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The Health and Housing Specialist: An Emerging Job Classification to Support Aging in Place in Subsidized Housing

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The Health and Housing Specialist: An Emerging Job Classification to Support Aging in Place in Subsidized Housing

A report by the Institute on Aging
at Portland State University



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Executive Summary

As the U.S. population ages, the availability of workers with a basic understanding of aging and health-related services has not kept pace. This is true in traditional health care organizations such as hospitals and primary care clinics as well as in long-term care settings and senior housing, including subsidized housing, the focus of this report. Nearly 1.8 million older persons receive some form of publicly-subsidized rental assistance. Some subsidized housing providers, including those that operate buildings designated for older persons, are developing new systems of service delivery that would either coordinate or provide health screenings, physical activity programs, nutrition programs, health monitoring, adult day health, and home care¹⁻². Such efforts are intended to deliver health-related services that allow older adults to remain in their apartment for as long as possible while also reducing their use of hospital emergency departments or nursing facility placement. However, because housing providers have not traditionally hired or contracted with health and social services workers, neither the specific job tasks, nor the qualities of workers, have been studied.

This report describes the findings from a study designed to identify the characteristics of subsidized housing employees who work primarily with older residents. The study took place during 2011-2012 and included interviews with housing providers, health and social services professionals who have clients in subsidized housing, current residents, and resident service coordinators who work in subsidized housing. A systematic job analysis, including a national survey with 87 service coordinators from 23 states, was conducted in order to identify the specific job tasks and the knowledge, skills, and abilities required of subsidized housing employees whose job would entail supporting aging in place for older residents.

Based on this study, it is clear that significant numbers of older residents of subsidized housing have a variety of unmet needs that place them at risk of eviction, hospitalization, and premature nursing home admissions. Four broad categories of supports identified by study participants include information and referral, health, social and personal care services, case management and care coordination, and building-specific supports. While most residents are independent and want to remain so, many need assistance on a short-term basis, such as during an acute illness or after a hospitalization. Others need on-going supports such as personal care, medication management, and health monitoring. Currently, few housing providers have a means of assessing or monitoring the health status or needs of residents. Most study participants believed that a designated staff person who could assess and monitor resident health would be beneficial, though some cautioned against creating an institutional environment or forcing services onto residents who do not want such assistance.

Study participants were asked to describe the kinds of tasks an employee, referred to here as a Health and Housing Specialist, would need to perform in order to support older residents who want to live in their apartment for as long as possible, or to “age in place.” That process resulted in eight task categories (see Appendix 3 for task definitions):

Tasks Required of the Health & Housing Specialist

1. Identify, assess, select, develop and maintain referral partnerships on behalf of Residents
2. Provide information and referral when asked by Residents
3. Determine building-specific needs to plan, organize, and implement on-site trainings, information sessions, and social activities based on input and need of Residents
4. Address with property management any concerns about the tenure of Residents
5. Evaluate Resident Services program progress by tracking and measuring information on behalf of Residents
6. Build supportive professional relationships with Residents
7. Assessment of Residents
8. Monitor Programs and Services for Success on behalf of Residents

After developing these task categories, we identified the knowledge, skills and abilities needed by a worker who would be responsible for completing these tasks. Using job analysis methods, 12 KSAs were identified as necessary for an employee hired for this staff position.

Knowledge, Skills & Abilities Required for the Health & Housing Specialist

1. Knowledge about older adults and individuals with disabilities
2. Knowledge about practice standards to support consumer direction
3. Knowledge about resources for older adults – what they are & how to access
4. Knowledge about agency policies, rules, guidelines, protocols
5. Writing skills
6. Oral communication skills
7. Cultural competency
8. Interpersonal skills
9. Assessment skills
10. Critical thinking & judgment
11. Observational skills
12. Mediation skills

Although a current staff position, usually called a resident services coordinator (RSC), is available in some subsidized housing properties, the RSC does not typically provide direct services, case management, or resident assessment. The participants in the current study were divided on whether a new staff position was necessary to support aging in place, or if the RSC position could be expanded to include additional job tasks. Most current RSCs, aware of current time demands and case loads, did not believe that they could take on additional tasks. Given their job description, education and training, some were hesitant to expand their job scope to include health-related tasks. Thus, a new staff position was viewed by some study participants as the most appropriate way to meet residents' unmet needs. This new position would work as part of a team with the RSC and property manager to support aging in place in subsidized housing. However, nearly every study participant recognized that with limited funding, such a position was unlikely to be supported. In

the following, we summarize the primary barriers and opportunities to aging in place, and then provide recommendations.

Barriers and Opportunities

Research participants identified several barriers and opportunities to supporting aging in place in subsidized housing, as well as specific challenges related to the workforce. Barriers and opportunities fall into three categories: resident-level, organizational-level, and systems-level.

At the resident-level, maximizing informal supports by leveraging residents' skills could provide an opportunity to support the goal of aging in place in subsidized housing. The mix of ages and abilities within a property was seen by some as an asset, such as when younger residents help out older residents or when older residents take on a nurturing role. Others conveyed the challenges of mixed properties, such as when younger residents create safety issues by allowing strangers into the building. Personal choice and independence can present a double-edged sword, in that self-determination in decision-making and living independently are positive, crucial elements in the provision of social services and supporting aging in place, but they also present challenges when necessary services cannot be mandated within the subsidized housing model.

At the organizational level, the breadth of knowledge needed for meeting the varied needs of older adults as they age in place seemed to be a barrier to the idea of relying on only one staff position. Furthermore, the scope of work required of this Health and Housing Specialist seemed to be unrealistic and potentially dangerous to the resident population. As such, many participants favored a team approach to supporting aging in place in subsidized housing. This type of approach could provide for complementary skills and knowledge and sharing of the scope of work. Also, a housing model designed to allow residents to age in their apartments cannot be fully functional without attention and modifications to the physical condition of the properties.

At the systems level, the extremely limited funding for supportive services and supportive staff is an ongoing challenge to supporting residents' ability to age in place. Among participants in this study, there was a clear pattern of either confusion over fair housing laws or a general avoidance of doing anything that could potentially be considered discriminatory or a violation of fair housing. In doing so, housing providers avoid asking residents questions about health-related topics, which can become a major barrier to supporting a resident's ability to remain independent. Finally, professionals and residents expressed frustration over the challenge of accessing services when they are only needed on a temporary basis, such as the lack of support for recuperative care for residents returning from a hospital stay.

Recommendations

As older residents of subsidized housing age in place, qualified workers will be needed who can respond to the health-related needs and social services associated with an aging population. Housing agencies need to specify the tasks that Health and Housing workers will complete, and identify the knowledge, skills, and abilities required to be successful employees.

1. **Initiate the Health and Housing Specialist Position:** Either create a new position, or expand the existing RSC position in subsidized housing, to include the job tasks and

categories and the necessary knowledge, skills, and abilities defined in this report. Funding support for this position, training opportunities, and consensus about the standards of professional practice are now needed to move forward.

2. **Consider a Team-based Approach:** It is likely that more than one job type is needed to support aging in place. A job analysis for a team-based approach could be conducted and modeled after similar other community-based teams.
3. **Develop Training Opportunities:** The most common type of education these study participants listed was gerontology, followed by social work and nursing. Knowledge of housing policies was also mentioned. Although a college degree might not be necessary for a Health and Housing Specialist, many participants saw the value in getting a degree. Given the multidisciplinary nature of the job, a dual degree program or coursework that covers health, social services, and housing, would be ideal.
4. **Use Existing Nurse Delegation Practices:** Oregon’s Nurse Practice Act offers an opportunity to extend medication management practices that are common in community-based settings such as home health, adult foster care, and assisted living. In these settings, a registered nurse teaches a lay staff person to perform traditional nurse functions such as reviewing health conditions (e.g., blood pressure screening, blood glucose monitoring), assisting individuals who self-administer their own medications, and administering medications. While medication management might be seen as “too much” for subsidized housing, study participants agreed that many residents would benefit from assistance setting up their medications on a regular basis, keeping track of any problems or side effects, and communicating with the resident’s physician as needed.
5. **Capitalize on Informal Supports:** Housing staff can help support the development and success of informal supports. Several study participants, including housing staff and current residents, described the value of neighbors helping each other. Most often these exchanges are informal, such as neighbors who occasionally pick up groceries for each other or check to make sure the other is doing alright. One building has a “good neighbor network” in which residents sign up to volunteer as needed to assist others on a temporary basis.
6. **Formalize Relationships with Local Service Organizations:** Study participants described both formal and informal relationships between local health and social service providers, including volunteers. The largest gaps appeared to be between mental health providers and nursing services, especially health monitoring and medication management. Privacy and confidentiality concerns limit communication between housing staff and health professionals and case managers. We suggest a task group of Aging and Disability Services, major housing providers, and mental health organizations, be formed to develop model memorandums of understanding that housing providers can adapt for their own use.
7. **Consider New Service Delivery Models:**
 - a. The Oregon Health Authority’s 2012 proposal to the Centers for Medicare and Medicaid Services included a demonstration project for Congregate Housing with Services that will partner and coordinate with Coordinated Care Organizations (CCO) for behavioral supports, substance abuse treatment, primary care, and CCO models such as onsite nurse practitioners and wellness programs on behalf of dual-eligible residents. This demonstration provides the opportunity to test the job tasks and the knowledge, skills and abilities identified for the Health and Housing Specialist. Specifically, this staff person could be the bridge between housing and the CCO, and could receive training from CCO staff such as nurses and social workers.

- b. Some subsidized housing residents require a level of services between independent living and community-based settings like adult foster care or assisted living. A means of providing short term and sporadic supports for individuals who do not meet nursing home eligibility admission criteria, but who are at risk of eviction, hospitalization, or nursing home use, is needed. Connecticut's program of assisted living services provided within subsidized housing offers a potential model.
- c. Housing providers require a method of monitoring the quality and success of resident services and resident outcomes. Home Forward, the region's largest provider of affordable housing, has experience and technologies that could be shared with other housing providers.
- d. Any service delivery approach within subsidized housing must account for the strong culture of independence within this setting. Service providers should be trained in person-directed care and respect for self-determination, and both services and modifications to the property should avoid creating an institutionalized environment.

Study Purpose & Background

The purpose of this study was to identify the characteristics associated with supportive services staff who work primarily with elderly residents of subsidized apartment buildings. A recent summit on affordable senior housing identified an “adequate workforce” as one of five key elements of successful housing and services models². This report describes a job position we refer to as a Housing and Health Specialist who would be hired to assist older adults who live in subsidized apartment buildings. We conducted a job analysis that identified the job tasks and the necessary skills, knowledge, and abilities required of the Housing and Health Specialist. An existing job category within subsidized housing, the Resident Services Coordinator (RSC), provided a starting point for the job analysis. In addition, this report identifies organizational and system-level barriers and opportunities to providing on-site health-related and supportive services that might help residents live in their apartments for as long as possible.

As the U.S. population ages, the availability of workers with a basic understanding of aging and health-related services has not kept pace. The Institute on Medicine (IOM) recently described the unique challenges associated with population aging. Specifically, older adults who experience chronic health conditions often rely on direct care workers to assist with health-related and supportive services. This category of worker is one of the fastest growing occupations in the United States and yet, as the IOM reported, “Many direct-care workers do not receive the education or training they need in order to be prepared for the care of older patients with complex care needs”³. Although RSCs do not provide direct care services, and in fact are prohibited from doing so when they are HUD-funded positions, this research asked whether certain forms of assistance could be provided by staff in an “aging in place model” of subsidized housing, and if so, what knowledge, skills, and abilities would be needed.

Subsidized housing is vital to low-income older adults in the United States, where 1.8 million older adults receive publicly-subsidized rental assistance⁴. Most subsidized rental apartments do not provide or coordinate supportive services on behalf of older residents. However, supporting aging in place in subsidized housing has been identified as a means of controlling publicly-financed long-term care costs, reducing unnecessary hospitalization, and improving the quality of life of older adults who choose to remain in their homes for as long as possible⁵.

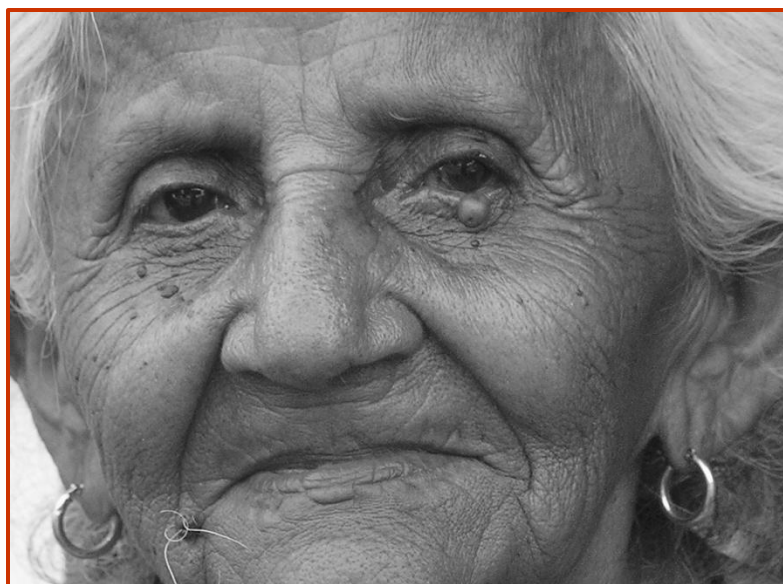
Most subsidized housing residents are independent and able to manage their daily activities and health-related needs. However, significant



and increasing numbers of older residents have mobility impairments, cognitive and mental health needs, and chronic health conditions that impair their ability to access basic resources and manage their personal care needs. An assessment of 130 subsidized housing residents in Portland, Oregon found about one-quarter had limitations in instrumental activities of daily living (IADLs) such as shopping, mobility, and managing finances, the average number of medications were 5.3 per person, and that 31% were at risk of social isolation⁶. In addition, these residents were culturally and linguistically diverse (27% speaking Chinese, 15% Russian, 9% Farsi, and 2% Korean), with health differences across language groups observed.

National surveys of subsidized housing residents age 62 and older have identified that about one-fourth of residents report difficulty doing housework, and one-fifth report difficulty doing laundry, performing personal care, taking medications and preparing meals⁷. IADL limitations and/or mental health conditions predict nursing home admissions among older subsidized housing residents⁸. A recent survey of New York City's 109,700 elderly public housing residents found that 29% had difficulty with activities of daily living, 79% had two or more chronic illnesses, and access to health care was an issue, with 11% regularly using hospital emergency departments for routine care⁹. The majority of residents had one or more chronic health conditions (84%), nearly all took medication (15% took 10 or more), and 27% reported falling in the prior 12 months¹⁰. Hospital use is also a concern for elderly subsidized housing residents, with one study of 877 residents reporting a hospital admission rate 2.3 times the rate of all older adults, and 3.4 times the admission rate of all low-income persons¹¹. Another study found that 34% of elderly residents had been hospitalized in the prior year¹⁰. These studies indicate that 25 to 30 percent of subsidized housing residents have health conditions and functional impairment that places them at risk of hospitalization, nursing home admission, or other negative outcomes.

Approximately 38% of older subsidized housing tenants live in their apartment until death, but 25% of them leave for a nursing home¹². In 2004, a year-long stay in a nursing home funded by Medicaid



cost an average of \$49,000, while a HUD Section 202 unit, plus the most frequently provided services (food, transportation and housekeeping) cost \$13,000⁷. Older subsidized housing residents with unmet health and social service needs are at risk of eviction, homelessness, high hospital use, and/or nursing home placement⁴¹³. Either delaying or preventing nursing home admissions could represent substantial cost savings for Medicaid and result in better quality of life for older adults.

Some housing providers are developing new systems of service delivery that would either coordinate or provide health screenings, physical activity programs, nutrition programs, health monitoring, adult day health, and home care¹. Such efforts are intended to deliver health-related services that allow older adults to

remain in their apartment for as long as possible while also reducing their use of hospital emergency departments or nursing facility placement.

Resident Service Coordinators in Subsidized Housing

Subsidized housing properties may employ or contract with staff whose job is to coordinate services and provide information and referral on behalf of residents who request such assistance. Employees called resident service coordinators (RSC) are trained to work with residents and their families, as needed, to promote housing stability. Most RSCs are assigned to work on-site at specific properties and many spend their time working across multiple subsidized apartment buildings. The primary role of the Service Coordinator in HUD housing is to “coordinate the provision of supportive services to the low-income elderly and nonelderly people with disabilities to prevent premature institutionalization, thereby improving residents’ quality of life.” Specific job tasks include: “Determining the service needs of eligible residents, identifying appropriate services available in the community, linking residents with the needed services, monitoring and evaluating the effectiveness of the supportive services, and performing other functions to enable frail and at-risk low-income elderly and nonelderly people with disabilities to live with dignity and independence”¹⁴.

HUD guidelines prohibit RSCs from serving as recreational or activities directors, providing direct services to residents, or performing housing management responsibilities. A survey of HUD-assisted developments reported that 46% had a HUD-funded service coordinator, 8% had a coordinator funded through other sources, and 43% never had a service coordinator¹⁴. Older (built before 1984) and larger properties are more likely than smaller and newer properties to hire a service coordinator (50% versus 26.9%)¹³. A survey of Low Income Housing Tax Credit properties reported 21% had an on-staff service coordinator, and 47% reported that residents could access a community-based service coordinator¹⁵. These relatively low numbers are due, in part, to limited funding sources for the RSC position.

The current RSC model will be further detailed in the *Barriers and Opportunities* section of this report.

Findings

Supports Needed by Subsidized Housing Residents with Health-Related Needs

As a first step in identifying the characteristics of subsidized housing staff who work primarily with older adults, 57 practitioners who work in health, social service, housing, and advocacy and have clients in subsidized housing, as well as 10 current residents, were interviewed. They were asked to describe the categories of support needed by older residents of subsidized housing and the tasks that a designated employee would need to complete in order to support aging in place. In addition, we reviewed Resident Service Coordinator positions described by the U.S. Department of Housing and Development (HUD) and posted online by housing providers (see *Methods* section for details).

Table 1. Categories of Support Needed by Older Residents of Subsidized Housing

1. **Information and referral** about and access to local resources and public benefit programs.
2. **Health, social, and personal care services** such as housekeeping, monitoring health conditions, medication management, shopping for food and other household items, food preparation, transportation, access to mental health counseling and crisis intervention, and substance abuse intervention.
3. **Case management and care coordination** including assessment, access to medical appointments, medications and medical supplies, scheduling appointments, and advocacy.
4. **Building-specific supports** such as security, meals, grab bars, operational doors and elevators, clean and safe building, 24-hour access to building staff, and coordination of meaningful on-site activities.

While this list of health and social supports might be familiar to those who work with older adults, several factors limit the availability or quality of such supports and services to residents of subsidized housing. These factors, described in more detail in the *Barriers and Opportunities* section, include eligibility criteria (e.g., age, disability status, income), housing laws and policies, individual and societal attitudes about independence and privacy, and a lack of funding and resources to pay for services. Here we provide details about the categories of support from the perspective of older residents and various professionals who deliver health and social services to them.

1. Information and referral

Residents' needs for information and referral are nearly as many and varied as the number of people who live in subsidized housing, but examples include questions about local resources, where to get discount food or household items, help with finances or filing income taxes, applying for public benefit programs (e.g., food stamps, supplemental security income, medical insurance). Some residents need information about how or whether different local resources are connected, how state and federal programs work, and help completing forms or paperwork. Residents might need to be

informed about which agencies provide which services, and the names of specific contacts within the agency. Older residents of subsidized housing have diverse communication and language skills: some have vision or hearing impairments; others have literacy challenges and some residents need information provided in languages other than English.

2. Health, social, and personal care services

The participants in this study described social and health-related issues faced by older residents of subsidized housing; many of these issues confirm what was described in the literature review above.

Medication management. Practitioners and RSCs were asked what a housing staff person could do if a resident told them that she was having difficulty managing her medications and had missed several doses. Only one participant believed that she could help a resident place medications in a pill box. Nearly everyone agreed that medication management is a major concern for older adults and individuals who have chronic mental illness. Below is an exchange between two RSCs reacting to the possibility of housing staff who could monitor resident medications:

“Being able to go every day and seeing they are taking the pills. That little piece changes a lot. It will actually save a lot of crises. Someone doesn’t take their antipsychotic meds, they are in the hospital for three weeks because they missed one week of meds. Getting it at the beginning is huge.” – RSC 1

“Per my supervisor I don’t do medication management at my job. So the new person having that ability would help.” – RSC 2

Temporary illness. Residents experience temporary bouts of illness, including post-surgery recovery, that limit their abilities for days or weeks at a time. A 77-year old woman explained that she was not able to ride the bus after her knee surgery, but that she was able to use a local non-profit agency that provides low-cost personal shopping and delivery for seniors and people with disabilities. She explained that after a time, “I got so I could walk a lot better and was able to do my own grocery shopping” and that “being independent” is important to her so she regularly volunteers, goes to the senior center for lunch, and swims for exercise weekly. An RSC from a different building described an organized network of resident volunteers who make friendly visits or phone calls on a temporary basis to assist a resident who “needs a little extra help.”

Preventive health and health promotion. During a group interview, six RSCs talked about the need for access to preventative medicine such as flu and pneumonia vaccinations. One said, “If we could keep them with their shots so they didn’t have to be in the hospital. Small pieces like that could really improve their health and longevity.” Other examples participants provided include: educational workshops on chronic health conditions, falls prevention, exercise and nutrition classes, chair yoga classes, and promoting exercise within informal support networks.

Mental health. Practitioners described situations in which one resident’s unmanaged mental health condition can result in paranoia and delusions that can trigger symptoms in other residents with similar conditions in addition to negatively affecting neighbors. RSCs described the difficulties of accessing mental health services, explaining that residents’ case managers are too busy to respond and that there are no mental health services aimed at prevention. This results in crisis management, such as contacting Adult Protective Services or calling 911 emergency responders for assistance.

The topic of hoarding was discussed in 9 of the 26 practitioner interviews and two of the resident interviews. A housing advocate said, “I mean that’s the biggest problem we have with eviction of seniors is tidiness and hoarding” and a property manager described a case of a resident who had lived at the building for many years, saying, “Every piece of mail she had ever gotten she threw on the floor... there was paper stacked this high on the floor, other than a path to her bed and her bathroom... the bottom piece of paper had to be ten years old.” However, after attempting to work with the resident, her daughter, and social services, he had to evict this tenant, explaining that, “I have only one staff person. I have 280 residents. We do everything we possibly can.”

3. Case management and care coordination

Some residents have case managers through mental health or aging services organizations, as well as eligibility workers for the Supplemental Nutrition Assistance Program (SNAP). Residents who lack case managers can “fall through the cracks” according to a property manager we interviewed. Housing staff, including property managers and RSCs, described minimal contact with case managers. They sometimes encourage residents to call their case manager, or to find out if they can get a case manager if they do not currently have one. As mentioned earlier in this report, RSCs do not typically offer case management or care coordination to residents.

4. Building-specific supports

For the purpose of this report, building-specific supports encompasses a range of activities and supports that are unique to each property. Some subsidized apartment buildings have employees who organize social or health-related activities, and while not all residents participate, others appreciate access to fitness and recreational programming. A few buildings have a congregate meal program. A 79-year old woman explained that her building (restricted to persons age 62 and older) had bingo on Monday evenings, church services on Wednesdays, movie nights, an exercise room, multipurpose room, library, “beautiful” grounds, and a dining room which she had begun using in the prior year. When asked why she started using the meal service, she explained that a friend who had “problems with her hands” encouraged her to try it “and I’m really glad I did. Not only for the food and the [cost] savings, I feel, but the social time is delightful.” In addition to these activities and services organized by the building staff, both residents and housing staff described resident-led activities. However, few subsidized buildings offer this level of services.

Building modifications. When thinking of aging in subsidized housing we cannot overlook the importance of the physical environment and the ways in which it either hinders or supports one’s independence. Many subsidized apartment buildings lack accessible units and other physical features that are needed to address the mobility limitations that often surface as part of the aging process. In fact, some studies have estimated that one in four older adults is likely to have a lower body limitation that necessitates a modification to their bathroom, entryway or other room in their home¹⁶. Other studies have associated accessible housing units with several health and quality of life indicators such as a tenant’s ability to integrate socially and physical activity levels. In a health assessment of older adults in subsidized housing researchers found that structural problems in buildings have also contributed to falls, which frequently lead to other serious health problems⁶. Therefore, many older adults will need various features, such as lever door handles, ramps, wider doorways to accommodate wheelchairs, non-slip floor surfaces, and bathroom aids, in order to maintain their independence as they age. While some newer properties have incorporated elements of accessibility, the vast majority of subsidized housing units do not have these features or they only

have them in a very limited number of units.

Dimensions of Resident Needs

Many of the supports that residents need are minor or temporary, while other supports require health promotion and activities to prevent health declines and possible move outs or hospitalization. For example, a housing advocate and a RSC described some of the “small” issues residents have:

“It was going great, and all he needed was help putting his socks on every morning. Just something so small.” – Housing Advocate

“Sometimes it’s just as simple as having someone come and loosen the [pill] bottles and line them up. This is one of the worst reasons I see people leave their homes, is because they can’t do this.” – RSC

“I have a couple of people who are blind who want me to read the mail for them so I write out their checks and they sign it and I send it off. It’s little things like that.” – RSC

Some issues, as in the latter example, remain relatively constant, while other seemingly small issues lead to crises and evictions or move outs. Examples include failure to take medication, inability to get out for groceries, and social isolation that can result in depression and poor health outcomes. Study participants described signs that might indicate a resident is at risk of decline, such as unkempt clothing or apartment, a recent fall, confusion, or changes to the resident’s usual routine. Any of these signs could be temporary, or could suggest that the resident is about to experience a crisis. In response to a question about how to react to a resident’s incontinence, two RSCs explained:

“It could be any number of things, a medical emergency to something that is long term, and hopefully your relationship gives you some clues to that.” – RSC 1

“You’d have a sense of history, the health history, the mental health history.” – RSC 2

These comments indicate the importance of an on-site staff person who is familiar with each resident. About noticing decline, another RSC said,

“There’s usually kind of warning signs where we can see someone is heading down that road. Assisted living starts flashing through my head because you can see where they are almost just not coping, having a hard time walking, not showing up for the community functions.”

Residents, in addition to RSCs and property managers, think about when independent living is no longer appropriate for specific residents. Here, an 87-year old woman who has lived in her apartment for over 10 years reflects on whether to stay or if it’s time to move:

“I have to move on, I feel. And yet, I have checked so many places out, and right now, as long as I can handle it... I’ll stay here. Although I thought, I’ll be honest with you, in 2012, I think I should be moving on. Because I’m already, I’ll be 87 and... it’s laborious, the cooking... cleaning the dishes, getting the food, washing and ironing, making your bed, cleaning your clothes, this and that, and this and that.” – Resident

Health and Housing Specialist: Job Tasks, Knowledge, Skills and Abilities

In an aging in place model of subsidized housing, support staff would assist residents with the types of needs described above. We asked research participants to think about the staffing needs for an “aging in place model” of affordable housing, and the specific job tasks and characteristics of an employee we called the “aging in place specialist.” Several participants had a negative reaction to this job title, suggesting that it could be seen as stigmatizing to residents. Several study participants suggested alternate titles, including: Service Specialist or Service Director, Independence Specialist, or (jokingly) Director of Everything. For the purposes of this report, and to distinguish this position from RSCs, we use “Housing and Health Specialist” to describe an employee whose job is to assist older adults who want to remain in their apartment for as long as possible.

A systematic job analysis (described in more detail in the *Methods* section) was conducted in order to identify the characteristics of an employee whose job would entail supporting aging in place among subsidized housing residents. The tasks associated with the job, as well as the knowledge, skills, and abilities of the employee, were identified based on review of advertised resident services coordinator job descriptions, interviews with health and social service professionals who work with subsidized housing residents, and the Occupational Information Network (O*NET), a searchable database that contains hundreds of standardized and occupation-specific descriptors for describing and classifying occupations.

Table 2 describes the eight broad task categories, and Appendix 3 contains the full list of tasks identified for this position. Tasks are defined as collections of activities that a worker must do in order to complete specific job objectives. The following task categories were identified after reviewing RSC job descriptions, interviews with RSCs and other professionals, and consultation with a job analysis expert. For this study, we focused on the needs of older persons, defined broadly as those aged 62 and older.

Table 2. Task Categories for Health and Housing Specialist in Senior Housing

1. Identify, assess, select, develop and maintain referral partnerships on behalf of Residents
2. Provide information and referral when asked by Residents
3. Determine building-specific needs to plan, organize, and implement on-site trainings, information sessions, and social activities based on input and need of Residents
4. Address with property management any concerns about the tenure of Residents
5. Evaluate Resident Services program progress by tracking and measuring information on behalf of Residents
6. Build supportive professional relationship with Residents
7. Assessment of Residents
8. Monitor Programs and Services for Success on behalf of Residents

Knowledge, Skills and Abilities Required of the Health and Housing Specialist

Table 3 describes the knowledge, skills and abilities required of the employee hired to complete the above tasks. The KSAs were identified based on RSC job description review, O*NET descriptions of similar jobs, and interviews with current RSCs and health professionals, and an online linkage survey with 87 current RSCs from 23 states. Most of the RSCs who completed the online survey worked in properties designated for elderly and disabled residents (93%), most were female (80%), and they ranged in age from 29 to over 60. Most were college educated, with 42% reporting a bachelor's degree and/or some graduate coursework, 34% with a graduate degree, 17% with a high school diploma, and 7% with an associate's degree. Based on the systematic method of identifying tasks and the associated KSAs, and the relationship between tasks and KSAs, this represents a comprehensive set of KSAs that housing providers can use to develop position descriptions, identify qualified workers, and organize training sessions.

The study participants who work in subsidized housing as property managers or RSCs explained the need for a staff person with some knowledge of age-related changes and chronic health conditions (number 1 in Table 3). Knowledge of the social and the medical aspects of aging, and the types of services and professionals available to meet such needs, were mentioned, with several participants describing an ideal candidate as one who had a combination of social work and medical training. For example, one RSC described the need for the Health and Housing Specialist to have “basic knowledge of anatomy, physiology and the medical community” and another described the ability to coordinate with informal networks among residents within a building. The need to understand and work with residents who have mental health conditions was an ongoing theme:

“What comes to mind for my properties is some depth of knowledge but also the breadth of knowledge with alcohol and drugs with mental health. Sometimes people forget there is a lot of alcohol and drug issues with the senior population. People need to differentiate mental health issues from medical. Sometimes for someone who is not versed in those issues, if someone acts funny they might make assumptions that aren't correct.” – RSC

The following first-hand account of what RSCs do on an average day provides an example of both the varied work that they do, as well as the limitations of the position as currently defined:

“When I get to work I put on a pot of coffee, open my door, check my email and phone messages and people just start coming in and asking for like we have zero income people in our site and our building activity committee decided I could hand out money so they could do laundry, so some might come in and get some money since they have no income. Some may need information on appointments, telephone numbers, some may need reminders about their lease and where they are violating their lease. So we might go through with that. The property office manager might send me information like they have been partying all night. Or I might be looking for a community member to do a presentation about, like this week we are doing one about free banking services. So it's different day to day - what the needs are. Might be getting someone to the food pantry in the building or referring them out where they might need more food and sometimes it's referring them to services because they do need case management or more attention than I can give.” – RSC

Table 3. Knowledge, Skills and Abilities Required of Health and Housing Specialist

1. **Knowledge about older adults and individuals with disabilities.** Basic understanding of the aging process and normal age-related changes, how disabilities affect function and daily life, basic understanding of chronic illnesses and disabilities and associated outcomes.
2. **Knowledge about practice standards to support consumer direction.** Principles of consumer direction, person-centered planning, person-centered thinking; balancing consumer direction and risk.
3. **Knowledge about resources for older adults – what they are & how to access.** Knowledge about private and public resources, eligibility criteria for public & private resources, how to seek out resources (e.g., databases, websites, networking).
4. **Knowledge about agency policies, rules, guidelines, protocols.** Basic knowledge about affordable housing policies, rental guidelines and privacy standards.
5. **Writing skills.** Writing action/service plans, case notes and other documents.
6. **Oral communication skills.** Active listening, motivational interviewing, presenting information clearly to residents, family members and service providers, mediating between residents and others.
7. **Cultural competency.** Ability to interact in respectful, culturally appropriate ways. Identify consumers’ strengths and challenges. Awareness of individual differences within and across cultural groups. Self-awareness of one’s own cultural competence.
8. **Interpersonal skills** Openness, creativity, work as a team member, flexibility, curiosity, ability to build rapport, ability to set boundaries when needed, ability to work with people in crisis.
9. **Assessment skills.** Ability to assess (i.e., “discover”) needs, values, preferences, strengths, challenges; determine how clients manage day-to-day activities; individualize approach to gathering information, using more formal assessment tools selectively and as appropriate.
10. **Critical thinking & judgment.** Determine what types of supports or services are needed, whether to contact family, which resources are appropriate, whether residents and service providers are able to follow through on action/service plans, when to follow up, when a higher level of care may be necessary.
11. **Observational skills.** Ability to determine through observation resident capabilities, living environment, strengths and vulnerabilities.
12. **Mediation skills.** Ability to facilitate purposeful conversations to reduce conflict between residents, or residents and family members, so that participants may express their interests and concerns and develop solutions.

The Health and Housing Specialist would need to assess the difference between illness and behavioral patterns. A Registered Nurse in the study explained that staff require a level of “sophistication” to interpret each individual resident’s behavior and know when to intervene.

Housing staff need to collaborate with professionals from a wide variety of local agencies, including health care, mental health care, and social services providers. The Health and Housing Specialist would need to identify the outward signs of mental or cognitive health decline and then depend on

the expertise of an assessment specialist at a local agency, for example, to 1) conduct a comprehensive assessment of the resident's condition and 2) provide recommendations for appropriate interventions. An RSC supervisor suggested that housing staff should get to know the primary contacts at organizations that serve residents, even attending staff meetings if possible.



Several participants described the importance of knowing who to call for expert information, whether for questions of program eligibility or how to understand the results of medical examinations.

Based on interviews with RSCs and individuals who supervise them, the Health and Housing Specialist is a generalist position that requires balance between assisting residents who want assistance, respecting the privacy and autonomy of those who don't, and intervening on behalf of those who are at risk of health decline and/or housing instability.

Basic Characteristics of a Health and Housing Specialist. In addition to the KSAs defined above, participants described the general characteristics necessary for an individual who works closely with older residents of subsidized housing. Suggestions from research participants include: “being caring and loving,” “have an interest in people, a genuine questioning about life... knowing their birthdays or knowing when their spouse passed away,” “being a good listener,” “having sophistication about how systems work,” being able to “set boundaries” with residents, and knowing how to “mediate” between residents and their family members.

Qualifications. While several participants did not believe that a college degree was necessary for a Health and Housing Specialist, others believed that such training would be of value. A woman with a Masters degree in Social Work explained, “One of the hugest things I learned in graduate school was to listen. Because I was way too quick to say, ‘Let’s do this.’ Just listening right is huge. It took me a while to figure it out.” The opportunity for ongoing education and training in health and housing policy, gerontology, health promotion, mental health, and similar topics, was described as necessary for this position. Such training must be balanced by a clearly defined job position and scope of services and tasks so that staff do not attempt to exceed the scope of their job.

Argument for a Team Approach

The intent of this research project was to identify the job tasks and characteristics of a subsidized housing staff position who would assist older residents, as needed, to successfully age in place. During the practitioner interviews, however, it became clear that the job was “too big” for one person, and that a team approach would be most appropriate. Although some buildings have RSCs, the current position scope and demands limit the extent to which the RSC can respond to resident needs.

An RSC supervisor with several years experience as an RSC, when asked to imagine an “ideal model” for aging in place, suggested the following scenario:

“If I was going to do 100 unit building, I would have two resident service coordinators, a property manager, two maintenance staff, an Americorps or assistant intern or something who was doing classes, skill building that kind of stuff. I would probably have a housekeeper on site and a couple of cooks, two cooks. I would make sure there was some form of transportation connected to the property whether it was a carpooling system, or access to a bus or van. Probably have a medical social worker and someone who did meds regularly. Then I would have one person in that team probably a resident services coordinator would be coordinating all the partners who come to the site for different things. One of the fantasies I have is that the school of naturopathy would be there and they would provide prevention services, nutrition services, herbs for people willing to try that route, acupuncture so alternative medicine. We would have to have a health plan in the building. The other thing I’ve toyed with a lot is whether child care could be in the building.”

A mental health provider suggested a team approach in which experts from outside the property are available to consult:

“I’m thinking of a model where you’ve got the day to day people that have the relationships with the residents, then they have a support team outside of that. They can consult a physician or mental health specialist, an RN, that type of thing.”

Although beyond the scope of this study, job analysis methods provide strategies for analyzing work done by teams. Developing work done by teams can inform the organization about the type of people to hire, training, compensation, and the defined roles of each team member. A team includes: 1) multiple people (at least two); 2) interdependent work, and 3) a shared goal¹⁷. Organizations must decide how specific or defined the jobs are within a team. For example, a housing provider whose staff include a property manager, RSC, and Health and Housing Specialist must decide whether to define these employees as a team with the shared goal of supporting aging in place, whether there are any shared job tasks or if they remain distinct, how to develop team-based training, leadership, and how to evaluate team effectiveness.

Barriers and Opportunities

Research participants identified several barriers and opportunities to supporting aging in place in subsidized housing, as well as specific challenges related to the workforce component. The following barriers and opportunities are sorted into three categories: resident-level, organizational-level, and systems-level.

Resident Level

Informal Supports. In most instances the informal supports among residents that emerge within a property are seen as an asset and an opportunity to help further the goal of aging in place in subsidized housing, particularly during a period of dwindling public dollars for supportive services. Previous research conducted by the study team showed that social support from both family and non-family members had a positive effect on residents' physical and mental health, and was in fact a safety net in times of need⁶. Throughout this study participants consistently noted the important role that residents play in helping their neighbors to thrive and remain independent, oftentimes unknown to the property management or other on-site staff. The extent and ways in which informal supports emerge varies significantly across properties and within properties. While not the norm, several RSCs told us about their efforts to harness these informal supports by creating and overseeing volunteer opportunities within their buildings.

“I think what often gets overlooked...is the residents themselves support services. It is phenomenal. I don't think anybody, unless you lived in the building you would know, I always maintain that when somebody's health is failing, we're always the last ones to know...somebody is taking out their garbage, somebody is cooking for them, somebody, until it becomes a crisis or something dramatic happens.” – Property Manager

“In two of my buildings we have a great program that offers a lot of support and comfort to people. And we call it the good neighbor volunteer network. We have a list of people who are willing to volunteer. They might be willing to do a friendly phone call, friendly reminders, or friendly visit. There's obviously things they absolutely can't do like give medications, set up medications, and handle finances. It's really set up for a temporary basis. That helps me a lot for a lot of reasons. One, it's offering support to residents. Two, I can't possibly know, with 300 people, what's going on with them. So having these fingers out in the community, let me know if you feel like somebody might need to be checked on or if you have some concerns.” – RSC

“I think about some of our older tenants and in some of our buildings, they have such good community. Everybody knows what's going on with everybody and oftentimes they're sitting with each other. They know somebody's sick. They know somebody's fallen. You [can] continue to build that community so that they can support each other also.” – RSC

Finding new ways to maximize both family and resident support of other residents, while leveraging residents' skills and talents in meaningful ways, could prove to be a necessary component of an affordable housing model that encourages aging in place.

Mix of Ages and Abilities. Interestingly, the mix of ages and abilities of residents within a

property was referenced by some as an asset and by others as a challenge. Many affordable housing properties are designated “elderly/disabled,” so in addition to housing individuals who are over age 62, they also provide housing to a younger population of adults with both mental and physical disabilities. Those who identified the mix of residents as an asset often cited examples of the younger, disabled residents assisting older residents with something physical in nature or older residents taking on somewhat of a nurturing role with younger, disabled residents. Study participants who disliked this particular mix of residents frequently discussed feelings of insecurity or uneasiness of living near individuals with mental illness.

“Mental health concerns are huge, and very disruptive to other residents. In fact, it did stop some people from aging in place because they just can’t deal with their neighbor.” – RSC

While outside of the scope of this study, there may be opportunities to explore both the benefits and challenges of a diverse resident mix versus an age-restricted setting, as well as three-generation intergenerational housing in which there are opportunities for volunteer activities and social events.

Personal Choice and Independence. Throughout the study, both practitioners and residents emphasized the importance of self-determination in decision-making regarding housing choice and the acceptance of supportive services. Unlike some more restrictive models of supportive or enriched housing, services in most subsidized properties cannot be mandated or forced upon residents. Rather, residents must be able to live “independently” without an expectation that the building or housing provider will facilitate their ability to be independent, and at the same time, a housing provider cannot force a resident to accept services as a requirement of residency. While self-determination and personal choice are regarded as basic tenets of social work practice and were consistently identified in this study as a critical component of any social service program, it is also perceived by some to be a challenge, particularly when the objective is to support aging in place and ensure that residents receive the supports necessary to do so. In this study the notion of self-determination came up most frequently in the context of a resident service coordinator or property manager trying to bring in additional services to support an older resident, with the resident refusing to accept services or even acknowledge a need for such services.

“When you look at seniors and you look at aging in place...if they don’t comply, if they don’t see a problem, if there isn’t an issue, the problem persists. You can put three staff members on it, but it all comes down to somebody making their own decisions. They still have to participate. At the end of the day, they have to participate or it doesn’t work.” – Property Manager

In some cases residents may realize they need additional help to remain independent, but do not want to tell anyone for fear that this could put them at risk of losing their housing or their ability to live independently.

“One of the barriers I see a lot, especially with this population, with your disabled senior folk, you don’t want to tell anybody what your deficits are. You don’t want to say I can’t do this for myself. You’re afraid you’ll be forced to move out. So I really try to explain to residents that I’m not part of management. I’m here for you and an advocate for you. And you telling me what is difficult for you helps me support that, so you can stay here.” – RSC

“We do have a very interesting juggling act...between people who are very independent and really clinging to that, and people who need services and trying to manage keeping the aging in place model going at our building while not, kind of thwarting the independence of those who can manage that.” – RSC

“I have found a greater resistance [among older residents] to accepting certain levels of personal care, medication administration, bathing, dressing...because there is more of a fear of letting it be known how much help is needed. So there is more of a resistance, I’ve found, from the clients if they are in a housing situation that they fear they might lose.” – Social Worker

Organizational Level

Breadth of Knowledge. One of the greatest challenges identified when considering the workforce needs in subsidized housing is the wide array of circumstances and scenarios that are possible and the enormous breadth of knowledge that would be required of the on-site staff. For example, RSCs expressed concerns about their lack of medical expertise yet they are often expected to know when a resident’s health has declined or how to intervene when it appears someone has stopped taking their medications. This can be even more complex when working with an aging population and identifying patterns of dementia or decline and knowing the most appropriate way to help the resident.

“What I’ve found is some of my folks can’t, they aren’t even quite capable of making the calls to get any homecare. So some sort of...somebody besides me that has the time and the knowledge to help them navigate that system.” – RSC

“They would need the basic knowledge of anatomy, physiology, and the medical community. You call the radiologist for this thing, you call the cardiologist for this thing and having kind of a bare bones understanding of how the medical community runs.” – RSC

As we explored this further during focus groups with RSCs, the idea of a team approach to on-site services emerged as a potential model that could help to overcome this challenge (see the *Job Analysis* section for more on the team approach). Having access to a network of professionals with differing backgrounds (e.g. mental health practitioners, bed bug experts, geriatricians) whom Health and Housing Specialists could call upon in different circumstances would ease some of the pressure to be familiar with so many domains.

“I keep wondering if all of these sorts of attributes of the ideal worker would be more or better suited to an interdisciplinary team. Maybe three or four people? Of course you probably already considered that, but this almost to me, you know, would be like a super human kind of staff person.” – RSC

Scope of Work. In addition to the extensive body of knowledge on-site staffing would need in order to support residents as they age in place, another major challenge relates to the scope of work for this staffing position and keeping it manageable and realistic for a single person to do on any given day or week. In the existing RSC model, the “caseloads” or resident populations are so large that RSCs frequently find themselves responding to crisis situations rather than preventing them. A 2006 study from HUD’s Office of Research and Development found that more than a third of

Section 202 households (HUD-funded properties designated for residents age 62 and older) lived in very large properties, with 100 or more units¹³ and due to funding constraints, most resident service coordinators are required to work at more than one property. A 2008 HUD-funded study of property managers estimated that a full-time RSC can serve approximately 50-60 elderly or disabled residents with sufficient time to provide 30 minutes of service coordination each week for every resident¹⁴. In a focus group of RSCs working in the Portland area, only one participant was assigned to work at a single property. However, she worked at a property with just under 300 units. Of the other focus group participants, one RSC worked across three properties, another at four properties and two split their time between five different properties.

“I really think you need to evaluate how many tenants there are and what your staff ratio is going to be. It can be intensive but when you are dealing with subsidized and lower income you are going to have some mental health issues and challenges. To me if we can build good relationships we could get things accomplished easier. If you have one staff per 30 or so that’s what our load is. In a single facility place you could go up to 40 or 50, but you have to evaluate that in the building.” – RN Case Manager

“We have 129 units and we don’t have a full time resident coordinator. Or even part time and I think a lot of times having that additional voice to find out what these residents need and what would make it better for them, whether it’s safer or better or their health, that would be huge.” – Property Manager

Taking into account the job tasks and expectations that are outlined in this report, it is unlikely that the Health and Housing Specialist could perform his or her job successfully with “caseloads” of this size. Therefore it is critical that “caseloads” are manageable and consider the resident population and service needs. As previously mentioned, an alternative means of confronting the scope of work challenge might be to develop a team-based approach to resident services.

Physical Conditions of Property. Although not specifically a workforce issue, the need for physical modifications to existing subsidized housing units was reiterated by housing and service providers throughout the study (more details can be found earlier in this report under *Building-Specific Needs* section).

“In my buildings, at least two of them, we don't have accessible units. And so people who need to have their walker in the bathroom, it doesn't work. We have this crazy design. When you walk in the front door to the left you have your bathroom and then there's another doorway to enter, in the studio, to enter into your kitchen and studio area. But the door, my butt barely fits through there let alone my butt in a wheelchair. That's so unfortunate. It was built over 40 years ago and they just didn't -- I run into that a lot. It's sad. People try so hard. Then they end up staying longer than they should because they're taking too many risks and then they fall and so forth.” – RSC

“Sometimes people have to move because of the design of the tub or whatever, it seems like kind of a sad reason to have to move to a different level of care. Um, and of course it’s prohibitively expensive to modify a place to meet those folks’ needs, so that would probably be the number one thing that comes to mind.” – RSC



“These modifications really make a big difference, not only in safety and ability of the client to live but also in happiness and feeling of security. I think that sense of security and safety is one of the first things that leads to or indicates success in the future. When people are starting to feel that they aren’t safe, I’ve seen them decline.” – Program Administrator

“Handicapped bars in the bathroom make the most [difference]. We get a lot of calls because they don’t have bars to

hold on to...we’ll scoop a lot of people out of a tub, lying next to a toilet. It would be simple if they just put grab bars next to the toilet. Those bathrooms that go to ADA specifications in all these buildings, they don’t have nearly as many falls in them in the bathroom.” – Emergency Responder

A housing model designed to allow residents to age in their apartments cannot be fully functional without attention and modifications to the physical environment.

Systems Level

Limited Funding for Supportive Services. Again and again throughout this study limited funding for supportive services in subsidized housing was identified as a major obstacle. As discussed in earlier sections of this report, the current model of resident service coordination is underfunded in such a way that, for various reasons, RSCs are often unable to provide the level of supports residents need. In order for Housing and Health Specialists to truly be effective in supporting residents’ ability to age in place, there must be available resources to fund the position at an adequate level. By maintaining the status quo and employing on-site support staff at such low levels (e.g., part-time or across several large multi-unit properties) neither residents nor housing providers will reap the full array of benefits of this model.

“Aging in place models exist in different places and they work. They happen to exist because there are wealthier families who pay for this. The model works but money is the component that prevents us from providing it to society at large.” – Program Administrator

Confusion over Fair Housing Laws. As we talked with property managers and RSCs there was clearly a pattern of either confusion over fair housing laws or a general avoidance of doing anything that could potentially be considered discriminatory or a violation of fair housing. As such, the majority of housing professionals interviewed for this study steered clear of asking residents about their health or service needs. While fair housing laws preclude property managers from rejecting an

applicant based on disability or a perceived liability, they do not prohibit housing providers from assessing a resident's health or service needs as long as it is done voluntarily and does not impact the resident's housing tenure. Despite this, many housing providers avoid engaging with residents around topics of health, which can become a major barrier to supporting a resident's ability to remain independent. Under the existing model, with such confusion over the limitations of fair housing laws, it is no wonder that RSCs feel like they are consistently dealing with crisis situations rather than intervening and providing assistance before something turns into a crisis. In many instances RSCs and other on-site staff are largely unaware of a resident's challenges or needs and therefore are unable to intervene until a crisis emerges.

“...so the question is would the aging in place expert be able to have the authority to either do the assessment and evaluation or to bring someone in to ensure that cleaning up this problem immediately is going to take care of the issue ...?” – Program Administrator

“Ironically it's from society and the housing authority, everybody wanting to not be intrusive in someone's life and let them make that choice. Fair housing, everybody has a right to this housing, but then it's bad for them. It's ironic it turns around and is hurtful.” – Property Manager

“I see in the Bud Clark Commons a really great example of how, when people move-in, they are going to sit down with a staff on site and do a pseudo assessment of what kind of person that person is - what they like, their hobbies and identifying from the onset what that person would like to see in their personal and the common areas as well. They are not putting down a big stack of paperwork with a bunch of illegible writing and explained what the rules of the building are, they have already been given the time and the energy of staff to say welcome, we might not be able to provide everything you want but this is an environment where we are trying to provide more support.” – Social Worker

Several property managers told us that they did not want to be perceived to be treating residents differently from one another so they simply avoided certain types of interactions with residents. As an example, one property manager told us that if she noticed a resident who needed help opening the front door because their hands were full of grocery bags, she would be hesitant to assist the resident for fear another resident would notice and wonder why she hadn't done the same thing for them.

“...in the back of my mind I think of all that liability stuff. It's like if you do it once, you've got to do it for everybody and you set precedents by doing this, and so now if you don't do it, and you probably have a really good reason for not doing it, but that doesn't matter. When somebody says you did it because, you didn't do it because of some protecting class, no, I did it because I was late for a meeting, so I ran out. You treated me differently then. It's something you always, working with staff across the board, in dealing with that, you've got to keep reminding them as well as myself sometimes, I've got to make sure I'm doing everybody the same way every time.” – Property Manager

Hospital Transitions and the Need for Temporary Assistance. Throughout the course of this study, professionals and residents themselves brought up the challenge of accessing services when they are only needed on a temporary basis. For instance, there appears to be a gap when it comes to

recuperative care for residents returning from a hospital stay. Also commonly mentioned was the need for temporary assistance with housekeeping.

“Another situation where we’ll have an elderly person go into the hospital and really be able to, you know, at some point take care of themselves when they get home, but not sick enough to stay in the hospital. Not well enough to be home. And having that little interim piece, or get sick enough at home.”
– RSC



Housing and Services Models in Other States

Some states have formalized affordable housing with services programs in place for older persons. These programs provide opportunities for other states to draw lessons about workforce decisions. Here we briefly profile programs in Connecticut, Vermont, and New Hampshire.

Connecticut. The state of Connecticut has taken an active role in promoting housing and services models that support aging in place. Unlike most other states, Connecticut licenses assisted living as a set of services, rather than a facility. By licensing assisted living as a service to be delivered in a residential setting, rather than licensing the facility itself, it becomes easier and more flexible to deliver supports to older adults in settings such as subsidized housing. The state also supports on-site services by providing grants that directly fund RSC positions in various subsidized housing settings. Through a partnership between the Connecticut Department of Economic Development, the Connecticut Association of Resident Services Coordinators in Housing, and the University of Connecticut’s Center on Aging, a series of online trainings and presentations on topics relevant to RSCs were developed and made available for free online. Connecticut currently has three programs that assist residents of subsidized housing, 1) a Resident Services Coordinators program, 2) an Assisted Living Demonstration Project, and 3) the Congregate Housing for the Elderly Program.

Research on these programs indicate that guidelines for RSC work must be consistent with current RSC expectations of what they should be doing on behalf of residents. Workforce policies and procedures must define a professional code of practices for RSCs, qualifications for the role,

confidentiality, informed consent, and the importance of promoting autonomy and self-determination. In addition, because most RSCs work alone with little or no supervision, while at the same time they must address complex, emotionally charged issues involving extremely frail, vulnerable elders, many RSCs could benefit from regular supervision from a knowledgeable social-service professional familiar with interpersonal, family, aging, and mental health issues¹⁸. These lessons are transferable to a Health and Housing Specialist and have implications for team-based work as well.

Vermont. Arguably the most innovative of all the states when it comes to housing and services that support low-income older adults, Vermont has made a strong commitment to reducing nursing home use and allowing people to live in settings of their choice. With the state's 1115 waiver, also called Choices for Care, low-income older adults can choose where they would like to receive long-term care services, whether it be in a nursing home, enhanced residential care home, or at home. More recently the state has supported the efforts of Cathedral Square Corporation, a major provider of affordable housing and healthcare, in their efforts to expand their program model, Support and Services at Home (SASH), to affordable housing properties throughout the state. SASH is currently operating in 7 Vermont counties and is expected to go statewide by the end of 2012. The SASH model is a team-based approach, often involving home health agencies, area agencies on aging and other local providers, where residents benefit from health and wellness assessments, assistance navigating the long-term care system, help in crisis situations, transitions support, check-ins and wellness supports from healthcare professionals.

New Hampshire. The state of New Hampshire has made substantial efforts to provide housing and services for individuals who have a chronic illness or disability. Services and supports, including home care, meal delivery, and information and assistance regarding Medicare and Medicaid, are intended to assist people with aging in place safely and independently. The state has a system that allows services to be delivered by a licensed home care agency to residents of public housing who qualify for the Medicaid 1915(c) waiver. In addition, one public housing authority runs a Congregate Housing Services Program and eventually became a licensed home care agency in order to meet the needs of older residents. The state also offers a package of services that includes nursing, nursing assistant, personal care, and homemaking, to individuals who live in a specific subsidized housing unit type and are participants of the Medicaid 1915(c) home and community based care program. On March 2, 2012, Centers for Medicare and Medicaid Services (CMS) announced the first award under the Affordable Care Act's State Balancing Incentive Payments Program, granting \$26.5 million to New Hampshire over three years to expand home- and community-based services in Medicaid.

Core Components of Vermont's SASH Program

- 1. SASH staff creates an organized, person-centered presence in the community.** The SASH staff embedded in the housing community includes a SASH Coordinator and Wellness Nurse. Staff utilizes person-centered approaches to build strong and trusting relationships with SASH participants. SASH staff focus their efforts around three areas of intervention that have proven most effective in reducing unnecessary Medicare expenditures: 1) Transitions support after a hospital or rehab facility stay, 2) Self-management education and coaching particularly relating to chronic health conditions such as diabetes, arthritis, etc., and 3) Care coordination.
- 2. Team-Based Care Management.** The SASH Coordinator and Wellness are part of a larger SASH team comprised of designated staff members from community provider organizations including: Home Health Agencies, Area Agencies on Aging, mental health providers, PACE, and other local providers. The roles and responsibilities of the team members are formalized through a Memorandum of Understanding (MOU) between all partner organizations. The team meets twice a month to coordinate care and action plan solutions for high risk SASH participants as well as discuss general health and information needs for the SASH community. Importantly, the community provider staff on the team also provides direct care to SASH participants in the community and can bring direct knowledge about high-needs participants to the team meeting and personally follow up on team recommendations for additional health-related interventions.
- 3. Information Sharing through Technology.** SASH participants agree to have their health related information shared on an as-needed basis with members of the SASH team. Communication between SASH team members and participants' PCP, family members and other support persons or organizations is also available as directed by the SASH participant. Having accurate and up-to-date information allows the SASH team to respond quickly and effectively when a SASH participant is facing a challenging or unexpected health situation. The efficiency of information sharing will be maximized by each senior housing community being equipped with the health information technology necessary to access the state's Health Information Exchange (HIE).
- 4. Individual and Population Based Approach to Care Management.** The SASH model focuses on the individual participant through the relationships formed with SASH staff and the development of individual Healthy Aging Plans (HAP) for each participant. The health and wellness goals and actions to reach the goals are determined by the SASH participant. The SASH staff then provides encouragement, support and coaching to help the participant meet those goals. The overall SASH population in a community is served by the creation of a Community Healthy Aging Plan (CHAP). The CHAP is developed by aggregating the information found in all SASH participants' assessments and identifying group programs that will meet the common needs. The CHAP includes specific interventions from a directory of evidence based programs organized around five key areas: falls, medication management, chronic conditions control, lifestyle barriers, and cognitive and mental health issues.
- 5. Maximize Volunteer Engagement.** The SASH model relies on maximizing the volunteer capacity within a community to meet the support needs of SASH participants. Volunteers provide companionship through "buddy" programs, assistance with shopping, cooking, and other activities of daily living.

Services: Comprehensive health and wellness assessment, help navigating the long-term care system, person-centered healthy aging planning, team-based crisis response, transitions support, Community Healthy Aging Plan practices, check-ins, coaching, wellness nurse, link to the Blueprint for Health's Community Health Team and Medical Home.

Source and location for more details about SASH: <http://cathedralsquare.org/future-sash.php>

Discussion and Recommendations

While resident service coordinators have been available in some subsidized apartment buildings for years, a combination of aging in place, older ages at which people move into housing, and the greater policy emphasis on alternatives to nursing homes has resulted in recent policy and provider attention to the need for supportive services. For example, there is some evidence that housing with resident services staff can accrue cost savings associated with reduced resident turnover, eviction proceedings, property damage, and reduced staff turnover and vacancies. In addition, strategies to support older adults in their current residence can result in cost savings to the long-term care system and increased community-based living choices for low-income older adults and persons with disabilities.

Housing staff who work with older adults represent a unique and emerging workforce category. The demand for staff with aging-specific knowledge is clear. Because these staff require knowledge of the health aspects of aging as well as health and long-term care systems, they represent a potential pipeline into nursing and other health-related professions. Increasing numbers of housing staff will require training, especially multi-disciplinary education that incorporates elements of social work and health care.

Because the focus of this study was on staffing to support aging in place in subsidized housing, we briefly summarize what study participants said in regard to whether aging in place is a reasonable goal and the challenges associated with this goal.

Is aging in place in subsidized housing a reasonable goal?

The majority of our study participants agreed that an aging in place model is “absolutely necessary” for subsidized housing because of the increasing aging population, economic realities, and a general human desire to support older adults as they age in our society. Participants agreed that an aging in place model for subsidized housing makes sense from an economies-of-scale perspective, acknowledging that providing supportive services to residents in a concentrated area is much more cost-effective than providing the same services to residents in scattered locations. Economies of scale generally make partnerships more attractive to private and public sector service providers because they allow a provider to serve more people at lower marginal costs. Study participants also recognized that an aging in place model of subsidized housing could potentially alleviate pressure and overuse of local emergency services and hospitals. Participants frequently expressed that, for this type of model to work, helping residents to age in place has to be a stated goal or mission of the housing provider. While the participants consistently agreed that this type of model is necessary, questions remain about how aging in place is defined and whether there are limitations to this model. Definitions of aging in place varied among participants. Most definitions reflected the notion that, as people age, they should be able to continue to live where they feel most comfortable, for as long as possible. For example:

“To me, aging in place is providing the supports for people to continue to live in their desired environment.” – Nursing Student Supervisor

“Someone living independently on their own and making their own decisions and choices. Being safe and happy in their own home.” – Case Manager

One of the main barriers to creating an effective model for aging in place is related to addressing the gaps in health and social service needs. There are often circumstances that arise from physical or mental health concerns that are not necessarily emergencies, but in the current RSC model, there's no mechanism in place to help people, such as on-call or mobile services. Usually, the needs either remain unmet, the RSC does their best to fill in, or emergency services are called to intervene. This is a serious and ongoing concern for RSCs which stems from lack of funding of services and uncoordinated care.

“I have a lot of folks who don't have any family and who have a mental health, you know decompensation moment or a breakdown and they're not a harm to themselves or others, but they're having a serious issue. There isn't anything there. There isn't any mobile services that aren't extreme. So I can contact, you know, their case worker who sees them once a month to prescribe to them or something, but that person doesn't come out.” – RSC

“So for mental health as well as physical health, if there was a visiting person that you could count on that, you know, had to cycle through our properties, because like you say, you call their mental health case manager and they don't come and visit ever.” – RSC

“One of the things that I find is that I'm responding to a crisis. And when it's crisis mode and there's a lag time in between when services would be available to that person, it can be very distressing for the client, very distressing for the people supporting that person. And if we actually had on-site services, whatever it was -- we talked about the skilled nursing facilities, but to have a health care, community health care workers on site. To have home care workers on site that could be accessed, I think, when needed, I think that would be an ideal situation.” – RSC

As mentioned previously in the *Barriers and Opportunities* section, another common situation occurs when someone is recovering from surgery or they're sick but not too sick to be in the hospital. Access to interim recuperative care is often unavailable.

“And for me it's a matter of the experience of a woman who is being diagnosed with cancer. She didn't last very long, um, but there was nobody to go with her to any of her treatments. I couldn't go, you know, I couldn't do it. Um, and there was no one.” – RSC

When does aging in place in subsidized housing become an unreasonable goal?

The potential limits to the ideal model of aging in place was a topic of considerable concern. Several thresholds for the model were repeatedly discussed in our interviews and focus groups, which include when residents are unable to manage their medications, dementia, and chronic hoarding.

Inability to manage medications. When residents become unable to manage their necessary medications, many behavioral challenges and serious health concerns can occur. This came up as a cause for transition and medication management came up as a service that would be good to provide to support the goal of aging in place. However when talking with RSCs, it was not a task they really wanted to take on for a number of different reasons, such as liability, being too busy, or not having enough knowledge or training to do this.



“My only worry with hiring an aging in place specialist to do med management is if this person was over-taxed, it would create a danger. And I think being an aging in place specialist is very much like being a resident services coordinator and you just have too much to do always. And I think medicine issues are too risky to throw into a busy schedule.” – RSC

Dementia and mental illness. Dementia came up as one of, if not the biggest, barrier to independence. Participants expressed concerns with assessment of dementia, irrational concerns about safety, and at what point residents would have to transition to a higher level of care.

RSCs, in particular, expressed concerns with assessment of dementia:

“The trickiest one is the dementia, because it’s not like a formal diagnosis oftentimes and we have a lot of people who are extremely, in terms of ADLs, high functioning with dementia. And we cannot have them leave just because they have that and we also can’t get them services because if you get assessed, that provider or that person who’s doing the assessment has no idea what their baseline is.” – RSC

Many times residents with dementia will have irrational concerns about their safety, like the maintenance person entering their apartment for example, when this simply is not the case.

“Then there's that fear element of people coming into their apartment. Must be very scary. Dementia adds a twist on to some of that. We had someone who thought our maintenance guy was going into her apartment all the time. He wasn't. It's just that thought of not feeling safe and having to address that.” – RSC

Some professionals felt that there are simple ways to support residents with dementia, depending on the level of their cognitive abilities:

“Definitely depends on the level. But I think there are simple supports that can be in place to help those people stay. I think about reminding people, let's go down to breakfast. Let's go down to lunch. Take a shower. Hygiene is a big thing with dementia, wash their clothes or change, change their underpants. Just cueing. I don't know. Sometimes that's excessive. Sometimes it's not. Sometimes it's occasional. Don't forget.” – RSC

Interestingly, mental illness did not garner the same concerns and was more or less talked about as a treatable problem. Though outside of the scope of this study, this shift and what may be the de-stigmatization of people with mental illness living in community settings should be explored further in future studies.

“A lot of the mental health issues that come up, so there's the person that has the illness, and the community as a whole. A lot of times the person who has the biggest problem is the community as a whole responding to this person, right? And figuring out interventions to reframe this idea of mental illness as mental diversity. But there are a variety of experiences in life and in trying to be supportive of one another and being compassionate and demythologizing that is important.” – RSC

Though mental illness seemed to be more accepted than dementia, there were some exceptions, particularly when the mental illness or behavioral problems became too much for the housing environment or residents could be characterized as “inhousable,” leaving housing providers in a difficult position.

“I would be concerned because in this kind of a situation this would be seen as the be all end all of housing placements and if someone were to fail where could they possibly go? If they are elderly there is support with the county and find another placement. But you consider behaviors with elders that are really difficult to deal with and disruptive and you get like a woman who is 68, we can't house her because she screams at night. She screams and screams at night and there is not a medical [reason], she is on the road to the state hospital I'm sure but right now she is in a hotel until she runs out of money and then she goes and sleeps in a homeless camp in the SW hills. It's just there are people, dare I say this because I'm a housing case manager I'm afraid to put this on record, but there are people who are almost 'un-housable' because of these behaviors that greatly affect their neighbors. The neighbors are paying tenants and should have a livable place. My concern would be what happens when someone fails in this situation, and how is this person going to manage their stress level? How much responsibility are they going to take on when these failures occur? They are inevitable.” – Housing Case Manager

Chronic hoarding. Frequently the expertise and resources required to address hoarding are unavailable and if it becomes an ongoing issue that cannot be resolved, it often leads to eviction. Several RSCs mentioned how helpful it would be to have a resource in the community that specializes in hoarding issues that they could call upon when necessary. In most cases hoarding was addressed via “muck-outs” and other major cleaning. However, there was little discussion about addressing the root causes or mental illness associated with hoarding behavior. Perhaps this is due to lack of access to resources for this locally.

“You sure hear a lot, at least within our agency, people say I wish there was just someone who was an expert in hoarding, that we could access them readily, so that they could come in. Cause when you have a hoarder and you don't really have the tools in your tool belt to convince them that there's a problem then it remains a problem for a long time.” – RSC

Recommendations

As older residents of subsidized housing age in place, qualified workers will be needed who can respond to the health-related needs and social services associated with an aging population. Housing agencies need to specify the tasks that Health and Housing workers will complete, and identify the knowledge, skills, and abilities required to be successful employees.

1. **Initiate the Health and Housing Specialist Position:** Either create a new position, or expand the existing RSC position in subsidized housing, to include the job tasks and categories and the necessary knowledge, skills, and abilities defined in this report. Funding support for this position, training opportunities, and consensus about the standards of professional practice are now needed to move forward.
2. **Consider a Team-based Approach:** It is likely that more than one job type is needed to support aging in place. A job analysis for a team-based approach could be conducted and modeled after similar other community-based teams.
3. **Develop Training Opportunities:** The most common type of education these study participants listed was gerontology, followed by social work and nursing. Knowledge of housing policies was also mentioned. Although a college degree might not be necessary for a Health and Housing Specialist, many participants saw the value in getting a degree. Given the multidisciplinary nature of the job, a dual degree program or coursework that covers health, social services, and housing, would be ideal.
4. **Use Existing Nurse Delegation Practices:** Oregon’s Nurse Practice Act offers an opportunity to extend medication management practices that are common in community-based settings such as home health, adult foster care, and assisted living. In these settings, a registered nurse teaches a lay staff person to perform traditional nurse functions such as reviewing health conditions (e.g., blood pressure screening, blood glucose monitoring), assisting individuals who self-administer their own medications, and administering medications. While medication management might be seen as “too much” for subsidized housing, study participants agreed that many residents would benefit from assistance setting up their medications on a regular basis, keeping track of any problems or side effects, and communicating with the resident’s physician as needed.
5. **Capitalize on Informal Supports:** Housing staff can help support the development and success of informal supports. Several study participants, including housing staff and current residents, described the value of neighbors helping each other. Most often these exchanges are informal, such as neighbors who occasionally pick up groceries for each other or check to make sure the other is doing alright. One building has a “good neighbor network” in which residents sign up to volunteer as needed to assist others on a temporary basis.
6. **Formalize Relationships with Local Service Organizations:** Study participants described both formal and informal relationships between local health and social service providers, including volunteers. The largest gaps appeared to be between mental health providers and nursing services, especially health monitoring and medication management. Privacy and confidentiality concerns limit communication between housing staff and health professionals and case managers. We suggest a task group of Aging and Disability Services, major housing providers, and mental health organizations, be formed to develop model memorandums of understanding that housing providers can adapt for their own use.
7. **Consider New Service Delivery Models:**
 - a. The Oregon Health Authority’s 2012 proposal to the Centers for Medicare and Medicaid Services included a demonstration project for Congregate Housing with Services that will partner and coordinate with Coordinated Care Organizations (CCO) for behavioral supports, substance abuse treatment, primary care, and CCO models such as onsite nurse practitioners and wellness programs on behalf of dual-eligible residents. This demonstration provides the opportunity to test the job tasks and the knowledge, skills and abilities identified for the Health and Housing Specialist. Specifically, this staff person could be the bridge between housing and the CCO, and could receive training from CCO staff such as nurses and social workers.

- b. Some subsidized housing residents require a level of services between independent living and community-based settings like adult foster care or assisted living. A means of providing short term and sporadic supports for individuals who do not meet nursing home eligibility admission criteria, but who are at risk of eviction, hospitalization, or nursing home use, is needed. Connecticut’s program of assisted living services provided within subsidized housing offers a potential model.
- c. Housing providers require a method of monitoring the quality and success of resident services and resident outcomes. Home Forward, the region’s largest provider of affordable housing, has experience and technologies that could be shared with other housing providers.
- d. Any service delivery approach within subsidized housing must account for the strong culture of independence within this setting. Service providers should be trained in person-directed care and respect for self-determination, and both services and modifications to the property should avoid creating an institutionalized environment.

Methods

The primary method used here was a job analysis. In order to learn about the characteristics of supportive services staff who work in subsidized housing, it was important to talk to people who currently work in, who have clients in, and who live in subsidized apartment buildings. Participants interviewed for this study include resident services staff, property managers, nurses, home health providers, mental health case managers, housing placement staff, social workers, and housing advocates. In total, 57 professionals and 10 current subsidized housing residents were interviewed. This study was reviewed and approved by the Portland State University Office of Research integrity.

Job Analysis

Job analysis is the “cornerstone” of human resources functions, serving as the basis for recruitment, hiring, and training functions¹⁹. A job analysis can professionalize an emerging occupation type by recognizing and validating the workers’ skills, knowledge and abilities. The job analysis identified the nature of RSC work, work environment, training and advancement, job outlook, earnings, and related occupations. The goal was to identify the core tasks and responsibilities required of on-site staff designated to support aging in place, and to categorize the knowledge, skills, abilities (KSAs) required to effectively complete these tasks and responsibilities. We began with RSCs, an existing job type in subsidized housing, but sought to expand this job type to address a housing model committed to aging in place.

For this job analysis, we used a systematic, multi-stage, multi-method, empirical process to develop a job description for on-site resident service coordinators who work primarily with elderly and disabled clients. The process (described in more detail below) included a literature review, review of the Occupational Information Network (O*NET) for similar job types, review of RSC job descriptions, 15 subject matter expert interviews, in-person interviews with 42 health, social services, and other professionals who have clients in subsidized housing (see Table 3 for sample description) and interviews with 10 residents, generation of job tasks, reduction and categorization of job tasks, generation of KSAs required to complete job tasks, KSA refinement, and a linkage survey that asked subject matter experts to link the KSAs to task categories. A criticality survey is often completed

before the KSA refinement and linkage survey, but we decided not to use this step for two reasons. First, we had access to only a small number of RSCs who participated in interviews and we did not want to overwhelm them with requests. Second, we were able to access RSC job descriptions and receive feedback from subject matter experts. Overall, this systematic process resulted in an empirically-based job description that housing and service providers can use to recruit and hire RSCs who work in properties designated for seniors and persons with disabilities.

Literature Review

The purpose of the literature review was to identify published research that could inform the development of an RSC position in subsidized housing for seniors and persons with disabilities. Three primary content areas were identified: resident services in subsidized housing, long-term care workforce, and emerging job professions. We reviewed literature for descriptions of worker skills, training or certification, workplace cultural norms, and workforce issues.

O-NET Review

O*NET is an online searchable database that contains details on hundreds of standardized and occupation-specific descriptors. This database is commonly used by organizational and industrial psychologists, human resource professionals, and others who need information about specific job types, workforce trends, and emerging occupations. The information is based on surveys of workers in each occupation and was last updated in 2010. O*NET is sponsored by the US Department of Labor/Employment and Training Administration and is available at <http://www.onetonline.org/>

Resident services coordinator was not listed as a unique occupation in O*NET. A search conducted September 2011 and updated May 2012 found that the closest match (100%) was “Residential Advisor.” Other relevant occupations included Personal Care Aide (63% match), Medical and Health Service Manager (59% match), Social and Human Service Assistant (53% match), and Social and Community Service Manager (49% match). The tasks and the required knowledge, skills, and abilities for these occupations provided direction in creating the tasks and KSAs used for the RSC description. Despite the similarities, there were important differences between these occupations and RSCs. For example, several of these occupations describe tasks that involve hands-on assistance with health-related tasks such as providing first aid (Residential Advisor) or “bedside or personal care, such as ambulation or personal hygiene assistance” (Personal Care Aide). These functions are outside the scope of Resident Services Coordinators as currently defined by AASC, HUD, and NRS. In addition, Residential Advisors most often work with youth or young adults, and thus the job tasks and skills refer to “students.” For the purpose of this analysis, we changed words to fit the specific context of subsidized housing, in this example, using the term “older residents.”

In the Appendix we provide O*NET descriptions of the Residential Advisor and Social and Human Service Assistants occupations (O*NET, 2012) since these two occupations had qualities most similar to RSCs.

Review of RSC Job Descriptions

RSC job descriptions were located through Internet searches and through contacts made with housing providers through this and prior research projects. A total of 19 job descriptions were reviewed from five states (Connecticut, Oregon, New Hampshire, Massachusetts, and Vermont), three national housing organizations (HUD, Enterprise, Mercy Housing), and two national professional organizations (American Association of Service Coordinators and National Resident

Services Collaborative). Most job descriptions were general to any property type, though some specified positions in either elderly or family properties.

In addition, we reviewed job descriptions for Information and Referral specialists and Options Counselors employed by either Area Agencies on Aging or the Aging and Disability Resource Center of Oregon. All job descriptions were systematically reviewed for specific tasks, KSAs, qualifications (e.g., education, certification, experience), and other job requirements.

Subject Matter Expert Interviews

A subject matter expert is an individual who has knowledge of the job being analyzed – either they work in the occupation or supervise workers¹⁷. We identified current RSCs through OregonON, a professional association and by snowball sampling. Thus, the sample was selected through convenience rather than randomly. A total of 15 RSCs participated in an interview. They were asked to think about a new job position, similar to a RSC but referred to as an “**aging in place specialist**” whose job would be to help residents age in place. Some of the questions included:

- How would the AIP specialist’s job **differ** from the current RSC job?
- What kinds of **tasks** would that person have?
- What **skills** or **specialized knowledge** would that person need to have?
- What **title** would you give this job, other than aging in place specialist?
- We’ve heard from some people that this may be too much for one person to take on. What do you think about a team approach to helping older adults to age in place? What would that team look like?

Table 4. Practitioner Interviews

<i>Professional Category</i>	#
Resident Service Coordinators	15
Social Service Providers	19
Health Care Providers	13
Emergency Responders	3
Property Managers	5
Housing Advocates	2
Total Practitioners Interviewed	57

Practitioner Interviews

In addition to interviewing RSCs, we chose to interview a range of practitioners who have clients in subsidized housing. The rationale was that practitioners have first-hand experience with the types of services and needs that housing staff might need to address in an aging in place model of subsidized housing. Practitioners were identified through local health and social service agencies; those who agreed to participate were asked to name others who would be able to contribute to the study. Table 4 lists the professional categories of these and the RSCs who participated, and Table 5 provides demographic descriptions.

Key questions asked in these interviews included:

- Some owners and operators of subsidized housing would like to have a specific aging in place model for older residents and persons with disabilities. Thinking about what it might take to provide this model, what are some of the main categories of support that residents might need to be able to age in place?
- What could this staff person do to delay or prevent an eviction, transition, or admission to higher level of care, and allow a resident to continue to live in their apartment?
- Even with this staff person, what might prevent an aging in place model from working?

Table 5: Practitioner Demographics

n=57	
Age (mean)	46
Female	65%
Years in current position (mean)	5
Take part in continuing education classes	41%
Completed graduate school	39%
Some graduate school	16%
Completed 4-year degree	25%
Completed 2-year degree	6%
Completed high school	14%

Resident Interviews

Ten current residents of subsidized housing agreed to be interviewed. They were contacted with the help of property managers and RSCs at two apartment buildings in Portland. All 10 residents had lived in their building for more than 12 months, 8 of them for over five years. They ranged in age from 69 to 87 (mean 79), included seven females, and all were born in the United States. Most identified as White, one as African American, two as multi-racial or ‘other’ race, and none identified as Hispanic. Three individuals had completed a four-year college degree. Two residents were married, five separated/divorced, one single, and two widowed. Seven had children living in the Portland area. Five currently receive Supplemental Nutrition and Assistance Program benefits. The monthly rent these residents paid, which is calculated based on their total income and adjusted for medical expenses, ranged from \$109 to \$647. Four residents paid less than \$200, three paid between \$201-\$400, and three paid more than \$400 per month. The interview guide included questions about a typical day, the residents’ health, use of health or social services if any, interaction with housing staff, expectations about continuing to live in the apartment, willingness to help other residents, and best aspects of the apartment building.

Interview Methods

We used three interview types in this research: focus group, small-group, and individual. Two focus group interviews, both with RSCs, were done in order to gather information from persons considered as subject matter experts. In addition, we used a modified focus group, comprised of

two or three participants, in order to blend the interactive strengths of focus groups and the capacity for in-depth detail and flexibility provided by individual interviews. Six individual interviews were conducted when it was not possible to coordinate a small group interview. All interviews were audio-recorded and transcribed. The interview guides with housing and service professionals included open-ended questions about topics such as categories of work done by RSCs, knowledge and skills that would be needed by staff who work with older residents, and whether aging in place is a reasonable goal for subsidized housing. In addition, participants were asked to respond to two scenarios that described a resident who was at risk of being moved from their housing, one due to unmanaged incontinence and the other a resident who was having difficulty managing medications.

Qualitative Data Analysis

The practitioner and resident interviews resulted in qualitative data. This data type is valuable when the goal is to learn from individuals' first-hand experiences, attitudes, and activities. These data were managed and analyzed in a software program designed for qualitative data (*Atlas.ti*) as well as in *Excel*. The primary analytic goal was to sort the data into categories that summarized the words and intent of the participants. In order to achieve this, a three-person study team read all transcripts and prepared two or three page narrative memos, using a template to ensure consistency, that summarized responses to interview questions and topics that participants raised. "Memoing" is a technique in qualitative research to generate theory and validate data that consists of writing about issues, interpretations, or questions that are circulated to other members of the research team and incorporated as topics of interest in ongoing research¹⁹. For this study, a memo template was modeled after the interview guide and included space for interesting quotes, primary themes, and other observations made by the interviewer or reviewer.

As a qualitative validity check, a second member of the research team completed what we're calling a "memo scan" with approximately half of all of the conducted interviews. In determining which interviews would be included in the memo scanning process, the team collectively eliminated any interviews that seemed to be least relevant based on the analytic memos and then, using a master list, selected every other interview for a memo scan. The memo scanning process entailed another reviewer reading the entire interview transcript, followed by additions and edits to the initial analytic memo. Through this process, the second reviewer was able to identify insights or inconsistencies that may have been overlooked by the initial reviewer. The research team then compiled common themes and patterns from the analytic memos. Finally, data were organized by different participant types (e.g., housing, service, clients) in order to make comparisons between, for example, health professionals and property managers.

Generation of Job Tasks and Knowledge, Skills, Abilities

Identifying the job tasks associated with a specific occupation is a major component of job analysis. The above stages helped to inform this process. Tasks statements were prepared in accordance with Department of Labor standards; such statements begin with a verb that states what gets done. The worker is not specifically mentioned but is implied in the statement. The verb is followed by an

object (what is done to) and then an optional infinitive phrase might be included to describe how and/or why the action is done. The examples shown in Table 6 were developed for this project to help participants understand questions about tasks.

Table 6. Example for Job Task Generation

SPANISH TEACHER

Tasks: Develop lesson plans, grade student work, lead classroom activities.

Knowledge: Knowledge of Spanish grammar & language, knowledge of teaching practices.

Skills: High-level Spanish speaking, reading and writing skills, time management, good communication, classroom management.

Abilities: Relate to students and parents, talking in front of groups.

POLICE OFFICER

Tasks: Patrols a designated area, responds to calls, issues tickets, arrests suspects, writes reports.

Knowledge: Knowledge of laws, knowledge regarding criminal activity, knowledge of local policies and procedures, knowledge of community resources.

Skills: Problem-solving, critical thinking, communication skills, listening skills.

Abilities: Keeping calm under pressure, understanding how the law applies to specific situations, physical ability to enforce laws.

Once the tasks are identified, the knowledge, skills and abilities required to complete the tasks must be specified. Table 7 below provides generic examples of KSAs. Interviews with current RSCs and supervisors proved the most successful for identifying the KSAs required of a staff position to support aging in place. Practitioner interviews provided useful information, though not as detailed. However, all interviews were reviewed and compared to relevant job descriptions, and the KSA list (Table 3) was generated and reviewed by organizational consultants and the study team.

Table 7. Examples of Knowledge, Skills and Abilities

Knowledge required	<ul style="list-style-type: none"> • What subject matter areas are covered by each task? • What facts or underlying principles do you need to understand in these subject matter areas? • Describe the level, degree, and breadth of knowledge required in these subjects?
Skills required	<ul style="list-style-type: none"> • What activities must you perform with ease and precision?
Abilities required	<ul style="list-style-type: none"> • What is the nature and level of language ability required on the job?

Linkage Survey

A linkage survey was conducted in order to validate the knowledge, skills, and abilities by asking a panel of subject matter experts to rate the importance of the KSAs to each of the task categories. In this process, KSAs are linked to task categories. To be considered a valid KSA, each KSA had to be

linked to at least one task category. Any KSAs that were not linked, or had a very low score, would be dropped from the final list. However, no KSA was rated as very low by the survey participants. An online linkage survey was developed (Appendix 4) and emailed to two groups of RCSs: 1). Oregon-based RCSs who participated in focus groups or who were identified through informal networks, and 2). RCSs affiliated with the American Association of Service Coordinators. A total of 87 completed most of the survey. The below tables describe participant characteristics. The total number of participants varies because not every participant answered the demographic questions. A question about primary client type was asked at the beginning of the survey (before some people quit the survey) so the number of respondents is much higher for this question.

Table 8. Linkage Survey Participant Primary Client Type

Primary Client Type	Count	Percent
Elderly Only	19	21.8%
Elderly and Disabled	62	71.3%
Other (including elderly)	6	6.9%
Total	87	100.0%

These demographic questions were asked at the end of the survey (after some people quit the survey) so the number of respondents is lower for this set of questions.

Table 9. Linkage Survey Participant Gender

Gender	Count	Percent
Female	57	80.3%
Male	14	19.7%
Total	71	100%
Missing	15	

Table 10. Linkage Survey Participant Age

Age	Count	Percent
29 or younger	3	4.4%
30-39	11	15.9%
40-49	20	29.0%
50-59	22	31.9%
60 or older	13	18.8%
Total	69	100.0%
Missing	18	

Table 11. Linkage Survey Participant Education

Education	Count	Percent
High School	12	16.9%
Associates Degree	5	7.0%
Bachelor's Degree	23	32.4%
Some Graduate School	7	9.9%
Completed Graduate School	24	33.8%
Total	71	100.0%
Missing	15	

The online survey drew respondents who work in resident services with older adults from across the country. The graphic representation below illustrates the places respondents identified as the city and/or state where they work. In this type of graphic, the larger the place name, the higher the frequency of the response. For example, California is the largest word because it was the most frequent response, whereas, Albuquerque is small because only one survey respondent works in Albuquerque.

Figure 1. Geography of Linkage Survey Respondents



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Appendices

Appendix 1: Sample Training Modules

While many housing providers and professional organizations have outlined and even developed trainings around resident services in subsidized housing, there are few formalized programs that offer academic credit or certification for completing the prescribed training. Below are examples of two of the more formalized training programs designed for RSCs.

Ohio State University and the American Association of Service Coordinators. The Ohio State University Medical Center and the American Association of Service Coordinators offer a professional certification program for individuals seeking comprehensive career training in resident service coordination. The online program requires students to complete eight core and six elective modules, with each module taking between one and three hours to complete. Recognizing that resident service coordinators work in a range of settings with a variety of different resident populations, the six elective modules allow the student to specialize in particular areas of interest. To be eligible for the certificate program individuals must either possess a Bachelor's degree or demonstrate five years of paid employment in social services. Once students have completed the fourteen modules they are required to pass a comprehensive exam. Though the program is delivered through Ohio State University, it does not carry academic credit, licensure or certification authority. To retain Professional Service Coordinator (PSC) designations, AASC requires all PSCs to renew every three years by accumulating 36 hours of continuing education.

The required 8 core modules include the following topics:

- Communication
- Diverse Lives, Diverse Needs
- Documentation
- Federal Programs
- Professional Conduct and Ethics
- Role of the Service Coordinator
- Substance Abuse: Realities and Hope
- Supervision & Program Outcomes

The 6 elective modules may be selected from the following:

- Aging, Memory and Alzheimer's Disease
- Elder Mistreatment: Defining, Understanding and Responding
- Embracing Life's Transitions: Decisions, Choices & Connections
- End of Life Care: Perspectives, Decision-Making, and Resources
- Health Literacy
- Life Management for the Service Coordinator
- Life's Losses: Bereavement, Grief and Coping
- Low Literacy: It's Time To Take It Seriously!
- Medication Use and the Older Population
- Mental Health Issues: Symptom Recognition, Intervention and Referral
- Navigating Medicare

- What is Healthy Aging?
- You Can't Tell By Looking! Communicating With Persons with Low Literacy Skills

For additional information on this training program, please visit: www.aasc.osu.edu

Connecticut Department of Economic and Community Development and the University of Connecticut Center on Aging. Through a partnership between the Connecticut Department of Economic Development, the Connecticut Association of Resident Services Coordinators in Housing, and the University of Connecticut's Center on Aging, a series of online trainings and presentations were developed and made available online and are free to download. Presentations are organized around the following topics:

- Consumer Legal Issues and Residential Service Coordination
- Beyond Scatter Rugs: RSCs and Evidence-based Fall Prevention
- Medications and Mood Disorders in Later Adulthood
- Win/Win Approaches to Conflict: Effective Communication and Resolving Disputes
- A Day in the Life of a Resident Service Coordinator: Strategies for Success
- Community Living: Independence and Empowerment
- Show Me the Money: Services, Entitlements, and Cash Resources for Clients in the Community
- Digging Deeper: What you always wanted to ask DSS and Social Security and now can
- Supporting People Who Are Living with Mental Illness

For additional information on this training program, please visit: www.ctrstraining.com

Appendix 2: Sample Job Descriptions

Sample 1: Enterprise Community Partners

The primary function of the resident services coordinator (RSC) is to effectively assist resident family members that have requested support in enhancing the quality of their daily lives and in more fully and successfully participating in the educational and economic mainstream. The position provides tenants with information about and supportive access to local services and resources that can assist the residents to achieve their life opportunities objectives. The resident services coordinator is an integral part of the housing and property team and plays a critical role in the overall positive maintenance of the property for the enjoyment of its residents and the respect of its neighbors.

Responsibilities

1. Welcome new residents (and establish contact with existing residents) and explain to them the resident services program, its offerings, and the RSC role in providing information and support in assisting residents interested in accessing local service resources.
2. Identify, assess, select, develop and maintain referral partnership relationships with local service resource agencies that effectively assist residents to achieve their life opportunities objectives.
3. Provide supportive linkages between residents and referral agency staff when residents or

agencies request assistance.

4. Work with the property management team when a resident is identified as being in jeopardy of eviction and offer linkages and referral support to the resident to positively and quickly rectify the situation.
5. Establish resident services program targets. Consistently track and measure program target progress. Regularly report program outcomes to both internal and external stakeholders. Analyze and utilize outcomes data as the basis for continuous program improvement.
6. Identify and assess individual and family needs when appropriate; inform the resident of available resources and provide support in accessing services successfully.
7. Help to facilitate tenant meetings and community-organizing and social activities if desired by residents.
8. Develop supportive professional relationships with residents that help them enhance the quality of their lives, empower them and encourage them in taking the steps to achieve self-sufficiency.
9. When requested, work with property management in mediating conflicts between tenants.
10. Complete other housing and resident related assignments as directed by the supervisor.

Suggested Skills/Background Needed

1. Enthusiasm in working with people
2. Experience with community organizing and the social service system
3. Knowledgeable about the daily realities facing low-income families
4. Some background and experience in affordable housing programs
5. Ability to multi-task and complete assignments that sometimes occur in a stressful environment
6. Strong verbal, written and interpersonal communication skills
7. Computer and technology proficient
8. Program evaluation experience helpful

Minimum Requirements

The successful candidate for the RSC position will possess:

1. A bachelor's degree in the field of human services, plus a minimum of 1 year of experience working with people of low income; or a minimum of 3 years of documented, successful experience in community development or community-organizing activities
2. A working knowledge of the local social service system or the proven ability to quickly develop such knowledge
3. The ability to identify, assess, select, develop and maintain community service referral partnerships that assist residents in achieving their life opportunities objectives
4. Excellent interpersonal, verbal, and written communication skills
5. Demonstrated experience in successfully working with diverse populations
6. Competent computer and technology skills
7. The ability to establish, maintain, track, measure and report to stakeholders the program's objectives and their efficacy in assisting residents to achieve their life opportunities objectives

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Sample 2: American Association of Service Coordinators

*Description for RSCs working in HUD-financed housing for residents 62+

Qualifications:

1. A Bachelor of Social Work or degree in Psychology or Counseling is preferable. Supervisory experience may be necessary in some situations.
2. Two to three years experience in social service delivery with an elderly and/or family populations.
3. Demonstrated working knowledge of supportive services and other resources in the area served by the project.
4. Demonstrated ability to advocate, organize, problem-solve and provide results for the residents they serve.

Objective of the position:

The Service Coordinator (SC) must work from an empowerment model. The goal of the program is self-actualization of residents. Residents should do as much as they are capable of doing themselves. The SC works in conjunction with the property manager. The SC and manager maintain a mutually respectful, collaborative relationship.

Functions:

1. Provides general service management which includes intake, education (services available and application procedures) and referral of residents to service providers in the general community. These social services may include meals-on-wheels, transportation, home health aides, homemakers, financial assistance, counseling, preventative health screening, and other needed services.
2. Develops a Resource Directory. This directory may include a listing of state and/or local service providers that residents can contact for assistance (e.g. services to families, children, individuals who are elderly, persons with disabilities, emergency assistance). In many cases, State and local governments can also provide a listing of the non-profit agencies with which they contract for services.
3. Sponsors educational events which may include subject relating to health care, agency support, life skills, referral sources, etc.
4. Facilitates the formation of Resident Associations within the property if the resident's are interested. The formation of these groups assists the residents in planning social events, organizing activities and discussing daily life issues.
5. Monitors the ongoing provision of services from community agencies and keeps the case management and provider agency current with the progress of the individual. Manages the provision of supportive services where appropriate.
6. Serves as a liaison to community agencies, networks with community providers and seeks out new services available to the residents.
7. Assists the residents in building informal support networks with other residents, family and friends.

Service Coordinators fulfill the following roles:

INVESTIGATOR

Service Coordinators conduct research on a daily basis. For example, they perform the following tasks:

- Analyze the types, frequency, and other characteristics of services that residents use, need, and want.
- Study available community services and their eligibility requirements.
- Research residents' participation in, and satisfaction with, educational and social programs, residents' interest in new programs, and barriers to greater participation.
- Assess residents' and community's resources and capacities.
- Observe residents for needs.

EDUCATOR

Service Coordinators inform residents about service availability, how to apply for services and benefits, consumer rights, and other relevant issues. They also inform other staff about the coordinator's role and about issues related to aging in place. This can help other staff do their jobs, know how and when to use the coordinator, and promote acceptance of the coordinator. (Effective coordinators also learn from residents and other staff.) Additionally, coordinators handle the following responsibilities:

- Organize programs on topics of interest to residents.
- Distribute consumer materials often available free from organizations such as State and area agencies on aging, the American Association of Retired Persons, the National Council on the Aging, senior centers, Councils on Aging, legal services offices, or the services or programs themselves (such as Medicare and Medicaid).
- Organize meetings to "teach" residents about housing development rules, regulations, and operations.
- Help managers and residents recognize and solve safety or accessibility problems.
- Connect residents with educational and recreational programs through the city or town, senior centers, Elderhostel, and other sources.
- Work with libraries.
- Arrange or conduct resident leadership training sessions in areas such as how to run a meeting or how to write bylaws.

COMMUNITY BUILDER

Effective Service Coordinators tend to recognize the impact of the social environment on, and the importance of a sense of community to individuals' health and well being. Service Coordinators perform the following tasks:

- Assist residents in forming or strengthening resident organizations.
- Help resident groups with activities and community issues.
- Help residents build informal support networks with other residents, family, and friends.

ADVOCATE/LIAISON

If a resident approaches the Service Coordinator and requests it, coordinators may act as liaisons with management or community agencies and often advocate on residents' behalf in groups, one to one, formally, or informally. Whenever possible, Service Coordinators should work with the social services director, manager and director to resolve issues together (without releasing confidential information). They may do the following:

- Advocate for additional and/or more appropriate supportive services.
- Plead residents' causes with management and seek solutions together with management.
- Educate service providers about residents' needs and lack of resources, and encourage providers to take advantage of economies of scale (serving more people for the same amount of money).
- Teach residents to advocate for themselves.

SERVICE FACILITATOR

Service Coordinators:

- Establish links to community agencies and service providers.
- Develop resource directories.
- Provide basic case management and referral services.
- Monitor the ongoing provision of services from outside agencies.

ADDITIONAL TASKS

- Fulfill the educational requirement as outlined by HUD.
- Inform residents about and help them obtain benefits for which they are eligible.
- Help residents interpret mail; may fill out forms that they can not fill out themselves; arrange utility, phone, medical, and other payment schedules; address errors or misunderstandings related to Social Security earnings, insurance billing, or death or survivors' benefits; make funeral arrangements for a loved one; connect with hospice and bereavement counseling or supportive services; and solve other "bureaucratic" problems.
- Implement onsite or mobile health services and screening.
- Set up telephone reassurance, crime watch, and "buddy" programs.
- Arrange for senior companions or volunteers or obtain employment.
- Help residents obtain equipment and devices such as walkers, wheelchairs, Talking Books, large-print telephones and other visual aids, grab bars, hearing aids, devices that compensate for impaired hearing, lever door handles, self-cleaning ovens, service or helper pets, and emergency response systems.
- Distribute emergency forms and help residents fill out the forms with their vital statistics information (to be kept with resident).
- Promote resident participation in local senior centers.

- Get residents involved in HUD’s Neighborhood Network Program, SeniorNet, or other computer-oriented programs aimed at reducing isolation and increasing independence.
- Help residents work with health care providers to establish medication setup and reminder services.
- Organize other reminder systems.
- Negotiate quantity discounts.
- Locate lower cost providers.
- Find services that can be delivered to residents or that offer transportation.

NOTE: HUD has a general policy that restricts direct provision of services by coordinators and is not to act as the property recreation/activities director/coordinator.

Appendix 3: Detailed Descriptions of Job Tasks and Clusters

Tasks and Task Clusters

Assess residents age 62+

Identify residents who are at risk of decline or move-out; conduct needs assessment of health, psychological, and social needs of residents; develop an individualized service plan for residents; periodically review and update resident service plans; visit apartments to look for health-related concerns such as hoarding, bed-bugs, accessibility, and incontinence; coordinate with case managers as appropriate and if permitted; organize and maintain assessment files; assist with relocating frail residents as needed; visit residents in hospital or rehab facility; coordinate with resident and health care providers when a resident returns from a hospital or rehab; respond to residents who have a sudden change in health status; include family of residents in assessment meeting if resident agrees.

Provide information and referral when asked by Residents age 62+

Identify the type of information needed by residents; provide relevant information and referral that addresses the needs and interests of residents; educate residents about entitlement programs and local resources; answer questions about how to complete applications for programs/benefits for older persons.

Identify, assess, select, develop and maintain referral partnerships on behalf of Residents age 62+

Identify local social service and resource agencies that provide services/benefits relevant to residents; select specific social service and resource agencies to partner with on behalf of residents; develop and maintain partnerships with local social service and resource agencies that provide aging services; monitor whether aging services are provided as agreed upon by partner agencies; create a directory of aging services providers for use by building staff and residents; advocate on behalf of Residents age 62+ who need services; identify culturally relevant partnerships on behalf of residents; strategize to identify services that promote stability, self-determination, and independent living for residents.

Determine building-specific needs to plan, organize, and implement on-site trainings, information sessions, and social activities based on input and need expressed by Residents age 62+

With resident input, identify on-site and off-site information sessions that residents want or need; plan, organize and implement social activities for residents; provide support to resident-led organizations; develop and maintain relationships with volunteers; identify culturally appropriate activities for residents.

Address with property management team any concerns about the tenure of Residents age 62+

Communicate with property management specific concerns about the tenure of residents; facilitate meetings between residents and property management; identify strategies for addressing housing-related issues on behalf of residents; coordinate with family, case managers, or other appropriate contact persons as needed; educate property management and other building staff about health and social services; mediate inter-resident conflicts; work with property management and other building staff to prevent evictions and unnecessary transitions to institutional care; explain lease requirements as needed.

Build supportive professional relationship with Residents age 62+

Encourage residents to be self-sufficient; be respectful of personal choices and lifestyles among residents; welcome new residents; explain to residents how the residents services program can help them learn about and access local resources; promote a positive social climate in the building; communicate with family of residents if appropriate.

Evaluate the success of the Resident Services program progress by tracking and measuring information on behalf of Residents age 62+

Maintain database of requests for services, service provided, and participation in resident service program events/activities; summarize data for use in reports shared with property management; use data to improve program as needed to meet needs of residents; monitor referral agencies for programmatic or other changes that affect access or quality; with approval from residents, monitor outcomes of any informal and referrals made in the prior few weeks; monitor outcomes of any social activities that took place (e.g. attendance and satisfaction); monitor outcomes of meetings with residents and property management team; monitor resident assessment process for consistency and outcomes.

Appendix 4: Electronic Survey of Job Tasks to Knowledge, Skills and Abilities

Figure 2. Electronic Linkage Survey Screenshot

Q13 What knowledge, skills, and abilities are needed for successful job performance in the following task category:

Determine building-specific needs to plan, organize, and implement on-site trainings, information sessions, and social activities based on input and need expressed by Residents age 62+

How important is each of the following?

*Scroll over the text in BLUE for additional details.

With resident input, identify on-site and off-site information sessions that residents want or need; plan, organize and implement social activities for residents; provide support to resident-led organizations; develop and maintain relationships with volunteers; identify culturally appropriate activities for residents

	Not at all Important	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important	Extremely Important
Knowledge about older adults and individuals with disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowledge about practice standards to support consumer direction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowledge about resources for older adults – what they are & how to access	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowledge about agency policies, rules, guidelines, protocols	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Writing skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oral communication skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural competency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assessment skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Critical thinking & judgment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observational skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mediation skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix 5: O*NET Review of Similar Occupations

Here we provide two O*NET occupation descriptions that are similar to Resident Services Coordinator: 1). Resident Advisor and 2). Social and Human Service Assistant. These descriptions are provided for analytic purposes; wages and employment trends may not be comparable to the RSC position.

1. Residential Advisor

Description: Coordinate activities in residential facilities in secondary and college dormitories, group homes, or similar establishments. Order supplies and determine need for maintenance, repairs, and furnishings. May maintain household records and assign rooms. May assist residents with problem solving or refer them to counseling resources.

Sample of reported job titles: Resident Director, Resident Assistant, Residence Hall Director, Residence Life Director, Resident Advisor, Residence Director, Unit Coordinator, Hall Coordinator, Residence Life Coordinator, Residential Life Director.

Tasks Required of Residential Advisors

- Enforce rules and regulations to ensure the smooth and orderly operation of dormitory programs.
- Provide emergency first aid and summon medical assistance when necessary.
- Mediate interpersonal problems between residents.
- Make regular rounds to ensure that residents and areas are safe and secure.
- Observe students to detect and report unusual behavior.
- Communicate with other staff to resolve problems with individual students.
- Counsel students in the handling of issues such as family, financial, and educational problems.
- Collaborate with counselors to develop counseling programs that address the needs of individual students.
- Develop and coordinate educational programs for residents.
- Develop program plans for individuals or assist in plan development.

Knowledge Required of Residential Advisors

- Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
- English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
- Psychology — Knowledge of human behavior and performance; individual differences in ability, personality, and interests; learning and motivation; psychological research methods; and the assessment and treatment of behavioral and affective disorders.
- Therapy and Counseling — Knowledge of principles, methods, and procedures for diagnosis, treatment, and rehabilitation of physical and mental dysfunctions, and for career counseling and guidance.
- Sociology and Anthropology — Knowledge of group behavior and dynamics, societal trends and influences, human migrations, ethnicity, cultures and their history and origins.
- Clerical — Knowledge of administrative and clerical procedures and systems such as word processing, managing files and records, stenography and transcription, designing forms, and other office procedures and terminology.
- Personnel and Human Resources — Knowledge of principles and procedures for personnel recruitment, selection, training, compensation and benefits, labor relations and negotiation, and personnel information systems.
- Administration and Management — Knowledge of business and management principles involved in strategic planning, resource allocation, human resources modeling, leadership technique, production methods, and coordination of people and resources.

Skills Required of Residential Advisors

- Active Listening — Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
- Monitoring — Monitoring/Assessing performance of yourself, other individuals, or organizations to make improvements or take corrective action.

- Social Perceptiveness — Being aware of others' reactions and understanding why they react as they do.
- Speaking — Talking to others to convey information effectively.
- Coordination — Adjusting actions in relation to others' actions.
- Critical Thinking — Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
- Negotiation — Bringing others together and trying to reconcile differences.
- Time Management — Managing one's own time and the time of others.
- Persuasion — Persuading others to change their minds or behavior.
- Service Orientation — Actively looking for ways to help people.

Abilities Required of Residential Advisors

- Oral Comprehension — The ability to listen to and understand information and ideas presented through spoken words and sentences.
- Oral Expression — The ability to communicate information and ideas in speaking so others will understand.
- Problem Sensitivity — The ability to tell when something is wrong or is likely to go wrong. It does not involve solving the problem, only recognizing there is a problem.
- Speech Clarity — The ability to speak clearly so others can understand you.
- Speech Recognition — The ability to identify and understand the speech of another person.
- Deductive Reasoning — The ability to apply general rules to specific problems to produce answers that make sense.
- Written Comprehension — The ability to read and understand information and ideas presented in writing.
- Inductive Reasoning — The ability to combine pieces of information to form general rules or conclusions (includes finding a relationship among seemingly unrelated events).
- Near Vision — The ability to see details at close range (within a few feet of the observer).
- Written Expression — The ability to communicate information and ideas in writing so others will understand.

Work Activities Required of Residential Advisors

- Communicating with Supervisors, Peers, or Subordinates — Providing information to supervisors, co-workers, and subordinates by telephone, in written form, e-mail, or in person.
- Assisting and Caring for Others — Providing personal assistance, medical attention, emotional support, or other personal care to others such as coworkers, customers, or patients.
- Establishing and Maintaining Interpersonal Relationships — Developing constructive and cooperative working relationships with others, and maintaining them over time.
- Resolving Conflicts and Negotiating with Others — Handling complaints, settling disputes, and resolving grievances and conflicts, or otherwise negotiating with others.
- Making Decisions and Solving Problems — Analyzing information and evaluating results to choose the best solution and solve problems.

- **Thinking Creatively** — Developing, designing, or creating new applications, ideas, relationships, systems, or products, including artistic contributions.
- **Getting Information** — Observing, receiving, and otherwise obtaining information from all relevant sources.
- **Organizing, Planning, and Prioritizing Work** — Developing specific goals and plans to prioritize, organize, and accomplish your work.
- **Monitor Processes, Materials, or Surroundings** — Monitoring and reviewing information from materials, events, or the environment, to detect or assess problems.
- **Scheduling Work and Activities** — Scheduling events, programs, and activities, as well as the work of others.

Work Context for Residential Advisors

- **Work With Work Group or Team** — How important is it to work with others in a group or team in this job?
- **Face-to-Face Discussions** — How often do you have to have face-to-face discussions with individuals or teams in this job?
- **Contact With Others** — How much does this job require the worker to be in contact with others (face-to-face, by telephone, or otherwise) in order to perform it?
- **Telephone** — How often do you have telephone conversations in this job?
- **Coordinate or Lead Others** — How important is it to coordinate or lead others in accomplishing work activities in this job?
- **Responsible for Others' Health and Safety** — How much responsibility is there for the health and safety of others in this job?
- **Frequency of Conflict Situations** — How often are there conflict situations the employee has to face in this job?
- **Structured versus Unstructured Work** — To what extent is this job structured for the worker, rather than allowing the worker to determine tasks, priorities, and goals?
- **Freedom to Make Decisions** — How much decision making freedom, without supervision, does the job offer?
- **Importance of Repeating Same Tasks** — How important is repeating the same physical activities (e.g., key entry) or mental activities (e.g., checking entries in a ledger) over and over, without stopping, to performing this job?

Job Zone for Residential Advisors

- **Title Job Zone Three: Medium Preparation Needed Education** Most occupations in this zone require training in vocational schools, related on-the-job experience, or an associate's degree.
- **Related Experience:** Previous work-related skill, knowledge, or experience is required for these occupations. For example, an electrician must have completed three or four years of apprenticeship or several years of vocational training, and often must have passed a licensing exam, in order to perform the job.
- **Job Training:** Employees in these occupations usually need one or two years of training involving both on-the-job experience and informal training with experienced workers. A recognized apprenticeship program may be associated with these occupations.

- **Job Zone Examples:** These occupations usually involve using communication and organizational skills to coordinate, supervise, manage, or train others to accomplish goals. Examples include food service managers, electricians, agricultural technicians, legal secretaries, interviewers, and insurance sales agents.

Education Levels of Residential Advisors

- Bachelors degree (48% of O*NET surveyed respondents)
- High school diploma or equivalent (27% of O*NET surveyed respondents)
- Masters degree (13% of O*NET surveyed respondents)

Interests Required for Residential Advisors

- **Social** — Social occupations frequently involve working with, communicating with, and teaching people. These occupations often involve helping or providing service to others.
- **Enterprising** — Enterprising occupations frequently involve starting up and carrying out projects. These occupations can involve leading people and making many decisions. Sometimes they require risk taking and often deal with business.
- **Conventional** — Conventional occupations frequently involve following set procedures and routines. These occupations can include working with data and details more than with ideas. Usually there is a clear line of authority to follow.

Work Styles Required for Residential Advisors

- **Dependability** — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
- **Stress Tolerance** — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
- **Adaptability/Flexibility** — Job requires being open to change (positive or negative) and to considerable variety in the workplace.
- **Self Control** — Job requires maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.
- **Concern for Others** — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
- **Integrity** — Job requires being honest and ethical.
- **Independence** — Job requires developing one's own ways of doing things, guiding oneself with little or no supervision, and depending on oneself to get things done.
- **Cooperation** — Job requires being pleasant with others on the job and displaying a good-natured, cooperative attitude.
- **Persistence** — Job requires persistence in the face of obstacles.
- **Attention to Detail** — Job requires being careful about detail and thorough in completing work tasks.

Work Values of Residential Advisors

- **Relationships** — Occupations that satisfy this work value allow employees to provide service to others and work with co-workers in a friendly non-competitive environment. Corresponding needs are Co-workers, Moral Values and Social Service.

- Independence — Occupations that satisfy this work value allow employees to work on their own and make decisions. Corresponding needs are Creativity, Responsibility and Autonomy.
- Support — Occupations that satisfy this work value offer supportive management that stands behind employees. Corresponding needs are Company Policies, Supervision: Human Relations and Supervision: Technical.

National Wages and Employment Trends for Residential Advisors

Median wages (2011)	\$11.80 hourly, \$24,540 annual
Employment (2010)	73,000 employees
Projected growth (2010-20)	Faster than average (20% to 28%)
Projected job openings (2010-2020)	45,700

State and National Wages, 2010, for Residential Advisors

Location	Pay period	Pay Range		
		Low (10%)	Median	High (90%)
United States	Hourly	8.12	11.75	18.88
	Annually	16,900	24,400	39,300
Oregon	Hourly	8.84	12.05	17.35
	Annually	18,400	25,100	36,100

Employment trends for Residential Advisors

Nationally, the employment trend between 2010 and 2020 indicates a positive change of 25%. In Oregon, the projected growth is smaller, with a projected change of 12% between 2010 and 2018.

2. Social and Human Service Assistants

Description: Assist in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.

Sample of reported job titles: Social Worker, Caseworker, Advocate, Homebased Assistant, Human Services Program Specialist, Mental Health Technician, Outreach Specialist, Addictions Counselor Assistant, Case Worker, Casework Specialist.

Tasks Required of Social and Human Service Assistants

- Keep records or prepare reports for owner or management concerning visits with clients.
- Submit reports and review reports or problems with superior.
- Interview individuals or family members to compile information on social, educational, criminal, institutional, or drug history.
- Provide information or refer individuals to public or private agencies or community services for assistance.
- Consult with supervisor concerning programs for individual families.
- Advise clients regarding food stamps, child care, food, money management, sanitation, or housekeeping.

- Oversee day-to-day group activities of residents in institution.
- Visit individuals in homes or attend group meetings to provide information on agency services, requirements, or procedures.
- Monitor free, supplementary meal program to ensure cleanliness of facility and that eligibility guidelines are met for persons receiving meals.
- Meet with youth groups to acquaint them with consequences of delinquent acts.

Knowledge Required of Social and Human Service Assistants

- Customer and Personal Service — Knowledge of principles and processes for providing customer and personal services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction. Therapy and Counseling — Knowledge of principles, methods, and procedures for diagnosis, treatment, and rehabilitation of physical and mental dysfunctions, and for career counseling and guidance.
- Administration and Management — Knowledge of business and management principles involved in strategic planning, resource allocation, human resources modeling, leadership technique, production methods, and coordination of people and resources.
- Psychology — Knowledge of human behavior and performance; individual differences in ability, personality, and interests; learning and motivation; psychological research methods; and the assessment and treatment of behavioral and affective disorders.
- Clerical — Knowledge of administrative and clerical procedures and systems such as word processing, managing files and records, stenography and transcription, designing forms, and other office procedures and terminology.
- English Language — Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
- Education and Training — Knowledge of principles and methods for curriculum and training design, teaching and instruction for individuals and groups, and the measurement of training effects.
- Public Safety and Security — Knowledge of relevant equipment, policies, procedures, and strategies to promote effective local, state, or national security operations for the protection of people, data, property, and institutions.
- Sociology and Anthropology — Knowledge of group behavior and dynamics, societal trends and influences, human migrations, ethnicity, cultures and their history and origins.
- Law and Government — Knowledge of laws, legal codes, court procedures, precedents, government regulations, executive orders, agency rules, and the democratic political process.

Skills Required of Social and Human Service Assistants

- Service Orientation — Actively looking for ways to help people.
- Social Perceptiveness — Being aware of others' reactions and understanding why they react as they do.
- Active Listening — Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
- Speaking — Talking to others to convey information effectively.
- Reading Comprehension — Understanding written sentences and paragraphs in work related documents.

- Writing — Communicating effectively in writing as appropriate for the needs of the audience.
- Coordination — Adjusting actions in relation to others' actions.
- Critical Thinking — Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
- Monitoring — Monitoring/Assessing performance of yourself, other individuals, or organizations to make improvements or take corrective action.
- Persuasion — Persuading others to change their minds or behavior.

Abilities Required of Social and Human Service Assistants

- Problem Sensitivity — The ability to tell when something is wrong or is likely to go wrong. It does not involve solving the problem, only recognizing there is a problem.
- Speech Clarity — The ability to speak clearly so others can understand you.
- Speech Recognition — The ability to identify and understand the speech of another person.
- Oral Comprehension — The ability to listen to and understand information and ideas presented through spoken words and sentences.
- Written Expression — The ability to communicate information and ideas in writing so others will understand.
- Oral Expression — The ability to communicate information and ideas in speaking so others will understand.
- Written Comprehension — The ability to read and understand information and ideas presented in writing.
- Information Ordering — The ability to arrange things or actions in a certain order or pattern according to a specific rule or set of rules (e.g., patterns of numbers, letters, words, pictures, mathematical operations).
- Deductive Reasoning — The ability to apply general rules to specific problems to produce answers that make sense.
- Category Flexibility — The ability to generate or use different sets of rules for combining or grouping things in different ways.

Work Activities Required of Social and Human Service Assistants

- Communicating with Supervisors, Peers, or Subordinates — Providing information to supervisors, co-workers, and subordinates by telephone, in written form, e-mail, or in person.
- Assisting and Caring for Others — Providing personal assistance, medical attention, emotional support, or other personal care to others such as coworkers, customers, or patients.
- Getting Information — Observing, receiving, and otherwise obtaining information from all relevant sources.
- Documenting/Recording Information — Entering, transcribing, recording, storing, or maintaining information in written or electronic/magnetic form.
- Establishing and Maintaining Interpersonal Relationships — Developing constructive and cooperative working relationships with others, and maintaining them over time.

- Identifying Objects, Actions, and Events — Identifying information by categorizing, estimating, recognizing differences or similarities, and detecting changes in circumstances or events.
- Organizing, Planning, and Prioritizing Work — Developing specific goals and plans to prioritize, organize, and accomplish your work.
- Updating and Using Relevant Knowledge — Keeping up-to-date technically and applying new knowledge to your job.
- Making Decisions and Solving Problems — Analyzing information and evaluating results to choose the best solution and solve problems.
- Communicating with Persons Outside Organization — Communicating with people outside the organization, representing the organization to customers, the public, government, and other external sources. This information can be exchanged in person, in writing, or by telephone or e-mail.

Work Context of Social and Human Service Assistants

- Telephone — How often do you have telephone conversations in this job?
- Contact With Others — How much does this job require the worker to be in contact with others (face-to-face, by telephone, or otherwise) in order to perform it?
- Face-to-Face Discussions — How often do you have to have face-to-face discussions with individuals or teams in this job?
- Work With Work Group or Team — How important is it to work with others in a group or team in this job?
- Freedom to Make Decisions — How much decision making freedom, without supervision, does the job offer?
- Frequency of Conflict Situations — How often are there conflict situations the employee has to face in this job?
- Structured versus Unstructured Work — To what extent is this job structured for the worker, rather than allowing the worker to determine tasks, priorities, and goals?
- Deal With External Customers — How important is it to work with external customers or the public in this job?
- Deal With Unpleasant or Angry People — How frequently does the worker have to deal with unpleasant, angry, or discourteous individuals as part of the job requirements?
- Time Pressure — How often does this job require the worker to meet strict deadlines?

Job Zone for Social and Human Service Assistants

- Title Job Zone Three: Medium Preparation Needed
- Education: Most occupations in this zone require training in vocational schools, related on-the-job experience, or an associate's degree.
- Related Experience: Previous work-related skill, knowledge, or experience is required for these occupations. For example, an electrician must have completed three or four years of apprenticeship or several years of vocational training, and often must have passed a licensing exam, in order to perform the job.
- Job Training: Employees in these occupations usually need one or two years of training involving both on-the-job experience and informal training with experienced workers. A recognized apprenticeship program may be associated with these occupations.

- **Job Zone Examples:** These occupations usually involve using communication and organizational skills to coordinate, supervise, manage, or train others to accomplish goals. Examples include food service managers, electricians, agricultural technicians, legal secretaries, interviewers, and insurance sales agents.

Education Level of Social and Human Service Assistants

- Bachelors degree (47% of O*NET surveyed respondents)
- High school diploma or equivalent (26% of O*NET surveyed respondents)
- Masters degree (12% of O*NET surveyed respondents)

Interests Needed by Social and Human Service Assistants

- **Conventional** — Conventional occupations frequently involve following set procedures and routines. These occupations can include working with data and details more than with ideas. Usually there is a clear line of authority to follow.
- **Social** — Social occupations frequently involve working with, communicating with, and teaching people. These occupations often involve helping or providing service to others.
- **Enterprising** — Enterprising occupations frequently involve starting up and carrying out projects. These occupations can involve leading people and making many decisions. Sometimes they require risk taking and often deal with business.

Work Styles for Social and Human Service Assistants

- **Dependability** — Job requires being reliable, responsible, and dependable, and fulfilling obligations.
- **Concern for Others** — Job requires being sensitive to others' needs and feelings and being understanding and helpful on the job.
- **Self Control** — Job requires maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.
- **Cooperation** — Job requires being pleasant with others on the job and displaying a good-natured, cooperative attitude.
- **Integrity** — Job requires being honest and ethical.
- **Attention to Detail** — Job requires being careful about detail and thorough in completing work tasks.
- **Social Orientation** — Job requires preferring to work with others rather than alone, and being personally connected with others on the job.
- **Stress Tolerance** — Job requires accepting criticism and dealing calmly and effectively with high stress situations.
- **Persistence** — Job requires persistence in the face of obstacles.
- **Adaptability/Flexibility** — Job requires being open to change (positive or negative) and to considerable variety in the workplace.

Work Values for Social and Human Service Assistants

- **Relationships** — Occupations that satisfy this work value allow employees to provide service to others and work with co-workers in a friendly non-competitive environment. Corresponding needs are Co-workers, Moral Values and Social Service.

- Support — Occupations that satisfy this work value offer supportive management that stands behind employees. Corresponding needs are Company Policies, Supervision: Human Relations and Supervision: Technical.
- Independence — Occupations that satisfy this work value allow employees to work on their own and make decisions. Corresponding needs are Creativity, Responsibility and Autonomy.

Wages and Employment Trends for Social and Human Service Assistants

Median wages (2011)	\$13.82 hourly, \$28,740 annual
Employment (2010)	384,000 employees
Projected growth (2010-2020)	Faster than average (20% to 28%)
Projected job openings (2010-2020)	189,100

State and National Wages, 2010 for Social and Human Service Assistants

Location	Pay period	Pay Range		
		Low (10%)	Median	High (90%)
United States	Hourly	9.03	13.56	21.55
	Annually	18,800	28,200	44,900
Oregon	Hourly	9.48	12.81	19.67
	Annually	19,700	26,600	40,900

Employment trends for Social and Human Service Assistants

Nationally, the employment trend between 2010 and 2020 indicates a positive change of 28%. In Oregon, the projected growth is smaller, with a projected change of 18% between 2010 and 2018.

Appendix 6: Professional Organizations for RSCs

State Associations for Resident Service Coordinators:

- CARSCH - Connecticut Association of Resident Service Coordinators in Housing
- MARSCH - Massachusetts Association of Resident Service Coordinators in Housing
- MRSCA - Maine Resident Service Coordinator Association
- NHAPSC - New Hampshire Association of Professional Service Coordinators
- NYSARSC - New York State Association of Resident Service Coordinators
- RISCC - Rhode Island Service Coordinator Collaborative
- RSC - Vermont Resident Service Coordinators

Official American Association of Service Coordinators State Chapters:

- | | | |
|-------------|----------------------|----------------|
| Alabama | Maryland/DC/Virginia | South Carolina |
| California | New Jersey | Tennessee |
| Colorado | North Dakota | Wisconsin |
| Connecticut | Ohio | |
| Florida | Pennsylvania | |