MEETING THE NEEDS OF OLDER TENANTS

A Practical Guide for Supportive Housing Providers

2025

Contents

Introduction

Welcome and Purpose of this Toolkit

Supportive housing providers are encountering a significant demographic shift as the population of older adults, particularly those aged 50 and above with histories of homelessness, continues to grow. This "graying" of the tenant base presents unique challenges and necessitates adapted approaches to care. Aging adults who have experienced homelessness often face complex health issues, including chronic illnesses and geriatric conditions, significantly earlier than the general population. Additionally, older adults in supportive housing often face distinct mental health needs and potential accessibility barriers. The average life expectancy is notably lower, which further highlights the unique challenges that this group faces.

In response to these needs, this toolkit is designed to equip service and housing providers in New York with best practices solicited from providers across the state. In late 2023, CSH facilitated a series of four “Healthy Aging Forums” to discuss the needs and best practices related to aging tenants in New York. Based on that forum, CSH developed a “Healthy Aging Training Series” that featured six training sessions that were co-designed with supportive housing partners and providers in New York. After the completion of the training series, CSH developed a peer learning cohort and provided 1:1 technical assistance to providers upon their request. Through all the engagements, CSH compiled tips, tricks, and best practices from providers.

This toolkit is the culmination of this work and offers essential insights, resources, and lessons learned designed to assist supportive housing providers in crafting effective solutions for older adults within their communities.

The Landscape of Aging in Supportive Housing

The population often termed the "invisible population" (older adults aged 50 and over who are or were homeless) demands attention. This group has expanded notably, constituting nearly half of all single homeless adults.[1] Concurrently, supportive housing, a proven method for addressing the needs of formerly homeless individuals, is witnessing a "graying" of its tenant base. Presently, around 40% of tenants in supportive housing are over 50.[2] This shift results from long-term tenants aging in place and the housing of

[1] Learning Brief: Homelessness and Health Needs Among Older Adults - Community Solutions
[2] Size, Characteristics, and Needs of the Population of Older Adults Experiencing Homelessness - Addressing Homelessness Among Older Adults: Final Report - NCBI Bookshelf

individuals from an increasingly older, formerly homeless population. Consequently, affordable and supportive housing providers nationwide are adapting by designing projects specifically for aging adults. It's imperative now to focus on solutions addressing the housing, health, and social support necessities of older adults to foster healthy aging.

The median age of individuals experiencing homelessness has consistently increased, a trend showing no signs of reversal. Projections suggest the number of older adults will essentially double by 2050.[3] Individuals aging while homeless, particularly those with chronic homelessness histories, have been prioritized for housing recently. Furthermore, older adults in stable housing face a heightened risk of homelessness. This demographic confronts distinct challenges; aging adults with histories of homelessness tend to develop chronic illnesses and geriatric conditions 15-20 years sooner than their peers in the general population.[4] When unsheltered, they face increased vulnerability to isolation, swift health decline, and premature death. The average life expectancy for an older adult with a history of homelessness is markedly lower, at 64 years as compared to 80 years for older adults without a history of homelessness.[5]

These national trends are particularly acute in New York. In New York City, the number of sheltered homeless individuals aged 55 and older grew dramatically between 2004 and 2017, with forecasts predicting significant further increases by 2030.[6] The average nightly count of adults 65+ in city shelters more than doubled between 2014 and 2023.[7] Within New York's supportive housing system, the proportion of residents over 55 may exceed national averages, with one survey indicating over 42% fell into this age group.[8] Research confirms that homeless older adults in NYC exhibit geriatric conditions far earlier than housed peers, emphasizing the urgent need for appropriate housing and services.[9]

Acknowledgement

We thank the NY Health Foundation for their generous support of this work.

[3] Homelessness-Older-Adults.pdf
[4] Geriatric Conditions in a Population-Based Sample of Older Homeless Adults - PubMed
[5] Mortality among the homeless: Causes and meteorological relationships - PubMed
[6] Aging-Homeless-Study-Report.pdf
[7] Serving Seniors: The Aging Homeless Population| Housing Finance Magazine
[8] CSH Document: Aging and Thriving: - A Call to Strengthen Supportive Housing for Older Adults in NYC
[9] Independence for a Lifetime: Recommendations to New York City Supportive Housing Task Force

Key Concepts & Guiding Principles for Supporting Aging Residents

To promote shared language in New York related to aging tenants in supportive housing, a few key concepts and terms that are referenced in the toolkit are defined below:

Aging-in-Place

Aging-in-Place is the concept that individuals should have the opportunity to live in their chosen home and community safely, independently, and comfortably, regardless of age or ability. Within supportive housing, this translates to empowering residents to remain in their current housing setting for as long as possible, even as their health, mobility, cognitive, or social support needs evolve over time. For providers, embracing aging-in-place requires a proactive commitment to flexibility, adapting services, supports, and potentially the physical environment to align with residents' changing requirements. This approach prioritizes resident choice and familiarity, helps maintain vital social connections, and aims to prevent premature or unnecessary transitions to higher levels of care and/or institutional settings.[10]

Healthy Aging

Healthy Aging, as defined by the World Health Organization, is understood as the ongoing process of developing and maintaining the functional ability that allows for well-being in later life. This functional ability encompasses meeting basic needs, decision-making, mobility, relationship building, and societal contribution. It shifts the focus beyond merely the absence of disease towards optimizing opportunities for physical, social, and mental wellness throughout a person's life course. For supportive housing providers, this means orienting support towards enhancing residents' overall quality of life across all dimensions of wellness. It involves actively promoting participation in meaningful activities tailored to their interests and abilities, fostering social connections within the community, and working to maximize individual independence and function, enabling residents to thrive.[11]

---

[10] Aging in Place: Growing Older at Home | National Institute on Aging

[11] Ageing and health

Ageism

Ageism refers to stereotyping, prejudice, and discrimination directed towards individuals or groups solely based on their age. It can manifest subtly or overtly in various forms: institutional ageism embedded in policies or practices, interpersonal ageism in interactions between individuals, or even self-directed ageism where older adults internalize negative societal beliefs about aging. People who hold negative views about their own aging (self-directed ageism) live on average 7.5 years fewer than their peers in the same age group.[12] For supportive housing providers, recognizing and actively combating ageism is crucial. This requires ongoing staff self-awareness and training to challenge personal biases and dismantle any organizational practices that might unfairly limit opportunities, disrespect, or devalue older residents. Upholding an anti-ageist environment involves celebrating the diversity of aging experience, affirming the rights of older adults, and genuinely valuing their unique perspectives, experiences, and contributions.[13]

What are some examples of ageism?

- Refusing to hire people over or under a certain age
- Disregarding someone's concerns or wishes due to their age
- Treating older adults as though they are invisible or unintelligent
- Speaking to older adults in "baby talk"
- Believing that cognitive impairment is normal in aging
- Assuming all older adults want or need help with particular tasks
- Referring to a moment of forgetfulness as a 'Senior Moment'

Dignity

Dignity signifies the inherent and unconditional worth possessed by every human being. In the context of supportive housing, upholding dignity means consistently treating tenants with respect, valuing their perspectives, safeguarding their privacy, and interacting in ways that affirm their identity and individuality. For providers, this translates into tangible

[12] Ageism Fact Sheet - Ageism Awareness Day_0.pdf
[13] Global report on ageism

actions in daily practice – from ensuring personal care is delivered respectfully and privately, to genuinely involving residents in decisions concerning their lives and care, listening attentively to their concerns, and maintaining strict confidentiality.[14]

Autonomy

Autonomy is the fundamental capacity and right of individuals to exercise self-determination – to make their own informed choices about their lives, care plans, and daily activities based on their values and preferences, without facing coercion or undue influence from others. In supportive housing, respecting autonomy requires providers to actively support residents' right to make decisions, even when those choices might entail some level of risk (always considered within legal and ethical frameworks, and accounting for decision-making capacity). This involves providing clear, understandable information about options and honoring refusals of care. Effectively upholding autonomy often necessitates a delicate balance and collaborative dialogue between respecting resident choice and ensuring safety.[15]

Safety Using a Harm Reduction Lens

Viewing safety through a Harm Reduction lens represents a pragmatic approach focused on reducing the potential negative consequences associated with various risky behaviors, rather than demanding complete cessation of the behavior itself.[16] This applies to situations involving substance use, smoking, specific dietary habits, or choices impacting mobility and fall risk. This perspective acknowledges that risk-taking can be a part of human experience and prioritizes respecting individual autonomy alongside safety concerns. For supportive housing providers, implementing harm reduction involves moving away from potentially ineffective zero-tolerance policies. Instead, it emphasizes collaborative risk assessment with the resident, providing education on safer alternatives or practices (like strategies for safer smoking, falls prevention measures that support mobility choices, or access to managed alcohol programs), and offering resources to minimize harm, all while honoring the residents' choices and capacity for decision-making.[17]

---

[14] Maintaining the dignity and autonomy of older people in the healthcare setting - PMC
[15] Autonomy and Quality of Life for Elderly Patients | Journal of Ethics | American Medical Association
[16] What is Harm Reduction? - Harm Reduction International

Cultural Humility

Cultural Humility is best understood not as an endpoint (like "competence"), but as a lifelong commitment to self-reflection and critical self-assessment regarding one's own cultural background, beliefs, and biases. It involves actively learning about others' cultures while simultaneously acknowledging the inherent power imbalances often present in provider-resident relationships. The goal is to cultivate respectful, trusting, and mutually beneficial partnerships grounded in recognizing and honoring the resident's unique life experiences and cultural identity. It requires staff to approach interactions with genuine curiosity and openness, demonstrate respect for residents' varied beliefs, values, and practices (even when they differ significantly from their own), remain vigilant about personal biases, and be willing to adapt communication styles and support strategies to ensure they are culturally sensitive, relevant, and truly person-centered.[18]

Unique Needs of Older Residents in Supportive Housing

"Aging is associated with changes in dynamic biological, physiological, environmental, psychological, behavioral, and social processes." – National Institute on Aging[19]

Aging may include the following changes:

- Biological: Structural, Sensory, Systems
- Psychological: Memory, Adaptions to Change, Reminiscence
- Sociological: Role Reversal, Crisis, Guilt, Limitations, Losses, Death

According to research, strengths of older adults can include:20

- Cognitive Function: There are many older adults who do not have difficulty with memory or recall.
- Happiness: Older adults are often happier than middle-aged and younger adults.

[18] What is Cultural Humility? The Basics | Division of Equity and Inclusion
[19] nia.nih.gov/sites/default/files/2017-07/nia-strategic-directions-2016.pdf
[20] Exploring Older Adults' Strengths, Problems, and Wellbeing Using De-identified Electronic Health Record Data - PMC

- Proactive Approach: Older adults often have greater pattern recognition skills that can lead to a more proactive approach in life.
- Individuals aged 50 and older who have faced homelessness often possess unique care needs, which are distinct from both younger homeless individuals and the general aging population.

Medical Needs

Living unsheltered leads to faster health deterioration compared to younger counterparts, as they grapple with complex, co-occurring chronic, physical, and behavioral health issues, alongside early-onset geriatric conditions. Compared to housed older adults, those who were formerly homeless exhibit higher rates of geriatric syndromes at much younger ages.

Mental Health Needs

Chronic stress from homelessness contributes to unique behavioral and mental health issues, physical disabilities, and substance use challenges, often worsened by premature geriatric conditions. Age-related cognitive decline, including conditions like Alzheimer's, dementia, and memory loss, occurs much earlier in this population compared to the general populace. These cognitive changes can manifest behaviorally and may demand intensive service interventions and unit modifications potentially unfamiliar to providers. Cognitive decline can impede access to services, health system navigation, appointment keeping, bill payment, adherence to medical advice, and performance of daily activities, sometimes leading to isolation or other mental health challenges.

Accessibility

Older tenants generally require greater accessibility in service delivery, needing reliable transportation, in-home or physically accessible service locations, and protocols for accessing emergency services anytime due to potential health crises or falls. Housing units may need modifications like ramps, grab bars, or accessible bathrooms to accommodate physical limitations. Transportation is often a significant barrier preventing access to off-site medical appointments, resources, or social visits.

Designing a Healthy Aging Service Program

Older adults living in supportive housing have unique needs that can be met through robust and strategically coordinated systems of service delivery. As supportive housing welcomes more older tenants, and as providers support aging in place, programs should be enhanced, tailored, and in some cases, redesigned to meet increasingly complex needs.

Using Data to Understand Need

For supportive housing providers to effectively meet the needs of aging tenants, it will require moving beyond anecdotal observations and intuitive responses towards a systematic, data-driven approach. A cornerstone of optimizing support for aging PSH residents involves a systematic approach to data utilization, beginning with strategic data collection. This requires identifying key metrics pertinent to aging—such as health status (including chronic conditions, hospitalizations, falls, medication complexity), functional dependencies (ADL/IADL needs assessed via standardized tools), service utilization patterns, and resident feedback, and embedding their collection into routine workflows. Data derived from diverse sources, including initial intakes, periodic reassessments, case management notes, Electronic Health Records (EHR), incident reports, service logs, resident surveys, staff observations, and HMIS, provides a rich foundation for understanding resident needs. Some of the key data points that providers may use to inform staffing and service programming include:

- *Demographics:* Age distribution, length of stay.
- *Health Status:* Diagnosed chronic conditions, frequency/reason for hospital/ER use, fall incidents, medication count/complexity, assessment results (e.g., depression, anxiety, cognitive function, etc.).
- *Functional Status:* Standardized ADL/IADL assessments, mobility levels, use of assistive devices.
- *Service Utilization:* Uptake of specific services (nursing, case management contacts, activity participation, personal care hours), missed appointments.
- *Resident Feedback:* Satisfaction surveys, formal/informal feedback mechanisms.

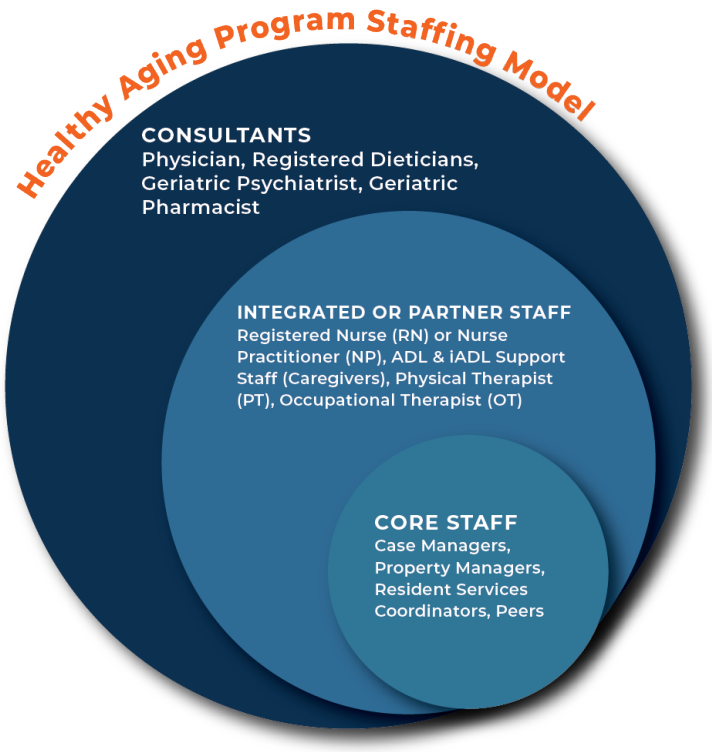
Regular analysis of this information by the team is crucial for interpreting trends, identifying patterns (like emerging health risks or service gaps), and synthesizing meaningful insights about the resident population and program performance. These insights then directly inform actionable strategies, such as adjusting staffing or service delivery. Please see some examples below:

- High rates of polypharmacy might indicate a need for RN/pharmacist medication reviews.
- Increased fall rates could lead to implementing evidence-based fall prevention programs and targeted OT home safety assessments.
- Data showing increased behavioral challenges linked to cognitive decline might prompt dementia care training.

Staffing Model & Enhanced Training

An ideal staffing structure requires an interdisciplinary team, each with specialized skills that work collaboratively and cohesively. At a minimum, new or modified service programs for aging tenants should include strategies for addressing the following:

- Primary Health Care
- Behavioral Health Care and Substance Use
- Care Coordination
- Wellness and Nutrition
- Activities of Daily Living
- Income and Benefits
- Legal Challenges
- Transportation
- Transitions to Higher Levels of Care
- End of Life Support & Care



Staffing ratios will depend on funding, building size, and resident acuity. However, caseloads should not exceed 10 tenants per services staff member for scattered site programs or 15 tenants per services staff member for single site.[21] Please see below a recommended staffing structure to support aging tenants:

- Case Management Team Role: Act as primary point of contact. Provide service coordination, psychosocial support, benefits advocacy, crisis intervention, and goal planning. At least 1 case manager should have an aging specialization and enhanced training in:
    - Common geriatric conditions (falls, incontinence, cognitive impairment, polypharmacy)
    - Chronic disease management
    - Navigating Medicare, Medicaid, Social Security, and long-term care waivers/services
    - Advance care planning facilitation
    - Recognizing signs of elder abuse, neglect, or exploitation
- Housing/Property Management/Landlord Staff Role: Maintain a safe and accessible physical environment, process reasonable accommodation under fair housing law (e.g., grab bars, ramps), and communicate with service staff regarding resident well-being or unit concerns.
- Resident Services Coordinator (or Similar) Role: Develop and facilitate age-appropriate social, recreational, wellness, and creative activities to combat social isolation, promote engagement, and build community. Examples could include gentle exercise classes (chair yoga), walking groups, gardening, art therapy, social hours, and educational workshops.
- Peer Support Specialist (with Aging Focus) Role: Leverage lived experience to build trust, engage residents (especially those hesitant with traditional services), offer support groups, model coping skills, provide advocacy, and assist with navigating aging-related challenges from a peer perspective.

[21] COVID-19 Homeless System Response: Case Management Ratios

Beyond the core staff, supportive housing providers should consider either an integrated or partnership model for the additional staff listed below. Under the integrated model, the supportive housing provider directly hires these roles as part of the team. This can create better coordination and accountability, but adds management complexity and additional funding considerations. Under the partnership model, the supportive housing provider contracts with third-party agencies to provide these staff roles. While this reduces management and funding complexity, it requires strong coordination between the agency, staff, and tenant.

- On-Site or Tightly Integrated Registered Nurse (RN) / Nurse Practitioner (NP) Role: Conduct health assessments, chronic disease management (in coordination with primary care), medication management support/monitoring, health education, care coordination with external medical providers (PCPs, specialists, hospital discharge), triage of acute issues, wound care, potential direct clinical services (depending on licensure/scope). Geriatric specialization is highly desirable.

- Personal Care / ADL & IADL Support Staff Role: Assist with Activities of Daily Living (ADLs: bathing, dressing, toileting, transferring, eating) and Instrumental Activities of Daily Living (IADLs: light housekeeping, meal preparation, shopping, laundry, medication reminders)

- Physical Therapist (PT) Role: Conduct functional mobility assessments (gait, balance, transfers, strength), develop individualized therapeutic exercise programs to improve mobility and reduce fall risk, provide gait training and instruction on safe use of assistive devices (canes, walkers), recommend environmental modifications to improve safety related to mobility, educate tenants and staff on fall prevention strategies and safe movement techniques. Geriatric specialization or extensive experience with older adults is highly valuable.

- Occupational Therapist (OT) Role: Evaluate functional performance in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), provide training in adaptive techniques and use of assistive devices/adaptive equipment (reachers/grabbers, sock aids, adaptive utensils, etc.), recommend and implement environmental modifications for safety and accessibility, and adapt tasks and routines to conserve energy and manage functional limitations (e.g., related to arthritis, low vision, cognitive changes). Specialization or experience in geriatrics, home modifications, or low vision is beneficial.

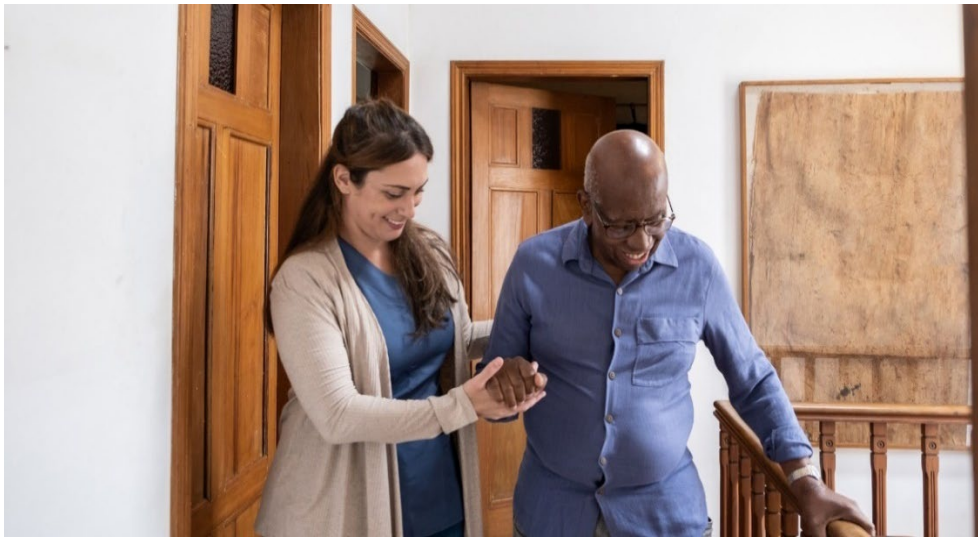
Additional Consultants (As Needed):

- Physician (for general medical needs/questions)
- Registered Dietitian (for nutritional needs)
- Geriatric Psychiatrist (for complex mental health needs in aging)
- Pharmacist (for medication reviews/polypharmacy)

Essential Partnerships

Given the complex health needs of aging residents, establishing strong partnerships with a wide range of healthcare providers is essential for effective service delivery and care coordination. Formal relationships with written agreements are needed with primary care physicians, mental health and substance use treatment providers, hospitals (especially for discharge planning coordination), home health agencies, visiting nurse services, specialized geriatric providers, pharmacies, and medication assistance/management services. Co-locating services, such as having partners provide care on-site or establishing integrated clinics (e.g., with an FQHC), can also greatly improve access.

Collaboration extends beyond healthcare to include various social service agencies critical for supporting older adults. Partnerships should be built with local Area Agencies on Aging, Aging and Disability Resource Centers, providers of transportation services (public transit, paratransit, volunteer driver programs), legal aid services or medical-legal partnerships (especially for benefits issues, advance directives, or addressing elder abuse), benefits enrollment specialists, and community centers offering social or recreational programs.



Meeting the Needs of Aging Residents

Assessments

Effective service provision begins with multidimensional assessments designed to identify the specific needs of older adults who have histories of homelessness. These assessments should be administered by case managers not only at intake, but also annually and after any critical incidents (such as falls or hospitalizations). Assessments must be delivered in ways that accommodate potential barriers, such as offering materials in multiple languages or formats suitable for those with hearing or vision impairments; patience and repetition may be needed to ensure tenant comprehension. Key areas of assessment and links to various assessments include:

- Functional Abilities: Evaluating functional abilities involves assessing both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
    - Katz ADL Assessment
    - Lawton iADL Assessment
    - Routine Task Inventory
    - Barthel Index of Activities of Daily Living
- Cognitive Status: Evaluating cognitive status is crucial to assessing the tenant's ability to comprehend and communicate effectively.
    - Cognitive Impairment/Dementia Assessment – Mini Mental Status Exam
    - Cognitive Impairment/Dementia Assessment – Mini Cog
    - Cognitive Impairment – Montreal Cognitive Assessment
    - Cognitive Assessments - SLUMS
- Mental Health and Loneliness: Assessments should explore a tenant's existing social connections and identify risk factors contributing to potential isolation.
    - Loneliness Scale - DeJong Gierveld
    - Differential Loneliness Scale (DLS)
    - Geriatric Depression Assessment

    - PHQ-9
    - Generalized Anxiety Disorder 7-item (GAD-7) scale

- Fall Risk: Assessing and addressing fall risk is crucial to ensuring the physical well-being of aging tenants.
    - Johns Hopkins Fall Risk Assessment Tool
    - Berg Balance Scale
    - Hendrich II Fall Risk Assessment
    - Fall Risk Assessment - MAHC 10
    - Home Safety Assessment Tool
- Other Assessments to Consider:
    - Medical Risk - Cumulative Illness Rating Scale
    - Healthy Aging Assessment - Wisconsin Institute of Healthy Aging
    - Bladder & Bowel Continence Assessment
    - Incontinence Impact Questionnaire, IIQ-7
    - Elder Abuse/Mistreatment Assessment
    - Hoarding Rating Scale

Providing Person-Centered Support and Services

Service plans must be centered around the individual, allowing for self-direction while being customized to specific needs, and comprehensive in scope. These plans are built upon the findings from the assessments that capture the complex interplay of physical health conditions, mental health challenges, functional abilities, and social support needs characteristic of older adults aging in supportive housing.

When tenants have existing support networks, such as family or close friends, engaging these individuals (with the tenant's consent) can be beneficial, particularly for coordinating care, providing social connection, or supporting end-of-life transitions. However, providers must recognize that many tenants lack these traditional supports, meaning housing staff often become the primary support system.

The service plans should encompass the following areas:

Addressing Physical Health Needs

Primary Care: Staff should actively assist tenants in connecting with primary care and other necessary healthcare providers. Integrating health care services, perhaps through visiting health staff, mobile health options like telemedicine, or even on-site clinics, can be highly beneficial for this population, addressing emerging issues early and potentially preventing institutionalization.

Medication Management: Additionally, managing medications can become difficult for tenants, especially those with cognitive decline or multiple prescriptions. Staff should work with residents and physicians to create assistance plans, maintain accurate medication lists, know which pharmacies are used, and potentially partner with external medication management providers if needed.

Medication Management Tools and Ideas:

- Medication reminders: verbal prompts, phone calls, written schedules
- Technology: smartphone or smart speaker reminders, medication timer boxes (automated dispensers), blister pill packaging
- Home care: aides can directly administer medications

Healthy Lifestyles (Nutrition, Exercise): Addressing nutritional needs is important, as older tenants may have dietary restrictions or difficulty preparing meals. Connecting them with meal benefits like SNAP or Meals on Wheels can help. Additionally, despite potential mobility challenges, promoting exercise is key for physical and cognitive health. This can range from on-site fitness centers to accessible classes like group walks, gentle aerobics, strength training, balance exercises, or yoga, potentially brought on-site by professionals.

Nutrition Support Tools and Ideas:

- Partner with local bakeries to pick up their daily leftovers and distribute to tenants (Panera often has programs for this!)
- New York meal delivery services for older adults include JASA, City Meals on Wheels, and Office for the Aging Home-Delivered Meals.
- Identify local senior centers that offer meals and schedule transportation for tenants to attend.

Fall Prevention Strategies: Falls are a leading cause of injury for older adults, potentially leading to hospitalizations and serious health decline. Prevention requires a multi-pronged approach involving regular health assessments (including eye exams and medication reviews for side effects that might cause dizziness), promoting exercises that improve balance, and making environmental modifications (like installing grab bars, ensuring adequate lighting, and removing tripping hazards).

Fall Prevention Tools and Ideas:

- Conduct home safety assessments for all aging tenants.
- Refer to free fall prevention classes (such as "Stepping On" and "A Matter of Balance") in your area.

Addressing Cognitive and Mental Health Needs

Identifying Cognition Barriers and Strategies: Based on the assessment results, providers should work to better understand any cognitive barriers that tenants face, as well as address the risks associated and document in the service plan. For example, if someone has mild dementia and forgets to take their medication, medication management will be a key part of the service plan.

Facilitating Access to Mental Health Services: Supportive housing programs must facilitate access to necessary mental and behavioral health care. This involves establishing clear referral pathways and formal agreements with mental health providers for both ongoing treatment and crisis intervention. Connect to geriatric-focused mental health programs.

Promoting Social Engagement and Reducing Isolation: Addressing mental health also involves combating social isolation, which is a significant risk for older adults, particularly those facing health challenges or cognitive changes. Providers should proactively create a variety of opportunities for social interaction within the housing community. This can include organizing on-site recreational and social events tailored to resident interests, such as bingo games, movie gatherings, peer support or "buddy" programs for new tenants, and special interest groups, classes, or workshops.

Social Engagement Tools and Ideas:

- Consider adult day programs for people who want daytime socialization and structured activities, as well as need help with some activities of daily living.
- Technology, such as robotic pets and AI, can help support people who are isolated. There are free pilot programs to provide these resources to eligible older adults in New York.

Ensuring Safety and Accessibility in the Housing Environment

Accessing Home Care Services: Many older tenants will eventually need assistance with daily activities to remain safely in their homes. Staff should be prepared to connect residents with necessary in-home services, such as those provided through Home and Community-Based Services (HCBS) waivers often funded by Medicaid, which can assist with personal care like bathing and dressing, or running errands.

Environmental Modifications for Aging Residents: Older adults often have higher rates of physical disability and limited mobility, making accessible housing crucial. While some supportive housing may only need minor adjustments, others, especially scattered-site units, might require significant rehabilitation to become accessible. Modifications range from structural changes like widening doorways/hallways, adding ramps, or installing stair lifts, to adding features like grab bars, handrails, accessible shower heads, brighter lighting, or emergency alert systems. Assistive devices like bath benches or raised toilet seats, and reconfiguring furniture placement are also common adaptations. Specific considerations for older adults might include storage and charging stations for mobility scooters.

How to request a reasonable accommodation or modification:

- You can ask anyone who works for your housing provider.
- You do not need to use the words “reasonable accommodation” or “reasonable modification” when asking for one.

- You are not required to make your request in writing, but it can be helpful for you and your housing provider to have a record of the request, when it was made, and what happened.
- Your request should explain how the accommodation or modification you are asking for is connected or related to your disability.
- Your request should include a description of the disability-related need and why a change is needed.
- Your request does not need to include detailed medical information about your disability and should include only enough information so that the accommodation you are asking for can be clearly connected to your disability.
- If you ask your housing provider for a change because of your disability and make clear why that change is needed, you have asked for a reasonable accommodation or reasonable modification.
- Wellness Checks: Older adults can benefit from consistent wellness checks. Providers may conduct wellness checks in a variety of ways, including daily phone call check-ins (with staff or a buddy), putting a sign on the door to indicate to staff they are okay (and staff check all doors daily), or implementing a life alert-type system.

Understanding Resources for the Aging Population

Entitlement Programs

For many older adults who have experienced homelessness, public benefits represent their primary, and often only, source of income for the remainder of their lives, making benefit maximization crucial for long-term financial and housing stability. Supportive housing providers play a critical role in ensuring tenants are enrolled in all benefits for which they are eligible, tracking potential changes in eligibility (e.g., aging into Medicare), and assisting with applications and renewals. Assistance must accommodate potential barriers faced by older tenants, such as hearing, vision, or mobility challenges, as well as cognitive impairments that might affect understanding.

- Social Security: Social Security is a vital social insurance program for not just for retirees, but also for workers with disabilities, spouses, survivors and dependents. It provides income to these individuals. To be eligible for Social Security based on their own work history, an individual must be over age 62, or meet the Social Security disability standard. The rules surrounding Social Security can be complex, so it is important to do sufficient research to accurately advise clients and to adequately address any questions or issues that arise. The full retirement age varies depending on the year the person was born! Calculator for the effect of early or late retirement: ssa.gov/oact/quickcalc/early_late.html

- SSDI: There is a type for social security for people with disabilities often referred to as SSDI. There are strict standards about who is considered "disabled" and less than 40% of applicants are approved. Applicants must be "unable to engage in substantial gainful activity because of a medically determinable impairment which is expected to last twelve months or result in death." This can include physical, mental, or combination of impairments. SSDI is an earned-benefit that has requirements to qualify. Often, when people obtain SSDI, they may qualify for Medicare.

- SSI: Supplemental Security Income is a federal program also administered by the Social Security Administration (SSA). Eligibility for SSI is based on financial need, in contrast to Social Security which is a social insurance program with eligibility based on work history. To be eligible for SSI, an individual must be age 65 or older, or meet the Social Security standard of disability. This program provides subsistence level income for aged, blind, or individuals with disabilities. In New York, SSI recipients are automatically eligible for Medicaid as soon as they are eligible for SSI. There are many complicated financial eligibility rules relating to income and resources apply to SSI recipients. For all of the Social Security programs, you can help clients apply at: www.ssa.gov -- They have resources to check eligibility and get a benefits estimate!

- Medicare: This federal health insurance program covers individuals aged 65 and older, and younger people with qualifying disabilities, regardless of income. It's crucial to understand its different parts: Part A (hospital/inpatient care, skilled nursing facility stays, hospice, some home health), Part B (doctor visits, outpatient services, tests), and Part D (prescription drugs). Enrollment often happens automatically, but tenants may have choices regarding plans, including traditional Medicare or Medicare Advantage managed care plans

Part A (Hospital Insurance)	Part B (Medical Insurance)	Part C (Medicare Advantage)	Part D (Rx Drug Coverage)
Pays for hospital, skilled nursing, hospice, some home health.	Pays for doctors, ambulances, labs, x-rays, durable medical equipment and supplies.	Receiving Parts A and B (and often D) through a private plan. There are several different types of Medicare Advantage plans.	Only available through private plans.
Medicare Savings Programs cover some costs.			Low Income Subsidy covers some costs.

Staff should be aware of potential costs like premiums and deductibles, the Low-Income Subsidy ("Extra Help") for Part D, and how Medicare interacts with Medicaid for dually eligible individuals. Tracking each resident's specific coverage is recommended for advocacy and service planning. There will be different steps based on someone's eligibility factors – you can visit https://www.medicare.gov/ to identify the correct path to enrollment. Generally, for people who are receiving social security benefits, you will want to start this process approximately 3 months prior to someone's 65th birthday. There are alternative pathways for folks receiving social security disability benefits that do not rely on age.

- Medicaid: A joint federal-state program providing health coverage to low-income individuals. Two key Medicaid programs for older adults are highlighted below:
- Medicaid HCBS Program: Home and Community-Based Services, often funded through Medicaid waivers, provide crucial support like personal care assistance (bathing, dressing), allowing individuals at risk of institutionalization to remain in their homes, including supportive housing.
- Medicaid PACE Program: Programs of All-Inclusive Care for the Elderly (PACE) is a type of HCBS program that offer a comprehensive, integrated set of medical and social services to individuals aged 55+ who are certified as needing nursing home level care but can live safely in the community. PACE aims to keep frail older adults at home by providing coordinated services through an interdisciplinary team, including primary care, therapies, day health centers, meals, transportation, and in-home care. Services are typically funded by Medicare and Medicaid for eligible participants, though PACE programs are not available in all areas.

Persons who are eligible for both Medicare and Medicaid are called “dual eligibles”, or sometimes, Medicare-Medicaid enrollees. For Medicare covered expenses, such as medical and hospitalization, Medicare is always the first payer (primary payer). If Medicare does not cover the full cost, Medicaid (the secondary payer) will cover the remaining cost, given they are Medicaid covered expenses.

Dual-Eligibility and Long-Term Care Medicaid

New York State prioritizes integrated care for dual-eligible members. The Dual Eligible Integrated Care Roadmap outlines initiatives to improve integrated care options across the state. These coverage options can include:

Medicare Advantage Plus (MAP) Plans: MAP is a program for people who have both Medicare and Medicaid. MAP eligibility includes:

- Are age 18 and older,
- Have Medicaid,
- Have evidence of Medicare Part A & B coverage,
- Are eligible for nursing home level of care (as of time of enrollment) using the Community Health Assessment (CHA),
- Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety,
- Are expected to require at least one Community-Based Long Term Services and Supports (CBLTSS) for more than 120 days from the effective date of enrollment
- Must enroll in a Medicare Advantage Product.

Program of All-Inclusive Care for the Elderly (PACE): PACE stands for Program for All-Inclusive Care for the Elderly. PACE programs offer a holistic approach by integrating medical, social, and long-term care services. Everything is provided via the PACE provider. PACE eligibility includes:

- Participants must be 55 years or older
- Reside in a PACE service area
- Meet the nursing home level of care criteria.

Original Medicare + Medicare Part D + Medicaid Managed Long-Term Care (MLTC) Plan: MLTC provides long-term care Medicaid benefits. Participants who are on Medicare continue to receive their Medicare benefits via Medicare. There is some flexibility of providers for persons receiving home and community-based services via MLTC, as select care services may be consumer directed. This means that rather than receive services by the MCO's network of licensed care providers, a program participant can hire their own caregiver.

To apply for the Medicaid Long-Term Care Programs listed above, applicants must be eligible for New York Medicaid:

- State residents can apply via their local Department of Social Services (DSS) office.
- Applicants must also call the New York Independent Assessor (NYIA) at 1-855-222-8350 to request a functional needs assessment.
- Once an applicant is determined eligible for the MLTC Program, a MLTC plan is chosen, and a second assessment will be completed and an individualized care plan created.
- Persons can contact New York Medicaid Choice at 1-888-401-6582 with questions about managed care enrollment, assistance with choosing a plan, and to enroll in a plan.
- Plans are assigned to eligible persons who do not select one.
- *Note:* The New York State Department of Health (DOH) administers the Medicaid Managed Long-Tem Care Program and the Department of Social Services (DSS) office determines eligibility.

Higher Levels of Care

Assisted Living provides a residential environment where seniors receive personal care services. It caters to those who need some assistance but still want to maintain their independence. While it doesn't offer intensive medical care, it does focus on social interaction and community living.

On the other hand, Skilled Nursing (often called nursing homes) operates as a 24-hour medical facility. It provides extensive medical services, including wound care, injections, and intravenous therapy. Skilled nursing facilities are staffed by licensed nurses and healthcare professionals. They accommodate seniors recovering from illness or injury, as

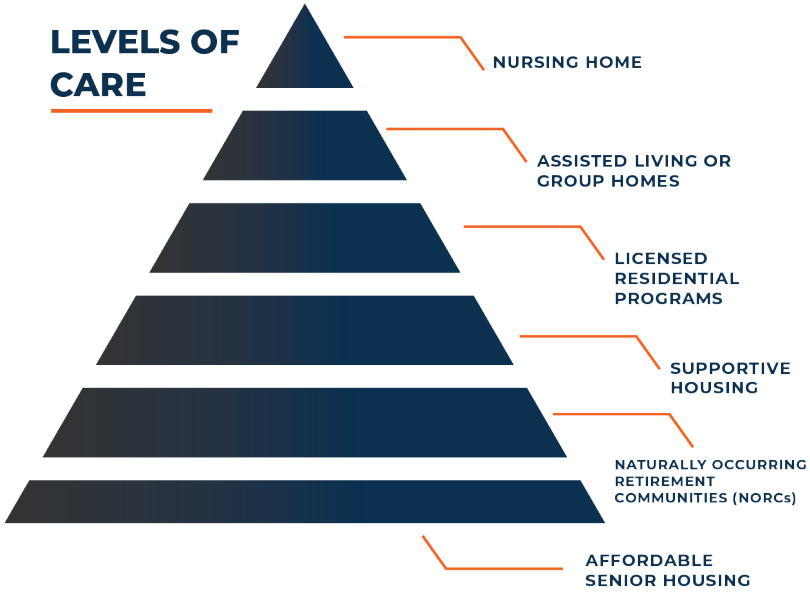
well as those with chronic conditions requiring intensive care. The room setup typically includes semi-private rooms and shared common areas.

Assisted living emphasizes personal care and independence, while skilled nursing prioritizes round-the-clock medical attention for more complex needs. The choice depends on an individual's specific care requirements and preferences.

Accessing higher levels of care can be challenging for clients with a history of mental health conditions and/or substance use disorders. Some providers of higher levels of care are more willing to serve clients that have extra support services following them when they move (such as case management, mental health clinicians, etc.)

Questions to Ask Before Recommending Higher Levels of Care

- What does a higher level of care mean?
- What resources are available in the community that have not yet been explored?
- What is the goal of a move?
- What does the client want?



End-of-Life Care and Transitions

Many individuals prefer to spend their final days at home. Supportive housing staff, often having built strong relationships with tenants, may be well-positioned to facilitate discussions about end-of-life wishes and planning. This involves helping residents understand options and potentially create advance directives, such as living wills or appointing a power of attorney for healthcare or financial decisions. Partnering with low-cost legal services or pro bono attorneys can assist residents in formalizing these documents. Please see below for additional information on the legal forms related to end-of-life planning:

Power of Attorney

A Power of Attorney (POA) allows one person (a principal) to appoint someone else (an agent) to handle their personal and financial affairs. Through a POA, they are granted authority to act on behalf of the individual in specific situations. Here are some key points about POAs:

Types of Powers of Attorney:

1. General Power of Attorney: Grants comprehensive authority for as long as the individual lives and remains of sound mind. The agent can act on their behalf in all matters.
2. Limited or Special Power of Attorney: Provides specific authority for a particular purpose or time frame.
3. Durable Power of Attorney: Remains effective even if the individual becomes incapacitated.

Healthcare Advanced Directives

An advance directive is a legal document that explains how someone wants medical decisions to be made if they become unable to make those decisions themselves. It guides their health care team and loved ones in determining the appropriate course of action. Essentially, an advance directive allows individuals to communicate their preferences ahead of time regarding the types of medical procedures or treatments they would or would not want. This only goes into effect if you are unable to speak for yourself or lack decision-making capacity (ex: unconscious). This form also provides space to indicated wishes to receive life pro-longing /sustaining medical interventions such as artificial nutrition or rehydration. This form also encourages appointing an "alternative" proxy in the event the person chosen is unable to be your proxy when the time comes. There are multiple types of advanced directives:

- Living Will:
    - This only goes into effect if you are unable to speak for yourself or lack decision making capacity (ex: unconscious).
    - This form also provides space to indicated wishes to receive life pro-longing /sustaining medical interventions such as artificial nutrition or rehydration.

- This form also encourages appointing an “alternative” proxy in the event the person chosen is unable to be your proxy when the time comes.

- Medical Orders for Life-Sustaining Treatment (MOLST):
  - Used specifically for someone who has advanced chronic, end stage serious illness.
  - The MOLST contains specific and actionable medical orders that transition with the patient across health care settings.
  - (Health care proxies and living wills typically contain more general instructions and cannot be followed by EMS providers in an emergency.)
  - MOLST applies as soon as a patient consents to the orders in it and a physician, nurse practitioner, or physician assistant signs it.
  - It is not conditional on a determination that a patient has lost medical decision-making capacity.
  - Request made to one’s doctor or healthcare facility
  - Does not need an attorney.

As tenants approach the end of life, staff should understand hospice and palliative care services to help residents access this type of support, enabling them to remain comfortably in their homes when possible.

Palliative Care

Palliative care (pronounced pal-lee-uh-tiv) is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness — whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. Palliative care is provided both inpatient and as an outpatient service.

End-of-Life Wishes Tools and Ideas:

The guides below can be a jumping off point to discuss end of life planning with tenants. While they are not legal documents, they can help start the important conversations:

- Five Wishes
- The Conversation Project - Get Started
- What Matters to Me Workbook - For Serious Illness

Hospice

A medical program/service that provides comfort focused care for people who face advanced illness and have stopped treatment to cure their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. The team typically includes: a doctor, social worker, chaplain, RN, and home health aides. Hospice can be provided in home or skilled nursing facility (or anyplace called “home” i.e. assisted living, etc.)

Hospice Eligibility: Hospice services are offered to individuals who are certified by a physician as being terminally ill and having a prognosis of 6 months or less if the disease runs its normal course. Terminal Illnesses can include:

- Cancer
- Congestive Heart Failure

- End Stage Pulmonary Disease
- Dementia
- End Stage Renal Disease
- HIV/AIDS
- End Stage Liver Disease

It is so important for residents to know that they will be mourned by others and not forgotten, that they matter and belong. Consider offering on-site memorial services (monthly, quarterly, yearly?) and explore alternative memorialization options:

- Tree of Life
- Memorial Books/Plaques/Benches
- Sharing a Meal and Stories

Financing Burial Options

It is important to let residents know what options are available to them. The Human Resources Administration (HRA) Office of Burial Services (OBS) assists individuals in need of financial assistance to meet funeral expenses for a deceased low-income New York City resident (decedent). Payment may be authorized to reimburse funeral expenses that have already been paid or pre-approval for payment may be authorized for the cost of a planned funeral. OBS can pay up to a maximum amount of $1,700 towards the cost of a funeral bill for a decedent's final disposition (which includes burial, cremation or burying of cremation ashes) to the decedent's relative, friend, Organizational Friend or authorized representative. In the event, the funeral bill exceeds $3,400, the cost of the burial plot, grave opening or cremation will be deducted from the total bill. If the remaining bill amount is less than $3,400, a burial allowance will be approved.

Sample Policies, Procedures, and Templates

Sample Aging in Place Policy

1. Purpose

[Organization] is committed to providing stable, safe, and supportive housing. This Aging in Place policy affirms our commitment to empowering residents to remain in their homes within our supportive housing community for as long as possible, even as their physical, cognitive, or healthcare needs change over time. The goal is to promote resident well-being, dignity, independence, and choice by providing appropriate support and coordinating necessary services within the scope of our capabilities and resources.

2. Scope

This policy applies to all current residents of [Organization]'s supportive housing programs. It outlines the principles, procedures, and responsibilities related to supporting residents who wish to age in place.

3. Definitions

- Aging in Place: The ability for a resident to live in their current housing unit safely, independently, and comfortably, regardless of age, income, or ability level, as their needs change over time.
- Supportive Housing: Affordable housing combined with coordinated supportive services designed to help residents maintain housing stability and achieve personal goals.
- Supportive Services: Services coordinated or provided by [Organization]'s staff, such as case management, service coordination, life skills training, connections to healthcare, mental health services, substance use treatment, benefits assistance, etc.
- Assessment: A formal or informal process conducted by designated staff (e.g., Case Manager, Service Coordinator) to evaluate a resident's changing needs, functional abilities, safety risks, and required supports.
- Service Plan: An individualized plan developed collaboratively with the resident (and potentially family/advocates) outlining goals, needed services, supports, and responsible parties to facilitate aging in place.

- Reasonable Accommodation/Modification: Changes to rules, policies, practices, services, or the physical environment necessary to afford a person with a disability an equal opportunity to use and enjoy their dwelling, as required by fair housing laws.

- Higher Level of Care: A living environment providing more intensive medical, personal care, or supervision than can be safely and adequately provided within the supportive housing setting (e.g., assisted living, skilled nursing facility, memory care unit).

4. Guiding Principles

- Resident-Centered: Residents are central to all decision-making regarding their care and housing. Their preferences, goals, and choices are prioritized.

- Dignity and Respect: All interactions and processes will uphold the dignity and respect of each resident.

- Safety: While promoting independence, the safety and well-being of the resident and the community remain paramount.

- Collaboration: Successful aging in place requires collaboration between the resident, [Organization]'s staff, family/chosen supports, healthcare providers, and community agencies.

- Fair Housing Compliance: All aspects of this policy will be implemented in compliance with the Fair Housing Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and relevant state/local regulations regarding non-discrimination and disability rights.

5. Procedures

5.1. Identifying Changing Needs: Changes in a resident's needs may be identified through:

- Resident self-report.

- Observations by staff (Case Managers, Property Management, Maintenance).

- Reports from family members, advocates, or healthcare providers (with resident consent).

- Regularly scheduled resident check-ins or assessments as part of standard case management.

5.2. Assessment Process: Please reference the Assessment Procedure.

5.3. Service Planning and Coordination: Based on the assessment, the Case Manager will work collaboratively with the resident to update or create a Service Plan. The plan will identify:

Specific needs and challenges.

Resident goals related to aging in place.

Required services and supports (e.g., home health aide, personal care assistance, physical therapy, meal delivery, transportation, assistive technology, medication management support).

Referrals to appropriate community agencies or healthcare providers.

Please note: Staff will assist the resident in accessing and coordinating necessary external services, but are not typically direct providers of hands-on personal or medical care.

5.4. Reasonable Accommodations and Modifications: Residents may request reasonable accommodations (changes in rules/policies/practices) or reasonable modifications (physical changes to the unit/common areas) related to a disability to support aging in place. Requests will be processed according to [Organization]'s established Reasonable Accommodation/Modification Policy. The organization will engage in an interactive process with the resident to determine the feasibility and appropriateness of requested accommodations/modifications.

5.5. Monitoring and Reassessment: The resident's situation and Service Plan will be reviewed regularly (e.g., quarterly, semi-annually, or as needed based on changing circumstances) by the Case Manager/Service Coordinator in collaboration with the resident. Significant changes in health, function, or safety will trigger a reassessment.

6. Roles and Responsibilities

Case Manager/Service Coordinator:

- Serve as the primary point of contact for Aging in Place support.
- Build trusting relationships with residents.

- Conduct assessments and coordinate the service planning process.
- Identify and facilitate connections to community resources and healthcare providers.
- Monitor resident well-being and effectiveness of the service plan.
- Advocate for resident needs.
- Document interactions, assessments, and plans according to organizational standards.
- Collaborate closely with Property Management and Maintenance staff.
- Property Management:
- Maintain a safe and accessible physical environment.
- Process requests for reasonable modifications in collaboration with case management/service coordination staff.
- Communicate relevant observations regarding resident safety or unit conditions to Case Management staff (respecting privacy boundaries).
- Address lease compliance issues collaboratively with Case Management, considering potential links to aging or disability needs.
- Maintenance Staff:
- Respond promptly to work orders, including those related to safety or accessibility.
- Report any observed safety concerns (e.g., falls risk, urgent repair needs) to Property Management or Case Management as appropriate.

7. Limitations and Transition Planning

- [Organization] is committed to supporting residents to age in place whenever feasible, but there may be circumstances where the resident's needs exceed the level of care and support that can be safely provided within the supportive housing environment.
- Circumstances that may necessitate consideration of a transition to a higher level of care include, but are not limited to:
    - The resident's health and safety needs cannot be adequately met with available in-home services and supports, posing a significant risk to the resident or others.

- The resident requires 24-hour supervision or medical care that is beyond the scope of supportive housing and available community services.
- The resident's condition or behavior poses a direct threat to the health or safety of other residents or staff that cannot be mitigated through reasonable accommodation or service intervention.
- The resident expresses a desire to move to a setting offering a higher level of care.

- Transition Process:
  - If concerns arise regarding the feasibility of continuing to age in place, staff will engage in open and collaborative discussions with the resident (and their chosen supports, with consent).
  - Multiple assessments and attempts to modify the service plan or environment will typically occur before considering transition as the only option.
  - The focus will be on exploring all available options to support the resident in their current home.
  - If a transition is deemed necessary or is desired by the resident, staff will actively assist the resident in exploring appropriate alternatives, making referrals, and coordinating the move to ensure a smooth and dignified transition.
  - Decisions regarding transitions will be documented, outlining the rationale, options explored, and the resident's involvement in the decision-making process.

8. Confidentiality

All resident information, including health status, assessments, and service plans, will be kept confidential in accordance with HIPAA, organizational privacy policies, and relevant funding source requirements. Information will only be shared with residents' consent or as required by law.

10. Grievance Procedure

Residents who have concerns or disagree with decisions made under this Aging in Place policy have the right to utilize [Organization]'s established Resident Grievance Procedure.

Sample Assessment Procedure for Aging Tenants in Supportive Housing

Goal: To ensure the comprehensive assessment of aging tenants (age 55 and over) at intake and following critical incidents to identify potential needs related to cognition, functional abilities, fall risk, and social connectedness, and to facilitate timely and appropriate referrals and supports.

Procedure:

1. Applicability:
    a. This procedure applies to all tenants of [Organization] who are age 55 and over.
    b. Assessments will be conducted at initial intake and following any critical incident that may impact a tenant's physical or cognitive functioning (e.g., hospitalization, significant fall, reported cognitive decline).
2. Assessment Tools:
    a. The following standardized assessment tools will be utilized:
        i. Cognitive Function: Saint Louis University Mental Status Examination (SLUMS)
        ii. Activities of Daily Living (ADLs): Either the Katz Index of Independence in Activities of Daily Living (Katz ADL) OR the Routine Task Inventory (RTI)
        iii. Fall Risk: Johns Hopkins Fall Risk Assessment Tool for Home Health Care
        iv. Loneliness/Social Isolation: DeJong Gierveld Loneliness Scale (6-item version)
3. Responsibility:
    a. Intake Assessments: The designated Case Manager will be responsible for administering these assessments during the initial intake process.
    b. Post-Critical Incident Assessments: The tenant's assigned Case Manager will be responsible for administering these assessments following a critical incident.
    c. Referrals: Case Managers are responsible for initiating and tracking all necessary referrals based on assessment results.
4. Procedure Steps:
    a. Intake Assessment:

i. Upon a tenant's admission who is age 55 or older, the Intake Coordinator or Case Manager will:

1. Explain the purpose of the assessments to the tenant in a clear and understandable manner, ensuring they provide informed consent.

2. Administer the following assessments in a private and comfortable setting:

a. SLUMS: Administer and score the SLUMS according to the provided instructions.

b. Katz ADL OR RTI: Administer either the Katz ADL or the RTI to assess the tenant's functional abilities.

c. Johns Hopkins Fall Risk Assessment Tool for Home Health Care: Administer and score the fall risk assessment.

d. DeJong Gierveld Loneliness Scale: Administer and score the loneliness scale.

b. Document the tenant's responses and scores for each assessment in the tenant's electronic health record (EHR), and in the tenant's service plan. The assessment scores should dictate follow-up actions in the tenant's service plan.

5. Post-Critical Incident Assessment:

a. Following a reported critical incident (e.g., hospitalization, significant fall, reported cognitive decline) for a tenant age 55 or older, the assigned Case Manager will:

i. Within 72 hours of becoming aware of the incident, schedule and conduct the same standardized assessments as outlined above.

ii. Document the tenant's responses and scores for each assessment in the tenant's EHR, clearly noting the "post-critical incident" nature of the assessment.

iii. Compare the current assessment results to previous assessments (if available) to identify any changes or new needs.

6. Workflow Based on Assessment Results:

a. Cognitive Function (SLUMS):

i. *Score ≥ 27 (High School Education) OR ≥ 25 (No High School Education):* No immediate referral for cognitive assessment is required. Continue to monitor for any reported or observed changes in cognitive function.

ii. *Score < 27 (High School Education) OR < 25 (No High School Education):* Initiate a referral to a medical professional (e.g., primary care physician, neurologist) for a more in-depth cognitive assessment.

iii. Documentation: Document the referral in the tenant's EHR, including the date of referral and the name of the referred professional. Follow up to ensure the referral was completed and obtain relevant information with the tenant's consent.

7. Activities of Daily Living (Katz ADL or RTI):

   a. *If the assessment indicates any difficulty or dependence in one or more ADLs:* Initiate a referral to a home care agency for an assessment of home care services. Additionally, consider a referral to Physical Therapy (PT) and/or Occupational Therapy (OT) for functional skills training and adaptive equipment recommendations.

   i. Documentation: Document all referrals in the tenant's EHR, including the date of referral and the agency/professional referred to. Follow up to ensure the referrals were completed and integrate any recommendations into the tenant's support plan.

8. Fall Risk (Johns Hopkins Fall Risk Assessment Tool for Home Health Care):

   a. *Score ≤ 6:* Continue to monitor fall risk during regular case management. Provide education on fall prevention strategies.

   b. *Score > 6:* Initiate a referral to Physical Therapy (PT) and/or Occupational Therapy (OT) for a comprehensive fall risk assessment and development of a tailored exercise and balance program. Additionally, the Case Manager will conduct a home safety assessment within 5 business days to identify and address potential fall hazards in the tenant's unit.

   i. Documentation: Document the PT/OT referral and the completion of the home safety assessment (including any identified hazards and implemented solutions) in the tenant's EHR.

9. Loneliness/Social Isolation (DeJong Gierveld Loneliness Scale):

   a. *Score ≤ 3:* Continue to monitor social engagement during regular case management.

b. *Score > 3:* Offer a referral to available peer support programs or groups. Increase the frequency of check-ins with the tenant to provide additional support and connection. Explore opportunities for increased social engagement within the building or community based on the tenant's interests.

i. Documentation: Document the offer of peer support and any acceptance, as well as the increased frequency of check-ins and any identified social engagement opportunities in the tenant's EHR.

10. Documentation:

a. All completed assessments, scores, interpretations, referrals, and follow-up actions must be documented clearly and promptly in the tenant's EHR or designated paper file.

b. Documentation should include the date of the assessment, the name of the staff member administering the assessment, the tenant's responses and scores, any identified needs, all referrals made, and the outcomes of those referrals.

11. Training:

a. All staff responsible for administering these assessments will receive comprehensive training on the proper administration, scoring, and interpretation of each tool, as well as the established referral workflows based on a tenant’s score.

Sample Procedure: Navigating Cognitive Decline and Dementia

Goal: The organization is committed to providing a safe, supportive, and person-centered environment for all residents, including those experiencing dementia or other forms of cognitive impairment. This policy outlines the procedures for identifying, assessing, and supporting residents with cognitive decline to maximize their independence, safety, and quality of life. This policy is guided by the principles of dignity, respect, and the right to self-determination, while prioritizing the safety and well-being of the resident and others.

1. Initial Assessment of Cognitive Impairment:
    a. Upon admission to the program, all tenants ages 55 and over will undergo a standardized cognitive screening using the Saint Louis University Mental Status (SLUMS) Examination. If a resident's SLUMS score falls below the established threshold, a referral to their primary care provider will be initiated.
    b. Please refer to the “Standardized Assessment Process for Aging Tenants” procedure for more information.
2. Ongoing Observation and Monitoring:
    a. All staff will be trained to recognize potential signs and symptoms of cognitive decline, including but not limited to:
        i. Memory loss that disrupts daily life.
        ii. Challenges in planning or problem-solving.
        iii. Difficulty completing familiar tasks.
        iv. Confusion with time or place.
        v. Trouble understanding visual images and spatial relationships.
        vi. New problems with words in speaking or writing.
        vii. Misplacing things and losing the ability to retrace steps.
        viii. Decreased or poor judgment.
        ix. Withdrawal from work or social activities.
        x. Changes in mood and personality.

b. Staff will document any observed changes in a tenant's cognitive functioning, behavior, or abilities in progress notes.

3. Safety-Focused Service Planning for Cognitive Impairment:
    a. Individualized Service Plan (ISP) Development and Update:
        i. For tenants identified to have cognitive impairment and/or diagnosed with dementia, their individualized service plan will be developed or revised in collaboration with the resident (to the extent possible), their family members or legal representatives (with the resident's consent).
        ii. The ISP will address the specific needs and risks associated with the resident's cognitive impairment, focusing on maintaining their safety and independence. Some of the risks to focus on include:
            1. Wander Risk Management: If tenants have a history of wandering, disorientation, and ability to understand safety instructions, strategies to address it may include:
                a. Visual cues (e.g., clear signage such as a notice on their door).
                b. Emergency information card (in a wallet, on a walker, etc.) in the event a tenant gets lost that includes contact information for the housing provider.
                c. Structured routines and activities (consider referral to adult day program).
                d. Staff awareness and regular check-ins.
                e. Personal safety devices (e.g., GPS trackers) with the resident's and/or legal representative's consent.
            2. Fire Safety Risk Management: If tenants are identified for fire safety risks associated with cognitive impairment, such as forgetfulness regarding cooking, smoking, or electrical appliance use, the ISP will include strategies to minimize fire risk, such as:
                a. Supervised cooking or assistance with meal preparation.

b. Restrictions on smoking in individual units (if deemed necessary and in accordance with housing policies).

c. Use of safety features on appliances (e.g., automatic shut-off, unplugging stove, etc.).

3. Medication Management: The ISP will outline the level of support needed for medication management, which may include:

a. Home care support for verbal reminders.

b. Medication organizers or pill boxes.

c. Direct administration of medications by a qualified healthcare professional through home care.

d. Communication with the resident's pharmacy and healthcare providers (are there medication options that do not require daily adherence?).

iii. Staff should identify any additional risks and develop customized solutions to mitigate risks in the ISP.

4. Accessing Guardian or Legal Support:

a. If a resident with cognitive impairment demonstrates a significant decline in their ability to make safe and informed decisions regarding their health, safety, or finances, and there are no existing legal supports in place (e.g., Power of Attorney), staff will notify Adult Protective Services (APS).

b. APS serves adults (age 18 and older) who, due to physical or mental impairments, are unable to protect themselves from abuse, neglect, financial exploitation or other harm, and have no one available who is willing and able to assist responsibly.

c. While the organization does not initiate guardianship proceedings directly, when there are concerns and APS has been notified, staff will:

i. Attempt to identify and engage with family members or trusted persons who may be able to assist the resident or pursue legal options.

ii. Provide information to the resident and their identified contacts about the process of obtaining guardianship or other legal support, such as Article 81 guardianship in New York State.

iii. If a resident's impaired decision-making poses an immediate and significant risk to their own safety or the safety of others, staff will take immediate action to mitigate the risk, following emergency protocols and contacting emergency services (e.g., 911) as necessary.

iv. If a resident with cognitive impairment demonstrates a significant decline in their ability to make safe and informed decisions regarding their health, safety, or finances, and there are existing legal supports in place (e.g., Power of Attorney, Guardian, etc.), staff will work with the designated legal support to coordinate additional services and/or explore higher levels of care.

5. Proposing a Higher Level of Care:

    a. Despite the provision of supportive services, there may be instances where a resident's cognitive decline progresses to a point where their safety and well-being can no longer be adequately ensured in the supportive housing setting.

    b. This may be indicated by a significant increase in safety risks (e.g., frequent wandering, inability to manage basic self-care despite supports), a decline in the resident's ability to participate in their ISP, or the need for a level of medical or personal care that exceeds the scope of supportive housing services.

    c. The decision to propose a higher level of care will be made through a collaborative process involving the resident (to the extent possible), their family members or legal representatives, and relevant medical professionals.

    d. A comprehensive assessment of the resident's current needs and risks will be conducted, documenting specific examples of why the current level of care is no longer sufficient.

    e. Staff will provide referrals to higher levels of care settings to the tenant and their support team (family members, legal supports, etc.).

f. If the staff is concerned about the safety and well-being of the tenant while working to move to a higher level of care, staff will notify Adult Protective Services.

Sample Procedure: Responding to a Tenant Death

Goal: This organization is committed to providing respectful and person-centered support to all tenants, including ensuring a dignified and appropriate response in the event of a tenant's death.

1. Discovery of a Deceased Tenant:
    a. Immediate Action: If a staff member (regardless of their role) discovers a tenant who appears to be deceased:
        i. Do Not Disturb: Unless there is an immediate safety risk, do not move the tenant or any items in the immediate vicinity.
        ii. Initial Assessment: Briefly assess for any obvious signs of life (e.g., breathing, pulse). If there is any doubt, immediately call 911.
    b. Immediate Notification: The staff member should notify the supervisor on duty.
2. Notification of Authorities: Upon receiving notification, the responding staff member (or the covering supervisor) will:
    a. Call Emergency Services (911): Clearly state the situation, the tenant's address, and any relevant information. Request that the appropriate authorities (police, paramedics, and/or coroner/medical examiner) be dispatched.
    b. Provide Information to Emergency Responders: Be prepared to provide any known medical history or relevant information to the responding emergency personnel.
3. On-Site Procedures:
    a. Staff Presence: At least one staff member (preferably the Case Manager or a designated colleague) should remain near the tenant's unit until emergency

services arrive. This staff member will be available to answer questions from the authorities and provide access to the unit.

b. Secure the Unit (If Necessary): Following the instructions of the authorities, staff may need to secure the tenant's unit to preserve the scene.

4. Notification of Next of Kin:

    a. Supervisor Responsibility: The supervisor (or designated management personnel) will be responsible for contacting the tenant's identified next of kin or emergency contact.

    b. Documentation of Notification: The supervisor will document the date, time, and method of contact with the next of kin, as well as the name of the person contacted and their relationship to the tenant.

5. Communication and Support for Other Tenants and Staff:

    a. The supervisor will communicate the situation to relevant staff members in a timely manner.

    b. Management will assess the needs of other tenants and provide appropriate support, which may include individual conversations, group meetings, or referrals to mental health services.

    c. The organization will offer support to staff members who may be affected by the tenant's death, such as debriefing sessions or access to employee assistance programs.

6. Post-Death Procedures:

    a. Staff will cooperate fully with the authorities (police, coroner/medical examiner) and follow all legal requirements regarding the release of the tenant's body and the handling of their personal belongings.

    b. The tenant's belongings will be securely stored until they can be released to the legal next of kin or as directed by the appropriate legal authority.

    c. The Case Manager and supervisor will review the circumstances of the death and ensure all necessary documentation is completed accurately and stored appropriately. This may include incident reports, communication logs, and any information requested by external agencies.

Sample Housing and Services Plan Template for Older Adults

NAME: ADDRESS & UNIT #:	CLIENT ID: DATE OF BIRTH:	DATE OF PLAN: REVIEW DATE:

1. Service/Treatment Goal:

2. Advanced Directives on File?: Yes or No

ASSESSMENT SCORES & ANY NOTES TO INFORM SERVICE PLAN			
Cognitive Function:	ADLs:	Fall Risk:	Loneliness/Social Isolation

STRENGTHS and RESOURCES:

FACTORS THAT THREATEN HOUSING STABILITY:

OBJECTIVE 1:

ACTION STEP	GOAL	WHO	BY WHEN

OBJECTIVE 2:			
ACTION STEP	GOAL	WHO	BY WHEN

OBJECTIVE 3:			
ACTION STEP	GOAL	WHO	BY WHEN

OBJECTIVE 4:			
WHAT	GOAL	WHO	BY WHEN
I agree to the Service Plan above.			

Tenant Signature: _____ Date: _____ Case Manager Signature:_____Date: _____

Key Partners for the Service Plan

Case managers should record an up-to-date contact list of the tenant's service providers below:

Service Area	Agency & Contact Information	Notes
Home Care (ADL Assistance)		
Home Health Medical Services		
Transportation		
Physical or Occupational Therapy		
Primary Care Doctor		
Pharmacy		
Mental Health Support and/or Psychiatry		
Other Medical Specialists		
Power of Attorney and/or Guardian		
Natural Supports (Family, Friends, etc.)		

Other:		
Other:		
Other:		
Other:		


CSH