Accommodative Residences
for Older Adults and Persons with Disabilities

Updated
Executive Summary
May 23, 2022

This Multi-Disciplinary Collaborative Non-proprietary Proposal promotes sustainable and replicable small privately owned community condominium residences that provide non-care supportive services to persons with disabilities regardless of type or age of onset. The innovative model utilizes personal resources to provide for the suite purchase and monthly expenses. Spouses, child, or caregivers can reside together through end of life in a person-centered environment maximizing freedom, comfort, and independence. The model further utilizes existing programs to provide coordinated caregiving and access to community-based care services. The model is socio-economically beneficial as the residences would provide better access to housing and services in the communities in which a person resides, including underserved areas.

ASSUMPTIONS:
There is a critical need for community based accommodative housing that facilitates appropriate service delivery for persons with acute and chronic needs.

The pandemic created and demonstrated challenges in large scale congregate care.

There is a demonstrated shift in policy and demand to transition from custodial care toward community-based services.

Demographics demonstrate an increasing need for non-government supported housing ownership and personal maintenance.

Medicaid needs to reduce costs and obtain better value for funds spent.

There should be a better a quality of life as people address the challenges of disability and dying.

Caveat: While the Proposal addresses a broad expanse of low and middle income populations needing supports and services benefits, the concept simply provides opportunities for developmental disabilities, mental health, or other types of supported housing.

PROPOSAL: Small privately constructed or renovated condominium suites that provide a Medicaid home ownership exemption for individuals otherwise eligible for congregate care. The residences would provide non-care services including a cook, common services, security, housekeeping and exterior area maintenance. The residents can live with spouses, child, or care giver through end of life without ever having to transfer. The community residence would provide maximum independence regardless of physical or mental health limitations including

dementia. Residents would receive appropriate care consistent with existing benefit and insurance programs with likely better value-based outcomes from hospitalizations.

The condo residence allows shared equity, expenses, governance, and long-term operation. As the residence could be in any small town or urban neighborhood, access, and contributions from family and friends can be maximized. Additionally, existing community-based service programs can be expanded or modified for integration of care, activities of daily living and normative activities.

Medicaid savings would occur though small economies of scale in service delivery, blended care and non-care services, ability to handle multiple "overnight" care residents, better medical outcomes after hospitalizations, and expanded access to community-based service programs currently existing. Additionally, there is better value for dollars spent comparing home services cost/care hours to residential nursing home costs/care hours.

A better quality of life is achieved through maintaining personal relationships with family, friends and community. The trauma of transition resulting from currently required transfers from home to congregate care is reduced and persons confronting cognitive deficits can remain in a home they own that accommodates the often-increasing challenges. Residences will also allow a spouse, child or caregiver to have an environment supportive of them as well, whether disabled or non-disabled.

The Proposal can also be utilized in supported housing programs, transitional housing, or an avenue for persons on public benefits to invest in home ownership as an exempt asset and build equity facilitating an exit off public supports.

COMPOSITION: The condo residences, either stand alone or clustered, would consist of suites directly opening to common interior areas with secure exterior areas accessible from the suites or interior common area. Suites would be of universal design with private bedroom, accommodative bath, sitting area, and hazard-free kitchenette. The suites could have 2 bedrooms such that a parent, child, or caregiver could co-reside. Exterior spaces would be of memory care design and include porches and patios, grass and gardens, playgrounds and walkways.

The Proposal is based upon the Green House Project concept as a demonstration of the design with achievable small economy of scale and service delivery. However, as the Proposal is based upon private ownership and responsibility for monthly expenses, government or large-scale funding is unnecessary and a stand-alone individual residential unit would be economically viable in any urban or rural environment. The residences could be clustered with enclosed courtyards or co-located with other types of housing for integrated and socially diverse communities.

OWNERSHIP: Affordable and permanent condominium residence ownership would be in a purpose built or renovated structure compliant with disability and memory care guidelines. Residents retain all exclusive ownership rights and responsibilities typical of primary home ownership for their individual condo suite. At any time, the resident can sell their interest as is

typical of any condominium interest, though one of the purchasers would need to be otherwise eligible for congregate care. Notwithstanding, while the equity may be accessed for any purpose, sufficient balances must be preserved to provide an uninterrupted income stream (ex. SSI, SSDI, pension, 401(k) etc.) to provide for long-term financial maintenance.

The ownership interest preserves resources and liquidity consistent with policy and purpose of Home and Community Based Services (HCBS) programs including Community Medicaid, Program of All-inclusive Care for the Elderly (PACE) as well as Mental Health and Developmental Disability. Unfortunately, many people live in homes that cannot structurally accommodate their disabilities; have service needs that cannot be appropriately provided; or they simply desire greater socialization. The residences could be simple or complex, and the purchase funds preserved can be used for non-Medicaid services and a source of funds for monthly expenses. People who are house rich and cash poor will be able to preserve their resources and provide for their future needs. Conversely, people with strong income but no residence can invest in an exempt asset and utilize monthly income for their expenses.

Residents would be responsible for their monthly expenses the same as if they were living in a private residence**.** Monthly expenses will vary the same as a retirement community, condo/coop or homeowners' association. Either the condo plan or resident governance could determine the extent of amenities or services that would be shared.

SERVICE DELIVERY: There are many existing community-based programs that provide nursing home avoidance services for chronic and acute disabilities including Community Medicaid, HCBS, PACE, Mental Health, Developmental Disability, Traumatic Brain Injury and long-term care. The common purpose and goals are to promote the best quality of life, self-facilitation, and least restrictive living environments toward maintaining and maximizing personal and financial independence.

Service delivery occurs through a combination and coordination of licensed caregivers, family, and community support. Most individuals have Managed Long Term Care Plans (MLTCP) which develop the care plans and largely subcontract for the delivery of services by licensed caregivers. A significant challenge is 24-hour care, particularly "overnights", though minimal care is necessary during those times. Additionally, significant "care" needs are assistance, prompting, companion care and supervision for which training, but not licensing, is necessary. Often, these are the contributions sought from family and community which require significant coordination and are met with vacillating results. Isolation and transfer trauma typically compound negative behaviors.

There are voids in service delivery. For persons living home, long term care services under MLTCPs **do not** cover supervision, companion care or prompting that is the basic need of most persons with dementia or overnight needs. Conversely, nursing home minimum staffing requirements are 3.5 hours of care per 24-hour day which cannot realistically provide appropriate dementia care and assistance. There is a dearth of mental health assistance or peer support currently in almost all programs for older adults, yet persons with dementia know full well the diagnosis and prognosis.

This Proposal promotes the ability to maximize family and community contributions and increases access to non-licensed assistance. During this caregiver crisis, available assistance expands to provide support in an environment that helps alleviate those burdens now imposed upon licensed caregivers.

The Proposal also anticipates better medical outcomes following hospitalizations as discharge would occur to an appropriate environment that facilitates necessary follow-up care and proper nutrition. There is a greater likelihood of reduced readmissions or extended rehabilitation as well as a reduction in negative behaviors for persons with dementia.

COMMUNITY SUPPORTS and SERVICES: Currently there are broad community supports and services for persons with disabilities across a wide spectrum, though far less for older adults with the same or similar types of disability. These include mental health services, peer counseling services, faith-based services, visitation and socialization that provide greater access both to and by residents. Community Based Services

Medicaid Advantage Plans (MAP), MLTCPs and the proposed expansion of PACE provide coordination of managed care, medical needs and service delivery in alternative settings and the opportunity to coordinate services, avoiding personal isolation, and protecting Medicaid from assuming the financial burdens of custodial care. Consumer Directed Personal Assistance Programs (CDPAP) also provide an opportunity for the sharing of resources for the most effective and personalized assistance.

There are many existing community-based nursing home avoidance programs for Developmental Disability, Mental Health, TBI as well as supported housing or transitional housing. These networks can be utilized for an expansion of care, oversight, supports or services for older adults as well.

LICENSING and INSPECTIONS: Existing nursing home regulations concerning design, construction, operational sustainability, and operator qualification should apply. These regulations ensure that residences will provide the environment and non-care services for appropriate delivery of managed care services consistent with program requirements.

The residence would be providing non-care supports and services little different than those provided in many retirement communities or existing condo/coop residential buildings which provide common food service, security, and interior/exterior area maintenance. Inspections and licensing should be consistent with the services offered and regulation as they would in any similar non-caregiving service industry.

All direct care services requiring licensing would be provided through existing MLTCP, HCBS and the emerging Program of All-inclusive Care for the Elderly (PACE). Consequently, existing regulations encompass care plan development, management, service delivery, and oversight. The expansion of community-based services provides opportunities for oversight such as inclusion in an Ombuds or local programs such as administered by Department of Social Services or the Office of the Aging.

The best defense against abuse and neglect is the involvement of family and community. The obligations of custodial care require regulation due to the imposition of housing and support responsibility upon a third-party entity. The Proposal eliminates such obligations as well as the Medicaid burdens, instead promoting financial and personal independence since the person utilizes their personal resources for their best purpose.

The expansion of community-based services can also provide mental health and peer services; oversight or Ombuds program; and expanded socialization opportunities.

BROAD APPLICATION: While most beneficial in providing an immediately implementable alternative for older adults, the residences can be utilized for transitional supportive residences, rental units or allow people with disabilities being able to share resources and services specific to their needs or desired supportive amenities. Additionally, parents of adult children with disabilities will be able to live with or provide for their future, comfortable their long-term needs will be met without becoming institutionalized.

CONCLUSION: The proposal provides an opportunity for individuals with disabilities regardless of age, whether living in rural or urban settings, to enjoy an appropriate living environment with improved quality of life while having their support and care needs met. Most importantly they will preserve assets and continue to reside in the community with their spouse and never have to move.

A goal was to provide a free market alternative to custodial care that could be built and operated on a local level independent of the need for government or large-scale investment. These residences can exist in any small community and take advantage of local resources regardless of whether a person needs governmental benefits.

Lastly, Medicaid will save resources through custodial care avoidance and better value for dollars spent. Substantial sums are spent for congregate care for 3.5 hours of a care a day while persons are exposed to transfer to nursing homes if they require more than 12 hours of home care. Smaller residences facilitate economies of scale that allow “overnight” care and increasing the likelihood of family and community contribution.

This Proposal was developed for the purpose of creating affordable, accommodative, and appropriate living environments while preserving assets and avoiding public dependency. As an ongoing collaboration, it is not intended to take “positions” but promote discussion to accomplish systemic change in addressing the housing and service needs of persons with disabilities.

Respectfully submitted,

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Lead Collaborator

A Note About the Proposal Development and Collaboration

This proposal is a multi-disciplinary collaboration among legal, elder, disability, health, care service and residential care professionals brought together through personal and professional direct involvement during the pandemic and recognizing the need for systemic response. All have acted in their individual capacities and no association or organization endorsement is represented.

Special thanks is extended to the Interdisciplinary Public Health and Palliative Care Certificate Program, Finger Lakes Geriatric Education Center at University of Rochester Medical Center.

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