



Housing and Aging

Forum Report Out



How can we help seniors live healthy - and independently - for longer? The answer requires creative solutions that cross the silos of housing, health care, and social services. This Report has been generated from transcripts and notes from our recent *Housing and...Aging* forum presented by the **Housing Development Consortium of Seattle-King County** and our program partners and sponsors.

sponsors



Housing and Aging Forum Presenters

Opening

Mayor Ed Murray, *City of Seattle*

Keynote

Nancy Eldridge, *National Center for Healthy Housing*

Moderated Panel Discussion

John Forsyth, *Seattle Housing Authority*

Liz Prince, *Aging and Long-Term Support Admin (ALTA)*

Debbie Thiele, *Corporation for Supportive Housing (CSH)*

Jay Woolford, *Senior Housing Assistance Group (SHAG)*

Housing and Aging Forum Planning Committte

John Morrison-Winters, *Aging and Disability Services*

Connie Devaney, *Kawabe House*

Ruben Rivera-Jackman, *King County Housing Authority*

LeighBeth Merrick, *LeadingAge WA*

Loren Tierney, *Housing Development Consortium*

Darlene Storti, *Northaven*

Caleb Marshall, *Rebuilding Together Seattle*

Valerie Thiel, *SAGE Architectural Alliance*

John Forsyth, *Seattle Housing Authority*

Maureen Kostyack, *Seattle Office of Housing*

Jay Woolford, *SHAG*

Linda Woodall, *SHAG*

Pam Derry, *Tonkin Architecture*

Sharonn Meeks, *WSHFC*

David Clifton, *WSHFC*



*How can we help seniors live healthy - and independently - for longer? The Housing And... Aging Forum, presented by HDC and its partners on **November 17, 2016**, explored creative cross-sector answers to this question, with a keynote address and panel discussion to identify promising areas for new partnerships and pilot projects. The approximately 170 participants, representing housing, healthcare and social services, brainstormed current trends and next steps in small table groups and discussions.*

This report provides a summary of key content shared at the event, including a sometimes-verbatim report back, thanks to CART services present at the forum. Table discussion summaries, presenter biographies, and links to key resources including the glossary and slide presentations of the speakers can be found in this report's appendix.

Opening Remarks

Marty Kooistra, Executive Director, Housing Development Consortium

Jay Woolford, Board Chair, LeadingAge WA

Maureen Linehan, Director, Aging and Disability Services, Seattle Human Services Dept.

In spite of everything we are trying to do, there is a quiet crisis in senior housing that we are all very well aware of. Thank you to the HDC planning group for continuing to hold that as a priority for us all, and to the sponsors for this event today.

It is so important to gather a broad number of stakeholders for this discussion. We are excited about bringing together this incredible brain trust to help in collectively addressing new ways to bring affordable housing - with support and services - to our senior communities.

It is our great honor to introduce Mayor Ed Murray, who has recently accepted the challenge of making Seattle an "Age-Friendly City", joining with hundreds of other cities and AARP to make our communities great places to grow up and grow old.

Welcome Remarks

Mayor Ed Murray, City of Seattle

It is an honor to be here. This is going to be a difficult period over the next three years in our history. The challenges for us are going to be significant, and if the new administration and Congress carry out their plans to significantly give tax cuts to those at the top, something will have to be cut for the rest of us. So it is going to give us a challenge of either being taken under by this or being creative.

In the 1980s, we saw money for affordable housing begin to disappear from the federal government. Seattle stepped up in a big way as the first city in the nation with a local housing levy. No other city had done this at the time.

Now more than ever, we require your best ideas about how Seattle can meet the needs of our growing senior population with successful housing solutions. We need to integrate this topic in everything we do, so that we don't talk about housing in isolation of other issues.

There are a number of ways that the City of Seattle supports seniors:

- Raising the minimum wage to \$15/hour benefits those seniors who may have no choice but to work to make enough income to actually afford housing.
- Passing new funding for parks helps seniors as well, because fixed-income seniors often use our parks and community centers for physical activity and social connections.
- Thanks to new levy resources, 71% of Seattle residents live near a bus that comes every 12 minutes. This directly affects seniors on fixed incomes because transportation is the second most costly item that seniors face.
- Seattle's Vision Zero initiative also benefits the senior population, as our goal is that nobody in Seattle is a victim of a collision with a car.

And all this comes back to affordable housing, because the housing that seniors need must be connected to transit, connected to open space and parks, and located where folks can walk safely to the store or doctor's clinic.

The HALA (Housing Affordability and Livability Agenda) is also absolutely about seniors. We look to you to identify how we ensure, as we build HALA out, that the issues of seniors and aging becomes truly integrated in what is the largest investment in affordable housing in the city's history. When HALA is fully implemented, we will increase by three times the number of affordable units that we are building today. That will be six times the amount that San Francisco is building.

We need to get this done. The housing levy is a part of it; the fees on commercial building are a part of it. We need to tie in that mandatory inclusionary piece so that every place we build multifamily housing, affordable units are built by the private sector. This means that in our urban villages we need the ability to build that affordable housing. The debate is not finished. The ability to increase affordable housing, three times what we are building today, is predicated on getting the "grand bargain" in place.

Finally, this is an important time - as we talk about seniors - to remember one of the great gifts that we have between generations is for generations to support each other. So today, as you focus on how to support seniors, I would ask you to think how you might simply send a message of support to young students from immigrant families in our public schools who are very concerned about whether they will be able to go to school in this city after January 21, 2017.

Thank you for what you do to make Seattle a model for the rest of the country.



Keynote address,

Nancy Eldridge, Executive Director, National Center for Healthy Housing

King County and Washington State have some of the most creative housers in this country, and you have one of the most forward-looking Medicaid programs in this country. You have all the ingredients to be the most awesome state in terms of working collectively in support of low-income seniors, in particular, but also all seniors generally.

Here is a tale of policy issues for baby boomers, who are today's seniors. The little boy on the right [in photo slide] was born in 1952 and the girl on the left [in photo slide] was born in 1953. Back then, the President made a Cabinet-level position HEW (Health Education and Welfare) because they realized the nation needed a standardized public education system with performance measures and a predictable funding source across the nation. Here [slide] are the same kids today. The little girl is now in a nursing home in California. She has very advanced multiple sclerosis. Now age 62, she will spend the rest of her life in a nursing home, in a shared room now paid for by Medicaid. Her brother is a truck driver in New England, and very fearful about what the new federal administration will do in terms of block-granting Medicaid and reducing Medicare taxes. These individuals happen to be one of my brothers and one of my sisters. We have got to have a system of long term care in this country that brings everyone together to support the baby boomer population and others.

We have a logjam in housing today. Most seniors want to age in place in their own homes or in their subsidized apartments. Even if they wanted to move, residents find that most states do not have capacity in their Medicaid-funded assisted living and nursing homes. And for those who want to move back out of higher care, we don't have enough affordable housing in the community. At a minimum, we do have fair housing protections that make sure that property owners cannot evict, encourage, or cajole their residents to move on because they have physical or mental health needs.

This situation faced us in Vermont. In our pilot SASH (Support and Services at Home) site, 49% of the residents failed a cognitive screening test. How do you manage housing when your residents stay with you forever? When you look at the determinants of premature death, the formal medical system provides only 10% of the solution – not much. However, if you want to increase longevity and safety of the seniors you serve, you need to address and support behaviors that promote better health. And, of course, behavior begins at home, so it makes great sense to look at models that are home-based.

Unlike the centralized education system created for the baby boomers in the 1950's, we now need to create a *decentralized* system that allows people to age in place. The infrastructure for this system has already been built, in the form of publicly supported senior housing, and we should use that asset to build a whole infrastructure of health systems.

This is a bipartisan issue. In the spring of 2016, the Bipartisan Policy Center issued the *Healthy Aging Begins at Home* report that made a number of recommendations around production, renovation, services, and aging in place. The best recommendation made was for CMS [Center for Medicare and Medicaid Services] to launch an initiative that would integrate healthcare, long-term services, and supports in publicly assisted housing.

The physician community and the hospital community have been incredibly effective in using the Affordable Care Act demonstrations to fund the kind of care management that we should be providing. Whether you are an Area Agency on Aging or a houser, you are the ones who are far better able to manage long term care than the traditional medical community. But if you are not organized, if you aren't coming to CMS with one voice, there will be no possibility of this getting funded. The idea that housing can play this role is still very much an uphill climb.

At the beginning of the SASH Initiative in Vermont, we started with a housing project and converted it to assisted living through a HUD grant in 2000. We poured every penny into it, and received Medicare and Medicaid reimbursement at about 42 cents on the dollar. Now there are 28 Vermonters who have an incredible assisted living housing -- but what about the other 200,000 older people in Vermont?

I decided that we cannot keep building our way out of this problem. We need to accept the infrastructure as it exists and create a program that is lean and non-duplicative.

So we drove around Vermont to find the biggest thought leaders in the housing world and invited them to get the housers organized. There are 22 nonprofits in Vermont that are now all organized. Every kind of housing organization is doing this intensive service delivery model -- an intensive care management model. Then we went to the ER doctors and hospitals with the data that their most expensive patients are residents of our senior housing, and that the housers could do a lot to support better health outcomes for these communities. And so the hospitals signed on to this work.

We became part of the Multi-Payer Advanced Primary Practices Demonstration, which was created by a Republican governor, and was funded with Medicaid, private insurance and Medicare dollars. Eight states have participated in this demonstration. In Vermont, when you bring the Medicare dollars in, you absolutely bring the rate of growth of Medicare spending down by 20 percent. In order to not duplicate what other agencies do, we now have Memoranda of Understanding among 65 organizations in the state (mental health, home health, hospitals, housers, etc.).

Overview of SASH

SASH is a voluntary program. No resident has to participate. The program includes:

- Uniform assessment, which includes ADL functionality, nutrition and cognitive screens. The assessment also serves as a shared care plan database that identifies the health areas to work on (diet, exercise, chronic disease, etc.).
- Central database, originally provided by the state. Provides dashboard reporting and ability to compare progress across sites. Currently, SASH is moving to a new database provided by our largest account carrier organization in the state. This site will better integrate the data with the ACO [Accountable Care Organizations] provider network, the housers and the community-based agencies.
- Directory for referrals was developed in a joint effort with the College of Medicine. Medical students take one year off their third year of medical school and become a fellow and help us build the directory and refine it. These new near-physicians now understand the absolute value of housing.

- Prevention. We use a selection of Evidence-Based Health Promotion programs. In addition, we certify all of our resident service coordinators that wish to be certified in Tai chi, which is very popular to gain strength and balance.
- Key payment from Medicare was originally at \$700 per person per year which is not enough to pay for full program, but it brought SASH along. It gave us a flexible global budget. This amount is currently being raised to \$900 per person per year, and includes an inflation factor for the future.
- No discharge or time limit. We did not want to discharge people and then wait for things to fall apart again. The program is ongoing, even when you move to a different residence (for example, with a family member) as long as you are in Vermont. Participants can disenroll, but the best way to get out of SASH is a “celestial upgrade”.
- SASH is a systems-change model. Unlike PACE which is very narrowly defined, SASH does not have set requirements for income, age, acuity, disability, etc. SASH is a system across an entire community that includes housing, Medicaid waiver, other supports, but appears seamless to the user. It is “payer agnostic”.
- Statewide. We have six districts in Vermont that follow the area agency on aging boundaries. Each one is a “regional housing organization”. We now have 140 affordable housing sites, serving 5,400 people.

We have achieved positive measurable results:

- An increase in the number of people who have advance directives. The national rate is 26%; the SASH rate is at 59%.
- Vaccinations: The national shingles vaccination rate is 27%; the SASH rate is 34%.
- Controlled blood pressure: The national rate, as recognized by the National Institutes of Health is 30%; the SASH rate is 77%.
- Falls: The World Health Organization rate of falls is 37%; the SASH rate is lower at 25% even though our participants are getting older, frailer and have a higher risk of falls.
- Cost savings: SASH slows the growth of Medicare expenditures; the growth in costs was lower by \$1500 per beneficiary in a recent evaluation.

And here is some good news to share:

- We received the American Public Health Association award just two weeks ago in Denver for our work in making great progress in meeting 2020 public health goals.
- The federal HUD currently has a \$15 million demonstration to try to test supportive services models in eight to 12 different states and at 40 separate sites over a five year period. There are many applicants currently seeking this grant, and I will be working with HUD to help implement this demonstration project.

In closing, we really need to build the system, in Washington state and nationally. It begins with organizing, and forming a unified message to take to CMS. In this state, you will need to define the scope of the work you pursue, whether statewide or countywide. Finally you will need to work to find a sustainable payment method that fits Washington state: working toward some form of all-payer reimbursement model makes a lot of sense.

Panel Discussion

Pam Piering, former director Aging and Disability Services, panel moderator

Liz Prince, Project Director, Money Follows the Person demonstration project, Aging and Long Term Services and Supports Administration (AL TSA)

AL TSA serves 64% seniors and 36% younger folks with disabilities, about 74,000 people a year. In order to be eligible for AL TSA services, you have to meet both financial and functional eligibility. This is determined through an individualized assessment. Most people interacting with AL TSA are very low income, but several of our programs can be tiered to different income levels, so we encourage individuals to have an assessment to determine if they are eligible. Here in Washington, 64% of our long term care services are provided in-home, and most of that is through our state plan services (Community First Choice) and our Medicaid waiver services, like Community Options Program Entry System (COPES).

What's new: WA State has a new Medicaid 1115 Waiver, part of our Medicaid Transformation process. Through this waiver and its three initiatives we are trying to fill in some of the gaps that we have in our existing services:

- Initiative 1 involves innovation projects that will be implemented by Accountable Communities of Health (ACH) across the State. This work is taking place at the regional level to transform the Medicaid system to serve the whole person and use resources more wisely.
- Initiative 2 is a long-term care proposal for people who are age 55 or older. It offers "Medicaid Alternative Care" which is designed to help our unpaid caregivers provide services for the Medicaid beneficiary. While we have paid for family caregiver support before, it has not previously been paid with Medicaid funding. This initiative also provides for "Tailored Supports for Older Adults" for people who have not yet spent down to the Medicaid income level. These are both very innovative services, and we are very hopeful for the final approvals. The types of support provided include caregiver assistance, training and education, and equipment/supplies.
- Initiative 3 is aimed at helping people obtain and maintain permanent housing. We have people who can't hold onto a paid care provider, often because of behavioral issues. Others cycle through residential settings with frequency. We are trying to find ways to deliver these services in people's homes that are not finding what they need in the larger system. Debbie, who is speaking next, will cover the benefits in more detail.

We also have a Health Home program in Washington state, centered on the medical home for our clients. If you meet certain eligibility criteria (on slide), you are enrolled in the program and receive community-based services that can help you find and stay in housing.

Debbie Thiele, Director of National Consulting Services for the Corporation for Supportive Housing.

The Corporation for Supportive Housing (CSH) is a national nonprofit organization that provides technical assistance, policy advocacy and direct lending to help create new units of supportive housing. Supportive housing is the solution to preventing chronic homelessness for people who need housing stability and who have complex chronic conditions.

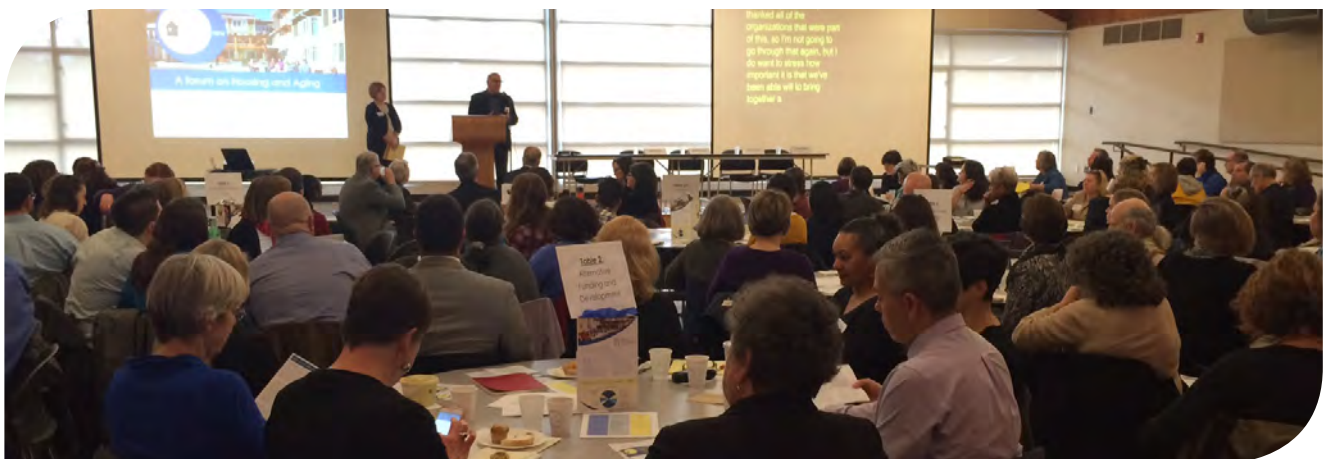
Supportive housing is not: residential treatment that we have in healthcare, transitional housing, or housing with resident services.

Supportive housing is: affordable housing paired with voluntary, but intensive, professional services that are designed to meet people where they are, and help them take the next steps to rebuild their lives, restore their independence, and recover from illness.

Recent research has determined that supportive housing is a way to address the needs of people who are not stably housed, who cycle in and out of emergency care, and/or are being discharged from institutions and yet still have a high level of complex needs. Supportive housing is for people who, but for services, don't succeed in housing, and for people who, but for housing, aren't able to access the human services and healthcare that they need.

At CSH, we are now looking at what's unique about a nation of people who are older and experiencing homelessness and chronic homelessness. We are starting to see a group of vulnerable elders, people who are age 50 and older who have had a significant episode or repeated episodes of homelessness as an adult. Although they may be 15-20 years younger, these individuals are starting to experience some of the geriatric health conditions that the general population experiences after age 65.

We now have the opportunity to reimburse tenancy support services to help people get housed and stay housed with Medicaid funding through the 1115 Waiver, Initiative #3. This population also needs care coordination to address the complex needs across behavioral health, primary care and geriatric healthcare systems. This can all happen within supportive housing and it can happen from the healthcare providers. We recently issued [a toolkit](#) that goes over some of this information and is available on our website: www.csh.org.



John Forsyth, Administrator, Seattle Housing Authority (SHA) Community Service Division

The Seattle Housing Authority houses about 34,000 low-income people who live in about 8,000 SHA home units. We also have close to 10,000 Section 8 “housing choice voucher” units or vouchers that are leased.

For the older population age 50+, SHA houses about 10,000 people. For those age 62+, the average income is \$11,000 a year and approximately 58% have a disability. We suspect that a vast majority of these elders qualify for both Medicaid and Medicare. The recent report referenced by Nancy [Bipartisan Policy Center] found that close to 70% of low-income public housing residents are dual eligible for both programs.

We have many partners in our work with elders to age in place successfully. Aging and Disability Services, our Area Agency on Aging, is a lead partner, providing case management for 1200 people in our high-rise buildings and senior housing program. For every dollar we give ADS, they leverage another two dollars through state Medicaid and City local funding. There are 430 of these individuals who receive home care to help with activities of daily living through the Medicaid Long Term Services program. We are all thinking of how to create better, more efficient system delivery of these services for our residents.

With respect to CSH, SHA provides over a thousand Section 8 vouchers to permanent supportive housing providers. There are a few hundred of those that are dedicated specifically to providers who are serving homeless seniors, and then we are also giving 120 vouchers here at New Holly, for assisted living in a building called Park Place.

Another key partner is [Full Life Care](#), for connecting people to mental health services and serving the function of being a payee as needed.

SHA also has a long term relationship with [Neighborcare Health](#), which operates federally qualified health clinics. Traditionally, we have worked more with them in our family communities. This year we copied a page out of the permanent supportive housing playbook and contracted with Neighborcare to offer a nurse in three of our buildings. This has been a popular program and we are expanding it next year to include another nurse.

Other partners include the Schools of Nursing, both at the University of Washington and at Seattle University. Student nurses assist people in our buildings with health-related needs. and Public Health has been an incredible resource in this area. Most recently we partnered up with epidemiologists to look at some of the data, particularly Medicaid.

One challenge we face is how to coordinate these services so that the folks in our buildings get the correct service they need in a timely manner. Nancy’s comments about the SASH program are really fascinating in this light because just within the Housing Authority we are trying to do that with people coming in and out of our own buildings. At the same time, we recognize that there is a huge need within our area to coordinate the services systems both with housing and healthcare.

Finally, I am struck by the fact that a lot of the answers for the housing and aging concerns have to come from the nonprofit and public sectors. It is very difficult to get money from philanthropy for these kinds of catalytic projects that influence the public sector. So I am excited about the conversation today.

Jay Woolford, Executive Director, Senior Housing Assistance Group (SHAG)
Board Chair, LeadingAge Washington

When SHAG started over 25 years ago, our mission was to provide housing for seniors in the moderate and affordable range - these folks were retiring on pensions, Social Security and had stable income coming in. These dynamics have changed dramatically for our organization and others. We operate communities from the Canadian border down to Olympia, about 4700 units. We predominately serve seniors, and we are funded through the Low-Income Housing Tax Credit program. We have not used HUD programs, and current options for these are few and far between.

Our focus originally was on moderate income. Most of our communities have been made up of residents at 50 and 60 percent of area median income: \$30,000 – 38,000 a year. But times are changing now. When you look at King County, our average income for a resident here is under \$20,000 a year, which actually puts them at the 35% income bracket, and trying to live in communities where they're qualified for 50 and 60 percent. So, our current profile is an average income of a little over \$15,000 a year, which is primarily Social Security, and our average age is 75 and rising.

Our residents are living longer in our communities as well. The vast majority is single women, and if you put couples into that, it's 80% women in our communities. We serve a population age 55 and older, but the 10% of our population who are under age 62 takes up 30% of our resources to help manage in the communities.

The Elder Economic Security Index as shown on the slide illustrates the income needed to meet overall monthly needs for older adults in affordable housing. When your income falls way short, and more is required for rent, where are you going to make up for it? Healthcare? Food? Transportation?

I want to leave you with the findings of a Harvard study that showed that the average renter over the age of 65 can only afford about two months of in-home assistance when it may be needed. It is incumbent on you here to figure out how we are going to support not only the folks living well below poverty level, but also moderate-income seniors who are just trying to make it in affordable housing communities today.



Moderator Question: What are one or two targets of opportunity that you are working on to enhance your housing/health approaches for vulnerable seniors?

Liz Prince: Right now, we are currently trying to contract with providers for supportive housing services. Please send them our way. You can contract through ALISA, Behavioral Health or through the Health Care Authority. For seniors, we are really trying to make these supportive housing services work better with our existing personal care services. So if that is of interest to you or your agency, please contact us.

Debbie Thiele: The biggest target of opportunity right now is the 1115 Waiver, and we have reached substantial agreement with CMS on the terms of that waiver and anticipate a final approval by the end of this year. The 1115 Waiver will authorize the reimbursement of supportive housing services and that will be a game changer in terms of our ability to scale supportive housing.

John Forsyth: King County Housing Authority and Seattle Housing Authority recently signed a data sharing agreement with Public Health that allows us to get Medicaid administrative data. This will give us an opportunity to see the health issues that Medicaid is addressing for our folks, and identify ways that we can work with partners, particularly healthcare, to make sure that their services are being coordinated. A companion piece is that the affordable housing providers, many here today, are having similar discussions with Public Health and will soon sign a data share agreement that will allow access to similar health data. There is a lot of potential coming out of this effort.

Jay Woolford: I am using a concept that I learned from Marty a couple of years ago, which is the idea of networked nonprofits. It's a model that we use. As a houser, we know that we aren't really in the business of being able to provide a lot of the support and services that are required. So it is incumbent on us to leverage the opportunities to be able to work with other organizations to help support them to be able to provide those types of services to our residents.

Moderator Question: Much of this work calls for developing new partnerships and strengthening current ones. "How" we do things together is important to address, as well as "what" we do. Do you have any thoughts, tips on what we should be having in mind as we look at future partnerships?

Liz Prince: We are looking to partner more fully with our home care agencies. I think we need to find ways, particularly when we see concentrations of folks getting served through supportive housing services, to make those personal care services work better, work more efficiently and meet more of the kinds of needs that people have.

Debbie Thiele: There is an opportunity now for formal contracting between supportive housing service providers and both ALISA and the managed care organizations in our state. Some behavioral health agencies will already be ready to implement the benefit. Those agencies as well as nonprofits that have never been connected to the Medicaid system can contract with ALISA now and with managed care organizations now in anticipation of that benefit. Those relationships need to start getting formed right now. It can be intimidating to reach out to the healthcare sector. We have a lot to learn about each other. Don't be afraid to have that first conversation.

John Forsyth: At times the discussion about how we support the people we house to age in place is overwhelming. We are not going to build our way out of it. So we need to think about both long-term strategies and short-term strategies, and sometimes these strategies don't involve money. For example, use of volunteers through the Schools of Nursing or other volunteer programs that are run by [Sound Generations](#). Often these can be key components to what we are trying to do together. There is also a high incidence of depression among the people we house, so improving social networking and building community can be a part of the solution. It is really the communities where we live that have the biggest impact on health outcomes.

Jay Woolford: Partnerships, like any relationship, are something that you have to work on, and you have to be intentional about it. One of the disappointments for me in trying to establish partnerships early on was the amount of time and effort that it takes to make sure that both sides are staying consistent. So my organization has brought on people whose purpose is to develop and nurture partnerships. We have a partnership and program group and also other staff whose purpose is to grow our stakeholder group, grow awareness, and continue to nurture those relationships.

“The forum reminded me not to work in silos. I plan to use the SASH example from the keynote as a model of inter-organization collaboration.” - Participant Quote



Table Break-out Notes

Table 1: Age-Friendly Architecture and Universal Design

Table Facilitators: Scott Starr, SMR Architects, Pam Derry, Tonkin Architecture

Current understanding:

- King County affordable planning is looking at housing as baby boomers age and rise of homeless older adults.
- There is also a concern about seniors living in rural areas, including Vashon Island, where retirement housing is more limited in availability.
- Not everyone wants to move to a complex, most of which are in urban areas.

Progress: Universal Design (UD) goes beyond ADA – not just ramps and grab bars. Buildings should be a platform for needed services and opportunities to enrich people’s lives.

- Universal Design could become a big marketing plus for single family developers.
- Spaces for socialization: There have not been many great examples of this, particularly with the social spaces. Many of the designs are too industrial, not friendly spaces. Problems with sound echoing -- difficult for people with hearing loss.
- Outdoor space and open spaces designed with Universal Design principles is important to ease isolation.
- Hearing concerns: Consider the “Hear Hear” system – amplification system that facilitates communications. Loop systems also needed. Portland has a requirement that all publicly located TVs must have captioning (e.g., sports bars). Also, with hearing, most developers just do minimum code. Example of flashing alarms – people must ask for this type of accommodation rather than it being standard. If it isn’t built into the unit, it is costly to do after the fact.
- Low vision: this is something that designers could do better on. Color contrast, glare prevention and lighting. There is a bias toward mobility requirements of ADA rather than vision and hearing.
- Mercy has some great examples of doing it right – common rooms, exam rooms for health providers, ability to provide health care where people live.
- Mercy is working on a project with no carpeting -- acoustic ceilings and artwork on walls that will absorb sounds. Recent push against carpet because of air quality – con is that falls are more impactful and hearing more difficult.
- Caleb Marshall (Rebuilding Together Seattle) has done a lot of work on play spaces. He sees a lot of low hanging fruit in single family homes – e.g., nightlights, transitions between doorways, toilet heights, moving laundry facilities.

Next steps:

- Hearing loss association.
- Reach out to healthcare providers while developing housing. Mercy received money for great furniture.
- Design for all users that come into the spaces.
- Reach out to contractors, manufactures who need to be educated on materials, needs, sustainability, and quality.

Table 2: PACE

Table Facilitator: Corina Kroll, ElderPlace, Providence Supportive Housing

Current understanding:

- PACE = All-inclusive healthcare for elderly, “one stop shop” coordinated by one team, includes health insurance, transportation and medical services.
- Patient doesn’t have to live in the building to get services.
- Age 55+ meets daily living needs.
- SeaMar medical home model features early morning team huddle to address housing, social services, etc.

Progress:

- Northaven has MSW services for independent living, community initiative grant; Imagine Housing has resident support specialist.
- Many of residents already have a primary care provider.

Next steps:

- We are behind the trend, the waitlist is so long.
- Address lack of knowledge with others, stigma possibly?
- Many RFPs and grants have preconceived ideas about what residents need, they need to keep current with trends.

Table 3: Community Building

Table Facilitators: Val Theil, SAGE Architectural Alliance, Darlene Storti. Northaven

Current understanding: Think of designing to “Build Community”, and get away from the idea of just designing a building.

- Provide different choices of group living: units with shared kitchens for living with friends.
- A multi-purpose room is a resource, an amenity that can be used to connect with community.
- Get people out of their apartments to socialize and connect. A coffee cart or donations from coffee shops are good tools. Add a coffee lounge with wifi in the lobby, where residents can come any time of day. Social connection is the biggest component to healthy aging. Combat depression. Give people a reason to stay healthy.
- Look at your building from Google Earth or an aerial view to see what resources, participants and potential partners are in the community around you. Then reach out and organize. Design the building to facilitate connectivity.
- Community access to a commercial kitchen is a huge resource – affordable meals, social connection, group cooking, demonstration cooking, healthy eating classes.
- Neighbors help residents with dementia as residents watch out for each other.
- Seniors with different cultural roots may have means of connection that vary between cultures.

Progress: Look for ways to build connections to the overall community.

- Not just for seniors, but intergenerational.
- Awareness of services and walkability has grown over past 5 years.
- Make use of the energy of students: include student apartments to tap into their participation, volunteerism and training.
- At Park Place Assisted Living (99% Medicaid) church and other outsiders are invited in to share the facilities and this also benefits residents.
- Northaven reached out to 35 surrounding neighbors to discuss how to organize to benefit the whole community. There is a community center and library at Northgate, but the resources are isolated and not well connected to the community who would use them.
- Northaven is a non-profit. They have found a small for-profit developer to help them.

Next steps: Connect to healthcare partners and other populations with similar needs.

- Providers such as health organizations don't think about buildings, they think about the people using their services. So talk to them about seniors being the start of this network and how it can be extended to families as well.
- A representative from Multiple Sclerosis noted that the age limits that define senior housing are too limiting because those that suffer for MS, Parkinson's, developmental issues, those with memory issues also need inclusive supportive housing and would benefit being included in the affordable senior housing. Need to break down barriers for entry.

Table 4: Medicaid 1115 Waiver

Table Facilitator: Liz Prince, ALISA

Next Steps:

- Cluster care/home care model
- There are concerns with current administration and U.S. congressional changes; will have to wait to see and respond accordingly
- Connect with partners in the community
- Connect with chronic homeless – people want to be involved – may not know how
- Supportive housing to address people with complex needs
- Break down silos – medical, DSHS, Housing: open doors for clients
- Information/education training of providers – how system will work, how to contract, referral process, eligibility
- These are new areas, the play book must be written
- We need to create capacity to achieve.

Table 5: Veteran Services

Table Facilitator: Marcy Kubbs, Veterans and Human Services Levy, King County

Current understanding:

- Vets and Human Services Levy serves some vets, but those w/highest housing barriers are still struggling to get into housing.
- This Levy is up for renewal in 2017 and will be on ballot August or November
- We need to prioritize veterans for housing & provide individualized services.
- Veterans Administration (VA) connection and advocacy for benefits is key.

Progress:

- There has been a national decrease in veteran homelessness of 48%.
- Locally, data isn't as positive. More new veterans are entering the homeless system monthly than vets being permanently housed.
- Working with cities to resolve veteran homeless situation by aligning funding & service providers.
- Encourage residents to connect with VA.
- Reconnecting with vets and information gathering.

Next Steps:

- Medical care – not fully meeting veteran needs
- Transportation to services is a huge issue
- Coordination of services
- Raise awareness of resources available
- Learn VA benefit language

Table 6: Health and Wellness

Table Facilitator: Mary Pat O'Leary, Aging and Disability Services

Current understanding:

- Hearing loss is overlooked as a major problem of aging, as Medicaid no longer covers hearing aids for adults.
- Mercy Housing has some clinic space in its development(s); some health providers to give care clinics in the buildings, facilitate care coordination @ the sites; how do we share data?
- Seattle Housing Community Builder – housing councils, have residents take leadership/how to build resources for them; promoting gatherings, tech, etc.

Progress:

- Mercy Housing: using evidence-based programs; trainers, community health worker programs, matter of balance; fitness rooms in the buildings.
- SHA: resident leadership, exercise programs, small grants for events.
- SHAG: roles and responsibilities for staff. No HUD funding to sustain the budget. Resident Service Coordinators & Resident Wellness Coordinators; care coordinators & behavioral health outreach; community partnerships associates; seeking volunteerism and resident leadership.
- Fall prevention; oral health care bags; hands-only CPR.

Next steps:

- Coordination & funding. "Us" not "me," data and sharing between groups.

Table 7: Mental Health

Table Facilitator: Mona Sanger, Senior Housing Assistance Group (SHAG)

Current understanding:

- Housing first
- Affordable Care Act
- In house, full life care service coordinators
- Medication management – Kelley-Ross Partnership
- Downtown Emergency Services Center (DESC)– nurse in building
- 911 crisis trained responders
- Geriatric Regional Assessment Team (moving to another program)
- Momentia – dementia program (calendar online)

Progress:

- Crisis team officers with Seattle Police Department
- Community Living Centers
- DESC meets individuals where they are
- Full life studio program
- Community outreach & empowerment promoted at SHA
- Transportation is available
- Intensive case management at Jewish Family Services, counseling
- Senior center partnerships
- Affordable care provides more access
- Housing first model is helpful. Support outside of institutions is good focus
- Connection of Senior Centers to mental health access
- More education, less taboo about seeking mental health care

Progress (continued):

- Better education of law enforcement
- Focus on assets; getting folks connected
- Teach people to do self-care, be as independent as possible.

Next steps:

- In-home support, Medicare providers at home
- Accessibility and transportation
- Friendly visiting (Full Life, Jewish Family Services, Catholic Community Services)
- Resources for undocumented elders, and culturally appropriate care
- Need: money, integrate mental health w/aging services, resources for those out of scope of care
- Incentivize housing managers to work more intensively to keep residents.

**Table 8: Activities of Daily Living (ADLs) and In-Home Care
Table Facilitator: Sean Walsh, Aging and Disability Services****Current understanding:**

- Some experience with assessing ADL's for housing-related contracts, using a HUD tool that assesses 6-7 ADL needs.
- Referrals made into the Long Term Care (LTC) system to DSHS Home and Community Service, but not knowledge about how Home Care assessments are made.
- A key problem is the absence of Home Care services for people with low ADL needs, or modest incomes that make them not eligible for LTC services.
- There is concern about the Home Care work force--both safety and competence issues for caregivers.

Progress:

- Some not aware of much progress happening on this topic. (Two participants were relatively new to the LTC system.); in a second session, it was noted that many changes have happened as a result of the Training Partnership, Adult Protective Services and other LTC systems.
- Bellweather brings discussion of Home Care to their Service Coordinator meetings.
- Archdiocese Housing has tried to get low cost home care workers into their buildings without much success.
- Mercy Housing has discussed eligibility for LTC services and are hoping to offer expanded access to medical services at one of their new buildings.
- Seattle Housing Authority (SHA) has an Aging in Place initiative that is hoping to address increased ADL and Home Care needs for aging residents.
- Kelly-Ross has been working with Neighborcare and other providers to do outreach for residents in their homes.

Progress (continued):

- Mercy Care has been making efforts in Bellingham to bring services into their buildings.

Next steps:

- More education on how ADL eligibility works for people referred into the LTC system.
- Home care will be a major need for aging residents both now, and especially in the future.
- There needs to be a new way for these services to be provided in an affordable way for participants.
- More networking opportunities, followed by small scale projects.
- Create alternate ways to deliver home care services to more people in a more flexible way, perhaps through Medicaid 1115 Waiver possibilities.

Table 9: Nutrition**Table Facilitator: Angela Miyamoto, Aging and Disability Services****Current understanding:**

- Older adults are often managing several chronic conditions that relate to nutrition (e.g. hypertension, heart disease, diabetes).
- Individuals may not disclose that they are going hungry.
- Three themes intertwine: cost/access; desire or inclination; education.
- Individuals often know the importance of nutrition but are presented with limited choices and options
- Chronically homeless individuals rely on shelters and community kitchens for meals.
- Limited geographic, seasonal, and affordable access to grocery stores, fresh foods.
- Food banks- choices made based on what is available; may not be close by; limited deliveries.
- Food stamps- getting enough versus getting healthy food.

Progress made:

- Residents are interested in nutrition and recognize the importance.
- Expanded partnerships with foodbanks, p-patch gardens.
- Movement from housing only to resident service coordinators; however, still is a perception that on-site services should be limited in "independent living" environments.
- Education has been successful when delivered by peers and/or combined with socialization opportunities.
- Staff at health clinics can provide diabetes education and workshops (e.g. Neighborcare).
- Resident service coordinators help residents navigate and access resources including food banks, market vouchers, SNAP benefits – resident initiated & limited time; funded primarily by HUD.
- Community rooms on-site – can coordinate potlucks and food bags if there is no kitchen.

Progress made (continued):

- Arrange events at end of month when residents are often going hungry.
- Community health workers in buildings – peer based support.
- DESC – full kitchens to offer meals at sites.

Next steps:

- Education needs to reflect personal goals and culture.
- Ongoing support required to help residents track and follow up on resource information.
- Resources that support shift to quality of food versus quantity.
- Expanding service coordination and understanding of what should be offered in housing settings.
- Support socialization opportunities w/meals and education.
- Expand healthcare provider knowledge of resources.
- Clinicians can provide education but this may only results in short-term changes (fear-based tactics); peer based education is more effective and long-lasting: Clinicians provide the WHY; Community Health Workers/Peers can provide the HOW.

Table 10: Demographics and Diversity

Table Facilitators: Ruben Rivera-Jackman, KCHA, Jessica Coifman, Generations Aging with Pride

Current understanding:

- Seattle is a diverse city – there's a growing aging population
- Larger portion of aging immigrants
- LGBTQ aging community will double by 2030
- 20% undocumented at shelters; additional barriers for those who are aging (i.e. no social security card)

Progress:

- More protected classes in Seattle but not yet federally.
- Unless services are within housing facilities, individuals will not stay housed.
- Identifying vulnerable populations in aging community – homeless, LGBTQ, POC, immigrants.
- Generations with Pride – offers LGBTQ training.
- King County Housing Authority (KCHA) – regionalize service provision, not operating in silos.
- Assessment in fair housing – addressing protected classes.

Next Steps:

- Why is low-income not a protected class?
- Incorporate service delivery in housing.

Table 11: Data

Table Facilitator: Andrew Calkins, KCHA

Current understanding:

- HIPAA issues.
- How do we show that interventions are working or not?
- Still a lot to learn about, what services are needed.
- Want to use data to target interventions.
- Need more best/promising practices.
- How many new folks coming into homelessness?
- Data not available in a dashboard, user-friendly format.
- Want to become a more data-driven organization, monitor outcomes.

Progress:

- RHA Health Fair, 15-20 organizations
- Mercy/Accountable Communities of Health (ACH) Data integration
- Hyde Shuttle for medical appointments, activities
- Food Lifeline produce
- Annual assessment of health –Long Term Supports and Services
- Not shared with housing
- 46 SHA buildings
- Are East King County Housing providers connecting with other older adult care providers/partnerships? In KCHA Bellevue sites, for families.
- Work at Northaven to connect with other community supports, shows that things are working.
- Fire department has data on what/where incidents are occurring.
- Looking at monitoring, super granular, of activity within a person's unit.
- Area Agency on Aging (AAA) uses output data, compares clients but only demographics, not about how people are improving or not.
- Good momentum.
- Center for Supportive Housing uses performance-based contracting; would be good to have it publicly available.

Next Steps

- Information sharing
- Roles definitions
- Intergenerational activities
- Medicare data integration

Next Steps (continued):

- Creating patient /resident ownership and choice over health services options access, patient-centered
- Path to employment, care training
- Managed care for dual eligible
- Need more data; consistent strategies to understand data
- Need better ways to track data of residents
- Need more evidence about what works
- More cross-sector collaboration and discussion
- More data linkages with people not at the table
- More data more publicly available in Dashboards
- Workshops on how to use data and interpret it

Table 12: Healthcare Transformation/ACHs

Table Facilitator: Bill Rumpf, Mercy Housing NW

What are sustainable, scalable means of housing-based health promotion?

Progress:

- Mercy uses Community Health workers who are multi-lingual and increase cultural competency. Mercy, NeighborCare, Global to Local all have community health workers in KCHA and SHA properties.
- Seattle Office for Housing (OH), is very supportive of the Medicaid benefit to support residents in need. OH oversees 12,446 homes, a large portion of which are occupied by residents aging in place, so it is a sustainability issue. "The future is in front of us." OH is open to helping organize technical support, advocacy training.
- Bright spots in rural mental health in Kitsap, Jefferson, and Clallam counties HARPS- Housing and Recovery through Supports, a program in 7 Behavioral Health Organizations (BHOs) in the state to help address range of behavioral and mental health issues, and Peer Bridgers, a state program to help transition people out of state mental health hospitals. Salish BHO would be a pass-thru for Medicaid 1115 Waiver dollars.
- Case managers at Asian Counseling and Referral Services (ACRS) are seeing a rise in Asian/Pacific Islander elders experiencing homelessness. Most of those served also have behavioral health issues. A bright spot is the front line staff/case managers.
- Plymouth Housing is partnering with Neighborcare and Harborview to provide a part-time on-site clinic at the Simons Building. The clinic serves everyone, not just residents of Simons or other Plymouth properties.
- Very excited about SASH.
- Mercy is getting intentional about boundary spanning, hired a new position to help with that. Going forward, particularly under new GOP federal leadership, pressure is on for demonstrable cost savings.

Table 13: Advocacy Strategies

Table Facilitator: LeighBeth Merrick, LeadingAge WA

Current understanding:

- Capture the data and translate it into advocacy tools, telling the engaging and captivating human stories.
- Media involvement
- Coalition building across complicated health and housing systems, partnering with like-minded advocacy groups and organizations, while recognizing real resource constraints.

Progress:

- Legislative, lobby days; meetings with elected officials; letter writing to elected officials (save Hyde Shuttle).
- Candidate forums with partners.
- Testifying at local council meetings.
- Educating providers, communities.
- Cross-sector work to bring systems together (example, Boundary Spanner – Mental Health expert work in OH to help Housing staff navigate mental health systems and identify opportunities for integration.
- Work with Fire Department to identify “hot spots” of vulnerable residents. Volunteer Chore/Catholic Community Services partners with the Bellevue Fire Departments to address needs.
- SHAG partnership with Qualis Health assists residents with diabetes management; could expand to other areas.

Next steps:

- Unified voice for all stakeholders and data to support advocacy.
- Capacity to support more cross-sector work to identify opportunities for integration.
- State LTSS and health care reform projects outreach to affordable senior housing providers; use of Medicaid 1115 Waiver opportunities (example: Tailored Supports for Older Adults).
- Advocacy for service coordination programs that work, like SASH; pursue new Health Home Medicaid care coordination program in King/Snohomish counties.
- Address what to do about people who are slightly over income for Medicaid.
- Address rental barriers for seniors with evictions.
- Hearing loss design.
- Involve the whole surrounding community to serve residents.
- Think, talk and act more systemically.

Table 14: Age-Friendly Communities

Table Facilitators: John Forsyth, SHA, Jon Morrison Winters, Aging and Disability Services

Current understanding:

- Age integrated: youth and elders
- Interdependency vs. “independence”
- Strengthen volunteerism
- Facilitates visitors/interaction
- A place where elders are both supported and appreciated, valued, provide leadership – the systems that support them are flexible – e.g., fire fighters, customer services, etc. The elder has to be a full partner, not “being done to”.
- Important to not see elders (or people with disabilities) as recipients of services – all in this together.
- Make sure the community is able to get information about services – help enable people to get the information on what systems are available. Communications and access to resources can be very difficult.
- Need to make it easy – neighborhood integration, make sure you can get what you need where you need it. Integral. Common sense approaches.

Progress:

- NE Seniors Together (NEST)
- Phinney Ridge Neighborhood Association
- Social Networks (internet-based)
- Timeshares

Next Steps:

- Aging in place at SHA, there are not a lot of places for people to transition and there are those who don't want to transition. How can we help people live in the community with a coordinated system and how do we create social networks.
- SHA is putting money behind community building – volunteer recognition initiative. A small sum of money to facilitate this work e.g., cards for bridge clubs, yoga instructor. Also what can we do to support external volunteers?
- Village concept – provides for individual needs (dog walking , home services, etc.) but also shaped by the community. Sees the older people and their voices as of value. Grassroots and multi-generational, support the social fabric. Leveraging community resources.
- The challenge to financing affordable housing is how strong partnerships are and financing the models. Don't want cash flow to go to services – maximize debt service v. having more access to soft money – math problem. Need to fundraise outside to get services.
- Give consideration to diversity and range of ethnicities of older population. Family housing should support the age spectrum in some communities where the families are multi-generational.

Next Steps (continued):

- Consider cooperative housing.
- Integrate ages in some housing: multigenerational models linking students and older adults.

Closing Remarks

Marty Kooistra, Housing Development Consortium

Group take-aways (audience response):

- Robust conversations between housing and healthcare providers.
- Let's not forget about seniors living in their own homes.
- Think act and talk more systemically – what makes a person's life whole and healthy.
- Housing as a verb!!
- Support for staff who are providing services in housing – pay is low, stress, need more training. Better support for them will increase quality of life for all.
- Opportunity for resident leadership and empowerment.
- Lots of preconceived ideas about what people need – RFPs are examples of this – challenge to make sure their voices are part of the conversation.



Many thanks to our forum presenters, sponsors, planning committee members, supporters and attendees for making this program possible.

As with all of our *Housing and...* events, we hope that this will only serve as a starting point for the work and collaboration ahead.

-HDC Staff

Appendix

Event Program	1
Presenter Biographies	2
Glossary of Terms	3

Presentation Slides

1. Keynote Presentation - Nancy Eldrdige, NCHH	6
2. Panel Presentation - Liz Prince, ALISA	34
3. Panel Presentation - Debbie Thiele, CHS	46
4. Panel Presentation - John Forsyth, SHA	56
5. Panel Presentation - Jay Woolford, SHAG	60

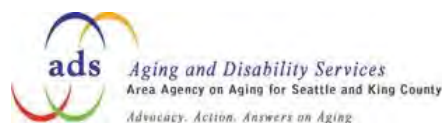
Roster of Forum Attendees.....	68
--------------------------------	----



A Forum on Housing and Aging

A Forum on Housing and Aging

Thank you to our partners and sponsors!



Thanks to our Housing and Aging Planning Committee:

Aging and Disability Services
HDC Senior Housing Affinity Group
Kawabe House
King County Housing Authority
LeadingAge WA
Northaven
Rebuilding Together Seattle
SAGE Architectural Alliance
Seattle Housing Authority
Seattle Office of Housing
SHAG
Tonkin Architecture
WSHFC

Welcome 9:05 am

Marty Kooistra, Executive Director,
Housing Development Consortium Seattle-King County

Introduction

Deb Murphy, Executive Director, LeadingAge WA

Introduction to Mayor Murray

Maureen Linehan, Division Director,
Aging & Disability Services, Seattle

Mayor Ed Murray, City of Seattle

Keynote

Nancy Eldridge, National Center for Healthy Housing

Panel Discussion

Pam Piering, Moderator

Liz Prince, Aging and Long-Term Support Admin (ALTA)

Debbie Thiele, Corporation for Supportive Housing (CSH)

John Forsyth, Seattle Housing Authority

Jay Woolford, Senior Housing Assistance Group (SHAG)

Break 10:45 am

Small Group Table Discussions

Closing Remarks and Adjourn, 12:00

Appendix 1

A BIG thank you to our keynote and panelists for joining us today

Nancy Eldridge, Executive Director for the National Center for Healthy Housing, joined NCHH in August 2015 after 16 years as the chief executive officer of the Cathedral Square Corporation, a Vermont-based nonprofit, where she increased the number of CSC's affordable housing communities to 28 and expanded its focus to include the health of Vermont's aging population. She is the founder of the Support and Services at Home (SASH) initiative, a team effort to help Medicare beneficiaries remain at home and get the services they need, when they need them. Ms. Eldridge holds a master's degree in urban and environmental policy from Tufts University, and in addition to continuing to support the improvement of substandard housing, Ms. Eldridge views the thousands of high-quality affordable housing developments across the country as a valuable asset in healthcare reform and essential to healthy neighborhoods.

Liz Prince, MA, LMFT is the Project Director for Washington State's Money Follows the Person (MFP) demonstration project, Roads to Community Living (RCL), located within the Department of Social and Health Services (DSHS), Aging and Long Term Supports Administration (AL TSA). As part of her role, she supervises a unit which oversees housing and quality initiative projects. Prior to joining DSHS in 2006, Ms. Prince worked in non-profit agencies in both field and administrative positions, working with varied populations including individuals with behavioral health issues, seniors, adults with disabilities, and those experiencing homelessness. Ms. Prince has been involved in state and local long-term service and support systems change activities for over 30 years. Ms. Prince received a bachelor's degree in psychology and women's studies from the University of Rochester, New York, and a master's degree in counseling psychology from John F Kennedy University in the Bay Area of California. She has been a licensed Marriage and Family Therapist since 1990, and a CAMFT Certified Supervisor since 2001.

Debbie Thiele

John Forsyth serves as the Administrator of the Seattle Housing Authority Community Services Division. In this position, John partners with community members and numerous organizations on initiatives promoting economic self-sufficiency; healthy aging-in-place; academic success; community building; youth development; and, fundraising. He currently leads the Aging-in-Place initiative for the Seattle Housing Authority which aims to assist older adults age successfully in SHA assisted housing. SHA houses 10,000 adults 50 years or older. John is an expert in developing partnerships with other public and non-profit organizations, as well as with private sector partners. In addition, under his leadership Seattle Housing Authority has successfully obtained and utilized grant funding from the Seattle Foundation; Gates Foundation; Robert Wood Johnson Foundation; JP Morgan Chase Foundation; HUD; and, the Department of Labor. John has a Masters of Public Administration from the University of Washington and a Bachelor of Arts from Whitworth University. Prior to joining Seattle Housing Authority, he spent over ten years working for non-profit agencies conducting community development and emergency relief work in developing countries.

Jay Woolford has over 25 years of executive experience in senior housing. Currently, he is the Executive Director of SHAG, the largest provider of affordable senior housing in Washington State. Under Jay's leadership, SHAG has focused on developing the supports and services necessary for providing its residents to safely continue to live independently through collaboration and partnerships with other non-profits. Jay currently serves as the Leading Age Washington Board Chair and previously chaired the Senior Living and Community Services Committee. He also serves on the Seattle Central Community College technical advisory council, University of Washington professional education advisory committee and the Policy Advisory Taskforce (PAT) of the Governor's Affordable Housing Advisory Board (AHAB) for Washington State. Starting out as an architect, he began focusing on senior housing early in his career and that interest in environment, place, support and community has carried forward. Jay started his studies in art and philosophy and graduated from Cornell University with a BArch.

A Common Language: Terms and Acronyms

Addressing the challenges of integrating housing and services for seniors will require creative solutions that cross the silos of housing, health care, and social services. The following list of terms and acronyms will help us develop a common language to work together to improve the lives of older adults in our community. Thank you for joining us!



Glossary of Terms

Accountable Care Organization (ACOs): A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

Adult Family Home (AFH): A state-licensed neighborhood home for two to six residents where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided. Some provide occasional nursing care and/or other specialized care.

Affordable Housing plus Services: An unlicensed, subsidized congregate property for low-income seniors that provide access to a range of health-related and supportive services available to residents on a voluntary basis when they need and want them.

Age-Friendly Communities/Age-Friendly Seattle: The AARP Network of Age-Friendly Communities encourages states, cities, towns and rural areas to pay increased attention to the environmental, economic and social factors that influence the health and well-being of older adults. The City of Seattle joined the AARP Network of Age-Friendly Communities in July 2016.

Area Agency on Aging (AAA): Established under the Older Americans Act (OAA) in 1973, AAAs allow older adults to “age in place” in their homes and communities by providing a range of services and living arrangements to choose from. King County’s AAA is Aging and Disability Services (ADS) in the City of Seattle Human Services Department.

Assisted Living Facility (ALF): A state-licensed facility for seven or more residents where staff assumes responsibility for the safety and well-being of the adult. Meals, laundry, supervision, and varying levels of assistance with care are provided. Some provide nursing care and/or other specialized care.

CCRC--Continuing Care Retirement Community: Offers accommodations on a continuum of care, from independent living to assisted living to nursing-home care, in one complex.

Home and Community-Based Services (HCBS): Services that may allow a senior or person with a disability to remain in their own home or community rather than moving to an institutional setting. Eligible individuals may receive Medicaid-funded services authorized by a case manager.

HUD 202 Program: A Housing and Urban Development (HUD) program that provides capital advances to nonprofit sponsors to finance the development of senior housing. HUD also provides rental assistance (known as Project Rental Assistance Contracts), which makes up the difference between the maximum rents that eligible seniors can pay (30 percent of adjusted income) and the operating expenses of a particular development. No funds have been appropriated for new Section 202 Capital Advances for FY 2012–FY 2015.

Independent Living: Apartments, cottages, condominiums, and single-family homes for senior residents who do not require assistance with daily activities or 24/7 skilled nursing but may benefit from convenient services, senior-friendly surroundings, and increased social opportunities.

Low Income Housing Tax Credit (LIHTC): The federal government's primary program for encouraging the investment of private equity to develop affordable rental housing for low-income households.

Medicaid: A program that helps low-income individuals pay for long-term medical and custodial care. Medicaid is funded primarily by the federal government and run at the state level, where coverage may vary.

Medicaid 1115 Demonstration Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects, giving states additional flexibility in order to demonstrate and evaluate policy approaches. Washington State recently received an 1115 Waiver with three components: Transformation Projects under Affordable Communities of Health, Long Term Services and Supports, and Supportive Housing/Supported Employment.

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Permanent Supportive Housing: Part of the homeless services system, Permanent Supportive Housing is a combination of housing and services designed for people with serious mental illnesses or other disabilities who need support to live stably in their communities.

Program of All-Inclusive Care for the Elderly (PACE): A voluntary managed-care program that provides long-term care and acute medical services, using Medicare and Medicaid benefits, to older and disabled adults who meet nursing-facility level of care.

Roads to Community Living: A Washington state demonstration project designed to help people with complex, long-term care needs move back into the community. Part of a federal project, "Money Follows the Person."

Quiet Crisis: A 2009 report with recommended strategies for improving and expanding senior housing in King County. *Quiet Crisis* was a collaborative effort of the City of Seattle Human Services Department/Aging and Disability Services, Seattle Office of Housing, Seattle Housing Authority, King County Housing Authority, and King County Department of Community and Human Services.

Section 8: Privately owned rental dwelling units participating in the government's low income rental housing assistance program. HUD pays a portion of the fair market rent value, with the tenant paying the other portion. Section 8 comes in two forms – tenant based and project based.

Skilled Nursing Facility (SNF): Nursing homes provide 24-hour supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board and laundry. Washington state's Department of Social and Health Services (DSHS) is responsible for licensing and oversight.

Universal Design: Refers to broad-spectrum ideas meant to produce buildings, products and environments that are inherently accessible to everyone regardless of age or disability.

Common Acronyms

ACO: Accountable Care Organization

ADL: Activities of Daily Living

APS: Adult Protective Services

ALTSA: Aging and Long-Term Support Administration

CMS: Centers for Medicare and Medicaid Services

CFC: Community First Choice (State Plan)

C.A.R.E. Tool: Comprehensive Assessment Reporting Evaluation

DOH: Department of Health

DDA: Developmental Disability Administration

EBITA: Earnings before interest, taxes, and amortization

HCS: Home and Community Services (part of ALTSA)

LTC: Long Term Care

LTSS: Long Term Services and Supports

MHP: Mental Health Provider

NFLOC: Nursing Facility Level of Care

POLST: Physician Orders Life Sustaining Treatments

PACE: Program of All-Inclusive Care for the Elderly

RCDA: Resident Care Discharge Allowance

RCS: Residential Care Services (part of ALTSA)

RCL: Roads to Community Living



A forum on Housing and Aging

Keynote Presentation



HOUSING
DEVELOPMENT
consortium

Nancy Eldridge
National Center for Health Housing

KING COUNTY

HOUSING & AGING FORUM

November 17, 2016



Why Healthy Housing for Older Adults?

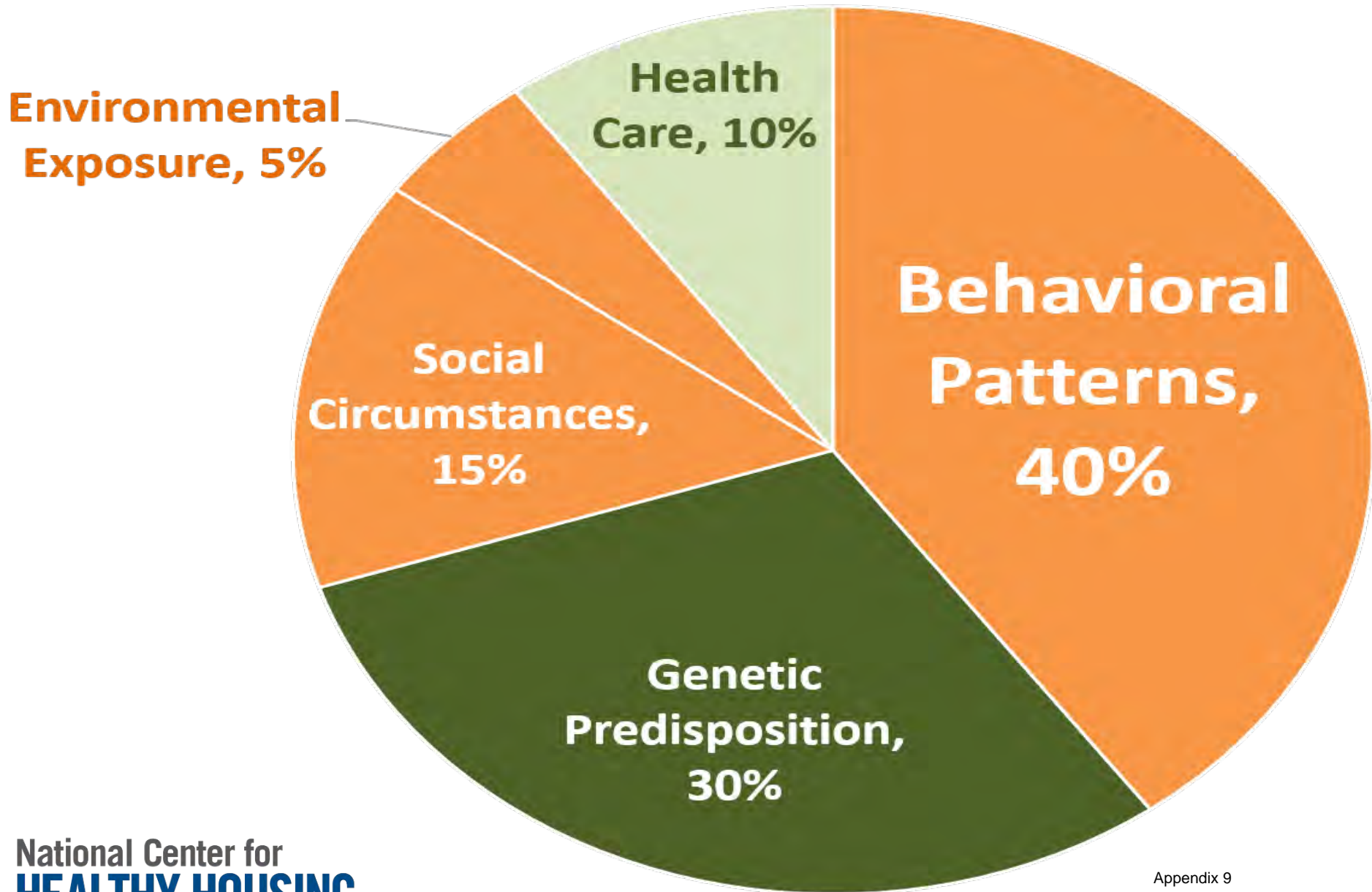


Seniors Aren't Going Anywhere



- Preference to stay at home
- Lack of care setting alternatives
- Lack of production of affordable housing
- Fair Housing Protections

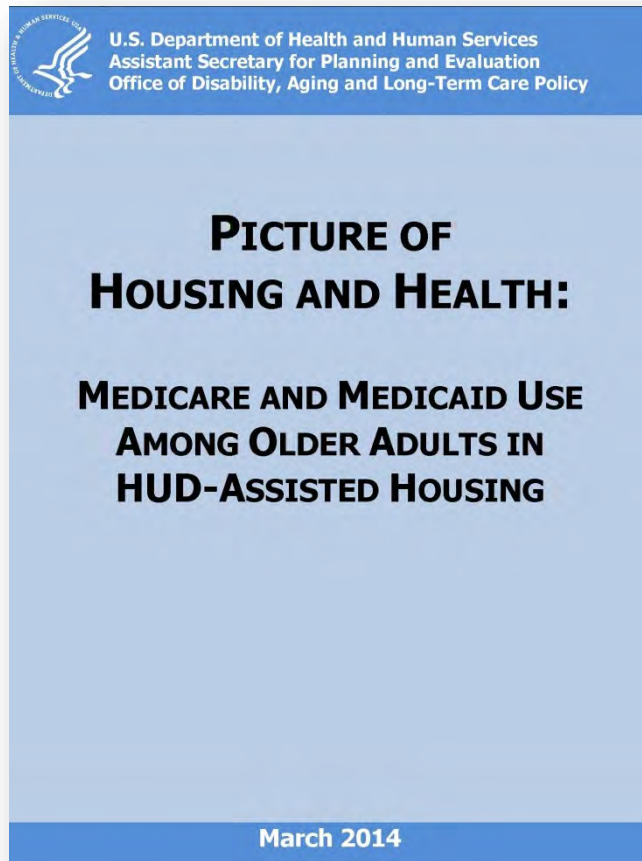
Proportional Contribution to Premature Death



Behavior Begins at Home



Reaching the Highest Need



- Starting with HUD assisted housing makes sense
- Build out from there.....

Housing: the Decentralized Network We Need



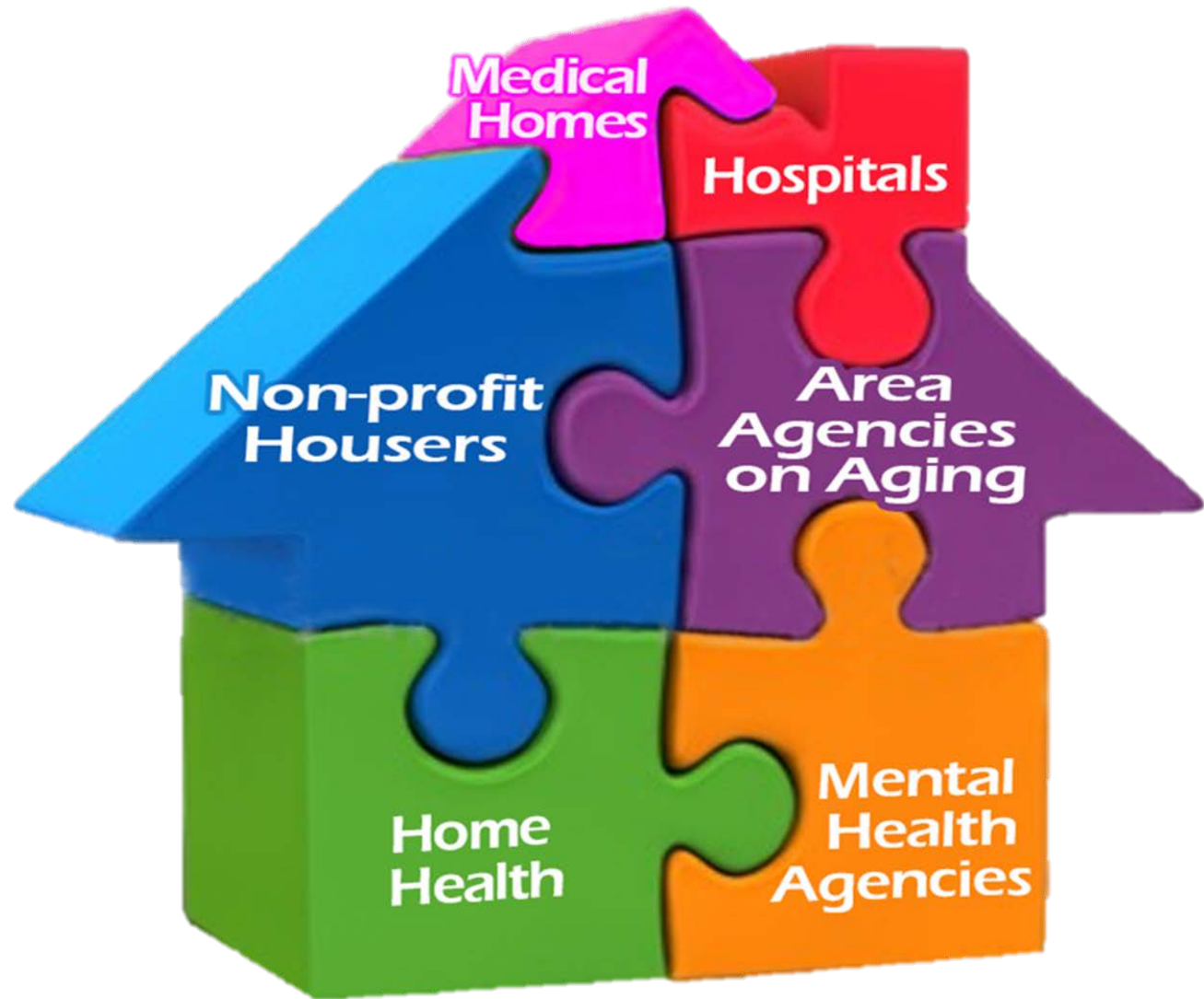
BIPARTISAN POLICY CENTER

Healthy Aging Begins at Home

The BPC recommends that CMS launch an initiative to integrate health care and LTSS in publicly assisted housing.

May, 2016

SASH: A Team Effort



Core Elements

- Uniform Assessment
- Shared Care Plan
- Centralized Database
- Evidence Based Practices
- Prevention



DATA, DATA, DATA

0-Vitals

1-Participant Information, Emergency Contacts, Provider and Legal

2-General Health, Wellness and Services

3-ADL/IADL

4-Falls

5-MACH-10 Falls Risk Assessment Tool

6-Mobility Survey

7-Nutritional Health Checklist

8-Cognitive Health Screening

9-Program Evaluation Activities

AUDIT

GAD-7

Lubben Social Network Scale (LSNS-6)

PHQ-9

S-MAST-G

A Menu of Evidence Based Practices

- CAPABLE
- PEARLS
- MATTER OF BALANCE
- EAT BETTER MOVE MORE
- CHRONIC DISEASE SELF MANAGEMENT PROGRAM
- IMPACT
- HEALTHY IDEAS
- WRAP

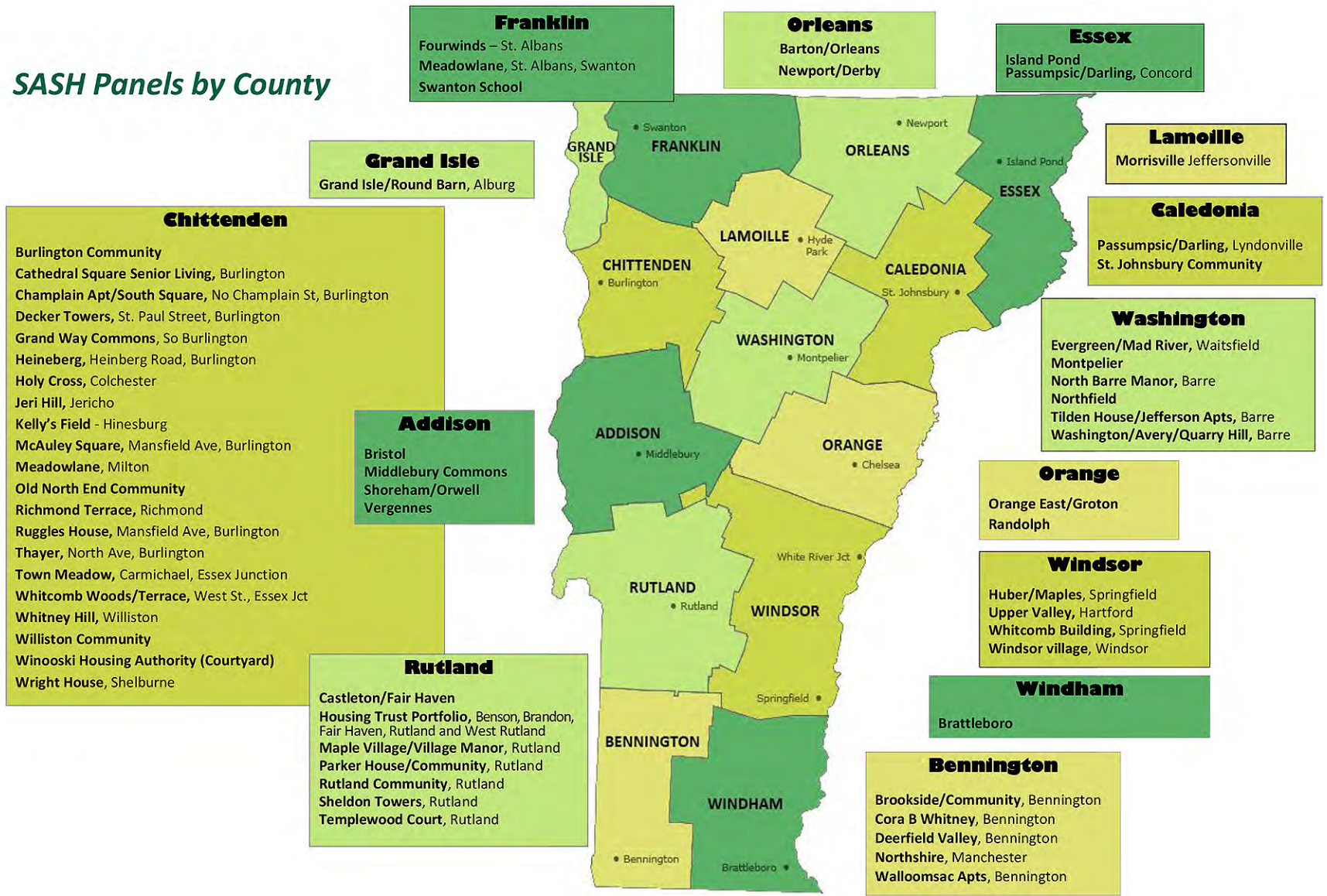


Systems Change

- Panels/Population Health
- Capitated Payments/Global Budget
- Flexible funding
- No Discharge
- Scale
- Agnostic Model



SASH Panels by County

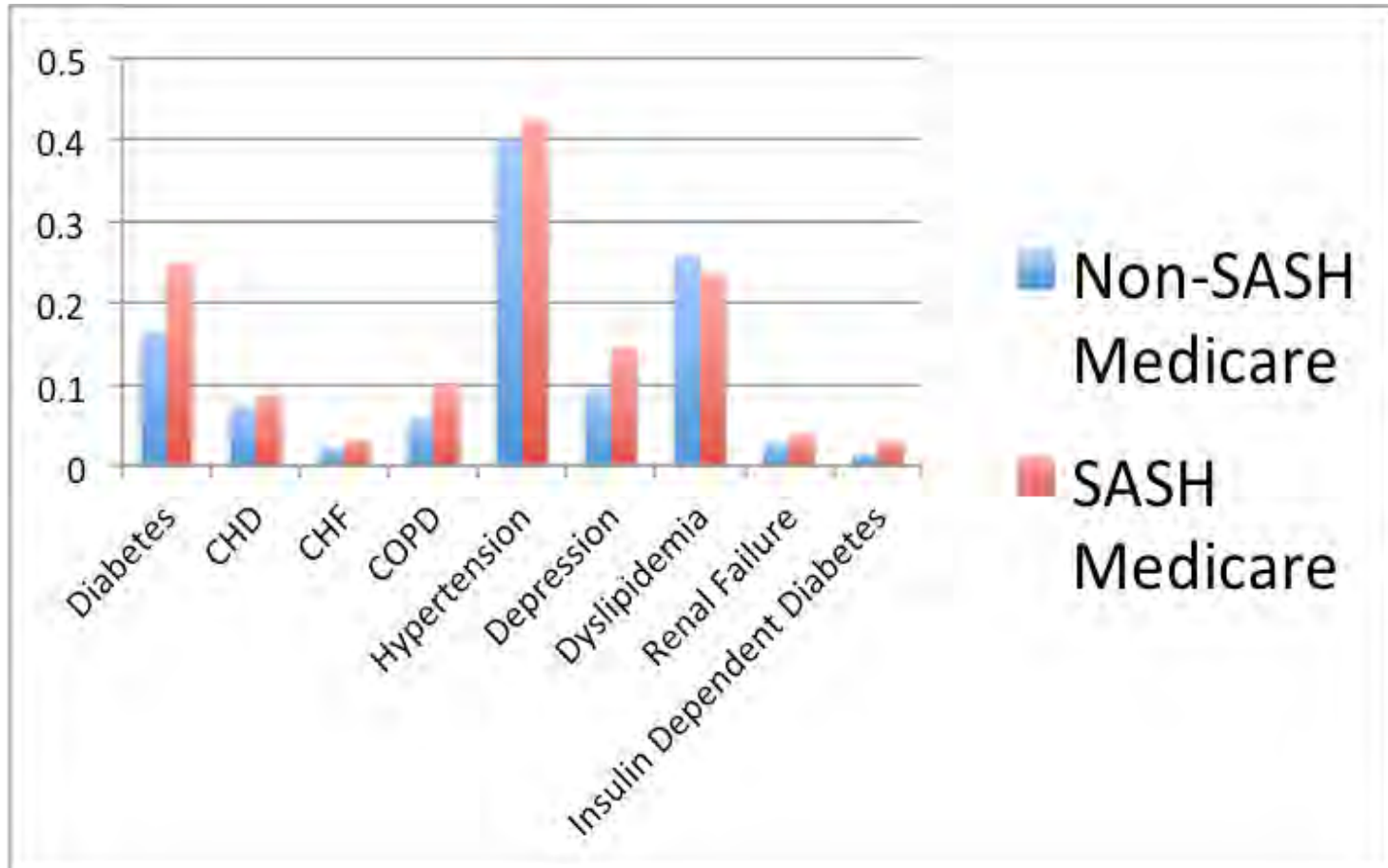


Statewide Systems

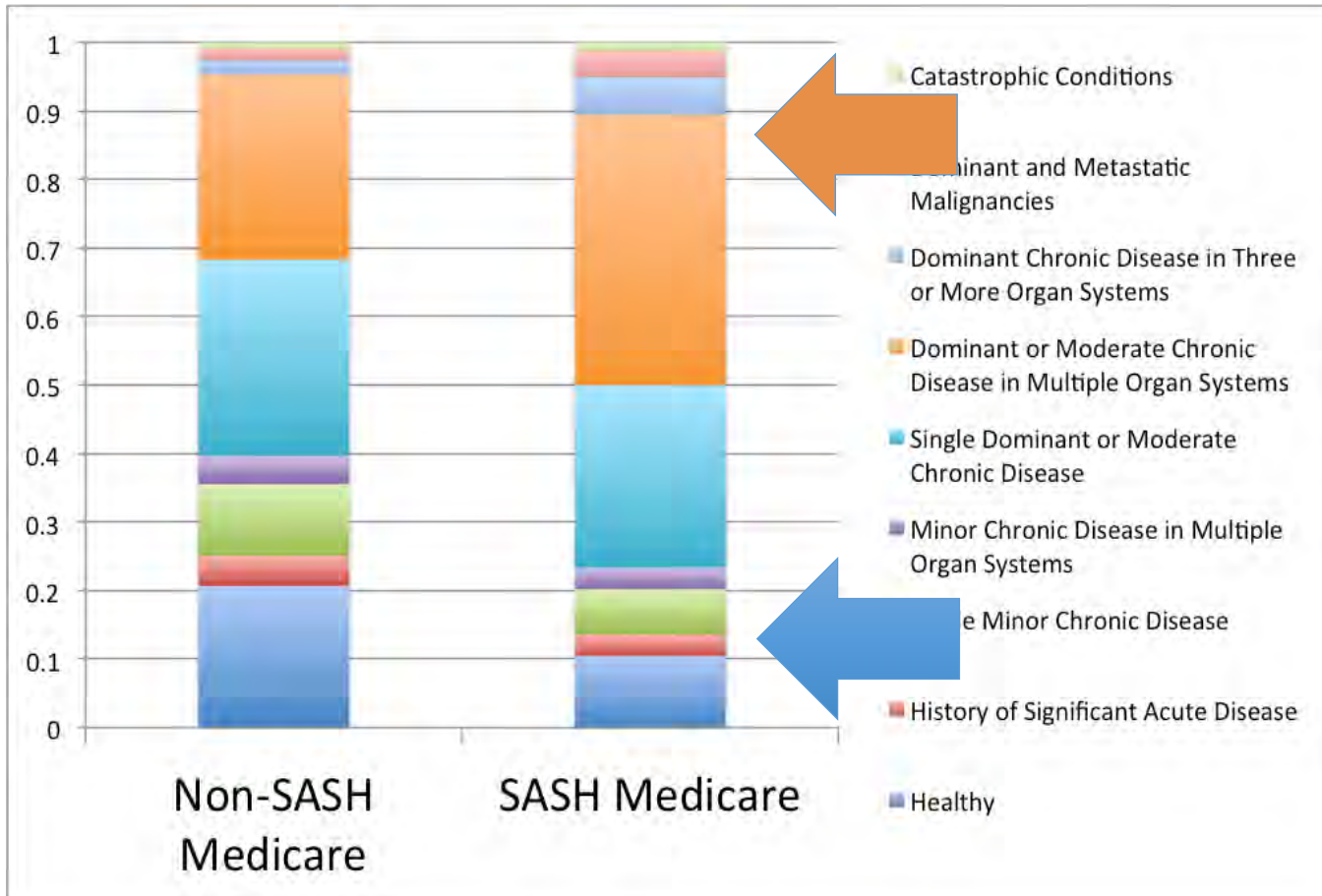
Washington's Got Housing!



Health Conditions in SASH Participants compared to Non-SASH Participants



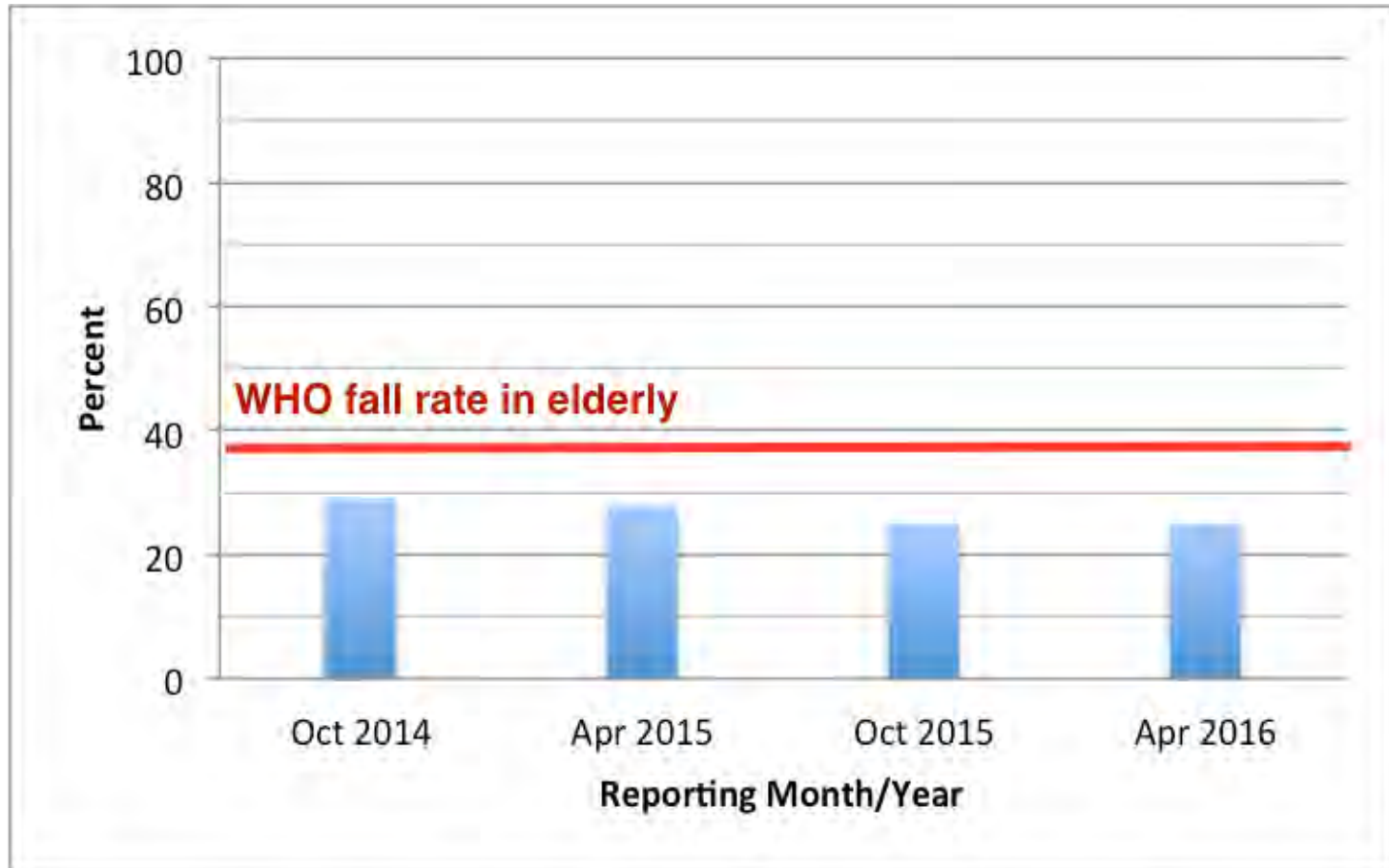
Clinical Risk Groupers (CRG) in SASH Participants compared to Non-SASH Participants



SASH Health Outcomes (Oct 2014 – Apr 2016)

	Oct 31 2014 (n=3076)	Apr 30 2015 (n=3603)	Oct 31 2015 (n=3807)	Apr 30 2016 (n=4098)
Advance Directives				
Documented	53%	53%	54%	59%
Immunizations				
Shingles Vaccine	20%	26%	30%	34%
Pneumococcal Vaccine	53%	57%	60%	63%
Flu Vaccine (seasonal)	19%	42%	11%	61%
Falls				
Fall (within 12 months)	29%	28%	25%	25%
Blood Pressure				
Checked within 6 months	52%	49%	39%	59%
If checked, in control	76%	74%	76%	77%

Percent of SASH participants who have fallen in the past 12 months



Major Findings: 2nd Annual Report

- January 2016
- SASH sample size = 1602
- 3 years of implementation

SASH continues to slow the growth of total annual Medicare Expenditures

*Growth in annual Medicare expenditures was statistically significantly lower, by an estimated **\$1,536** per beneficiary, in early panels*

APHA:
2016 Archstone
Award for
Excellence in
Program
Innovation

Denver October 2016



HUD Supportive Services Demo

- 40 intervention sites/40 control sites
- \$15M: 5 years
FR-5900-N-22



What's Next: Building on the Platform



- Tele-health
- Adding new interventions
- Build workforce
- Getting systems change models to scale nationally

Permanent Value Based Payment Methods

- Multi-payer pools
- Medicare Advantage at Home
- **All Payer Models**
- Financial Alignment Models
- Medicaid HMOs
- Medicaid Waivers



SCALE

- Congregate hubs
- Community dwellers
- All Medicare beneficiaries
- Family housing
- Homeowners
- Medicaid beneficiaries



Let's Build a System

- Organize
- Seek pilot funding
- Define scope
- Collaborate with health care system reforms
- Determine sustainable payment method



Nancy Rockett Eldridge, Executive Director, NCHH

neldridge@nchh.org

www.SASHVT.org

www.nchh.org/program/olderadults.aspx

www.nchh.org ♦ [@NCHH](https://twitter.com/NCHH) ♦ facebook.com/HealthyHousing

National Center for
HEALTHY HOUSING

Panel Presentation
Liz Prince, AL TSA

AL TSA : Aging and Long Term Support Administration

Transforming
Lives

Vision

Seniors and people with disabilities living in good health, independence, dignity, and control over decisions that affect their lives

Mission

To **Transform Lives** by promoting choice, independence and safety through innovative services

Serving approximately
74,000 individuals per year

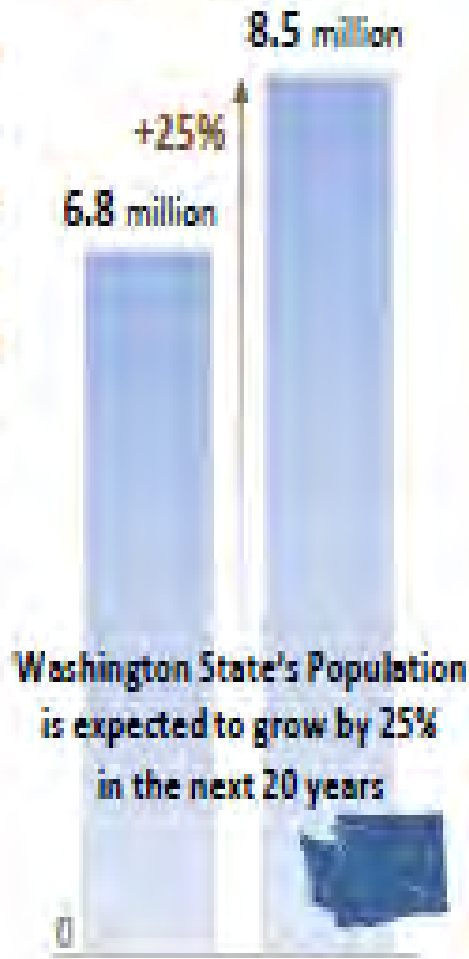
- Average monthly caseload 62,000
 - 36% individuals with disabilities
 - 64% seniors

WA: The Bigger Picture

PEOPLE

Increasing numbers

The state's population is expected to grow by 25 percent over the next 20 years—from 6.8 million to 8.5 million.



SENIORS

An aging population

TODAY ...



1 in 8 residents is 65 years or older

BY 2030 ...



1 in 5 will be 65 or older

More will be over 65, as baby boomers enter retirement. Demand for long-term care and health care services will increase, driven by chronic health conditions.

Functional and Financial eligibility requires an individual assessment by HCS

<https://www.dshs.wa.gov/altsa/aging-and-disability-services-long-term-care-manual>

Chapter 3, 7a – Assessment, Financial Eligibility for Core Programs

Medicaid Eligibility Standards

Medicaid Personal Care Benefit

Client requires substantial assistance with at least one, or minimal assistance with more than two, of the following direct personal care tasks:

- Eating, toileting, self-medication
- Personal hygiene, bathing
- Specialized body care, dressing
- Transfer/positioning, ambulation

Long-Term Care Income Standards

Income standards Used to determine income eligibility and financial participation in long-term care

Description	Effective	Amount
Medicaid special income level (SIL) 300% of the FBR . May change annually on January 1 based on consumer price index. Maximum gross income level for CN-P Institutional Medicaid. Note	1/1/2015 - 12/31/2016	2199
Federal Benefit Rate (FBR) Medically Needy Income Level (MNIL) Categorically Needy Income Level (CNIL) HCA Medical Standards chart	1/1/2015 - 12/31/2016	733
Federal Poverty Level (FPL) Increases annually on April 1	4/1/2016	990
Basic community spouse maintenance and family allocation. 150% of the 2-person FPL . Increases annually on July 1. for spouse and dependent.	7/1/2015	1992
Maximum community spouse maintenance allowance. May change annually on January 1 based on the consumer price index. (with excess shelter costs)	1/1/2015 - 12/31/2016	2981
Excess shelter cost standard. Increases annually on July 1. 30% of 150% of the 2-person	7/1/2015	598
Utility standard for determining excess shelter costs for a community spouse.		420

Approx. 75% of AL TSA's LTC clients pay between 0-\$196 in participation (120% Federal Poverty Level, or \$1,177 per month)

Long Term Care Core Programs

In-home support 64% (caseload approximately 40,000)

Includes:

- Community First Choice (State Plan)
 - Personal care (Individual and Agency Providers)
- Waiver services
 - COPES

Residential Care 20% (caseload approximately 12,000)

Includes:

- Adult Family Homes
- Assisted Living

Nursing Facilities 16% (caseload approximately 10,000)

1115 Transformation Waiver

Initiative 1 Transformation through Accountable Communities of Health	Initiative 2 Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care	Initiative 3 Targeted Foundational Community Supports
<p data-bbox="54 528 600 682">Delivery System Reform</p> <ul data-bbox="73 696 587 963" style="list-style-type: none">• Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.	<p data-bbox="734 528 1280 671">Benefit: Medicaid Alternative Care (MAC)</p> <ul data-bbox="753 692 1261 842" style="list-style-type: none">• Community based option for Medicaid clients and their families• Services to support unpaid family caregivers <p data-bbox="730 892 1300 1063">Benefit: Tailored Supports for Older Adults (TSOA)</p> <ul data-bbox="753 1078 1280 1306" style="list-style-type: none">• For individuals "at risk" of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria• Primarily services to support unpaid family caregivers	<p data-bbox="1400 528 1889 668">Benefit: Supportive Housing</p> <ul data-bbox="1381 685 1889 913" style="list-style-type: none">• Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do <i>not</i> include Medicaid payment for room and board. <p data-bbox="1406 935 1883 1106">Benefit: Supported Employment</p> <ul data-bbox="1406 1120 1864 1278" style="list-style-type: none">• Services such as individualized job coaching and training, employer relations, and assistance with job placement.
<p data-bbox="119 1363 552 1406">Transformation Projects</p>	<p data-bbox="1052 1363 1543 1406">Medicaid Benefits/Services</p>	

Initiative 2: Ages 55+ Eligible

Medicaid Alternative Care (MAC)

- Support unpaid caregivers, avoiding or delaying the need for more intensive Medicaid-funded services.
- Eligible for Medicaid but not currently using Medicaid-funded LTSS

Targeted Supports for Older Adults (TSOA)

- Avoid or delay the need for Medicaid-funded services
- Eligibility category and benefit package for people “at risk” of future Medicaid LTSS use who do not meet Medicaid financial eligibility criteria

Benefit packages: MAC & TSOA

Caregiver Assistance Services

- Services that take the place of those typically performed by unpaid caregiver

Training and Education

- Assist caregivers with gaining skills and knowledge to care for recipient

Specialized Medical Equipment & supplies

- Goods and supplies needed by the care receiver

Health Maintenance & Therapies

- Clinical or therapeutic services for caregiver to remain in role or care receiver to remain in home

Personal Assistance Services

- Supports involving the labor of another person to help recipient (TSOA only)

Initiative 3: Permanent Supportive Housing (PSH)

No age restriction

Benefit offered through three administrations:

- Health Care Authority (HCA)
- Behavioral Health Administration
- Aging and Long Term Support Administration (AL TSA)

Targeting individuals difficult to serve through traditional state plan/waiver services

- **Must meet one of the following criteria:**
 1. Chronically Homeless persons with disabilities (as defined by HUD), or
 2. Frequent or lengthy institutional contacts, or
 3. Frequent or lengthy adult residential care stays, or
 4. Frequent turnover of in-home caregivers or providers, or
 5. PRISM Risk score of 1.5 or above

Benefit Package - PSH

Housing transition services that provide direct support to help individuals obtain housing, including:

- Housing assessment and development of a plan to address barriers.
- Assistance with applications, community resources, and outreach to landlords.

Housing tenancy sustaining services that help individuals maintain their housing, including:

- Education, training, coaching, resolving disputes, and advocacy.

Supportive housing services **do not** include funds for room and board or the development of housing.

Health Homes: A program, not a place

Eligibility

- Medicaid eligible
- Has one chronic condition
- At risk for a second chronic condition
- Must have a PRISM score of 1.5 or higher

Housing

- Assists in access to housing
- Help maintain current housing
- Support health management
- Identifies gaps in care and makes referrals
- Provides transitional care after hospitalizations
- Assists with finding needed resources

July 2015-June 2016

66,957

Average annual
enrollment

9.32%

Encounter Rate

Contacts

AL TSA

- Website www.dshs.wa.gov/altsa

Healthcare Authority (HCA) 1115 Resources

- Website www.hca.wa.gov/hw
- Email medicaidtransformation@hca.wa.gov

Liz Prince

prince@dshs.wa.gov

360-725-2561

Panel Presentation
Debbie Thiele, CSH

Healthy Aging and Supportive Housing



The Source for
Housing Solutions

About CSH

Advancing housing solutions that:



**Improve the lives
of vulnerable
people**



**Maximize public
resources**



**Build strong,
healthy
communities**

Quality Supportive Housing

Targets the most vulnerable people.

Is affordable.

Requires only standard lease obligations.

Engages tenants in voluntary services.

Coordinates among partners.

Is integrated into the community.

Supportive Housing is for People Who:

- Are chronically homeless.
- Cycle through institutional and emergency systems and are at risk of long-term homelessness.
- Are being discharged from institutions and systems of care.
- Without housing, cannot access and make effective use of treatment and supportive services.
- Without services, do not succeed in housing



Unique Health Issues of Vulnerable Elders

Early-onset geriatric conditions

- **15-20** years earlier

Mortality

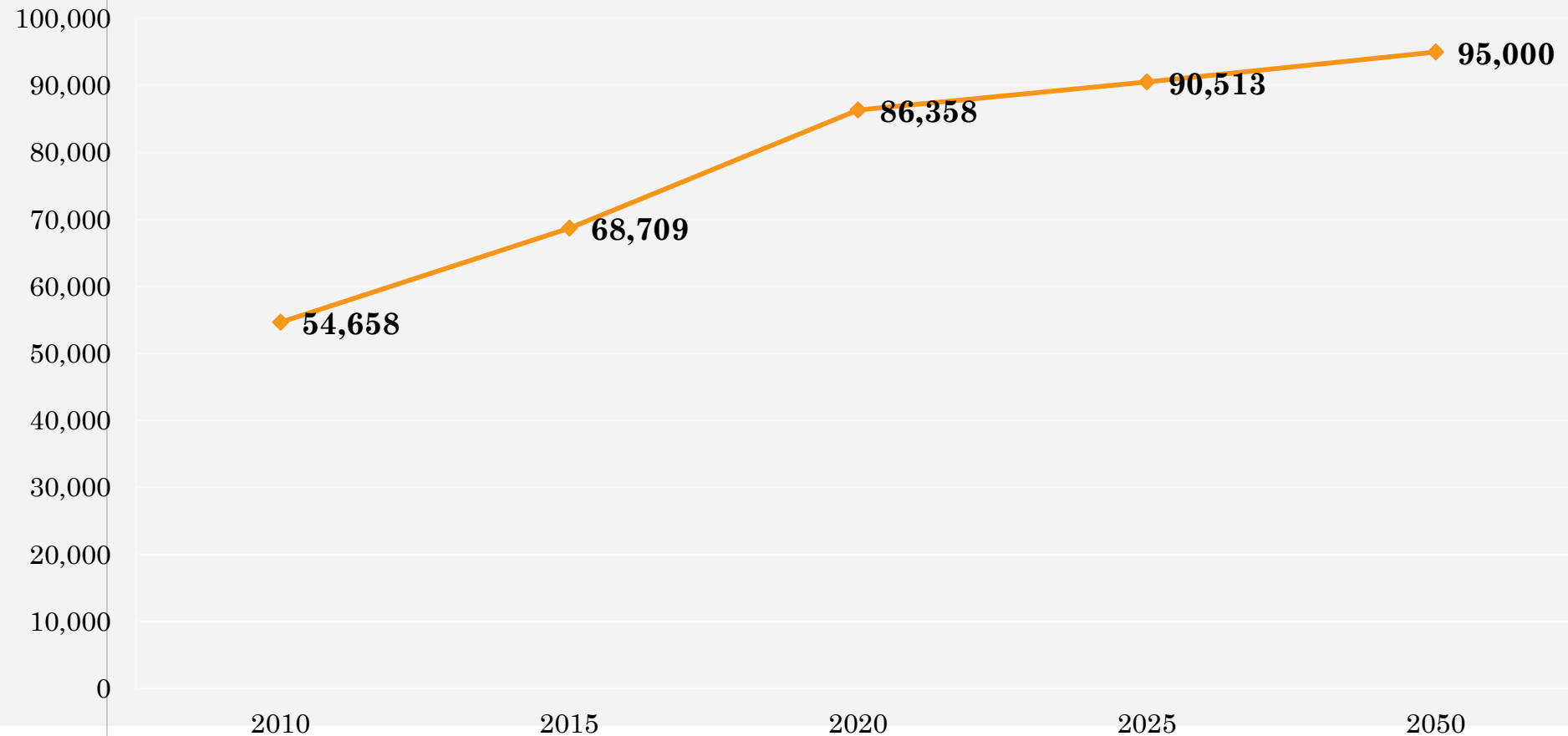
- **3-4 times** higher mortality rates
- Life expectancy is **63 years**
(vs. 80 years for general population)

Emergency Care

- More frequent visits to ER
- More health crises than younger peers

Potential Growth in Homeless Population Age 60 and Above

Homeless Population Age 60+



Supportive Housing Needs

Services

- Staff to client ratio of 1-15
- Tenancy support s and care coordination

Structural Changes

- Widening hallways and doorways
- Ramps, stair lifts

Features, Equipment, Technology

- Grab bars, handrails, removable shower heads,
- Monitoring and alert systems, brighter lighting, adjustable-height closet rods, emergency lights

Assistive Devices

- Bath/shower benches, walkers, canes, wheelchairs
- Emergency pull cords, Braille, magnification

Configuration

- Position of furniture, raised furniture, raised toilet seats, lowered beds and countertops

Health Aging Supportive Housing Toolkit



Healthy Aging in Supportive Housing

Toolkit for service providers, developers & property managers



September 2016

Available at
csh.org



Thank You!

Debbie Thiele
Director
National Consulting Services
debbie.thiele@csh.org

Panel Presentation
John Forsyth, SHA

Demographics

- SHA houses over 10,000 elderly adults (50 years +)
- 6,300 of these adults are elderly: 62 or older. Average age: 70
- 58% of elders have a disability
- Average annual income for elders is \$11,000

Social Services to Promote Independent Living



- SHA has multiple partners to provide social services to our aging population
- Key partnerships:
 - Aging and Disability Services – case management
 - ADS serves 1,200 annually, including 430 Medicaid Long Term Personal Care clients
 - Full Life Care, Neighborcare Health, University Schools of Nursing

Challenges and Opportunities We Face



- Leveraging our limited resources
- Coordination of services
- Sustainability of services
- Advocating with others to promote healthy aging and creating new resources

Panel Presentation
Jay Woolford, SHAG



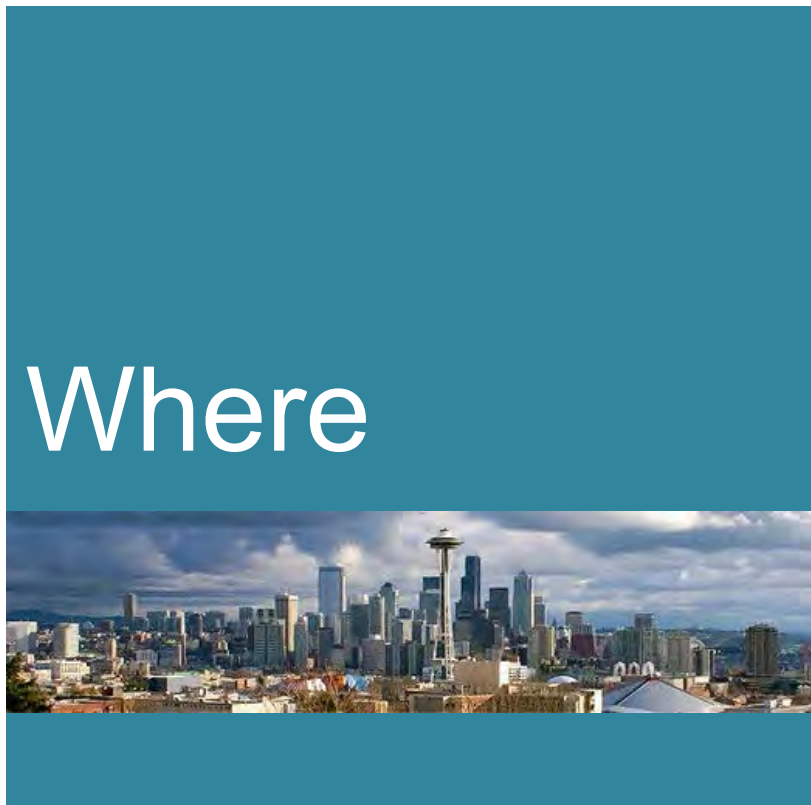


SENIOR HOUSING ASSISTANCE GROUP

25

YEARS AND COUNTING



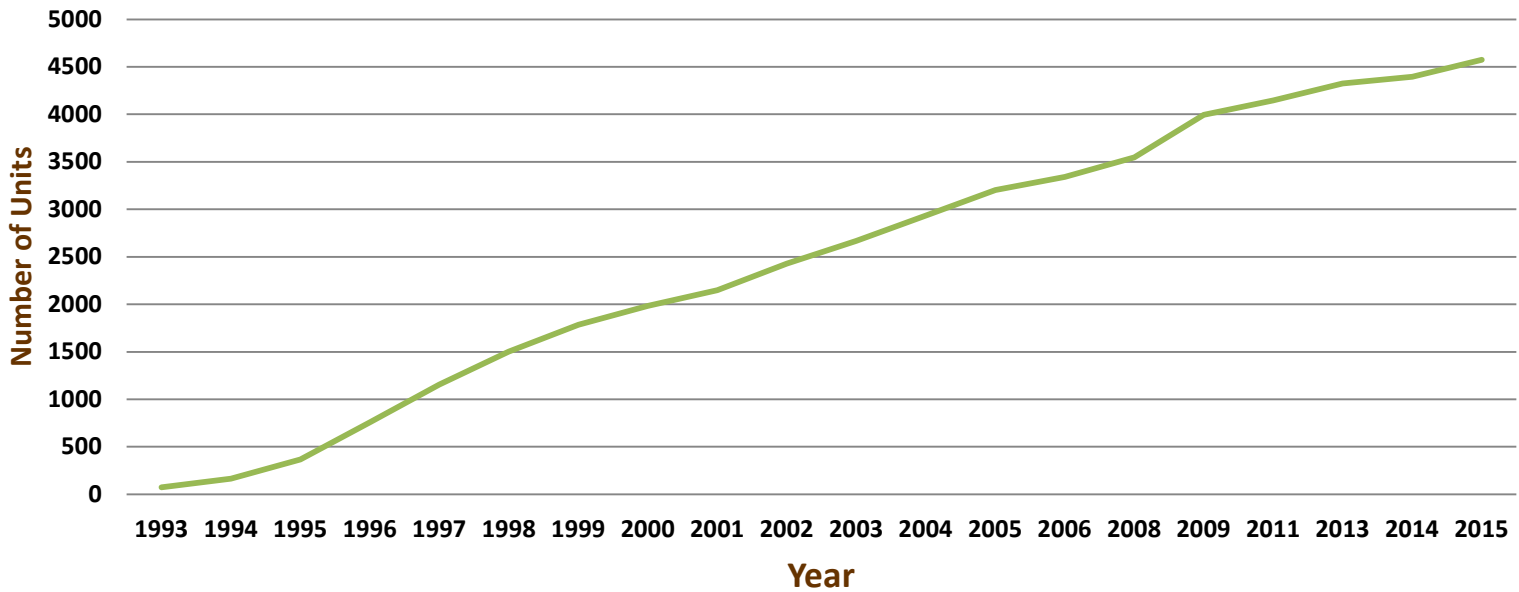




SHAG's 28 communities are located in neighborhoods throughout the Puget Sound region.

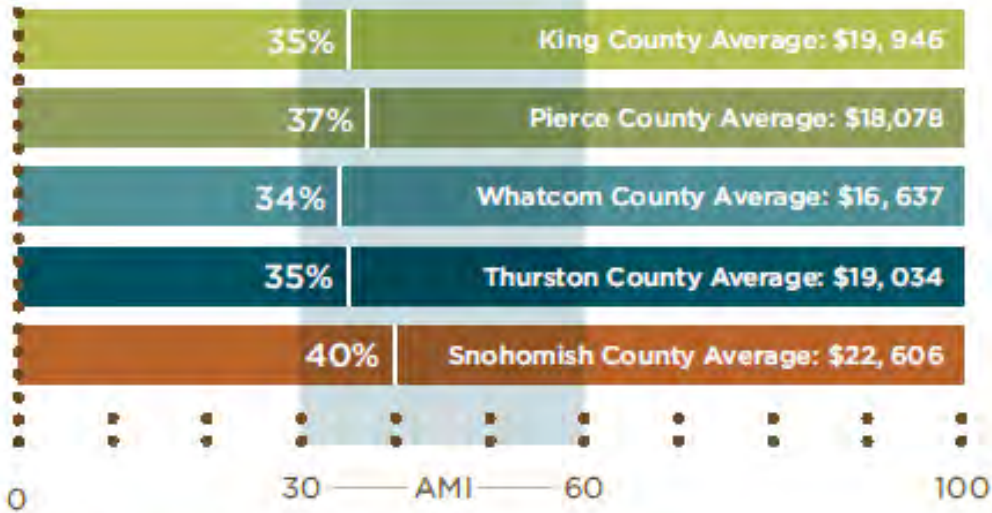
Enhancing and enriching the lives of seniors through affordable housing

SHAG growth



Supporting seniors never gets old.

RANGE OF INCOME OF SHAG RESIDENTS



30-60% is the Average Median Income (AMI)

\$18,797 is the average income of SHAG residents

Who we serve



SHAG RESIDENT LANDSCAPE

\$18,797



AVERAGE INCOME

75



AVERAGE AGE

75%



SINGLE WOMEN

11%



SECTION 8

38.6%



DISABLED

9.3%



UNDER AGE 62

Who?

Supporting seniors never gets old.

COST OF LIVING PER MONTH

65+

\$1,939

A SINGLE
1 BEDROOM RENTER

\$2,731

A COUPLE
1 BEDROOM RENTERS



The Elder Economic Security Initiative, The Elder Economic Security Standard Index for Washington

Why

Why?



THE HIGH COST OF HOUSING



Owner:
6-9 Years

The typical homeowner over 65 can afford in-home assistance for nearly 9 years or 6.5 years of assisted living.



Renter:
2 Months

The typical renter over 65, however, can only afford 2 months of these supports.

In 2012, one third of adults aged 50 and over (nearly 20 million households) paid more than 30% of their income for housing, including nearly 9.6 million who paid more than 50% of their income for housing.

THE HOUSING ASSISTANCE GAP



3.9 million

The number of low-income older renters eligible for housing assistance in 2011.

VS.

1.4 million

Due to a supply gap, the number of low-income older renters who actually received housing assistance in 2011.

Name	Email	Title	Organization
Josh Akers	jakers@kelley-ross.com	Clinical Pharmacy Institute Manager	Kelley-Ross Pharmacy Group
Isaac Alshihabi	isaac.alshihabi@csh.org	Loan Officer	Corporation for Supportive Housing (CSH)
Jenny Ap	jennya@multiculturalfamily.org	Aging and Disability Program	The Multi-Cultural Family Institute
Karen Atwood	bluerose0210@gmail.com	Vice President	Washington State Deaf Senior Citizens
Sara Baker	sara@housingconsortium.org	Policy Assocaite	Housing Development Consortium
Chrisha Bali	chrisha.bali@gmail.com		
Zee Baltuth	zbaltuth@bellwetherhousing.org	Resident Services Coordinator	Bellwether Housing
Ariele Belo	abelo@hsrc.org	Director of Deaf & Hard of Hearing Services	HSDC
Sarah Birkebak	sbirkebak@interimcda.org	Housing Services Coordinator	InterIm CDA
Tatiana Bogacheva		Program Director/ Social Worker	Circle of Friends
Allison Bolgiano	abolgiano@bellwetherhousing.org	Resident Services Coordinator	Bellwether Housing
Allison Boll	allison.boll@seattle.gov	Human Services Coordinator and Primary Care Liaison	Aging & Disability Services
Eden Bossom	edenb@kcha.org	Resident Services Coordinator	King County Housing Authority
Jennifer Burdzinski	jburdzinski@via-architecture.com	Architect	VIA Architecture
Daniel Burnett	daniel@housingconsortium.org	Member Services Associate	Housing Development Consortium
Andrew Calkins	andrewc@kcha.org	Senior Program Manager	King County Housing Authority
Marguerite Carlson	margueritec@beacondevgroup.com	Sr. Housing Developer	Beacon Development Group
Judi Carr	judi.carr@comcast.net		
DaJenae Carter	dajenaec@gmail.com	Residential Counselor	DESC
Andy Chan	andy.chan@seattlehousing.org	Community Builder	Seattle Housing Authority
Vicky Chavez	vchavez@crisisclinic.org	Community Living Connections Intake Lead	Community Living Connections - Crisis Clinic
David Clifton	david.clifton@wshfc.org	Assistant Director, Multifamily Housing and Community Facilities	WA State Housing Finance Commission
Jessica Coifman	jess.coifman@gmail.com	Interim Coordinator	Generations with Pride
Carolyn Cunningham	ccunningham@uwkc.org	Impact Manager	United Way of King County
Rosemary D'Agrosa	rosemaryd@neighborcare.org	Interim Homeless Programs Manager	Neighborcare Health
Cynthia Danielson	cynthiad@ccsww.org	Resident Service Coordinator	Catholic Housing Services
Wendy Davis	wendy.davis@rhf.org	Resident Services Director	Park Place Assisted Living
Pam Derry	pam@tonkinarchitecture.com	Principal/Architect	Tonkin Architecture
Trina Dickerson	ldickerson@ywcaworks.org	Case Manager	YWCA
William Dorn	bdorn@northhavenseniorking.org	DIRECTOR OF DEVELOPMENT	Northaven Senior Living
Stephanie Van Dyke	stephanie.vandyke@seattlehousing.org	Director of Development	Seattle Housing Authority
Nancy Eldridge	neldridge@nchh.org	Executive Director	National Center for Healthy Housing
JP Emery	jpemery@gmail.com	Senior Associate / Architect	Ankrom Moisan Architects Inc.
Katie Escudero	katiee@kcha.org	Moving to Work Policy Analyst	King County Housing Authority
Lisa Fabatz	lff@rentonhousing.org	Resident Services Coordinator	Renton Housing Authority
Jeannie Falls	jeannie@pmsc-dtfb.org	Executive Director	Pike Market Senior Center and Food Bank
Irma Farsch	irmaf@comcast.net	Advisory Board	Sound Generations

Name	Email	Title	Organization
John Forsyth	john.forsyth@seattlehousing.org	Community Services Administrator	Seattle Housing Authority
Carrie Fox	carrie.fox@spl.org	Librarian	Seattle Public Library
Shanon Gerhardt	sbroumley@ywcaworks.org	Apartment Manager	YWCA
Tavona Givens	tgivens@ywcaworks.org	Health Engagement Manager	YWCA
Stephanie Goldfarb	sgoldfarb@jfsseattle.org	Intake & Assessment Specialist	Jewish Family Service
Ken Grant	kgrant@kelley-ross.com	VP Marketing & Communications	Kelley-Ross Pharmacy Group
Mark Gropper	mrg@rentonhousing.org	Executive Director	Renton Housing Authority
Kathryn Gruber	kathryng@shag.org	Resident Services Coordinator	Senior Housing Assistance Group (SHAG)
Adam Halpern	ahalpern@jfsseattle.org	Director, Aging in Place	Jewish Family Service
Douglas Hathaway	doug_hathaway@earthlink.net		
Jessica Herzer	jessicah@fulllifecare.org	Roads to Community Living/WA Roads Program Director	Full Life Care
Courtney Hillman	courtney.hillman@seattlehousing.org	Community Builder	Seattle Housing Authority
Steve Hillson	shillson@hsrc.org	ALD Specialist and Technician	HSDC
Amy Holland	amy.holland@seattle.gov	Contracts Manager	Aging & Disability Services
Molly Holmes	mollyholmes27@gmail.com	Chair	Aging and Disability Services Advisory Council
Mary Holscher	maryholscher@gmail.com	Member	PNA Village
Whitney Joy Howard	whitneyjoy8@gmail.com		
Justin Hunt	justinh@ankrommoisan.com	Associate	Ankrom Moisan Architects
Vicki Isett	vicki@community-homes.org	Executive Director	Community Homes, Inc.
Dawn Jordan	djordan@ywcaworks.org		YWCA
Valerie Kendall	valerie.kendall@kingcounty.gov	Affordable Housing Planner	King County
Dimitri Kiselov			Circle of Friends
Chris Klaeyen	chris.klaeyen@seattlehousing.org	Sr. Policy Analyst	Seattle Housing Authority
Florence Klein	fklein@silverplanet.org		Aging and Disability Services Advisory Council
Marty Kooistra	marty@housingconsortium.org	Executive Director	Housing Development Consortium
Maureen Kostyack	maureen.kostyack@seattle.gov	Housing Program and Development Manager	Seattle Office of Housing
Corina Kroll	Corina.Kroll@providence.org		Providence ElderPlace
Jolene Kron	jkron@co.kitsap.wa.us	Residential and Long Term Care Programs Manager	Salish BHO
Dat Ksor	dat.ksor@novoco.com	CPA	Novogradac & Company LLP
Marcy Kubbs	marcy.kubbs@kingcounty.gov	Project/Program Manager - VHSL	King County DCHS
Jennifer LaBrecque	jennifer.labrecque@seattle.gov	Homeownership & Weatherization Program Manager	Seattle Office of Housing
John Lambert	johnl@snovalleyhousing.org	President, Board of Directors	Snoqualmie Valley Housing Solutions
Maria Langlais	maria.langlais@seattle.gov	Strategic Advisor	City of Seattle, Aging and Disability Services
Jan Laskey	jan.k.laskey@baml.com	SVP, Community Development	Bank of America Merrill Lynch
Joanne LaTuchie	jlatuchie@mercyhousing.org	Vice President of Real Estate Development	Mercy Housing Northwest
Joy Levien	jlevien@capitolhillhousing.org	Resident Services Coordinator	Capitol Hill Housing
Karen Lewis	klewis@deltadentalwa.com	Senior Program Officer	WDS Foundation

Name	Email	Title	Organization
Maureen Linehan	maureen.linehan@seattle.gov	Director	City of Seattle, Aging and Disability Services
Long Lun	longl@nhwa.org		Neighborhood House
Dayna Lurie	dayna_lurie@cantwell.senate.gov	King County Outreach Director	Office of Senator Maria Cantwell
Denise Malm	dmalm@wallingfordseniors.org	Social Worker	Wallingford Community Senior Center
Fran Marasow	fran@professionalmedicalcorp.com	President	Professional Medical
Caleb Marshall	cmarshall@rtseattle.org	Executive Director	Rebuilding Together Seattle
Shanti Martin	shmartin@ywcaworks.org		YWCA
Francesca Martin	fmartin@compasshousingalliance.org	Chief Program Officer	Compass Housing Alliance
Rachel Mathison	rachelm@imaginehousing.org	Director of Supportive Services	Imagine Housing
Sharonn Meeks	sharonn.meeks@comcast.net	Market Development	WA State Housing Finance Commission
Gigi Meinig	gigi.meinig@seattle.gov	Planner	Aging and Disability Services
Ann Melone	ann.melone@usbank.com	VP	U.S. Bank
LeighBeth Merrick	lmerrick@LeadingAgeWA.org	Director of Senior Living & Community Services	LeadingAge Washington
Leslie Miller	lmiller@kirklandwa.gov	Human Services Coordinator	City of Kirkland
Allison Mims	amims@northhavensenioreliving.org	Housing Occupancy Specialist	Northaven Senior Living
Angela Miyamoto	angela.miyamoto@seattle.gov	Planner	Aging and Disability Services
Danielle Montrose	danielle@pmsc-dtfb.org	Social Services and Member Resources Coordinator	Pike Market Senior Center and Food Bank
Leslie Morishita	lmorishita@interimcda.org	Real Estate Development Director	InterIm CDA
Michelle Morlan	michelle@lotusdevpartners.com	Principal	Lotus Development Partners
Jon Morrison Winters	jon.winters@seattle.gov	Planning and Development Specialist	City of Seattle, Aging and Disability Services
Ed Murray		Mayor	City of Seattle
Yelena Mushkatina	ymushkatina@jfsseattle.org	Geriatric Care manager	Jewish Family Service
Emma Nauman	enauman@desc.org	Case Manager	DESC
Riana Nolet	rianan@phinneycenter.org	Director	PNA Village
Cicily Nordness	cicily.nordness@seattlehousing.org	Supportive Services Coordinator	Seattle Housing Authority
Mary Pat O'Leary	marypat.oleary@seattle.gov	RN Planning and Development Specialist	Aging and Disability Services
Nicki Olivier Hellenkamp	nicki@housingconsortium.org	Mobilization and Policy Manager	Housing Development Consortium
Samantha Oppenheimer	sammieo@udel.edu	Case Manager	DESC
Alexandra O'reilly	aoreilly@bellevuewa.gov	Human Services Planner	City of Bellevue
Larry Owens	larry.t.owens@jci.com	Local Government Solutions	Johnson Controls
Andrea Owner	aowner@plymouthhousing.org	Director Prop. Mgmt	Plymouth Housing Group
Tereasa Palmer	tpalmer@mercyhousing.org	Regional Manager of Resident Services	Mercy Housing Northwest
Kate Parker	kparker@mercyhousing.org	Regional Director of Resident Services	Mercy Housing Northwest
Donna Phillips	donnaphillipswa@gmail.com		
Pam Piering	ppiering@comcast.net		Panel Moderator
Samantha Poss	sposs@desc.org	Registered Nurse	DESC
Anna Preyapongpisan	apreyapongpisan@ywcaworks.org	Director of Housing	YWCA

Name	Email	Title	Organization
Liz Prince	prince@dshs.wa.gov	Project Director, Money Follows the Person	Aging and Long-Term Support Admin (AL TSA)
Laura Ramsey	hatsramsey@gmail.com	President, Board of Directors	South Park Senior Center
Eileen Rasnack	eileenr@ccsww.org	Program Manager	Catholic Community Services
Debra Rhinehart	debra.rhinehart@seattle.gov	Strategic Advisor	City of Seattle - Human Services Dept.
Kelly Rider	kelly@housingconsortium.org	Government Relations & Policy Director	Housing Development Consortium
Ruben Rivera-Jackman	rubenr@kcha.org	Senior Resident Services Manager	King County Housing Authority
Joyce Robertson	joycer@shag.org	Director	Senior Housing Assistance Group (SHAG)
Danielle Rogers	drogers@wallingfordseniors.org	Program and Outreach Specialist (AmeriCorps)	Wallingford Community Senior Center
Charles Romero	cromero@via-architecture.com	Architect	VIA Architecture
Bill Rumpf	brumpf@mercyhousing.org	President	Mercy Housing Northwest
Mona Sanger	monas@shag.org	Resident Wellness Counselor	Senior Housing Assistance Group (SHAG)
Celine Santiago	celine@go-vetrans.com	Administration and Finance	VETRANS
Dave Sarju	david.sarju@seattle.gov	Human Services Dept, Deputy Director	City of Seattle
Sue Shaw	sueshaw108@yahoo.com		Aging and Disability Services Advisory Council
Anna Shields	ashields@kelley-ross.com	Community Pharmacy Resident	Kelley-Ross Pharmacy Group
Sue Siegenthaler	sue.siegenthaler@seattle.gov	Program Specialist	HSD/ADS
Krista Sneller	krista.sneller@seattle.gov	RN Consultant	City of Seattle Aging and Disability Services
Scott Starr	sstarr@smrarchitects.com	Architect	SMR Architects
Sarah Stiteler	sstiteler@redmond.gov	Senior Planner	City of Redmond
Darlene Storti	dstorti@northhavenseniiorliving.org	Executive Director	Northaven Senior Living
Sidney Strong	sidneystrong1@gmail.com		
Valerie Thiel	val@sagearchalliance.com	Principal	SAGE Architectural Alliance
Debbie Thiele	debbie.thiele@csh.org	Executive Director	Corporation for Supportive Housing (CSH)
Diana Thompson	artemis_21@comcast.net	Advocacy Chair	Bellevue Network on Aging
Meghan Thompson	meghant@imaginehousing.org	Resident Support Specialist	Imagine Housing
Loren Tierney	loren@housingconsortium.org	Member Services Director	Housing Development Consortium
Roger Tucker	rtucker@eworks.org	Executive Director	Environmental Works
Kayla Valy	kvaly@bellevue.wa.gov		City of Bellevue
Kristy Vess	kvess@hsdc.org	Client Advocate	Hearing, Speech and Deaf Center
Linda Wells	linda.c.wells@kingcounty.gov	Community Services Program Manager	King County DCHS
Helene Wentink	helene@community-homes.org	Director of Advancement	Community Homes, Inc.
Kathleen Wilcox	kathleenwilcox@outlook.com	Consultant	Aging and Disability Services Advisory Council
Alan Wittenberg	alan.wittenberg@swedish.org	Social Worker	Swedish
Josephine Wong	josephine.wong@kingcounty.gov	Deputy Director	King County - DCHS
Linda Woodall	lindaw@shag.org	Manager, Programs and Partnerships	Senior Housing Assistance Group (SHAG)
Jay Woolford	jayw@housing4seniors.com	Executive Director	Senior Housing Assistance Group (SHAG)
Malra York	marla.york@seattle.gov	Resource Coordinator	Major's Office for Senior Citizens

Name	Email	Title	Organization
Eva Zakharevich	ezacharevich@jfsseattle.org		Jewish Family Service
Ellen Ziontz	ellen.ziontz@seattlehousing.org	Community Builder	Seattle Housing Authority
Walter Zisette	wzissette@capitolhillhousing.org	Community Developer	Capitol Hill Housing
Kira Zylstra	kira.zylstra@allhomekc.org	Assistant Director	All Home