorable for an ACH, other initiatives might prove more suitable. By deploying a strategy with more modest dimensions, a public housing authority can avoid many of the complexities of an ACH and still provide vital services to its residents. There is precedent in North Carolina for some of these alternative prototypes⁸¹, as well as examples from across the country.⁸² Starting with a smaller program allows the housing authority to gain experience, to experiment and, over time, to develop a more ambitious package of services. Services and projects can be mixed and matched, adjusted to available funding and undertaken in partnership with other area providers. Among the many possibilities are⁸³:

- *Multiunit assisted housing with services or other types of congregate housing.*

MAHS can provide a level of care approximating that of an ACH. Because MAHS and other independent residential options are not licensed, they do not require prior approval from DHHS nor do they need to obtain a Certificate of Need. MAHS do not have to satisfy a statutorily defined level of need and can appeal to a robust range of tenants in a variety of settings. Since services are provided by a licensed home care agency, the housing authority does not have to take on the additional duties.

Conventional congregate housing is costly; however housing subsidies, Medicaid-funded personal care services, careful service coordination, use of volunteer efforts and other measures can make it affordable to public housing tenants.

- *On-site service coordinator.* Service coordinators have been shown to be effective at providing services without unnecessary duplication, negotiating terms, making referrals, managing cases and guiding public housing tenants through the maze of public supports. HUD’s Congregate Housing Service Provider Program, although closed to new applicants, is hailed as a prototype for what can be accomplished, even

- with a part-time services coordinator.⁸⁴ Frequently, the service coordinator is the starting point for an expansion of services. Few service coordinators can substitute for the full panoply of services offered by an ACH, but they can connect tenants to the services that are most important to each individual.⁸⁵
- *On- or near-site clinics, workshops or screening programs.* These can be staffed by local hospitals, university-based service partnerships, doctors or other health care providers. Program organizers may volunteer their time for educational, charitable, prevention-based or other purposes. Alternatively, the housing authority can negotiate for a reduced rate.
 - *Health and wellness training for housing authority personnel.*
 - *Modifying existing housing.* The housing authority can perform a risk analysis and modify the facility so it is more user-friendly for older tenants, enhancing mobility and safety.
 - *Coordination of volunteer services.* The housing authority can organize the provision of some services, such as meals, through local volunteer, faith-based or community organizations, or social agencies.
 - *Adult day care or adult day health care.* Adult day care and adult day health care provide an organized program during the day in a group setting. Programs can include a variety of activities designed to meet the needs of individual participants and can include referrals to other community resources. Adult day health care offers regular health services to individual participants. Medical examinations are required for both; meals and snacks, if appropriate, are also expected.⁸⁶

Older adults in public housing often do not receive the care they need. By bringing the adult care home to them, a housing authority can effectively and economically provide the services tenants need to stay in their own home. But numerous hurdles confront the housing authority that wants to go into the ACH business. A public housing authority must consider whether the ACH is feasible, given its resources, services already available in the community, tenant preferences, regulatory and licensing strictures and other considerations. Even if the housing authority determines that an ACH is feasible, more targeted programs may be easier to fund, set up and operate.

Issue #2:

Whether this model is allowable under current State and federal laws and rules and if not what changes are needed.

Federal Law

No federal law explicitly prohibits the establishment of an adult care home in public housing. Although numerous indicators point to HUD's tacit approval, no law explicitly condones this model either.

Federal housing policy has tentatively endorsed the hybrid affordable-housing-with-services paradigm as a promising way to serve older tenants, and the ability of housing authorities to engage in the provision of services is referred in a number of federal housing laws. Public

housing authorities are permitted to finance tenant programs and services that “are directly related to meeting tenant needs and providing a wholesome living environment.”⁸⁷ HUD makes assistance available to housing authorities for “activities related to the provision of services, including service coordinators for elderly persons or persons with disabilities.”⁸⁸ The Quality Housing and Work Responsibility Act of 1998 specifies that housing authorities can form and operate wholly owned or controlled subsidiaries or enter into joint ventures “for the purpose of providing or arranging for the provision of supportive or social services.”⁸⁹ It also instructs the HUD Secretary to establish an operating fund “for the purpose of making assistance available to public housing agencies,” for, among other things, “activities related to the provision of services, including service coordinators for elderly persons or persons with disabilities.”⁹⁰

HUD has sponsored numerous programs—the Congregate Housing Service Provider, Assisted Living Conversion Program, Section 202 Supportive Housing for the Elderly, Multifamily Housing Service Coordinators program, HOPE for Elderly Independence Demonstration, Resident Opportunities and Self Sufficiency Resident Service Delivery Models Program, for example—to incentivize the provision of services for the elderly in subsidized housing.

While some of these programs have been available to non-profit and private developers only, some, like the HOPE for Elderly Independence Program, provide grantee housing authorities with funding for supportive services. The Service Coordinators for Public Housing Agencies program provided funding for up to 15 percent of eligible services, which included health-related services, mental health services, services for non-medical counseling, meals, transportation, personal care, bathing, toileting, housekeeping, chore assistance, safety, group and socialization activities, assistance with medications and case management.⁹¹ Likewise, the Resident Opportunities and Self Sufficiency Grant Program enables public housing authorities to “provide and coordinate supportive services that lead elderly and/or disabled public housing residents to independent living.”⁹²

Public housing authorities in other states have relied on support and funding assistance from HUD to build, own and run assisted living facilities in public housing.⁹³ While HUD’s predominant interest remains “brick and mortar” housing, even its website—which depicts housing authorities as providers of services, including “support programs for the elderly”⁹⁴—reflects the agency’s “new focus of providing supportive services to enable frail older residents to ‘age in place’ longer.”⁹⁵ Nevertheless, HUD has not adopted the model of an ACH in public housing in policy, funding choices or administrative rulemaking.

North Carolina State Law

In the same vein, state law does not squarely address the legality of this particular model. Residential facilities that offer supportive long-term care are regulated at the state level and each state has its own term for, and definition of, these facilities. North Carolina’s iteration of this model is the “assisted living residence,” defined as “any group housing and services program for two or more unrelated adults ... that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies.”⁹⁶ Assisted living residences may be self-contained apartment units or single/shared rooms. They are distinct from

nursing homes, which provide long-term care of chronic conditions or short-term convalescent or rehabilitative care of remedial ailments, for which medical and nursing care are indicated.

Adult care homes (ACHs) are one of two types of assisted living residences, as defined in North Carolina. According to North Carolina statute, ACHs are residences where “the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice agencies.”⁹⁷ People in ACHs typically need some help with personal care, keeping up with medications and limited supervision, but not regular medical care.⁹⁸ ACHs can serve the general population or the “elderly” only.⁹⁹

Licensing and inspection of ACHs is generally overseen by the North Carolina Department of Health and Human Services (DHHS). Licenses must be renewed annually and DHHS has the authority to issue a provisional license, revoke a license or deny a license renewal.¹⁰⁰ DHHS works with county departments of social services to conduct routine monitoring under the oversight of the Division of Health Service Regulation. Facilities can be inspected at any time and are required to be inspected every two years by the Division.¹⁰¹ North Carolina law prescribes resident/staff ratios and training requirements for ACH personnel.¹⁰²

If this model is permissible (and on the face of the law, it is), a public housing authority must, of course, comply with these legal standards, as well as building and zoning codes. These overlapping regulations extend to every corner of the building: flooring, lighting, stairs, sounding devices and other safety features, electrical systems and other physical plant requirements.¹⁰³

Before any construction can start however, the housing authority must first obtain a Certificate of Need (CON).¹⁰⁴ Implemented in North Carolina to control health care costs and to prevent maldistribution and duplication of facilities and services, the CON prohibits the construction, modification, acquisition, relocation, conversion or addition of new institutional health services without prior review and approval of a CON application by DHHS.¹⁰⁵ The CON applies to “health services” and “health service facilities” (including adult care homes) as defined statutorily.¹⁰⁶

North Carolina law stipulates that an application for a CON must demonstrate that a need exists for the proposed services among the identified target population, that the project does not duplicate existing services or facilities and that the applicant has the resources to provide the services in the proposal.¹⁰⁷ An applicant must also show that the proposed project is the least costly or most effective alternative, that they have sufficient funds for capital and operating needs and that the project is financial feasible. The statute requires that the CON application pay particular attention to the impact of the proposal on traditionally underserved groups (low income persons, racial and ethnic minorities, women, handicapped persons) and the elderly.

Every year, the Medical Facilities Planning Section of the Division of Health Service Regulation publishes the State Medical Facilities Plan, allocating the maximum number of health service facility beds, by category, and establishing the application review schedule. The methodology used to measure need is simple: calculate the projected number of residents by county and age group and then multiply that number by a predetermined use rate. According to the 2010 plan,

with the exception of eight identified counties, “there is no need for additional Adult Care Home beds anywhere else in the State.”¹⁰⁸

This measure does not take into account many of the more nuanced factors enumerated in the application review criteria. As a result, the need determination may be overbroad, failing to distinguish between different kinds of adult care homes, populations or types of developers/operators.¹⁰⁹ Nor does this formula take the condition of existing facilities into account. As an expert on aging observed, “There could be a county [in North Carolina] that has only two very old facilities in which no one wants to live. If someone wanted to build a better adult care home in that county, as long as the existing facilities had vacancies, the permit would be denied.”¹¹⁰

Notwithstanding apparent shortcomings in its determination of need methodology, the CON is simply one of manifold regulatory requirements that a housing authority, like any other developer, must comply with in order to construct and operate an adult care home.

Issue #3:

How State-County Special Assistance and federal public housing subsidies would work together and whether this could result in a reduced State-County Special Assistance rate for these types of entities and possible savings for the State.

Sadly, the disjuncture between long-term care assistance and housing is vividly demonstrated by the relationship, or lack thereof, between State-County Special Assistance and federal public housing subsidies. The two exist in discrete spheres, and while they could potentially work together, no mechanism currently exists that would allow them to do so.

State-County Special Assistance (SA) is an optional state supplement to Supplemental Security Income (SSI), the federal program for very low-income adults. Because North Carolina adopted and incorporated by reference Title XVI of the Social Security Act, income eligibility requirements for SA are the same as those that govern SSI.¹¹¹ Title XVI stipulates that “assistance paid, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937..., the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949..., or section 202(h) of the Housing Act of 1959 shall be *excluded* [italics added] as income.”¹¹² Therefore, federal public housing subsidies are not considered income according to SA regulations.

Consequently, the SA rate remains the same whether the recipient is in a private adult care home or one operated by a public housing agency. As SA income guidelines are constituted now, no reduction in rate would occur as a result of the implementation of an adult care home in public housing, and the cost savings to the state would be nil for this particular program. The long-term care literature suggests that the state may realize savings overall due to decreased nursing home use,¹¹³ but the foreseeability and magnitude of these savings is beyond the scope of this study.

Furthermore, it should be noted that this question has not been conclusively answered by state administrative agencies; therefore, this analysis should not be considered a settled matter.

Conclusion

Compared to many other states, North Carolina's elderly poor enjoy significant long-term care supports that postpone or obviate the need to enter a nursing home. Nevertheless, gaps in programs and services exist and the state will be hard-pressed to prevent them from growing. "More people," warns a recent issue of the North Carolina Journal of Medicine, "will require either community-based or institutionalized care, both [*sic*] which have the potential to place significant financial and emotional burdens on family members as well as put pressure on government budgets."¹¹⁴

Creative solutions are required to address this looming demand. Integrating assisted living services into subsidized housing projects offers one approach that has been tested nationally.¹¹⁵ However, the form taken by assisted living services varies tremendously: programmatically, structurally, organizationally, financially. Any public housing authority contemplating moving into the assisted living sphere must first consider which, if any, of these many permutations best matches its needs, given capacity constraints, resident needs, community resources, potential partners, funding sources and other variables and restrictions. The lack of coordinated policymaking between the housing and health care silos only complicates an already arduous process, and requirements like North Carolina's Certificate of Need may prevent it altogether.

As Congress was warned ten years ago, "a large and growing number of seniors will face triple jeopardy: inadequate income, declining health and mobility, and growing isolation."¹¹⁶ This "quiet crisis," as it was then called, is on our doorstep. Given the state's straitened budget, it is especially critical that it respond in an informed and effective manner. To do that, we must know more about existing levels of need in order to accurately assess current programs and develop effective and fiscally sound alternatives. The state must leverage current resources and break down the barriers that inhibit collaboration between groups. Efforts to coordinate housing on the one hand, and health and aging on the other, are already underway in North Carolina and should be encouraged. And we ought to heed the valuable lessons offered by new initiatives taking place here and throughout the country.

The challenges posed by an aging population are too great, and the time too short, to rely on any one solution. If one path is closed, other options must be pursued with energy, vision, imagination and leadership. Our elderly family, friends, neighbors, community members and fellow North Carolinians deserve no less.

Acknowledgments and Notes

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Notes

¹ This study was primarily written by Heather Hunt, assistant director of the UNC Center on Poverty, Work and Opportunity, with the assistance of Gene Nichol and Wendy Spitzer.

² Grayson K. Vincent and Victoria A. Velkoff, *The Next Four Decades, The Older Population in the United States: 2010 to 2050*, U.S. Census, Current Population Reports, P25-1138 (Washington, DC: GPO, 2010), 4. "Baby boomers" are the generational cohort born between 1946 and 1964.

³ "Older," "elderly" and "senior" in this report all refer to adults 65 years old and over, unless otherwise stated.

⁴ Vincent and Velkoff, *The Next Four Decades*, 3.

⁵ Vincent and Velkoff, *The Next Four Decades*, 1.

⁶ Vincent and Velkoff, *The Next Four Decades*, 3.

⁷ Vincent and Velkoff, *The Next Four Decades*, 4.

⁸ Vincent and Velkoff, *The Next Four Decades*, 3.

⁹ Vincent and Velkoff, *The Next Four Decades*, 4-5.

¹⁰ Vincent and Velkoff, *The Next Four Decades*, 8.

¹¹ Gordon H. DeFries and Polly Godwin Welsh, "Long-Term Care Challenges Ahead for North Carolina: 2010 and Beyond," *NC Medical Journal* 71, no. 2 (March/April 2010): 133.

¹² Milbank Memorial Fund and the Council of Large Public Housing Authorities, *Public Housing and Supportive Services for the Frail Elderly: A Guide for Housing Authorities and Their Collaborators*, Milbank Memorial Fund (2006), 3, <http://www.milbank.org/reports/0609publichousing/0609publichousing.pdf> (accessed July 18, 2010).

¹³ North Carolina Division of Aging and Adult Services, "Aging North Carolina: The 2009 Profile," (2009), 1, <http://www.dhhs.state.nc.us/aging/cprofile/2009Profile.pdf> (accessed July 20, 2010).

¹⁴ *Ibid.*, 4.

¹⁵ North Carolina Study Commission on Aging, "Report to the Governor and the 2006 Regular Session of the 2005 General Assembly,"

[http://www.ncga.state.nc.us/documentsites/legislativepublications/Study%20Reports%20to%20the%202006%20NC GA/Aging%20-%20Study%20Commission.pdf](http://www.ncga.state.nc.us/documentsites/legislativepublications/Study%20Reports%20to%20the%202006%20NC%20GA/Aging%20-%20Study%20Commission.pdf), 6 (accessed July 18, 2010); North Carolina Division of Aging and Adult Services, *Aging North Carolina: The 2009 Profile*, 5.

¹⁶ Current North Carolina population statistics from U.S. Census Bureau, "2006-2008 American Community Survey, 3-Year Estimates," Table S0201. State population projections are available from the North Carolina Office of State Budget and Management, "North Carolina Population by Age, 2020 to 2030," http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/statesingle_age_2020_2030.html, (accessed July 20, 2010).

¹⁷ North Carolina Division of Aging and Adult Services, *Aging North Carolina: The 2009 Profile*, 3. These counties are Cherokee, Clay, Transylvania, Macon, Haywood, Henderson, Polk, Yancey, Avery, Ashe, Alleghany, Moore, Brunswick, Carteret, Pamlico, Hyde, Dare, Tyrrell, Currituck and Perquimans.

¹⁸ U.S. Census Bureau, "2008 American Community Survey 1-Year Survey," Table C18101.

¹⁹ DeFries and Godwin Welsh, "Long-Term Care Challenges Ahead for North Carolina: 2010 and Beyond," 133.

²⁰ North Carolina Institute of Medicine Task Force on Long-Term Care, *Executive Summary, A Long-Term Care Plan for North Carolina: Final Report* (Durham, 2001): 1, <http://www.nciom.org/docs/ltxecex.pdf> (accessed July 21, 2010).

²¹ U.S. Census Bureau, "2006-2008 American Community Survey, 3-Year Estimates," Table S0201.

²² U.S. Census Bureau, "2006-2008 American Community Survey, 3-Year Estimates," Table C17024.

²³ U.S. Census Bureau, "2006-2008 American Community Survey, 3-Year Estimates," Table C17001.

- ²⁴ For a discussion of the poverty measure and older adults, see Ke Bin Wu, *Income, Poverty, and Health Insurance Coverage of Older Americans, 2008*, AARP Public Policy Institute Fact Sheet 196 (Washington, DC: AARP Public Policy Institute, 2010): 6-7. Recognizing the shortcomings of the official measure, the Census Bureau produces alternative measures of poverty. Looking at the measure that most closely resembles the one endorsed by the National Academy of Sciences (which includes personal health care expenses), the national poverty rate for older Americans in 2008 was 18.7 percent. See U.S. Census Bureau, “Alternative Poverty Estimates Based on National Academy of Sciences Recommendations, by Selected Demographic Characteristics and by Region (CE),” <http://www.census.gov/hhes/www/povmeas/tables.html> (accessed July 18, 2010).
- ²⁵ North Carolina Behavioral Risk Factor Surveillance System, “2009 BRFSS Survey Results: North Carolina: Disability,” North Carolina State Center for Health Statistics, <http://www.epi.state.nc.us/SCHS/brfss/2009/nc/all/disabled.html> (accessed July 18, 2010).
- ²⁶ U.S. Census Bureau, “2006-2008 American Community Survey, 3-Year Estimates,” Tables C25072 and C25093.
- ²⁷ U.S. Department of Housing and Urban Development, “A Picture of Subsidized Households,” http://www.huduser.org/portal/picture2008/form_1S4.odb (accessed July 22, 2010).
- ²⁸ Keith Wardrip, *Strategies to Meet the Housing Needs of Older Adults*, AARP Public Policy Institute Insight on the Issues 38 (Washington, DC: AARP Public Policy Institute, 2010): 8.
- ²⁹ Dennis W. Streets and Ann C. Eller, “Long-Term Services and Supports in North Carolina,” *NC Medical Journal* 71, no. 2 (March/April 2010): 140.
- ³⁰ North Carolina Division of Aging and Adult Services, “Expenditures by County, Agency and Service,” “State Totals by Agency” and “Table III-B Report” for SFY 2004 to 2009,” <http://www.dhhs.state.nc.us/aging/expenddata.htm> (accessed July 22, 2010).
- ³¹ DeFrieze and Godwin Welsh, “Long-Term Care Challenges Ahead for North Carolina: 2010 and Beyond,” 133. See also Judith Feder and Harriet L. Komisar, *The Role of Long-Term Care in Health Reform*, testimony before the Subcommittee on Health Care, Committee on Finance, March 25, 2009, 111th Cong., 2nd sess., <http://finance.senate.gov/imo/media/doc/032509jftest.pdf> (accessed July 22, 2010). Family caregivers in North Carolina are estimated to provide over 900 million hours of care at an economic value of \$8.9 billion annually. North Carolina Division of Aging and Adult Services, *North Carolina Aging Services Plan, 2007-2011: Putting the Pieces Together* (Raleigh, NC, 2007), 67.
- ³² North Carolina Institute of Medicine Task Force on Long-Term Care, *Executive Summary, A Long-Term Care Plan for North Carolina*, 4.
- ³³ Mary Anne P. Salmon and Gary M. Nelson, “The Need for Paid Long-Term Care in North Carolina: 2010 to 2020 and Beyond,” *NC Medical Journal*, 71, no. 2 (March/April 2010): 144.
- ³⁴ AARP Knowledge Management, *Long-Term Care in North Carolina*, State Long-Term Care Brief (Washington, DC: AARP, 2009), 1.
- ³⁵ In state fiscal year 2008, Community Alternatives Program for Disabled Adults (CAP/DA) services cost \$268 million; Medicaid Personal Care Services (PCS) and Personal Care Services–Plus cost \$319 million. North Carolina Division of Medical Assistance, *Medicaid in North Carolina Annual Report, State Fiscal Year 2008* (Raleigh, NC, 2009), 27 (PCS) and 29 (CAP/DA).
- ³⁶ North Carolina Gen. Statutes § 131D-2.1(5).
- ³⁷ North Carolina Gen. Statutes § 131D-2.1(3).
- ³⁸ North Carolina Gen. Statutes § 131D-2.1(10). See also Karl Polzer, *Assisted Living State Regulatory Review 2010* (Washington, DC: National Center for Assisted Living, 2010), 139-140.
- ³⁹ North Carolina Gen. Statutes § 131D-2.1(10).
- ⁴⁰ See North Carolina Gen. Statutes § 131D-2.1(10) for all requirements.
- ⁴¹ Bernadette Wright, *Assisted Living in Unlicensed Housing: The Regulatory Experience of Four States* (Washington, DC: AARP Public Policy Institute, 2007), 28.
- ⁴² See North Carolina Division of Aging and Adult Services, “Continuing Care Retirement Communities,” <http://www.ncdhhs.gov/aging/faq.htm#q500> (accessed July 15, 2010) and North Carolina Department of Insurance, *Continuing Care Retirement Communities: 2008 Reference Guide* (Raleigh, NC Department of Insurance), I-V.
- ⁴³ See North Carolina General Statute §§ 58-64-20(3) through (15).
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- ⁴⁵ North Carolina Division of Medical Assistance, *Medicaid in North Carolina Annual Report, State Fiscal Year 2008*, 76, Table 11.
- ⁴⁶ Ellen O’Brien, *Long-Term Care: Understanding Medicaid’s Role for the Elderly and Disabled*, Kaiser Commission on Medicaid and the Uninsured (Washington, DC: Henry J. Kaiser Family Foundation, 2005), i.

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⁵⁷ Salmon and Nelson, “The Need for Paid Long-Term Care in North Carolina: 2010 to 2020 and Beyond,” 146.

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⁵⁹ “With resources already inadequate and with the proportion of the North Carolina older population growing, increasing numbers of seniors who are on fixed incomes will find it more difficult to live in safe, accessible, and affordable housing in the community, and some may be forced into unnecessary or premature placement in a facility.” North Carolina Division of Aging and Adult Services, *North Carolina Aging Services Plan, 2007-2011: Putting the Pieces Together*, 34. “Waiting lists for home and community-based services prevent financially eligible individuals from receiving services, leading to inappropriate institutionalization and unmet needs.” O’Brien, *Long-Term Care: Understanding Medicaid’s Role for the Elderly and Disabled*, 21.

⁶⁰ Robert Wilden and Donald L. Redfoot, *Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons with Low Incomes* (Washington, DC: AARP Public Policy Institute, 2002), 27. See also Alisha Sanders, Mary F. Harahan and Robyn Stone, “Affordable Senior Housing: The Case for Developing Effective Linkages with Health-Related and Supportive Services” (prepared for the National Summit on Affordable Senior Housing with Services, Washington, DC, May 25, 2010), 2.

⁶¹ Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, iii and 10. See also Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, *A Quiet Crisis in America*, (Washington, DC, 2002), 27.

⁶² Milbank Memorial Fund and the Council of Large Public Housing Authorities, *Public Housing and Supportive Services for the Frail Elderly*, 16.

⁶³ Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, 1. See also Stephanie J. Fonda, Elizabeth C. Clipp and George L. Maddox, “Patterns in Functioning Among Residents of an Affordable Assisted Living Housing Facility,” *The Gerontologist*, 42, no. 2 (April 2002): 178-187 (finding that the functional abilities of low income residents of an affordable assisted living facility in North Carolina remained more stable—thus delaying deterioration and institutionalization—than their community-based counterparts).

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⁶⁷ Stephen Golant, “Affordable Clustered Housing-Care: A Category of Long-Term Care Options for the Elderly Poor,” *Journal of Housing for the Elderly*, 22, nos. 1&2 (2008): 35-36.

⁶⁸ Gardiner, “Elderly Public Housing & Assisted Living: A Timely Collaboration for Aging Seniors,” 6.

⁶⁹ Milbank Memorial Fund and the Council of Large Public Housing Authorities, *Public Housing and Supportive Services for the Frail Elderly*, 18.

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⁷³ For a more detailed discussion of project considerations, see Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, 23-31; Milbank Memorial Fund and the Council of Large Public Housing Authorities, *Public Housing and Supportive Services for the Frail Elderly*, 22-24; Robert Wood Johnson Foundation, *Coming Home®: Affordable Assisted Living* (Princeton, N.J., Nov. 2009), 32-34, <http://www.rwjf.org/reports/npreports/cominghomee.htm> (accessed July 15, 2010); Golant, “Affordable Clustered Housing-Care: A Category of Long-Term Care Options for the Elderly Poor,” 37-38.

⁷⁴ Lawler, *Aging in Place*, 25.

⁷⁵ 42 U.S. Code Service § 1437e(b).

⁷⁶ Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, iii.

⁷⁷ Golant, “Affordable Clustered Housing-Care,” 38.

⁷⁸ Mary Harahan, Alisha Sanders and Robyn I. Stone, *Lessons from the Workshops on Affordable Housing Plus Services Strategies for Low- and Modest-Income Seniors* (prepared for the U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation and U.S. Department of Housing and Urban Development, Office of Policy Development and Research, August 2006), 9. Workshop participants noted that one concern “is the lack of predictability of Medicaid funding levels from year to year, making it difficult for housing providers and their residents to know who will be eligible for services and what will be covered.” *Ibid.*

⁷⁹ Harahan, Sanders and Stone, *Lessons from the Workshops on Affordable Housing Plus Services Strategies for Low- and Modest-Income Seniors*, 11.

⁸⁰ Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, 28.

⁸¹ Preiss-Steele Place, an assisted independent living residence for low and moderate income seniors in Durham, was developed by Development Ventures, Inc., a nonprofit housing development corporation created by the Durham Housing Authority. It provides a la carte services provided by a variety of community agencies. Astor Dowdy Apartments, subsidized multi-unit assisted housing with services in High Point, is owned by the Housing Authority of the City of High Point. It offers voluntary meals and a HUD-funded Congregate Housing Services Program. Koinonia Apartments in Lenoir is HUD-funded Section 202 housing with onsite services (meals, housekeeping, health care and activities) that are provided at little or no cost to residents.

⁸² For examples of different types of hybrid assisted living/public housing models in other states, see Milbank Memorial Fund, *Public Housing and Supportive Services for the Frail Elderly*, 8-11; Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, 33-63; and Cedar River Group, “Appendix: Models of Supportive Housing for Low-Income Seniors” in *Quiet Crisis: Age Wave Maxes Out Affordable Housing, King County 2008-*

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⁸⁴ Sanders, Harahan and Stone, *Research on Affordable Senior Housing with Services Strategies*, 1.

⁸⁵ Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, 12.

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⁸⁷ U.S. Housing Act of 1937, 42 U.S. Code Service § 1437a(c)(2).

⁸⁸ U.S. Housing Act of 1937, 42 U.S. Code Service § 1437g(e)(1)(D).

⁸⁹ 105 Public Law 276, 515.

⁹⁰ 105 Public Law 276, 519.

⁹¹ 60 Federal Register 10764, 10765.

⁹² 68 Federal Register 21002, 21519.

⁹³ Examples include Helen Sawyer Plaza, in Miami, Florida, which is operated by the Miami Dade Housing Authority; Magnolia Gardens in Pinellas Park, Florida, owned by the Pinellas County Housing Authority and managed by a private company; the Minneapolis Public Housing Authority and the St. Paul Housing Authority, which both operate assisted living programs throughout specific high-rises; and Sunrise Towers, operated by the Laconia (New Hampshire) Housing Authority.

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⁹⁶ North Carolina Gen. Statutes § 131D-2.1.

⁹⁷ North Carolina Gen. Statutes § 131D-2.1(3).

⁹⁸ North Carolina Division of Aging and Adult Services website, “Adult Care Homes,”

<http://www.dhhs.state.nc.us/aging/agh.htm> (accessed August 4, 2009).

⁹⁹ North Carolina Gen. Statutes § 131D-2.1(5)a and b. The statute defines “elderly person” as anyone over the age of 55 who requires assistance with activities of daily living or who has dementia.

¹⁰⁰ North Carolina Gen. Statutes § 131D-2.4 and 2.7.

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¹⁰³ Bernadette Wright, *Assisted Living in Unlicensed Housing*, page 27; Polzer, *Assisted Living State Regulatory Review 2010*, 142-143.

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¹⁰⁸ North Carolina Division of Health Service Regulation, *North Carolina 2010 State Medical Facilities Plan* (Raleigh, NC, Jan. 1, 2010), Table 11C: Adult Care Home Bed Need Determinations (Proposed for Certificate of Need Review Commencing in 2010).

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¹¹⁵ Wilden and Redfoot, *Adding Assisted Living Services to Subsidized Housing*, v.

¹¹⁶ Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, *A Quiet Crisis in America*, 4.

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