NeighborWorks® PROGRAM

Aging in Place

Coordinating Housing and Health Care Provision for America's Growing Elderly Population

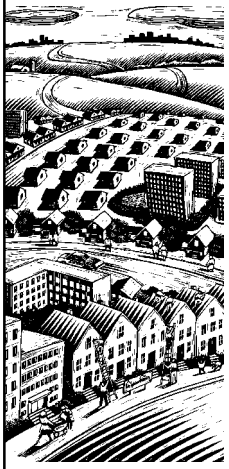
NEIGHBORWORKS® CAMPAIGN FOR HOME OWNERSHIP 2002

JCHS

Kathryn Lawler

Fellowship Program for Emerging Leaders in Community and Economic Development

October 2001



Joint Center for Housing Studies of Harvard University
Neighborhood Reinvestment Corporation

NEIGHBORHOOD REINVESTMENT CORPORATION

Neighborhood Reinvestment Corporation was established by an Act of Congress in 1978 (Public Law 95-557). A primary objective of the Corporation is to increase the capacity of local community-based organizations to revitalize their communities, particularly by expanding and improving housing opportunities.

These local organizations, known as NeighborWorks® organizations, are independent, resident-led, nonprofit partnerships that include business leaders and government officials. All together they make up the NeighborWorks® network.

JOINT CENTER FOR HOUSING STUDIES OF HARVARD UNIVERSITY

The Joint Center for Housing Studies analyzes the ways in which housing policy and practices are shaped by economic and demographic trends and provides leaders in government, business and the nonprofit sector with knowledge and tools for formulating effective policies and strategies.

Established in 1959, the Joint Center is a collaborative unit affiliated with the Harvard Design School and the Kennedy School of Government. The Center's programs of research, education and public outreach inform debate on critical housing issues and illuminate the role of housing in shaping communities. The Policy Advisory Board, a diverse group of business leaders in the housing sector, provides support and guidance for the Center and its activities. The Joint Center also receives input from its Faculty Committee, which draws on the expertise of a university-wide group of scholars.

This paper was written under the support of the Neighborhood Reinvestment Corporation's Emerging Leaders in Community and Economic Development Fellowship, which provides opportunities for highly qualified professional students at Harvard University to research and publish applied analytical projects of interest to the community-development field.

Author's Note: This paper would not have been possible without the close collaboration of M. Scott Ball and David Haltom at the Community Housing Resource Center in Atlanta, Georgia.

Harvard Joint Center on Housing Studies
1033 Massachusetts Avenue
Cambridge, MA 02138
(617) 495-7908
www.jchs.harvard.edu

Neighborhood Reinvestment Corporation
1325 G Street NW, Suite 800
Washington, DC 20005
(202) 220-2300
www.nw.org

Table of Contents

Executive Summary

The elderly population is rapidly expanding while the core tax-paying population is shrinking. The ratio of working Americans to retired Americans will drop from 5 to 1, to 2 to 1 over the next fifty years. As the elderly population grows, and subsequently the need for adequate elderly health and housing services grows, the resources to provide services will decrease. Finding a more efficient means of service delivery is of paramount importance. Today, however, the current connections between elderly health and housing are tenuous at best. As a result, the most desirable and most cost-efficient method of aging — aging in place — is difficult, even under the most ideal conditions.

As independent services, the current systems of health and housing delivery do not meet the need of aging Americans. The health and housing concerns of an elderly individual are often interrelated. Health concerns can create or compound the problems of an aging housing stock, and housing concerns can create or compound health problems for aging individuals. When a living environment is affordable and appropriate, an aging individual is more likely to remain healthy and independent. When an individual maintains good health, he or she is more able to keep up with the maintenance of his or her living environment. As the population ages in an aging housing stock, it becomes difficult to distinguish a health concern from a housing concern.

To develop an efficient method of service delivery, the long-term care system must reflect this interrelationship between health and housing. Most of the current inefficiencies in the delivery of aging services occur during the provision of both overcare, providing more housing or health care than required, and undercare, when inadequate service provision compounds problems and increases expense. A customized model of care avoids the inefficiencies of overcare and undercare by matching services and facilities to an individual's need rather than matching an individual to an existing service or facility.

Aging in place with supportive services is not only the most desirable way of aging, but can achieve the efficiencies of the customized care model. Successful aging-in-place strategies minimize the provision of inappropriate care, and therefore the overall costs, by offering a range of flexible services and calibrating those services to fit the needs of the individual. Rather than a rigid service-delivery system, aging-in-place strategies create both health care and housing options that provide support at the margin of need as defined by an individual's personal desire and efforts to live independently. Aging in place works best as part of a comprehensive and holistic approach to the support needs of an aging individual and an aging community.

The existing regulatory, structural, financing and implementation barriers, however, prevent providers from developing a comprehensive approach to the health and housing needs of America's seniors. Federally funded health and housing subsidies were designed to operate in isolation, each achieving separate public goods — adequate health care for the poorest Americans and affordable housing units not provided by the market. As a result, the organizational systems through which these services are delivered, as well as the regulations, performance measurements and implementation guidelines that determine which services can be delivered to which individuals, can often conflict and impede coordination.

Moving forward, in pursuit of a more efficient use of limited resources to meet the growing demand, we can continue to seek out and increase the connections between health and housing services. Congress can alter eligibility criteria and the Departments of Housing and Urban Development and Health and Human Services can examine their various standards and regulations to iron out conflicts. As the elderly population doubles in size throughout the coming decades, these "patches" may not withstand the demand, let alone achieve the efficiencies needed, to stretch decreasing public funds. While it is very important that these two systems start to work together rather than continue in the current state of isolation, connecting these systems may not be enough.

Opportunities exist, however, on the federal, state and local level to re-imagine a health and housing system that reflects the interrelationship between the health and housing concerns of seniors, facilitating rather than inhibiting the coordination necessary to meet the growing demand.

Federal. Rather than deliver funds through separate funding channels to separate state and local agencies with different jurisdictions, the current isolated budgeting systems could merge in a local or state level agency. This agency would then be responsible for contracting with local or state private or public providers to deliver comprehensive and coordinated health and housing services, eliminating the need for providers to navigate their own way through the separate systems.

State. Each state is in the process of examining and restructuring its current community-based term care system as a result of the 1999 Supreme Court Olmstead ruling. This includes, but is not limited to, Medicaid waivers. Housing is a critical component of community-based care, but has not been included in the current planning process. State and local housing providers should be included in this important planning process if the mandates of the Supreme Court are to be met.

Local. Community-based nonprofit organizations can play a number of critical roles in the development of aging-in-place programs. Using the powerful assets of their community networks and revitalization programs, these organizations can serve the Naturally Occurring Retirement Communities in their neighborhoods; employ the paraprofessionals needed for a range of health and housing services (e.g., handymen and personal care assistants); inject aging into the local community planning process; and recognize the benefits of keeping the economic and social contributions of seniors in their communities.

Aging is universally experienced — without regard to race, class, income, education, religion, or gender — yet for the most part, it is experienced in isolation. In over 60 interviews between June and August 2001, with health and housing providers, nonprofits and for-profits, health and housing trade associations and academics, all participants not only discussed their work and expertise in the field of aging, but articulated the story of their aging parents or in-laws, aunts, uncles or neighbors. They all spoke of the difficulty they experienced navigating the separate systems of health and housing services and the challenges this separation presented to maintaining quality care for their relatives as they continued to age. The connection between health and housing for the elderly is intuitive and logical for professionals involved in service provision, for

children as they care for their elderly parents and individuals when they contemplate their own aging process. The public systems of housing and health care do not reflect the interrelationship of health and housing, causing frustration and incurring greater expense for the country as a whole.

The inefficiencies of the isolated service-delivery systems impede coordination and prevent the development of a customized model of care, one which calibrates support according to the level of need. To meet the growing demand for services, the connections between health and housing systems can be increased or the systems can be re-imagined to better reflect the reality of elderly health and housing concerns. The latter may offer the best chance of providing services with the highest level of efficiency to the rapidly growing elderly population.

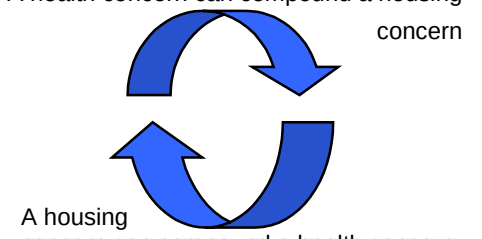
I. Aging in an Aging Stock

The bureaucratic separation and lack of local coordination between health and housing services creates a rigid service-delivery system that prevents seniors from successfully aging in place.

The systems of neither health delivery nor housing delivery can adequately meet the needs of aging Americans as independent spheres of service. The health and housing concerns of an elderly individual are often interrelated. Health concerns can create or compound the problems of an aging housing stock, and housing concerns can create or compound health problems for aging individuals. When a living environment is affordable and appropriate, an aging individual is more likely to remain healthy and independent. When an individual maintains good health, he or she is more able to keep up with the maintenance of his or her living environment. As the population ages in an aging housing stock, it becomes difficult to distinguish a health concern from a housing concern.

Most seniors own the homes in which they live. The home-ownership rate for individuals between the age of 62 and 74 is 81.2 percent; between the ages of 75 and 84, it remains high at 76.9 percent.[1] As these homeowners age and their bodies become increasingly frail, the regular maintenance and upkeep of a home can become physically difficult to manage. As the medical needs of an aging senior and the repair needs of an aging house increase, both place demands on the fixed income of a retiree. When the monthly pharmacy bill grows, the senior is less likely to be able to afford a needed roof or furnace replacement. A leaky roof or inadequate heating can not only create substandard housing conditions, but can compound health concerns as well.

Elderly Health and Housing



This circular relationship between health and housing exists in the rental market as well. A building which twenty years ago housed working 55-year-olds is now a building of 75-year-old, frail retirees. As individuals continue to age in place, the building's management company will discover that the health of residents has surfaced as a housing concern. An older resident who forgets to turn off the stove may present a safety risk to the entire building. A resident may require assistance cleaning the apartment or preparing food, and the management company, initially out of a concern for the building, may find itself addressing the health and supportive-service needs of its residents.

Despite this relationship, the health concerns of an aging individual are addressed by one agency or set of services while the same individual's housing concerns are addressed by different sets of nonprofit and/or government organizations. This separation is closely related to the way the housing and health industries were designed and continue to operate in distinct markets. While the private sector has developed a greater number of models that combine both health and housing services, the public sector has continued to separate the two.

[1] Department of Housing and Urban Development. *Housing our Elders.* November 1999.

Public subsidies are designed to produce either health or housing services — but not both. Government-sponsored health programs and housing programs were designed to produce distinct public goods. They were created in isolation, as different line items in local, state and federal governments. Public housing programs and government mortgage subsidies were created to increase the number of affordable and adequate housing units. The public system of health services was established to promote general public health and well-being, to provide health care for the very poor and to decrease the likelihood of an outbreak or epidemic. The missions of public health and housing agencies were not only isolated but mutually exclusive.

As a result of this separation, there are very few programs which address both the health and housing needs of a senior, making it difficult for seniors to remain in their communities as they age. Retirees are confronted by two undesirable options as they become frailer — overcare and undercare. They are often forced to choose between entering an expensive, restrictive elderly institution before the need arises, or remaining in their homes alone, to face the pressures of rising medical expenses and a deteriorating shelter while on a fixed income.

Communities are unnecessarily limited to this pair of undesirable options primarily because health care has not been coordinated with "housecare" in such a way as to holistically support the senior population. As a result, the last third of a person's life can be spent making radical life changes in response to comparatively minor changes in physical or physiological condition. A problem in one knee can render a home's stairs insurmountable, shrinking a person's world to the space of a few rooms. Forgetfulness can force an otherwise healthy and productive person into a nursing home, as medication schedules become difficult to maintain.

Issues of senior housing and senior health can not be dealt with in isolation. In fact, they can not easily be separated. A housing problem can create a health problem and a health problem can create a housing problem. While this is true for most age groups, it is particularly true for aging adults. In 55 years, the number of people 65 and over will more than double, the number of those 75 and older will triple and the number of people 85 and older will quintuple.[2] As the share of the population requiring integrated services continues to grow, service providers at the local, state and federal level will need to find a way to coordinate elderly health and housing, because the costs of isolated services are too high.

[2] Burkhardt, John. "Mobility Needs in a Maturing Society." *Coming of Age, Federal Agencies and the Longevity Revolution*, 1999.

II. Aging Demographics

Overcoming these barriers to the coordination of health and housing services takes on greater importance as more Americans live longer and the elderly population continues to grow at a very rapid pace.

The Changing Landscape

The number of elderly individuals requiring services will increase dramatically over the next two decades. Individuals are living longer and wish to remain in their homes as they age. At the same time, the informal support networks provided by family and friends are taxed more heavily than ever before. Retiring parents live further away from their children than in any other time in history. More and more of these children are in two-income households where both husband and wife are working full-time. The son or daughter who used to coordinate and provide health and housing services, either because of lack of time or the distance between them, is unable to provide the same level of care. "American society has traditionally looked to daughter power supplemented by daughter-in-law power [to support the elderly]…. But many daughters and daughters-in-law now work all day at jobs outside the home, live thousands of miles away and have their own children to attend to. As the oldest-old grow ever older their daughters will become old and frail themselves. So the country is in the market for alternatives."[3]

The nature of long-term care is changing as well. Throughout the 1990s and into the 21st century, different models of combining health and housing services to facilitate aging in place have developed. The private market is beginning to discover that the high-end assisted living model may not be as sustainable as previously thought. Construction rates are down from peak levels. In 1998, 32,700 new units were built. As of April 2001, only 7,900 new units were under construction. The Senior Housing Association estimates the current vacancy rate of assisted living facilities at 10 percent, and in some markets, such as Charlotte, North Carolina, the rate is as high as 50 percent.[4]

The approach to aging services is beginning to shift. Americans are more aware of the changing nature of the country's population — fewer younger, tax-paying workers and more retirees on fixed incomes. A few states have taken note of the impending demographic shift and have started long-term planning efforts to prepare for the growth in their elderly population, focusing on the use of technology and more cost-efficient options for delivering care.

[3] Stanfield, Rochelle. "Aging of America." *National Journal,* July 20, 1996.

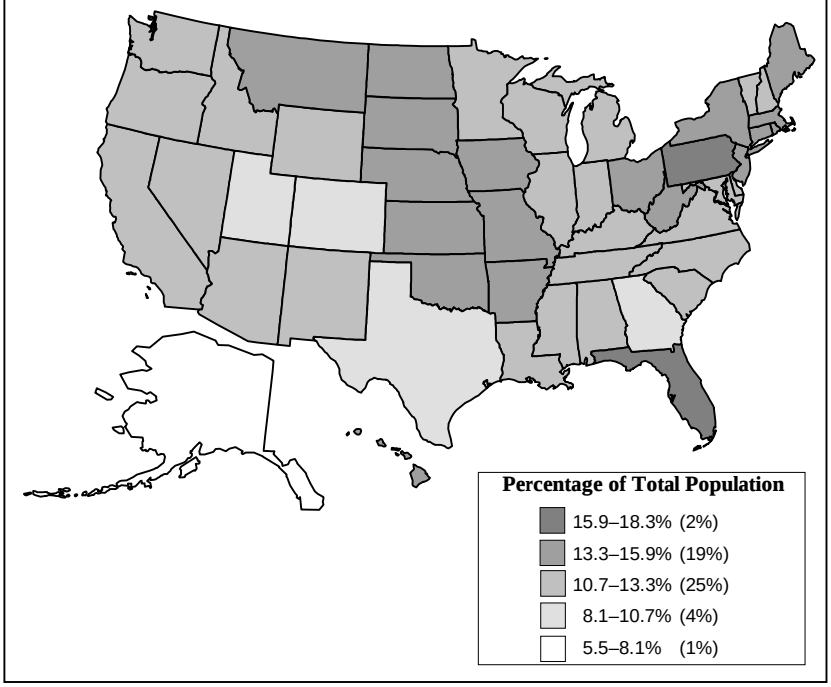
[4] Smith, Ray. "Assisted Living Firms Grapple with Oversupply." *Wall Street Journal,* April 18, 2001.

The Growing Elderly Population

Where do the elderly live?

There 34 million Americans above the age of 65. On average they make up 10 to 13 percent of each state's population. Those states with the highest concentration of the elderly are Florida, the northeastern region and the Midwestern corridor.[5]

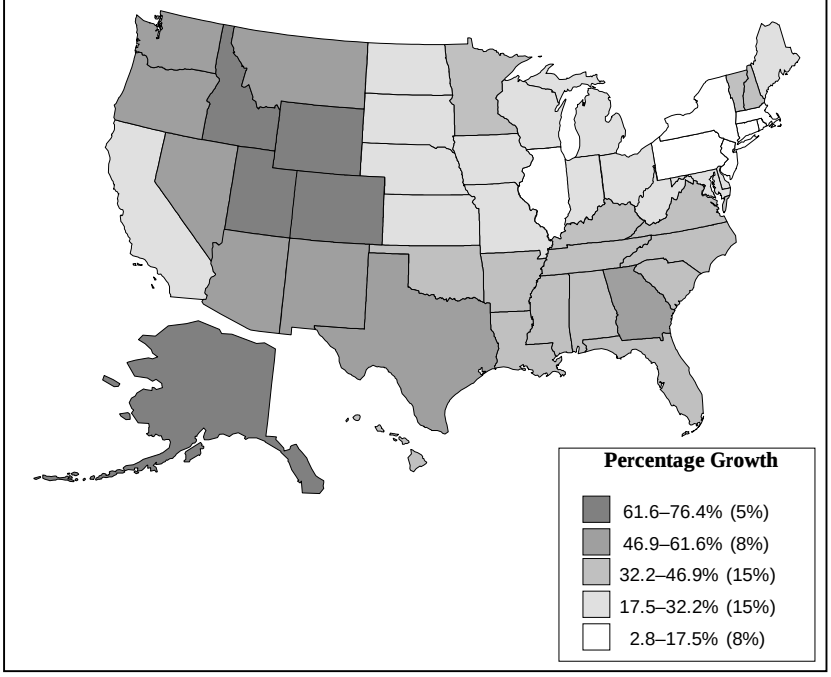
Percent of Population Above the Age of 65, 2000



Which areas will experience the greatest shifts in the elderly population?

The elderly population is projected to double in size to well over 70 million by 2025. The states that will experience the greatest increase in the number of residents over the age of 65 are in the west and south. As a percent of the total state population, states in the west and southwest will experience the greatest increases.[6]

Percent Growth in Elderly Population, 2000–2015



[5] Based on data from the 2000 U.S. Census.

[6] Based on data projections from the 1990 U.S. Census.

In what types of housing do the elderly live?

Nationally, the home-ownership rate of Americans over age 65 is close to 80 percent and remains high as people age. The majority of seniors live in suburban areas, though the percentages change when the distribution is analyzed along tenure type. The majority of renters live in central cities. Some differences arise when comparing regions of the country: the Northeast has the largest percent of seniors living in multifamily units (31.45 percent); the South has the largest percent of seniors living in single-family units (87.07 percent). Seniors in the West and Northeast live primarily in suburban and central city areas, while seniors living in the Midwest and the South live primarily in suburban and non-metro areas. The type of unit, community and tenure will have significant implications for the delivery of health and housing services.[7]

Elderly Housing: Type and Location

Characteristics	Total Occupied Units		Tenure				Region							
			Owners		Renters		Northeast		Midwest		South		West	
	000s	%	000s	%	000s	%	000s	%	000s	%	000s	%	000s	%
Total Senior Units	21,423	100.00	17,196	80.27	4,227	19.73	4,664	21.77	5,157	24.07	7,561	35.29	4,041	18.86
Tenure														
Owner	17,196	80.27	17,196	100.00	—	—	3,344	71.70	4,238	82.18	6,399	84.63	3,215	79.56
Renter	4,227	19.73	—	—	4,227	100.00	1,320	28.30	919	17.82	1,162	15.37	826	20.44
Units in Structure														
Single Family	17,289	80.70	16,101	93.63	1,188	28.11	3,198	68.57	4,153	80.53	6,583	87.07	3,333	82.48
Multifamily (2+ units)	4,135	19.30	1,095	6.37	3,039	71.89	1,467	31.45	983	19.06	977	12.92	708	17.52
Urban / Rural Areas														
Central Cities	5,874	27.42	4,064	23.63	1,810	42.82	1,386	29.72	1,268	24.59	1,916	25.34	1,304	32.27
Suburbs	9,708	45.32	8,123	47.24	1,586	37.52	2,570	55.10	2,032	39.40	3,161	41.81	1,946	48.16
Non-Metro Areas	5,840	27.26	5,009	29.13	831	19.66	708	15.18	1,856	35.99	2,485	32.87	792	19.60

In what housing do the future elderly live?

Though many individuals will make changes in their housing conditions before they turn 60, it is helpful to examine where the baby boomers, the future elderly, are living now.[8]

Baby Boomer Housing: Type and Location

Characteristics	Total Occupied Units		Tenure				Regions							
			Owners		Renters		Northeast		Midwest		South		West	
	000s	%	000s	%	000s	%	000s	%	000s	%	000s	%	000s	%
Baby Boomers aged 45 to 54	20,048	100.00	15,223	75.93	4,825	24.07	3,972	19.81	4,780	23.84	6,910	34.47	4,387	21.9

[7] Data from the 1999 American Housing Survey.

[8] *Ibid.*

Does the housing of the elderly meet the needs of the elderly?

One-fifth of the elderly are overhoused, living with someone else in a dwelling where bedrooms outnumber household members by more than one.[9] This figure underestimates the true number of seniors who are overhoused, because it does not include elderly who are living alone in homes that are bigger than they need.

Though it varies by type of disability, approximately half of the elderly have had their homes modified to be appropriate for their disability level.

Need for Modification vs. Presence of Home Modification[10]

	Number (000s)	%
Total number of households with elderly individuals	22,790	—
Total households with disabled elderly people	5,028	—
Home has any modification	2,258	44.90%

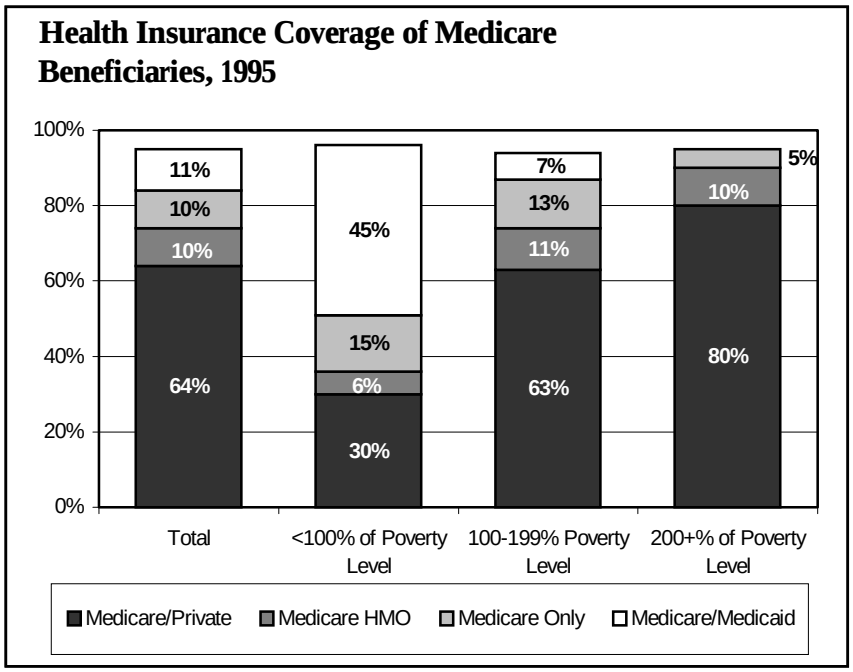
Presence of Home Modification Appropriate to Specific Disability[11]

Elderly individual has difficulty with:	Number (000s)	Presence of appropriate modification
Entering and exiting the house	1,586	49.4%
Going up and down the stairs	2,095	41.2%
Opening and closing or going through the doors	647	53.6%
Moving between rooms	873	54.2%
Reaching bathroom facilities	1,134	48.0%
Bathing, getting in and out of tub or shower	1,864	44.3%
Uses wheelchair or electric cart	584	49.2%
Reaching kitchen facilities	794	14.1%
Cooking and preparing food	1,255	12.7%
Seeing even when wearing glasses	1,568	1.4%
Hearing even when wearing an aid	1,612	16.4%

[9] Department of Housing and Urban Development. *Housing Our Elders.* November 1999.
[10] Louie, Josephine. *Housing Modifications for Disabled Elderly Households.* Harvard University Joint Center on Housing Studies, W99-8, September 1999.
[11] *Ibid.*

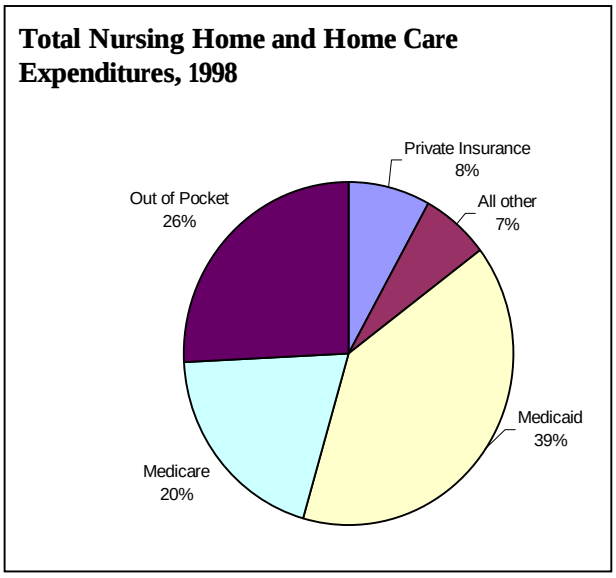
How do the elderly receive their health-care services?

In the United States all citizens over the age of 65 are entitled to receive Medicare. The poorest elderly are eligible for additional coverage under Medicaid. The income eligibility criteria vary from state to state, but in general are tied to the National Poverty Level statistic.[12]



How do the elderly fund long-term care?

The majority of long-term care services in the United States are funded through Medicaid and Medicare.[13] Which populations are eligible for services and what types of services are supported through these programs are critical components of any efforts to coordinate health and housing services.

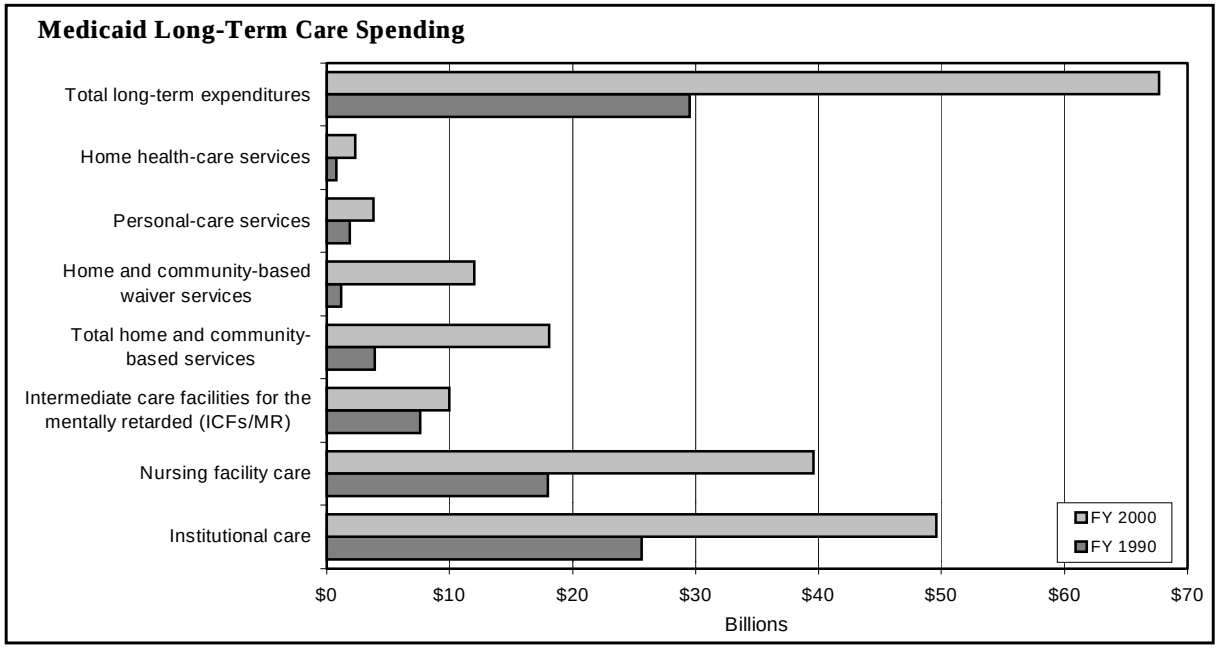


In the early 1980s, Congress began to address some of the institutional bias in the Medicaid program. Up until that point most of the Medicaid funding was only available for nursing home facilities. Over the years as Medicaid spending has increased, so has the share of funds spent on home and community-based care services (see chart below).[14]

[12] Kaiser Commission on Medicaid and the Uninsured. *Medicaid Eligibility for the Elderly.* May 1999.

[13] Feder, Judith, Harriet Komisar and Marlene Niefield. "Long-Term Care in the United States," *Health Affairs,* Vol. 19, No. 3, May/June 2000.

[14] *Ibid.*


Medicaid Long-Term Care Spending
Total long-term expenditures
Home health-care services
Personal-care services
Home and community-based waiver services
Total home and community-based services
Intermediate care facilities for the mentally retarded (ICFs/MR)
Nursing facility care
Institutional care
FY 2000
FY 1990
$0
$10
$20
$30
$40
$50
$60
$70
Billions

III. Examining the Costs of Aging Services and Methods of Service Delivery

The Expenses of Aging Services

There are a significant number of expenses and inefficiencies associated with this separation of health and housing services. As with most issues, the prevention of a problem is the most cost-effective form of treatment. The separation of health and housing services does not allow for the treatment of a health problem through the prevention of a housing problem, and vice versa. When seniors, often the most stable forces in the neighborhood, are forced to move out in search of more adequate and affordable health and housing services, communities suffer. Communities also suffer when a resident in need of services is unable to move out; as their health deteriorates, their inability to maintain their home and subsequent deterioration of the housing stock negatively affect the community's health. As cities struggle to increase and preserve their affordable housing stock, they can not afford to let the older homes, often some of the most affordable, deteriorate.

Costs of Isolated Service Delivery

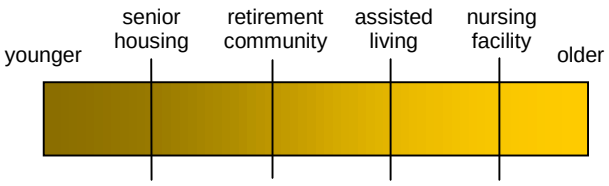
- Difficult to achieve cost savings through prevention programs
- Loss of seniors forced to move because of health problems
- Loss of housing stock because frail seniors can not properly maintain their properties

Production Rather Than Custom Model: The Procrustean Bed of Myth

Aging services are most expensive when they are delivered in a production rather than customized care model. The overcare or undercare resulting from the production model can compound an existing health or housing service need, decreasing the quality of life and increasing the costs of care. Allowing individuals to age in place with calibrated support services offers a more efficient form of care, maximizing an individual's capacity for self-help and maintaining his or her economic and social contributions to a community.

No one package of services will fit the needs of the growing elderly population. In order to achieve economies of scale, large service-delivery programs develop service packages that deliver the same set of health and housing services to a large number of individuals. While there may be different levels of services, care is not tailored to the need of the individual but the median need of the majority. In many industries, this process achieves valuable cost savings. In the field of elder care, a production model is far more likely to result in too much care delivered to some and not enough care delivered to others. In 1973, Elaine Brody recognized the production model service delivery of nursing homes and compared it to the Procrustean bed of Greek myth — in which victims were either chopped or stretched to fit the bed.

Aging Spectrum



Production Model: Moving from facility to facility

Production-model services are increasingly unpopular, as individuals do not wish to be stretched or chopped, and the cost savings do not seem to materialize. In a rigid, large-scale service-delivery system, care is most likely to be provided inappropriately, either falling short of (undercare) or in excess of (overcare) the actual individual's need. Both overcare and undercare are more costly than customized care since resources are either wasted on those who do not need them, or the resulting health complications of inadequate care incur greater total costs.

Overcare. Overcare is defined as the provision of inappropriate long-term care. This is most likely to occur when an individual is faced with too few options either because options are not available or are unaffordable. When a change in health or mobility renders the current residence inadequate, without alternatives the next and rather drastic step is a long-term, full-care facility. These facilities provide care at specific service levels, inhibiting the possibility of individual customized care. While this move anticipates future health-care needs, it provides expensive services above the current level of need.

> **Consequences of Overcare**
> *Expensive self-fulfilling prophecy of overcare.* When an individual is given more care than necessary or is unable to maximize his or her independence because of restrictive service models, he or she is more likely to live a shorter, less productive life of decreased quality. Often the loss of freedom and mobility can cause depression and confusion, accelerating an individual's deterioration. Extensive "research in learned helplessness details the destructive effects the regimens of overcare can have on the human spirit, creating listlessness, depression, and abandonment of efforts to exert control."[15]As overall health decreases, the level of necessary service increases, making overcare a self-fulfilling prophecy.

Undercare. Undercare is defined as the inadequate provision of health or housing services with regard to an individual's level of need. This is most likely to occur when an individual lives in substandard housing or is "over-housed," that is, he or she lives in a house that is much larger than necessary or manageable. Undercare also occurs when, due to a lack of mobility or accessible transportation, an individual may not be receiving the proper level of care to maintain good health and prevent illness or catastrophe. By neglecting either the health or home of an individual, undercare can incur unnecessary health and housing expenses.

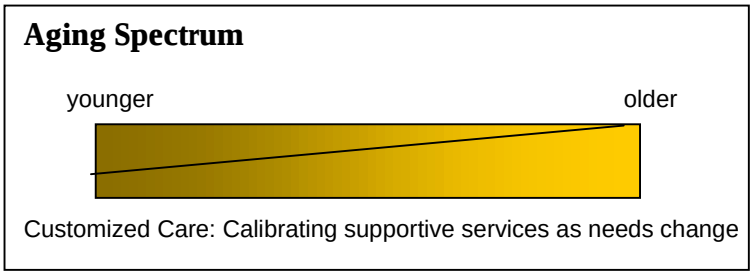
> **Consequences of undercare.**
> *Costs of poorly maintained housing stock.* Many seniors struggle to maintain a home that served them well while raising a family but in the latter half of their lives has become too big and expensive for one individual to maintain. "More than 1.45 million elderly households still lack some of the most basic elements of housing security, such as complete plumbing or a reliable source of heat. A half-million of these households live in severely inadequate units."[16] Without assistance, the home can rapidly deteriorate and cause damage both to the individual's health

[15] Kane, Rosalie. "Long-Term Care and a Good Quality of Life: Bringing Them Closer Together." *The Gerontologist,* June 2001.
[16] Department of Housing and Urban Development. *Housing Our Elders.* November 1999.

and the community at large. Maintaining a home is much cheaper than rehabilitating it after it has suffered from a roof leak or plumbing problem over the course of time. When it comes to housing, preventive maintenance can save thousands of dollars in more substantial repair costs.

Expense of catastrophic illness. As an individual ages, proper nutrition, regular health examinations and appropriate medication can provide a high quality of life with maximum freedom and dignity. When individuals do not receive the level of nutrition or health care necessary to maintain their health, they are more susceptible to catastrophic events: falling and breaking a bone, suffering a heart attack, getting more infections, etc. Health care and rehabilitation services associated with such an event can be very expensive and could have been avoided, had consistent and appropriate care been administered. For example, a number of studies by the American Academy of Family Physicians demonstrated that elderly individuals who experience a fall are more likely to incur greater long-term health costs and higher rates of morbidity.[17]

Offering a range of health-care and housing options reduces costs by maximizing an individual's capacity for self-help. It matches professional services with the needs of individuals rather than matching individuals with the professional services or facilities that might be available. Inappropriate support, either too much or too little, can undermine and hinder the efforts of individuals to remain functionally independent, can shorten the length of their independent lives and severely cripple their ability to contribute to the social, civic and economic well-being of their communities. With a growing elderly population and an increased demand for services, communities can stretch limited dollars by creating custom-care models that avoid giving too much care to those who do not need it.



Aging in Place — The Preferred Method of Aging

A long-standing assumption has existed that as an individual grew frailer, he or she required a continuum of senior living facilities, physically moving from one residence to another, as health or housing service needs changed. Increasingly over the last ten years there has been growing acceptance of the idea that older persons do not necessarily need to relocate as their needs change, but can modify their environment by adding supportive services and reconfiguring their residence. This "revised view of the housing continuum therefore stresses the elasticity of conventional housing in terms of its ability to accommodate a wider spectrum of older persons." It can be achieved by "creating a wider variety of options for frail older persons that facilitate

[17] Fuller, George. *Falls in the Elderly.* White House Medical Clinic, Washington, D.C., April 2000; and Steinweg, Kenneth. *The Changing Approach to Falls in the Elderly.* East Carolina University School of Medicine, November 1997.

aging in place in physically supportive residential settings linked with services."[18] Aging in place requires the coordination of health and housing programs to deliver a customized level of care in an individual's current environment.

In the last decade aging in place has not only become the most desirable way of aging but also in most cases it is the more cost-efficient way of aging. The AARP reported in May 2000 that "the desire to remain in their current residence for as long as possible becomes more prevalent as age increases. Seventy-five percent of those age 45 to 54, and 83 percent of those age 55 to 64 *strongly* or *somewhat agree* that they wish to remain in their homes as long as possible, while 92 percent of those age 65 to 74 and nearly all of those age 75 and over (95 percent) want to do so."[19] Aging in place has become a part of the public rhetoric in the last ten years. Seniors and their children are starting to envision, and demand, a range of options beyond the nursing home. Policy makers generally agree that keeping elderly individuals out of nursing homes is the primary objective of aging policy.[20]

Successful aging-in-place programs minimize the provision of inappropriate care, and therefore the costs, by offering a range of flexible services and calibrating those services to fit the needs of the individual. Rather than a rigid service-delivery system, aging-in-place strategies create both health-care and housing options that provide support at the margin of need as defined by an individual's personal desire and efforts to live independently. Aging in place works best as part of a comprehensive and holistic approach to the support needs of an aging individual and an aging community.

Consequences of Aging in Place

Maintain social network. Aging in place promotes self-sufficiency, encourages cost-saving interdependence between friends and neighbors in the community, offsets social isolation, and does not involve costly professional support unless necessary. Rather than relocating individuals to a facility, allowing them to age in place keeps valuable social networks. Relocating can entail the loss of friendships, regular shopping and entertainment areas and familiar support personnel, resulting in a significant loss in the quality of life, personal control and dignity. Aging in place allows all of these powerful networks to remain intact, providing both quantitative and qualitative benefits. A recent study completed by the Department of Health and Social Behavior at Harvard University concluded that "compared with persons who had 5 or 6 social ties, those who had no social ties were at increased risk for incident cognitive decline after adjusting for a variety of socio-economic and physical factors."[21]

[18] Pynoos, John. "Current Problems and Future Directions." *Coming of Age, Federal Agencies and the Longevity Revolution,* 1999.

[19] AARP. *Fixing to Stay: A National Survey of Housing and Home Modification Issues.* May 2000.

[20] Author interview with Bobbie Sackman and Jennifer Fish, Council of Senior Services, New York, New York, July 16, 2001.

[21] Bassuk, Shari. "Social Disengagement and Incident Cognitive Decline in Community-Dwelling Elderly Persons." *Annals of Internal Medicine,* Vol. 131, No. 3, 1999.

Limit the negative effects of relocation and dramatic transitions. The very act of moving an individual can be expensive. Searching for the appropriate facility can be time consuming and can often result in the expense of overcare. Finally, any move can be traumatic, but a move resulting in the loss of functional independence is particularly difficult to recover from and can result in confusion and diminished self-help capacity.

When an individual is allowed to age in his or her community with social support networks intact, costs are minimized and care is delivered in response not to a rigid service-delivery model, but to actual need. Communities save needed resources by reducing the amount of unnecessary service to individuals who could and would prefer to be more independent. Despite the benefits and cost savings which can be achieved by avoiding overcare and undercare, historical, structural and regulatory barriers keep health and housing services separate.

This separation affects the quality of life for most aging Americans. It is important to note that two groups in particular are not as concerned with the separation of health and housing services: the very wealthy and the very sick. Those elderly Americans for whom price is not a concern have access to a full range of health services and full-time paraprofessional and professional assistance. They can afford to move to different living environments or modify their current environment to suit their particular housing needs. In general, wealthier individuals have private insurance to supplement services provided by Medicare, and repair and maintenance costs to their home do not severely limit their income.

Because each individual will face the physical or mental disabilities caused by aging differently, some individuals will require significant medical assistance throughout the aging process. For these individuals, staying in their homes may not be a realistic option, nor would it necessarily be desirable. In that case, the need for a continuum of housing and health services is less important and the more critical concern is the quality of care delivered inside nursing facilities.

IV. Barriers to the Coordination of Health and Housing Services

Though the benefits of customized care are largely recognized by the professionals and consumers, the current system of public subsidy for housing and health care does not facilitate coordination. The separation of these systems is rooted in the very beginning of government intervention.

History

Government involvement in housing began as a remedy to health and safety problems. Substandard housing had become a fire hazard and a source of disease in the industrialized cities of the northeast. Immigrants seeking jobs had begun to overcrowd the few neighborhoods that would welcome them, and landlords had taken little initiative to protect their tenants from the mounting health and safety threats of the stressed housing stock. Local governments became involved out of concern for the general public health, not an individual household's right to quality housing. Both disease and fire were hard to limit or quarantine and the worsening housing conditions of these immigrant neighborhoods had begun to pose a threat to their surrounding cities. In response to this general public threat, municipalities began to implement building codes and zoning regulations that would control how housing was built.

It was not until the federal government became involved in housing, in the 1930s and 1940s, that the focus of government efforts shifted to individual housing units and the well-being of individual households. Ironically, as the concern in housing broadened and moved from local to federal levels, the focus of that concern became more narrow and shifted from the "public" issues of general health and safety to more individual, "private" concerns for the affordability and adequacy of individual housing units for individual households. With this shift to a broadly based but narrowly focused public interest in the housing stock, the natural link between health and housing was lost. As a result, over the past half-century housing and health agencies diverged in the channels of government appropriations, budgetary cycles and subcommittees. The separate budgeting structures that have developed now make it difficult to recognize the original link between pubic health and private housing that initially drew the government into the housing arena.

Primary Points of Bureaucratic Disconnect Between Housing and Health

HOUSING	HEALTH
Managed by the IRS and the Department of Housing and Urban Development.	**Managed** through the Department of Health and Human Services.
Funded as tax deductions, tax credits, subsidies and grants to individuals and municipalities.	**Funded** as entitlements, subsidies and grants to individuals and states.
Calculated as tax credits and deductions before the annual revenue projections. Budgetary programs calculated by appropriations.	**Calculated** as Medicare entitlements program by the Finance Committee before budget allocation. Budgetary programs calculated by appropriations.

HOUSING	HEALTH
Administered by the state.	**Administered** by the locality.
Awarded: To an individual or family meeting financial criteria; assistance is received when unit becomes available.	**Awarded:** To any individual who meets physical and financial criteria; individual receives services immediately after qualifying.
Operate: Under 30-year mortgages and affordability requirements ranging from 10 to 40 years.	**Operate:** Using 1-to-2-year funding cycles.
Subsidy: Follows the housing unit.	**Subsidy:** Follows the individual.
Performance Measured by production: Number and affordability of units created.	**Performance Measured** by need: Number of individuals left unserved.

Budgetary and Structural Barriers

Federal Budget Process

Because the current systems of health and housing services were conceived in isolation, so remain their respective funding sources, performance standards and regulatory bodies. The funding for health and housing programs is not only distributed through different agencies, but very different funding channels. These differences can make it very difficult to meld programs or coordinate services. The largest public-health subsidies are delivered through both entitlement programs (Medicare) and budgetary programs (Medicaid), both of which are overseen by the Department of Health and Human Services. States are required to match federal Medicaid funding and, as a result, play a significant role in determining the nature of eligible services, and how and to whom they are administered. The largest housing subsidies are administered through the IRS (mortgage interest deductions and low-income housing tax credits), local Public Housing Authorities and the Department of Housing and Urban Development. The separate funding channels do not run parallel. Rather, the funding of housing programs and the funding of health programs follow very different courses.

Type of Funding	Budgeting Process
Low Income Housing Tax Credit, mortgage interest deduction	Calculated before revenue projections are totaled.
Housing subsidies administered by HUD	Reviewed in annual budget negotiations of House and Senate — House Appropriations VA, HUD and Independent Agencies Subcommittee, Senate Banking, Housing and Urban Affairs Committee.
Medicare	Overseen as an entitlement by Senate Finance Committee and House Ways and Means Committee.
Medicaid	Reviewed in annual budget negotiations of House and Senate — House Appropriations Labor, Education, Health and Human Services and Education Subcommittee, Senate Health, Education, Labor and Pensions Committee.

The Department of Housing and Urban Development and the IRS manage housing

subsidies. Health subsidies are managed through the Department of Health and Human Services. Housing dollars come as tax deductions, tax credits, subsidies and grants. Health dollars come as entitlement funding, subsidies and grants. The different types of funding are reviewed and appropriated separately. The tax credits and interest deductions are calculated before the annual revenue projections. The Finance Committee of the Senate and the Ways and Means Committee of the House appropriates funding for Medicare, because it is an entitlement program. Medicaid, along with all the HUD grant and subsidy programs, is reviewed in the subcommittee process of the Senate and House. The Labor, Health and Human Services and Education subcommittee of the House Appropriations Committee and Senate Heath, Education, Labor and Pensions Committee review the Department of Health and Human Services budget. The VA, HUD and Independent Agencies subcommittee of the House Appropriations Committee and the Senate Banking, Housing and Urban Affairs Committee review the Department of Housing and Urban Development's budget.

The budgeting process at the federal level does not create incentives for cross-agency coordination. It can not recognize the relationship between health and housing as is necessary for efficient service delivery. If an increase in HUD funding addresses the home repair problems of a senior resident, saving Medicaid dollars by avoiding an expensive health problem, these savings can not be recognized. In the current budgeting process, they would be recorded as an increase in HUD spending and a decrease in HHS spending. The relationship between the two, and therefore the justification for any increase is lost. (See diagram of federal budgetary system, next page.)

Inconsistent Jurisdictional Boundaries

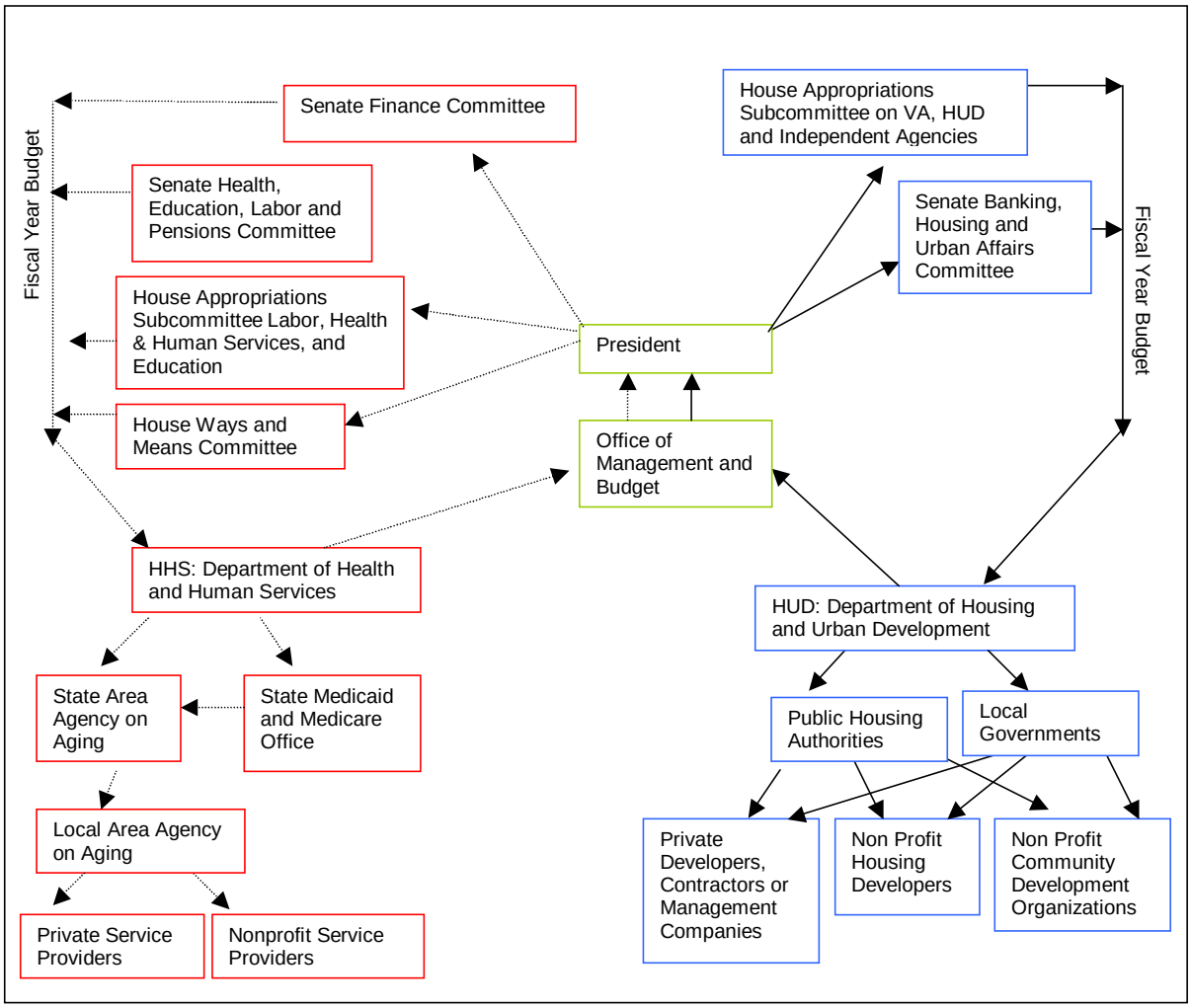
After health and housing funds have passed through the federal budgeting process, they follow two very different paths to the "ground." These divergent paths can impede coordination. Health dollars, Medicaid and Medicare, are largely administered and regulated at the state level. Most hospitals and direct health-care providers file for their own reimbursement and assist clients as they apply for eligible services under Medicaid and Medicare. The structure can vary state to state, but most have a Department on Aging or Elder Affairs to coordinate a number of the supportive service and waiver programs. Critical service funding for seniors also comes through the Older Americans Act, the Social Services Block Grant and the Veterans Administration. The state, through the Local Area Agencies on Aging (AAA), subcontracts with a number of nonprofit and private-sector service providers. The AAA can also perform a number of screening and referrals services, including applications for Medicaid waivers.

HEALTH	Administered by the state
HOUSING	Administered by the locality

Federal housing dollars, unlike federal Medicaid dollars, go directly to localities or local housing authorities. Public Housing Authorities exist in the gray area of a "quasipublic agency," neither fully public nor fully private. They control a significant amount of tenant-based and project-based housing subsidies. Local governments control a number of other housing subsidies, including CDBG and HOME funds. States operate Housing Finance Agencies and some states have housing trust funds or tax-credit programs.

The jurisdictions of housing and health providers rarely match up. Organizations attempting to coordinate health and housing services must apply to a number of state and local agencies. Each level of government with its own geographic boundaries also has a separate set of regulations and performance measurements. It is incumbent on a provider who attempts to coordinate health and housing services to run in between the agencies and translate one agency's regulations and requirements to the other.

Federal Budgeting Process: Health And Housing Dollars



Regulatory Barriers

Under the current system, regulations can also prevent coordination of services. HUD has the option of committing funds to support a population (e.g., the elderly) that HHS is targeting or vice versa. This may put moneys in the same place, but it doesn't insure that the moneys can be used together. Without altering the regulations and eligibility criteria, there is no guarantee that the funds can actually be used on the same project or to coordinate services for the same individual.

HEALTH	Regulated by medical standards
HOUSING	Regulated by construction and development standards

The regulations of Medicaid, Medicare and federal housing programs are designed to insure high quality of service and high accountability. HHS and HUD have an obligation to track where and how public funds are spent, and the regulatory bodies at the state and local level reflect that obligation. The difficulty in coordinating these services arises because the housing regulations protect one public good and the health regulations another. Medicaid and Medicare come from a medical model, whereas housing programs come from a bricks-and-mortar perspective. Both attempt to avoid a worst-case scenario. Medicaid and Medicare regulations prevent neglect and mistreatment of individuals who are not well. Housing regulations are designed to insure the financial feasibility of its projects and the affordability of housing for those most in need.

There are a number of regulations and eligibility criteria which make it difficult to use both health and housing dollars to serve the same individual. Here are just two examples of the complications that can arise when attempting to combine public health and housing dollars.

- Low Income Housing Tax Credits (LIHTC) can not be used for medical facilities, but the IRS has not clearly stated where the line falls between a residential facility and a medical facility. Assisted Living facilities lie somewhere in between a medical and a residential facility, but the criteria for LIHTC eligibility has only been determined through private rulings and revenue rulings. The most informative ruling was made in September 1998, but even that did not clear up how frequently residents can receive medical assistance and still qualify the facility under a residential ruling.[22]

- Section 8 vouchers can only assist with rental payments if the total rent does not exceed 40 percent of an individual's income. In order to qualify for Medicaid an individual must be very low-income and physically require nursing-home services. Many states use the federal SSI guideline of $530 per month to qualify an individual for Medicaid; therefore the monthly rent can not exceed 40 percent of $530, which is $212. If an individual qualifies for Medicaid, a Medicaid waiver can be used to pay for the personal care services offered in an Assisted Living facility. Assisted Living facilities usually provide three meals a day to residents. Medicaid can pay for food preparation, but not raw food costs. The cost of the food must then be incorporated into the rental costs, and $212 is not enough to cover rent, let alone additional food costs. Section 8's 40 percent requirement does not take into account that the monthly food costs are also being paid for and therefore an individual could afford a higher rent payment.

Eligibility Barriers: Eligible Services and Individuals

To allow the elderly to age in place as long as possible, health and housing resources must support a range of health and housing conditions. The major elderly health and housing programs restrict both who can receive services and which services are eligible for reimbursement. The restrictions and guidelines for each program vary and often conflict with one another.

[22] Gray, Jim. *Using the Low-Income Housing Tax Credit for Assisted Living Facilities.* National Cooperative Bank Development Corporation.

Four primary points of tension created by the eligibility criteria are described here.

HEALTH	Individual meets criteria and will receive services
HOUSING	Individual meets criteria and waits for unit to become available

Not enough services are eligible for Medicare reimbursement. Medicare only provides home-health and personal-care services to address acute medical needs. Medicare finances long-term care through its limited skilled nursing facility (SNF) and home-health benefits. In most cases the SNF and home-care services paid for by Medicare are short-term, rehabilitative care, related to a hospital stay or outpatient procedure. Medicare will also provide part-time home health care and personal-care services to homebound individuals, but has strict definitions of what it means to be homebound. If an individual is able to shop for him or herself but needs assistance with bathing and medication reminders, he or she would not qualify as homebound and could not receive the services under Medicare.[23] With its present level of benefits, Medicare is not designed to provide ongoing assistance to maximize self-help and independence for the person who is aging in place.

Only the sickest and the poorest seniors can receive care through the Medicaid program. Medicaid does provide ongoing long-term care services, but the eligibility criteria pose challenges for providers who attempt to coordinate health and housing services. Individuals have to be very frail and very poor to receive services. Only those who meet very low-income standards and whose physical needs require nursing home–level assistance can qualify for assistance under Medicaid. "You have to be on the absolute bottom financially and physically to get any assistance."[24] These physical and financial eligibility criteria of the Medicaid program prohibit the funding of any incremental care that might maximize independence, before an individual becomes physically or financially dependent.

"We know well that the provision of a few targeted services, such as respite care, home modifications, a wheelchair ramp, bathtub railings, or personal-care attendants can often maintain a high level of functioning in seniors or individuals with disabilities. These targeted services often prevent catastrophic events, prevent slow declines in functioning and are a cost efficient and critical component of good public health policy,"[25] but can not be provided by Medicaid until an individual meets both the financial and physical criteria. Individuals have to be quite frail to qualify for services, which means any assistance that may extend independence prior to becoming frail can not be funded. Those who are just above the income guidelines (in many states this is the SSI guideline of $530 per month) cannot qualify for Medicaid assistance, nor can they afford to pay for these services in the private market. Those who do not yet physically qualify as nursing-home eligible, but who need some assistance with minor daily activities to remain in their homes, cannot receive Medicaid services.

Housing subsidies primarily support renters, but most seniors are homeowners. Most housing subsidy programs support elderly rental housing, while the majority of elderly citizens

[23] Author interview with Robbie Rhymer, Symbion Health Services, July 6, 2001.

[24] Testimony of Ray Czalchowiski, Congressional Commission Public Hearing, Syracuse, New York, July 30, 2001.

[25] Testimony of Ray Scheppach, Executive Director, National Governors Association, before the Senate Special Committee on Aging, July 18, 2001.

own their homes. Elderly homeowners do receive assistance with the cost of their housing through local property-tax exemption and tax-deferral programs. Some localities use their Community Development Block Grant funding to support elderly homeowners through home repair programs. The largest home-ownership subsidy, however — the mortgage interest deduction — does not apply or provide benefit to many elderly homeowners. Most own their homes outright. Those who are still making mortgage payments are usually in the later part of their mortgage, when the bulk of the payment is principal rather than interest.

The challenge of housing affordability for America's seniors extends beyond elderly renters, but the subsidies do not. Thirty percent of all elderly pay more than thirty percent of their income in housing costs. HUD reported that the affordability crisis among the elderly is distributed evenly between renters and owners.[26] As of 1999, 1,721,266 of the 34 million Americans over the age of 65 reside in publicly assisted rental units.[27] While it is critical that rental subsidies remain intact, they serve only 3 percent of elderly Americans.

Health dollars are distributed as an entitlement; housing dollars are distributed as a limited subsidy. Each year federal and state governments project how many people will qualify for Medicaid and Medicare and set aside the amount required to serve those individuals. As individuals meet the eligibility criteria, they receive the services. Which services Medicare recipients receive is determined at the federal level. The services that Medicaid recipients receive are determined at the state level. For example, a state can determine how many home and community-based Medicaid waivers it will fund, requiring that all other Medicaid recipients receive long-term care through a nursing facility.

Housing, on the other hand, operates in a very different eligibility universe. HUD generally sets the income restrictions which qualify an individual for housing assistance. Each year, only a certain percentage of the units needed to house the individuals who meet the eligibility criteria are funded. Individuals who meet the criteria but for whom a unit is unavailable wait in line to receive services.

These separate eligibility universes make it difficult to coordinate health and housing services for the same individual to allow him or her to age in place. Consider this example: if Mrs. Jones receives a home and community-based waiver from the state because she has qualified financially (low enough income) and physically (requires nursing home level assistance), she can begin to receive personal-care services in her home. Because of her low income, Mrs. Jones will also qualify for the city home-repair program funded through Community Development Block Grant (CDBG) from HUD. If the city is only funded to repair 200 homes each year, Mrs. Jones could wait several months or years until her name rises to the top of the waiting list. In the meantime, she has been receiving personal care services in her home, but her roof continues to leak, rendering the home unlivable. She will have to move to a nursing home not because of a lack of health care, but the lack of funding for housing assistance.

[26] Department of Housing and Urban Development. *Housing Our Elders.* November 1999.
[27] Kochera, Andrew. *A Summary of Federal Rental Housing Programs.* AARP Public Policy Institute, May 2001, p. 2.

V. Lessons from Providers

Despite the barriers and obstacles in coordinating health and housing programs, across the country a number of nonprofit agencies, both housing and health-care agencies, have combined health and housing services to support aging in place. Generally these efforts have required creativity, and a means through which projects could be conceived outside of the traditional health or housing model. In interviews with over 60 health and housing professionals across the country, a number of key elements and lessons emerged.

Four Key Components of Aging in Place

The range of appropriate services can vary depending on how an individual ages, but there are four key elements that have been consistently present in the most successful aging-in-place programs.[28]

- ***Choice:*** Providing both health-care and housing options that meet the diverse needs of individuals as they move through the later third of their lives. Options should be affordable along the income spectrum so that all elderly or their caregivers are able to choose from a range of alternatives.

- ***Flexibility:*** Offering a range of services that can be applied in a variety of contexts. Flexibility requires that the level of health and housing be adjustable whether an individual lives in a single-family home, rents a privately or publicly managed apartment or resides in an assisted-living facility.

- ***Mixed Generations:*** Maintaining mixed-generation communities in order to maximize a senior citizen's capacity for self-help and his or her ability to contribute to the community. People both old and young benefit from being around each other. Seniors often provide day care, tutoring and general stability when they are involved in the daily routines of young families, and young people can keep seniors engaged, active and looked after as they become frail. While most of this intergenerational mixing can occur naturally, it does take proactive planning to ensure that communities are not designed in such a way as to *prevent* opportunities for generations to mix.

- ***Calibrated Support:*** Establishing infrastructure through which housing and health-service needs can be assessed and the appropriate level of coordinated service delivered. To prevent undercare or overcare, calibrated support requires the ongoing assessment of an individual's health and housing condition as well as services that meet a range of different needs.

Major Concerns for Aging-in-Place Programs

There are a number of challenges in developing and maintaining aging-in-place programs that are specific to each state's Medicaid regulations, housing subsidies, housing trust fund and

[28] Based on a series of 60 interviews with senior service providers across the country between June and August 2001.

housing finance agencies as well as private foundations and resources. Despite these differences, providers across the country voiced a number of concerns and common themes.

Aging in Place in a Rural vs. Urban Context. Providers in both urban and rural contexts struggle to serve seniors with very limited resources. When asked to articulate the primary concern for seniors in their communities, rural and urban providers responded differently. All rural providers interviewed for this report stated that their smaller communities were better at keeping seniors involved in the community and providing in-home support. When that support could no longer serve their needs, senior residents had no other option except nursing facilities far from home. Rural communities could support facilities that house 10 to 18 residents, but those models do not provide enough incentive to interest developers. Cen-Tex Certified Development Corporation in Austin, Texas, has developed a 16-room, 7,000-square-foot facility for rural communities, but has had difficulty finding appropriate financing or interested development partners.[29] While the lack of housing options poses a problem for urban providers as well, the inadequate number of supportive services and the difficulty in coordinating those supportive services was most often articulated as their primary concerns.

Understanding the Market for Assisted-Living Facilities. Because assisted-living facilities are expensive to build and difficult to retrofit, most financing institutions require extensive market studies that show an area can support the facility. Traditional market studies that analyze age, income, housing tenure and other demographics do not accurately predict whether or not a community can support an assisted-living facility. The question "what makes a senior move into a facility?" is answered differently by every senior who faces different challenges of aging. Community groups, however, have proven to be invaluable resources for understanding the market for supportive living facilities. Knowing the specific housing and safety concerns in a neighborhood, the communities within the community (either ethnically or religiously centered) and the likelihood that if a certain resident leader or social group moves into the facility, others will follow, can position community groups to read the market for a facility more accurately than a study. Codman Square CDC in Dorchester, Mass., undertook a community-led study in 1996 using volunteers to knock on doors and interview residents, and holding focus groups at the local senior center and health clinic. As a result two congregate-care facilities were built in the community and have remained successful.[30]

The physical deterioration of a house can cause mental health deterioration. The relationship between the mental health of a senior and the physical condition of his or her home was articulated so many times by housing providers, it bears mention. As many community-based organizations described, their home-repair grant and loan programs were not set up as senior programs but had become senior programs by default. Again and again the directors of these repair programs mentioned the change a roof repair or furnace replacement could create in the life of a senior. It was not just that water no longer came in when it rained, or that heat was now flowing freely in the coldest weather, but the senior felt more "in control," "better able to cope," and "more empowered to care for themselves" after these repairs were made. The

[29] Author interview with Rosa Valdez, Cen-Tex Certified Development Corporation, July 12, 2001.

[30] Tu, Trang. *Market Study for Affordable Assisted Living In Dorchester, Massachusetts.* Codman Square Community Development Corporation, September 1996.

executive director of Neighborhood Housing Services in Boise, Idaho, explained, "if you can transform a home for someone, you can transform their lives."[31]

"We are good at housing, we are not good at delivering services." Over and over, community-based housing providers noted that their housing activities helped them to understand the needs of local seniors, but did not prepare them to become social-service providers. The different skill sets needed for the provision of social services forced housing developers and managers to seek partners to deliver supportive services to their residents. The shape and nature of these partnerships varied from community to community, but the providers who felt they were able to fill the service needs of their residents or community members did so through partnerships. St. Mary's Development Corporation in Dayton, Ohio, attributes the success of its senior facilities to its partnership with the county's combined health district. The county provides a nurse who then works out of the senior apartment complex, serving both residents of the building and residents in the surrounding community. Without this service their residents could not remain in the building.[32]

Partnerships can occur in a variety of places. Community-based organizations with successful collaborations with local health providers found that working together on their first project led to many other joint ventures. St. Petersburg (Fla.) Neighborhood Housing Services was asked to serve as the fiscal agent for a state-funded initiative that focused on housing- and construction-related issues. That project formed a number of subcommittees, one of which was a health committee. The director of the St. Petersburg NHS found himself on the health subcommittee thinking through how his organization's community-development activities had implications for health-education efforts. As a result of these meetings, the St. Petersburg NHS became involved in another state-funded program designed to address the impact of diabetes on families and communities. Though diabetes is not limited to seniors, the conditions it causes (amputation, blindness) worsen with age and can jeopardize independent living. The regular meetings and phone conferences throughout the diabetes initiative created "the relationships and broadened the thinking of both health and housing providers and positioned us to work together in the future. We now have a channel for communication and collaboration with a number of health providers."[33]

The Southeast Senior Housing Initiative in Baltimore, Maryland, has been participating in a four-year demonstration project with the Robert Wood Johnson Foundation designed to prevent falls and keep seniors in their homes. This collaboration has allowed them to consider an involvement in health services they would not have imagined several years ago. The foundation pulled together a collaboration of the Baltimore Neighborhood Based Medical System, John Hopkins Medical School, Banner Neighborhood Services, Neighborhood Housing Services of Baltimore, Southeast Senior Housing Initiative and the Baltimore City Commission on Aging. A doctor will refer an individual to the City Commission on Aging. The commission performs a thorough intake process and refers the individual to the appropriate agencies. The Southeast Senior Housing Initiative will modify the home with grab bars, handicap ramps, etc. NHS of Baltimore

[31] Author interview with Tom Lay, Neighborhood Housing Services of Boise, Inc., August 2, 2001.

[32] Author interview with Elaine Clingman, St. Mary's Development Corporation, July 31, 2001.

[33] Author interview with Askia Muhammad Aquil, St. Petersburg Neighborhood Housing Services, St. Petersburg, Florida, July 23, 2001.

will work with the individual to provide a low-interest home rehabilitation loan if any further repairs are needed. The partnership members are now exploring how they can become certified for Medicaid reimbursement to provide individuals with enough services to keep them out of nursing homes. They have also begun planning for potential assisted-living models inside clusters of traditional Baltimore row houses. By working together on the foundation-sponsored project, a number of new, never-before-considered possibilities have emerged.

VI. Opportunities for the Coordination of Health and Housing Services

HUD recognized the circular relationship between health and housing in its 1999 analysis of the housing conditions of America's elderly when it found that "assistance and support that would enable a homeowner to age in place undoubtedly represent the single largest category of housing need for elderly Americans."[34] Supporting aging in place requires both housing and health services to manage successfully, run efficiently and operated at the lowest possible cost. In an era of tight budgets and increasing service demand, agencies at the federal, state and local levels have new incentives to discover the most efficient means to deliver services to the growing elderly population.

Opportunities for the coordination of health and housing services exist at the federal, state and local levels.

Federal Opportunities: Align Isolated Programs and Redirect Funding Sources

While increased funds will be necessary to provide services to the growing elderly population, in the current political climate it is hard to imagine either HHS or HUD receiving substantial additions to their annual budgets. Without assuming that any new funds would be available, the federal agencies can still take action to enhance the coordination of health and housing services. In the current condition of isolated funding channels, and conflicting regulations and eligibility criteria, a coordinated approach to health and housing services can be achieved through (1) the alignment of current services and the creation of comprehensive programs inside HHS and HUD, and (2) the redirection of the current health and housing funding channels toward rather than away from one another. These strategies are not mutually exclusive, and should be pursued simultaneously so that the federal budgeting and funding structure begin to reflect the relationship between health and housing concerns for older Americans.

Align current services and develop comprehensive initiatives inside the HHS and HUD organizational structures. This strategy simply aims to create the possibility that health and housing programs can overlap. As it stands now, many regulations and program requirements and restrictions prevent health and housing programs from working in concert. By eliminating some of the regulatory and eligibility barriers to coordination, there is a greater opportunity for providers at the local level to find more possibilities than obstacles to a comprehensive approach to elderly health and housing.

The regulatory barriers, incompatible eligibility requirements and performance measurements that present significant obstacles to providers when matching HUD funding with HHS funding could be catalogued and reconfigured. While the specific adjustments to eligibility criteria are the subject of a more detailed analysis, some examples could include, but would not be limited to:

1. Altering the requirement that total rent costs not exceed 40 percent of an individual's income in order to receive a Section 8 voucher when that individual is living in an assisted-living facility.

[34] Department of Housing and Urban Development. *Housing Our Elders.* November 1999.

2. Developing new Section 8 waiting list preference criteria for elderly individuals who are attempting to move into assisted-living facilities.
3. Expanding the populations covered under Medicaid services.
4. Integrating Medicare and Medicaid services for those who are eligible for both programs.
5. Examining HUD insurance criteria to pinpoint difficulties in insuring assisted-living facilities.
6. Expanding the Medicaid home-modification waiver to include home-maintenance issues which affect an individual's health.
7. Examining types of home-care services offered through Medicare, and expanding the eligibility criteria for those services.
8. Establishing criteria that distinguish assisted-living facilities from medical facilities for the purposes of Low Income Housing Tax Credit eligibility.

Both HUD and HHS have started a number of more comprehensive programs in the last couple of years, which should be continued and expanded upon. For example:

HUD Service Coordinator Grant: In fiscal fear 2001, $24.2 million was made available to allow multifamily housing owners to assist elderly individuals and people with disabilities living in HUD-assisted housing to obtain needed supportive services that enable them to live as independently as possible in their own homes. The program provides funding for the employment and support of service coordinators who help residents obtain supportive services from the community that are needed to enable independent living and aging in place. The grant does not provide funding for any direct service delivery; rather the service coordinator operates as a broker of existing community services, helping residents identify their particular needs and the local agency or service which can best assist them. At the end of 2000, this program was expanded to allow, but not require, service coordinators to work with residents in the surrounding communities as well as residents of the multifamily development itself.[35]

HUD Assisted Living Conversion Program: This program allows seniors living in subsidized multifamily units to remain in the same residential development while they age, rather than move to another facility if their need for supportive services increases. In fiscal year 2001, HUD made $100 million available for the conversion of eligible multifamily units to Assisted Living Facilities (AFL). The program provides funding for the physical costs of converting some or all of the units in a multifamily development into an ALF, including the unit configuration, common and service space and any necessary remodeling consistent with HUD's or the state's statute or regulations. Under this program, ALFs must provide support services, such as personal care, transportation, meals, housekeeping and laundry. The grant does not fund the provision of supportive services. Services must be paid for through resident fees, grants, etc. This program is in the very early stages of development, but if funded adequately, can play a critical role in allowing seniors in subsidized units to remain in their homes as they age.[36]

HHS-sponsored PACE Program: PACE (Programs of All-inclusive Care for the Elderly) was originally developed by San Francisco's On Lok Senior Health Services. The program pools Medicare and Medicaid funds to provide a range of acute and long-term care services for older

[35] Federal Register, Volume 66, Number 38, February 26, 2001, p. 12362-12367.
[36] Federal Register, Volume 66, Number 38, February 26, 2001, p. 12339-12345.

adults through the use of interdisciplinary teams of health professionals. The PACE model includes in-home services, day care, laboratory and ambulance services, skilled nursing facility care, medical specialty services and restorative and supportive services. The PACE provider receives a fixed monthly fee for each individual enrolled in the program. This amount is based on the enrollee's entitlement for PACE, not the enrollee's physical condition or type of services needed. PACE then provides the individual with all of the care that might be needed and is not allowed to disqualify an individual because his or her condition or service needs have changed. PACE's financing structure creates incentives for maintaining the health of seniors enrolled in the program.

There are now 25 fully capitated PACE sites, 10 pre-PACE sites, and The Centers on Medicare and Medicaid will authorize an additional 20 programs each year. The program has successfully integrated Medicare and Medicaid for frail elderly and provided a community-based rather than institutional setting for comprehensive care.[37]

Create a "Third Way" — an alternative program that sends both federal health and housing dollars to a single agency. This agency could operate at the federal, state or local level. Distinct opportunities present themselves at the state level, because of the current Medicaid and housing finance agency jurisdictions. As it presently stands, the funding streams diverge. Advocating for a "third way" is just an argument to turn those funding streams toward one another to better reflect the relationship between health and housing concerns of older Americans.

The third agency would be given the flexibility to mediate between the conflicting regulations and eligibility criteria of federal and state health and housing programs. This agency would then be charged with establishing a comprehensive financing and/or grant program for aging-in-place services using the expertise of both housing and health professionals. Rather than have service providers or housing developers apply to multiple and separate housing and health resources, this one-stop agency would pool those moneys and create a single application process. This unified process would eliminate the current conditions under which each provider essentially creates its own combination of health and housing services by applying to multiple grant and financing sources. It would establish a structure that *promotes* coordination and similarities and commonality between health and housing services. There will still exist a number of very difficult challenges in providing affordable health and housing services to America's low-income seniors, but under a system which is set up for coordination, many of the administrative and regulatory burdens could be lifted.

A third, alternative program could exist inside current state agencies (e.g., department on aging, elder affairs or the housing finance agency) or become a third entity. The advantage of a completely separate third entity is that it could leave behind the housing and health perspectives and invent a new paradigm, which would better reflect the interrelationship of health and housing. Often it is not only the regulations and eligibility criteria that stand in the way of coordination, but is also the unwillingness of providers, administrators, regulators and lenders to let go of

[37] Chu, Gary and Jocelyn Pan. "Comprehensive Care for the Elderly: Is PACE the Answer?" *Harvard Health Policy Review,* Vol. 2, No. 1, Spring 2001.

traditional health and housing delivery structures or to compromise any components of health and housing development procedure.

An example of this type of resource pooling that delivers supportive services inside health facilities is the Massachusetts Housing Finance Agency's ElderChoice program.

ElderChoice is a program operated by the Massachusetts Housing Finance Agency (MHFA), which assists developers who are building and operating housing for seniors who need assistance to continue to live independently. The MHFA tackled the difficult challenge of building affordable housing with supportive services for low-income individuals by combining the lower interest rates provided through its tax-exempt and taxable bond financing program with the subsidy of Medicaid waivers. Developers interested in providing affordable assisted-living facilities need not navigate the financing and Medicaid services separately; the funding streams are coordinated by the MHFA. Developers need only apply to the MHFA, a one-stop shop. In the MHFA program, the affordable assisted-living model requires that 20 percent of the units remain affordable to low-income residents, while the remainder are market-rate units. The MHFA worked with the Massachusetts Medicaid office to qualify these developments for Group Adult Foster Care waivers. The waivers provide $34 per day to fund the supportive services provided to the low-income residents of the assisted-living facility. The guarantee of this waiver has allowed developers to move forward with their projects knowing that the funds for service delivery can be worked into the operating pro forma. By streamlining the funding process, the MHFA has been able to build 14 developments to date, producing over 1,200 assisted-living units through the ElderChoice program.[38]

State Opportunities: The Interjection of Housing into Olmstead Planning Process

In July 1999 the Supreme Court issued the Olmstead v. L.C. decision, which interpreted Title II of the Americans with Disabilities Act, requiring states to administer their services in the most integrated setting appropriate to the needs of qualified individuals with disabilities. The ruling obliges states to develop an Olmstead Plan which reorients their services toward community-based rather than traditional institutional settings for all those protected under the Americans with Disabilities Act.

The stage is set for significant changes in the long-term care system, if only all the actors are present. The future of community-based care is being discussed in the Olmstead planning sessions. It is the time and the place to re-envision how community-based affordable housing with supportive services can be provided. This is the need of the disability community and the need of the aging community. Success requires the cooperation of both health and housing services, and the Supreme Court has issued a ruling which may force states to become more creative than they have ever been before. Even though HUD was not mentioned in the ruling and the jurisdiction for the Olmstead plan falls under HHS, it is imperative that housing providers inject themselves into the Olmstead Planning process. This will not only accomplish the goals of the Olmstead ruling, but create the collaboration needed to accomplish the goals of successful aging in place.

[38] Author interview with Frank Creeden, Massachusetts Housing Finance Authority, August 2, 2001.

The Office of Civil Rights (OCR) has been given the authority to oversee Olmstead enforcement. The OCR, along with officials from the Centers on Medicaid and Medicare, has been providing technical assistance and support to those states involved in the planning process. A recent study on states' progress toward meeting the mandates of the Olmstead Ruling found that:

1. Only a few states have finalized their plans and most will complete them in 2001.
2. The scope of most state Olmstead Commissions is broad and includes all people with disabilities, including the developmentally disabled, the physically disabled and those with mental illnesses, as well as **older people with disabilities.**
3. The progress of most states has been slow because of the complex issues that must be addressed to create a comprehensive community-based care plan. The largest and most difficult issues identified across the country are:
   - Assessing people who are at risk for institutionalization;
   - Defining institutionalization and reviewing placement activities in institutions;
   - Developing home-based service infrastructure given the personal-care and nursing-aide labor shortage;
   - **Finding affordable and accessible community-based housing;**
   - Locating accessible transportation; and
   - Identifying sources of funding within state budgets.[39]

A Supreme Court ruling presents a particular kind of mandate, and lends a certain weight and urgency to the process. To fulfill the requirements of the Olmstead ruling, health and housing providers need each other more than ever and share a common agenda. To date, however, only health departments and social-service agencies have been involved in the Olmstead planning process. "Of the 22 Olmstead-related plans that states have sent thus far to HHS for review, not a single one mentions housing. None of the state plans reflect discussions or partnerships with state housing or community development departments. As of September 2000, none of the committees formed, Executive Orders issued or legislation enacted by states in response to Olmstead, mentions housing or includes housing officials or experts."[40]

Recently, though, affordable housing was identified as a key issue for Olmstead compliance. On July 16, 2001, Claudia Schlotzberg, the OCR official in charge of the Olmstead planning process, arranged a technical-assistance teleconference to teach state personnel working on Olmstead plans the basic elements of the Section 8 program. The time is ripe to include housing providers in the Olmstead dialogue, and the effects may be long-lasting.

[39] Fox-Grage, Wendy. *The States' Response to the Olmstead Decision: A Status Report.* National Conference of State Legislatures, March 2001.

[40] Miller, Emily. "The Olmstead Decision and Housing: Opportunity Knocks." *Opening Doors,* Issue 12, December 2000.

Local Opportunities: The Critical Role of the Community-Based Nonprofit

Community development corporations and community-based nonprofits can play a vital role in coordinating health and housing services for the elderly, because they are often the organizations with the greatest connection to residents and to the local service network. There exist both health and social-service models for community-based nonprofits and housing and community development models. Organizations that are combining health and housing services for the elderly do so by default. They were either first a housing organization which needed services to support its residents, or a service organization that found that the primary needs of their clients included housing. The common factor is that they are connected to the residents through their ongoing work in the neighborhood. Community-based organizations are often the first to know of a new health or housing concern for a local senior. They are positioned to identify trends in the elderly population's needs, and possess the creativity and flexibility to calibrate the support to effectively match that need.

Identifying Community-Specific Needs of Local Seniors: Nuestra Comunidad, Boston, MA

Nuestra Comunidad is a community-development organization in Boston's Roxbury community. It has been an active presence in the community for several decades, and as a result its networks and connections throughout the community run deep. It has identified and, because of its unique position in the community, is attempting to address two very specific needs of its long-time senior residents. Many of the seniors in Roxbury own their homes, but as with much of Boston's housing stock, these are 2-to-3-family homes — "double and triple deckers." The rental income from the extra units could greatly assist those seniors struggling on a fixed income; however, as the seniors have become more frail, they are less and less able to manage the administrative and maintenance responsibilities of a landlord. Many seniors, as a result, have opted to keep these rental units vacant. Nuestra Comunidad is working to develop a program to rehabilitate and manage these extra units, providing extra income for the seniors and affordable units for the community.

An equally important concern facing Nuestra Comunidad is that its long-time resident leaders are aging. The lack of affordable rental units or supportive housing facilities in the community has forced many of these seniors to leave. To avoid losing the great value these seniors bring to the community, Nuestra Comunidad is working to develop alternatives, including better coordination of in-home health-care services.

As the aging population continues to grow and local communities search for cost-effective ways to satisfy the increased demand, community-based nonprofits are well positioned to fill the gap. There are a number of specific opportunities presented by the interrelationship between health and housing that community-based organizations should consider:

Naturally Occurring Retirement Communities. Professors at the University of Wisconsin coined the concept of Naturally Occurring Retirement Community (NORC). It usually describes a community in which over 50 percent of residents are over the age of 65. NORCs are not senior housing developments; rather they are communities in which a majority of residents, having aged in place, are now senior citizens. The NORC model uses the density of seniors to

provide services in place rather than transport seniors to service facilities or relocate seniors to alternative living facilities. New York has a number of examples of successful NORC projects, and the attached case study on Penn South highlights the successes of the most famous NORC. The benefits of the NORC model do not have to be limited to high-density apartment complexes; community-based organizations can play a critical role in expanding the model.

There are many entrepreneurial opportunities to capitalize on the collective purchasing power of an organized community of seniors, and mission-driven community-based nonprofits are uniquely positioned to seek them out. Service buyers' co-ops can be formed for the purpose of procuring lower-cost services. Penn South Housing Co-op in New York City worked with St. Vincent's psychiatry program to have its fellows rotate through the co-op as part of a gero-psychiatry training program. It gave the psychiatrists much-needed experience in the field, while providing free care to Penn South seniors. Nursing service was the most expensive staff line of the budget for Penn South Co-op. The co-op formed a partnership with the Visiting Nurse Service of New York, which saw an opportunity to find reimbursable cases for the agency, while providing free nursing care to co-op residents. Beth Israel Hospital and St. Vincent's Hospital both opened offices at Penn South as they realized that the co-op supplied many new potential patients. In addition to providing an opportunity for improved and coordinated care, the offices provided free services in exchange for assistance in marketing to residents. As a result of the Visiting Nurse Service and the hospital offices, Penn South now receives free screenings, lectures, flu shots and other services for its senior residents.[41]

The NORC model has been used primarily in high-density apartment complexes, but is now being tried out in a lower-density residential neighborhood model. The primary concern in applying the lessons of the high-density model to a residential model is how to define community. Community-based nonprofits, through their direct experience with residents, are best positioned to answer that question. Whether the community is defined geographically or through association with a specific community center, church or synagogue can frame the application of the NORC concept. Through their local experience, the community-based nonprofit is usually best positioned to answer the question of how community is defined.

Alternative NORC models are beginning to emerge. HUD recently awarded a grant to the community in Greenbelt, Maryland, to expand the NORC concept to a single-family house model. The Community Housing Resource Center in Atlanta, Georgia, is partnering with the Atlanta Jewish Community Center to develop a neighborhood-based NORC model, based on the lessons of Penn South and others in New York City.

Paraprofessional capacity of nonprofits. Community-based nonprofit organizations are particularly well suited to deliver "paraprofessional" services. The work of paraprofessionals is invaluable to the delivery of calibrated support — care that matches the level of services delivered to the needs of the individual. It avoids the expense of providing too much care to those who do not need it and not enough care to those who do. In the case of housing, this could mean hiring a handyman to complete minor repairs for the seniors in a designated sector

[41] Yalowitz, Nat and Bassuk, Karen. *An Intergenerational Community With Supportive Services: The NORC Model at Penn South Program for Seniors*, Penn South Co-op.

of the city. To deliver supportive services that do not require a licensed RN, a nonprofit may be better suited to hire and coordinate the house calls of a certified nursing assistant. These skilled individuals do not cost as much as a licensed nurse or plumber would and employing them directly through the nonprofit could facilitate the delivery of more comprehensive care. Paraprofessionals working for a community-based nonprofit can also reduce the expense of these services to seniors themselves. A not-for-profit corporation can deliver services at cost and does not require the profit margins a for-profit corporation would. A number of community-based organizations already incorporate handymen into their housing services. The challenge is to expand the model and include personal-care assistants to offer paraprofessional health care as well.

Utilizing community planning to coordinate health and housing services. In most localities, community-based organizations (CBO) are invited to participate in long-term, ongoing community-planning efforts, zoning changes, the designation of special historic districts, etc. Community groups often host public meetings or forums to discuss a city or county's future development. In this role as community advocate and community voice, the CBO can play a unique role in insuring that a community's design and regulations support seniors who are aging in place. The community planning process can be familiar ground for health organizations as well. A locally based initiative can utilize existing relationships to pull planners, health-care workers and housing providers together.

Florida has recently organized a statewide program to help communities assess their "elder-friendly status" and implement plans to change facilities, housing, transportation and supportive services (see case study, page 45). While it was conceived at the state level, the program requires grassroots organizing and community support. It relies heavily on the networks through which CBOs, CDCs, senior centers, health clinics and neighborhood associations commonly operate. In those states without a gubernatorial initiative like Florida's, the same advocacy can be done through the ongoing work of CDCs, CBOs and their other nonprofit partners.

Aging and Community Revitalization

Community-based organizations not only serve residents but work to meet the goals of neighborhood revitalization. Often the process begins with a neighborhood clean-up or a landscaping project at the local park, and leads to housing rehabilitation and new construction. Finally it includes, for most communities, economic development and ensuring access to basic transportation and retail services.

Aging in Place and Community Revitalization: A Common Agenda

- Community stability
- Public safety
- Rehabilitation of housing stock
- Diverse community demographics, spanning different age and economic groups
- Promoting home ownership — most seniors own the homes in which they live
- Civic and community responsibility

As local organizations struggle with the many challenges of community revitalization, issues of senior health and housing arise, not because of a senior-oriented-mission, but because the community members most in need are above age 65. The programs for home repair, home-rehabilitation loans, even public safety and transportation, become senior programs by default. Seniors who have been living in the community for decades, but can no longer afford to paint

their houses, mow their lawns or fix their front porches can become the primary concern of those neighbors revitalizing the community. "We are witnessing this connection between health and housing for seniors in our neighborhoods. The stress and anxiety from the redevelopment of neighborhoods and rising property taxes brings seniors into the housing office and we start from there."[42]

Senior residents of a neighborhood may be customers of local community-revitalization programs because of their needs, but their inherent value make them powerful assets to the same revitalization efforts. One of the primary goals in revitalization strategies is achieving stability — stable housing stock, stable residents who are invested in the development of the community, rebuilding high-quality schools, parks and public services. Seniors can be a primary source of this stability. The oldest residents are often the long-term residents of the neighborhood, having purchased their homes 25 to 30 years ago. They are most often home and property owners rather than renters, who, out of their history and experience, have a large stake in the community. Keeping those seniors in their homes maintains "eyes on the streets" — seniors acting as crime watchers throughout the day while other residents are at work. Many times, elderly residents are the primary source of day care and after-school care. Communities that use the volunteer hours of senior residents in tutoring and reading programs improve the quality of their schools.

The present senior cohort has been called "the great generation." They are the Americans who survived the Great Depression and fought in World War II. They have been known as one of the most civic-minded generations, who invested heavily in their community organizations, led the Rotary and Jaycee clubs, and always exercised their right to vote. These individuals and their ethics are invaluable to community-revitalization efforts, particularly in distressed urban areas. Allowing seniors to age in place maximizes not only their independence, but also the many social and economic benefits they bring to the community.

[42] Author interview with Askia Muhammad Aquil, St. Petersburg Neighborhood Housing Services, St. Petersburg, Florida, July 23, 2001.

VII. Three Approaches to the Coordination of Health and Housing

To examine ways in which state and local governments could consider an alternative approach — a third way, to combine health and housing services for seniors, three very different projects are summarized in the following pages. These projects are very different in nature but their approaches illustrate how alternatives can be considered on the ground.

Regional Planning in Atlanta, GA: Using GIS Technology to Create New Health and Housing Partnerships

The Atlanta region has begun a process of exploring new partnerships between health and housing providers. Employing the tools of geographic information system (GIS) technology, it has used maps to locate communities with the highest density of seniors, communities with seniors at risk and communities with diverse age populations. The mapping technology has also been used to locate current health and housing facilities. This project is still in the early stages of its development, but it illustrates how technology can be used to help illustrate the possibilities for change and partnership.

Using Community Assets: Penn South NORC

The Penn South Cooperative in New York City illustrates how one community measured its own assets to develop a new way of addressing its growing aging population. Rather than send its residents into nursing homes, this community recognized its own economies of scale and how the number of senior residents, rather than presenting a liability to the building management, could be leveraged to benefit the entire community. It has developed a number of well organized services to keep seniors in place.

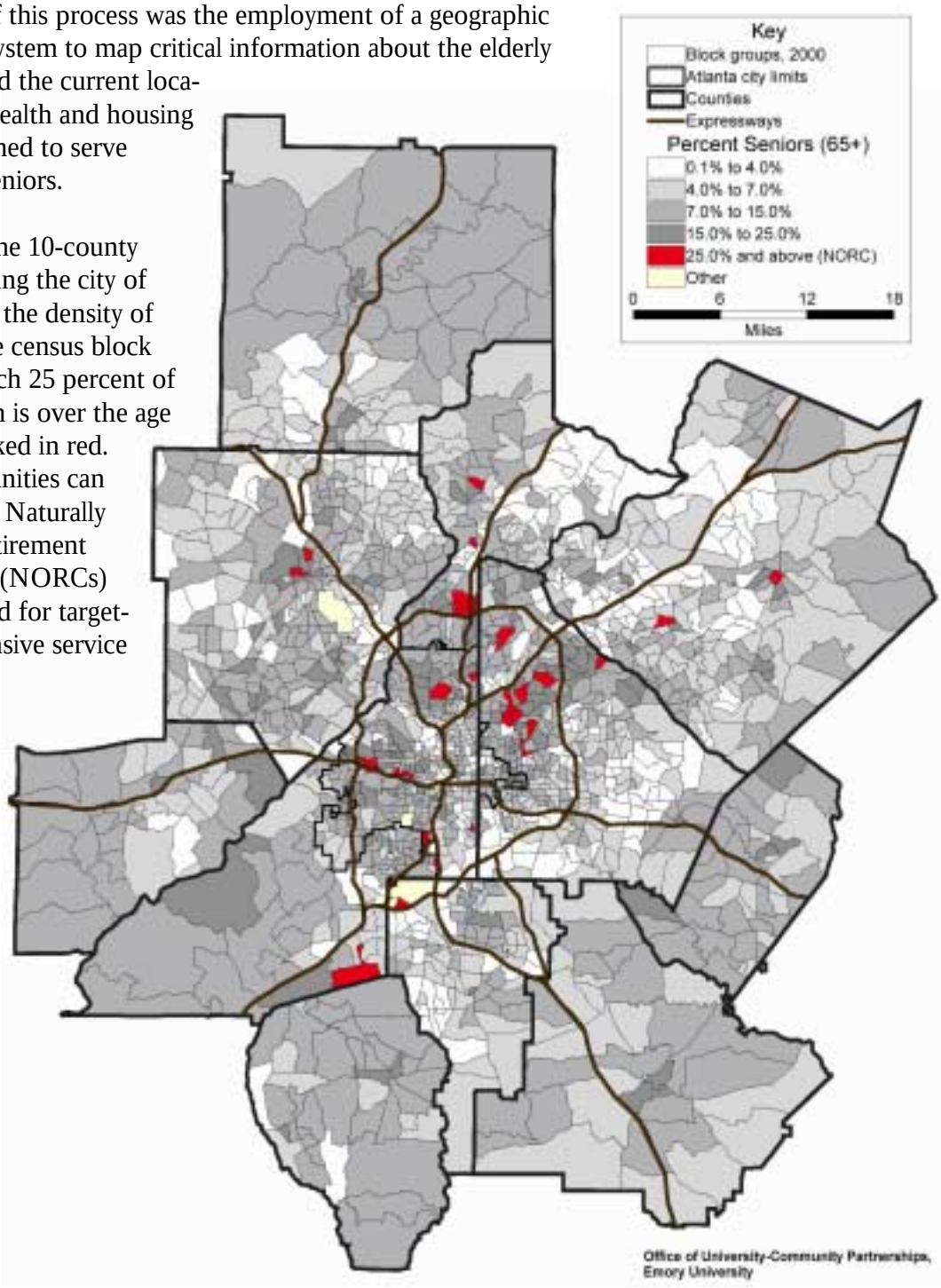
Statewide Community Assessment: Florida's Elder Community Program

This project is also in its early stages of development, but illustrates a state approach to keeping seniors in their homes and communities. This project empowers local communities to assess what aspects of their locality do not support senior residents and then prioritize the changes they are ready to make and fund.

Case Study: Using Geographic Information System Technology To Examine New Health and Housing Partnerships in Atlanta, GA

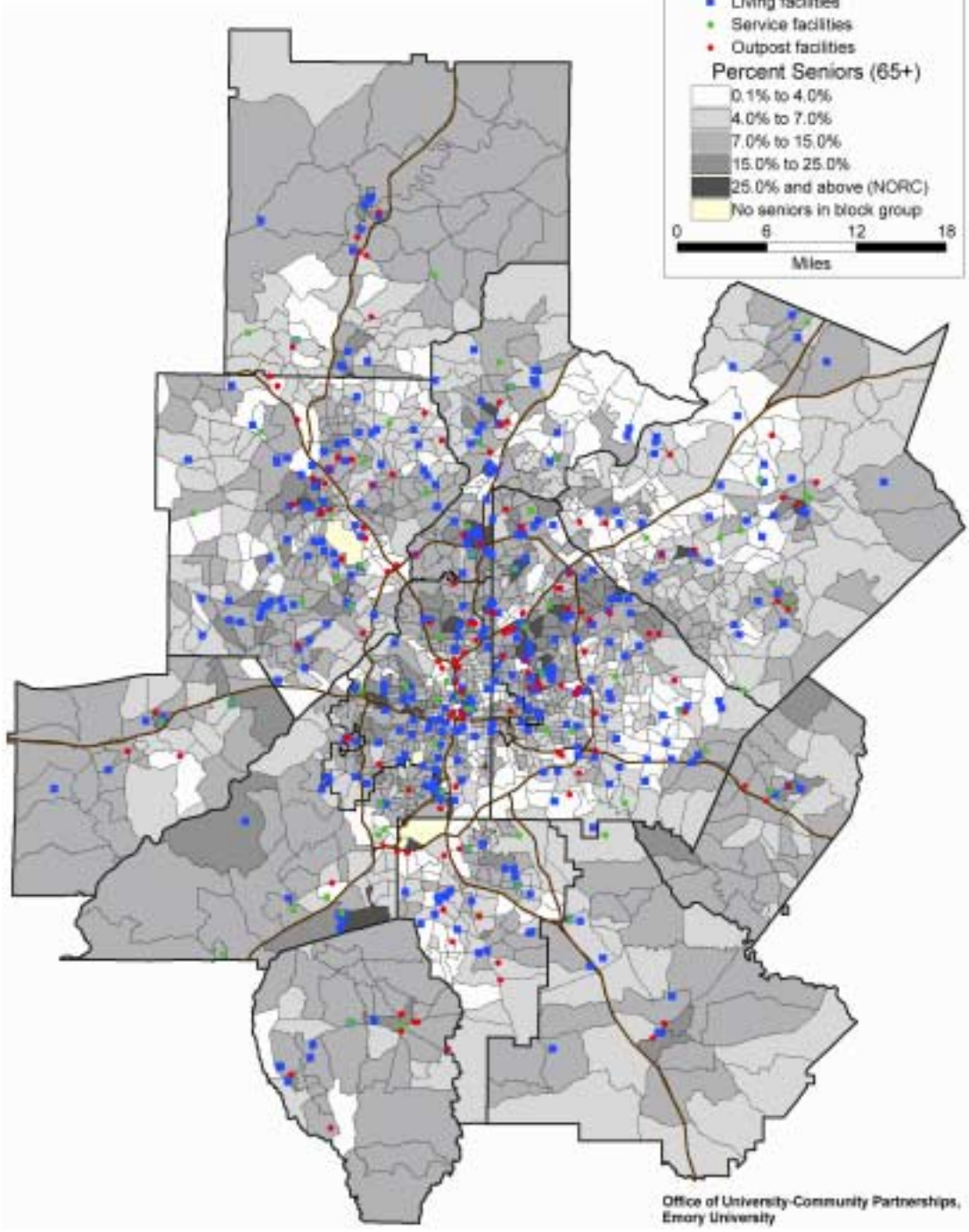
The Atlanta Regional Commission, Emory University and the Community Housing Resource Center partnered to develop a detailed toolkit outlining variety of tax, planning, zoning, housing and health policies to support seniors aging in place. The toolkit is designed to assist local government officials as they face the challenges of a growing elderly population. A critical component of this process was the employment of a geographic information system to map critical information about the elderly population and the current location of both health and housing services designed to serve the region's seniors.

This map of the 10-county region, including the city of Atlanta, maps the density of seniors. Those census block groups in which 25 percent of the population is over the age of 65 are marked in red. These communities can be considered Naturally Occurring Retirement Communities (NORCs) and considered for targeted comprehensive service delivery.



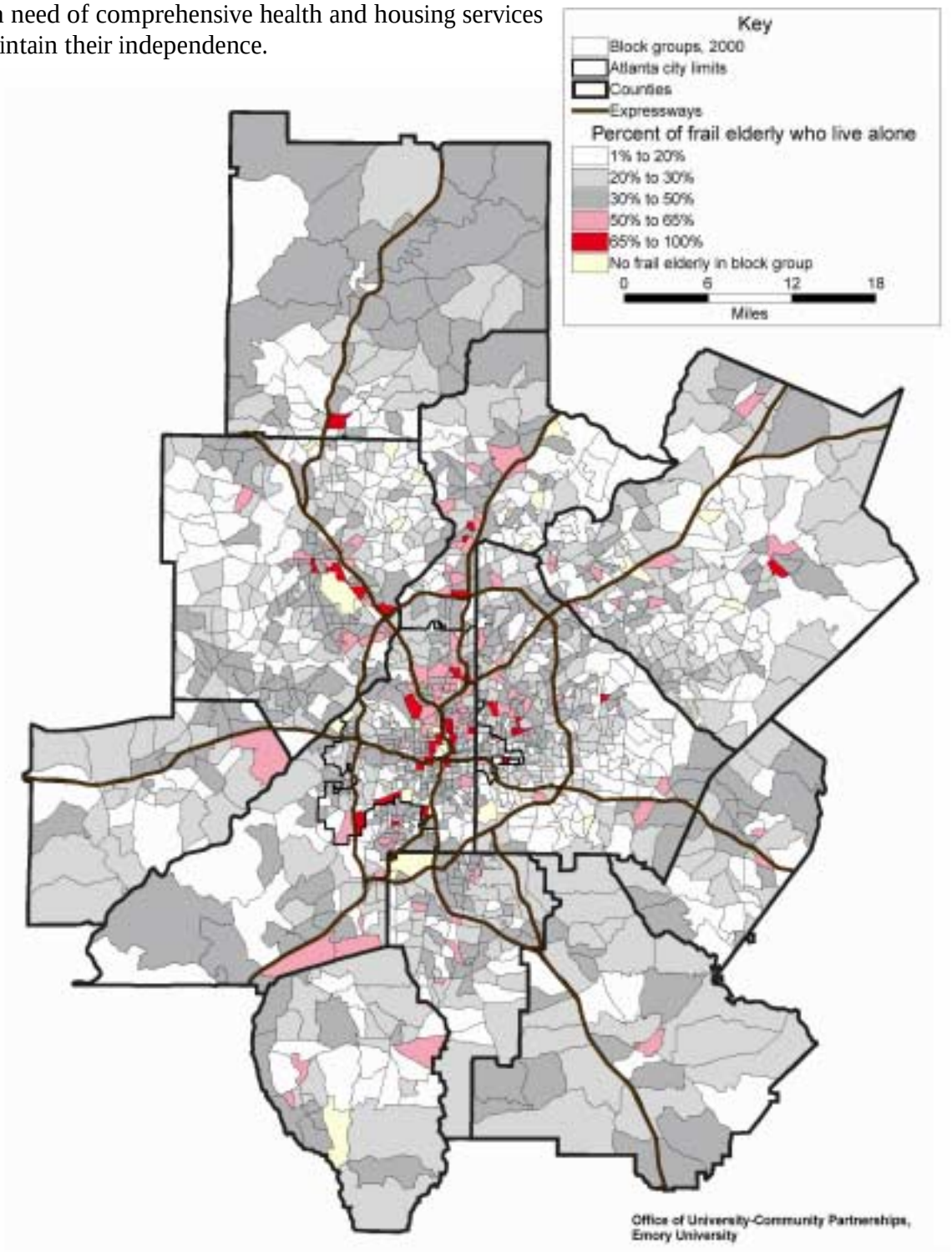
Locating Senior Health and Housing Providers

The locations of service providers and major senior living facilities are mapped throughout the 10-county region. Living facilities included nursing homes, continuing-care retirement communities, assisted-living facilities and HUD 202 buildings. Service facilities included senior centers and health clinics. Services which operate out of one location but serve a larger geographic area are indicated as outpost facilities. These included home-health services, Meals-on-Wheels programs and personal-care assistance.



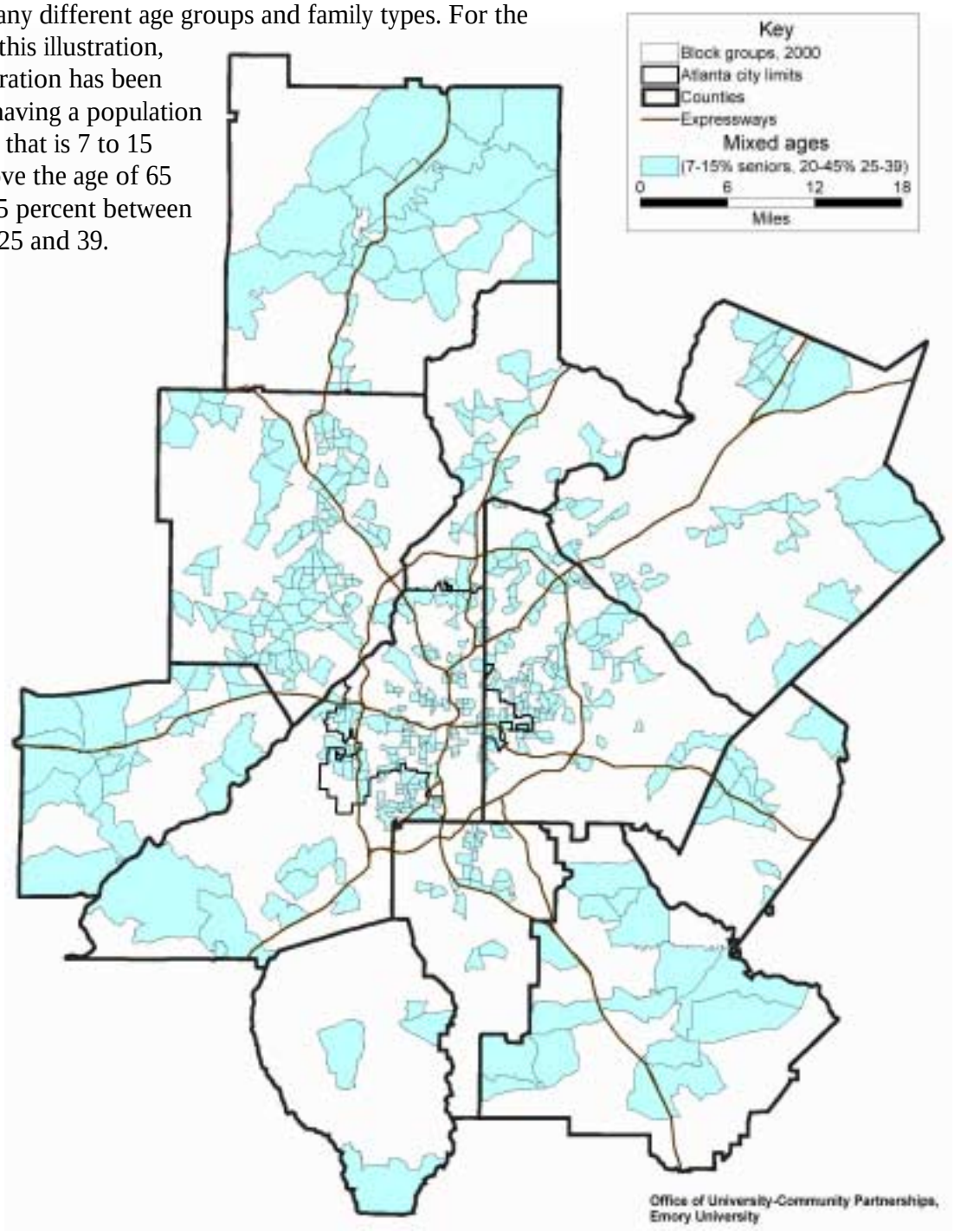
Frail Seniors Living Alone

This map of the 10-county region identifies census block groups with a high percentage of seniors above the age of 75 who are living alone. These seniors have been identified as high-risk and in need of comprehensive health and housing services to maintain their independence.



Mixed-Generation Communities

This map identifies which census blocks contain mixed-generation communities. Aging-in-place programs tend to be more successful when they occur in communities that are not all seniors, but have many different age groups and family types. For the purpose of this illustration, mixed-generation has been defined as having a population distribution that is 7 to 15 percent above the age of 65 and 20 to 45 percent between the ages of 25 and 39.



The detailed Regional Toolkit on Aging can be found at the Community Housing Resource Center's web site at www.chrcatlanta.org.

Case Study: Penn South NORC [43]

Introduction

Penn South is a cooperative housing development of 2,820 units and 6,200 residents in the Chelsea area of Manhattan in New York City. It is a moderate-income, nonprofit, limited-equity housing cooperative composed of 10 high-rise apartment buildings. Constructed by the International Ladies Garment Workers Union in 1962, Penn South has always been a place where a sense of common purpose could flourish. The co-op structure thrived at Penn South, not only providing a basis for collectively owning and managing property, but also serving as a vehicle for collective entrepreneurial endeavors, including their comprehensive aging-in-place programs.

Perhaps one of the most striking ventures undertaken by Penn South was the construction of its own electricity-generating facility. Through innovative and energy-efficient techniques, the co-op has been able to cut its utility costs by a third since removing itself from the city power grid — even after figuring in the amortized cost of constructing the facility. In addition to the power-plant venture, the co-op has developed several on-site commercial properties and an 800-car parking facility. These business ventures help support the co-op's $22,000,000 annual operating budget and keep the cost of housing low for its residents.

Penn South has developed a long track record of innovative endeavors to support collective living since it opened. It is not surprising that as Penn South's community began to reach its retirement years, the co-op board began to brainstorm on how the struggles inherent to aging could be met collectively.

Penn South Discovers the NORC Concept

By 1985, more than 75 percent of Penn South's population was over 60, and the co-op board began to investigate possible ventures to support the senior residents. As part of these investigations, the board came across the research of Michael Hunt and Gail Gunther-Hunt in which the term "Naturally Occurring Retirement Community," or NORC, was coined.

NORCs have generally been understood as buildings, apartment complexes, or neighborhoods, not originally planned for older people, where over time the majority of the residents have become elderly. The researchers recognized in a 1985 study that NORCs differ from the stereotypical retirement community, and "yet are the most common form of retirement community in the USA." According to the Hunts' study, Penn South did not need to transform itself into some form of senior housing complex; rather it already was a senior housing complex — a NORC — and simply needed to be recognized as one.

NORC Support: Penn South Program for Seniors and Penn South Social Services, Inc.

Once the Penn South Co-op had declared itself a NORC, the co-op board set up a special committee, the Penn South Program for Seniors (PSPS), charged with developing programs to

[43] From a July 2001 author interview with David Smith, and additional information from Bassuk, Karen and Nat Yalowitz. "Innovative Social Policies: The NORC Programs." Presentation to the Asia-Pacific Regional Conference for the International Year of Older Persons, Hong Kong; April, 1999.

forestall nursing-home placement and encourage the elderly to remain in their own homes among family, friends and caring neighbors.

PSPS selected three primary agencies to provide the programs and services to the NORC: Self-help Community Services, Inc., Jewish Home & Hospital for the Aged, Inc., and the Educational Alliances, Inc. UJA-Federation of New York, a major private philanthropic organization, contributed funds to assist the program. Many other social and health agencies in the community also agreed to bring their services to the co-op.

Within a few years of operation, PSPS had achieved a firm level of organizational integrity, acceptance within the co-op community, and recognition within the field. A new nonprofit corporation had been organized called Penn South Social Services, Inc. (PSSS) to assume the fiscal responsibility for and policy determination over PSPS. PSSS enabled the NORC to formally contract with social and health agencies and receive direct government and foundation grants. PSPS was now mobilized, sheltered within its own 501(c)3 organization, and gaining momentum. Soon both the acronyms "NORC" and "N-SSP" (NORC Supportive Service Program) would be written into state legislation.

From Seed Money to a Stable, Collective and Public-Minded Enterprise

In 1994, after a campaign spearheaded by PSPS, New York state passed legislation providing support for NORC Supportive Service Programs. The N-SSP legislation established a channel to fund housing and social services in a coordinated manner. The program sought to prevent costly housing problems common to senior residents, and strengthen intergenerational ties in the housing complex. It was endorsed by both political parties in the legislature and was approved by two governors of opposing political parties. As the result of the program's early successes, New York City also took an interest in NORC programs (and their highly organized blocks of voting constituents) and created its own local N-SSP legislation to supplement the state program.

Fourteen N-SSPs now operate in New York state under the N-SSP legislation and funding. These programs represent more than the self-serving demands of a senior population: they save public dollars by requiring each housing entity that requests state funds to match the grant with its own funds as well as philanthropic dollars. Each N-SSP is designed as a collaborative venture between New York state, a housing company, and social-service and health agencies. The N-SSPs often receive collateral benefits by providing attractive sites for private medical providers, home-care agencies, and other service providers. These private providers come to take advantage of the efficient service delivery produced by concentrated populations of seniors. As a result of partnerships with private providers, New York state dollars have leveraged almost four times as many dollars in private investment, above and beyond the required philanthropic match. According to the New York state legislature, N-SSPs saved the state an estimated $11 million over three years by forestalling 460 hospital stays and 317 nursing-home placements.

Summary

PSPS offers care coordination of services, group recreation, education, cultural and artistic programs, home-care coordination and non-acute nursing care, social day care for those with dementia, volunteer opportunities in all aspects of the program, health-education and preventive

services, money management and advocacy. Over 900 co-op members and over 1,200 non-member seniors utilize PSPS services and programs. Additional services to the community have been formed by Penn South Seniors, including school tutoring and intergenerational activities to help meet the community's child-care needs. The staff of social workers, nurses, and home-care coordinators has been supplemented by the presence of geriatric medical and psychiatric staffs from two nearby medical centers that opened offices in the co-op. Over 50 percent of the care coordination caseload is over 85 years of age and nearly 24 percent is over 90 years of age. At the center of all of this activity is a fairly simple catalyst: the Penn South residents asserted the value of their role in society, refused to be isolated from each other, and stayed in the neighborhood they called home.

Case Study: Florida's Elder Community Program

In March 2000, the state of Florida launched its Elder Ready Communities Program. Organized through the Office of Elder Affairs, this program offers communities around Florida the opportunity to assess their own facilities, services, housing stock and recreational activities, and develop a plan to improve the quality of life for current and future senior residents. While the state provides guidance to communities and furnishes assessment tools and a procedural framework, residents complete most of the work on the ground. This grassroots approach not only encourages residents to get involved, but allows those who live in the community to decide their own priorities and develop their own plans for making their community more elder-friendly. A community can decide to spend as much as or as little as they can afford to make improvements to their transportation, recreation or housing facilities and at a pace they can sustain, providing the maximum level of flexibility. Currently 23 communities are participating in the program and one grocery chain has become an elder-friendly business. The goal of the Office of Elder Affairs is to have all of Florida's communities Elder Ready by 2006.

Defining an Elder Friendly Community

Florida defined an Elder Friendly Community as a community "that creates a physical and emotional environment that celebrates positive aging, encourages self care and engages elders in a variety of activities. They are an open neighborhood, town or an entire city where intergenerational activities and bonding takes place; where interdependence and connectivity are the key ingredients. Elder Friendly Communities possess the infrastructure of services, the street designs, the leisure activities planning, the walkable streets, the consumer protection and zoning laws and elder friendly businesses and government agencies that enhance an elder's independence."

Purpose

The state of Florida designed the Elder Friendly Communities Initiative to raise awareness of the importance of considering the needs of older residents as part of the planning process, from older residents who are doing fairly well physically to the older resident with special medical and psychological needs. Older residents often have unique needs that are, in some cases, overlooked in the planning process, a process that begins with zoning laws, and continues with the architectural design of houses, buildings or facilities, development of transportation systems, recreational activities, street lighting and accessibility. As a result, Florida set three primary goals for the Elder Friendly Communities program:

- Increase the awareness of the value of elders to Florida's communities and the need to prepare for the projected growth of elders in the population.
- Create recognition that most of the planning ordinances and characteristics of a community that can make it elder ready are "invisible" and primarily decided at local levels.
- Assist communities in identifying the areas where they need improvement in order to become Elder Ready, using their own community standards.

Motivating Forces Behind the Elder Friendly Initiative

Florida developed its Elder Friendly Communities because it recognized the important role seniors play in the economy and social fabric of Florida and the demographic changes on the horizon.

Seniors are a major part the economy:

- Seniors have an annual income exceeding $2 trillion dollars and 50 percent discretionary spending power.
- Elderly residents own over 70 percent of the financial assets in America.
- Seniors control nearly $9 trillion in net worth.
- Senior citizens pay significant share of property and sales tax. In Florida seniors pay over $1.4 billion in local taxes and property taxes and $3 billion in sales tax.
- Florida's seniors support local schools with $1.1 billion in taxes.

Florida measured the social impact of its senior population:

- More than 1.7 million seniors are volunteering in Florida, providing more than 366 million volunteer hours per year at an estimated value of $4.4 billion.
- Seniors are actively engaged in philanthropic giving.
- Seniors provide an intergenerational benefit through their activities with Florida's youth population (for example, extensive mentoring programs throughout the state).

Along with the rest of the United States, the number of senior citizens in Florida will continue to grow in the coming decades. The projected demographic changes will have a significant impact on Florida's population:

- More than 50,000 residents retire to Florida every year.
- Elders are living longer, healthier lives and this trend will likely continue.
- In the 21st century, older people will out number children for the first time in history.
- Florida has the highest percentage of seniors of any state in the nation (nearly one in four persons in the state is above the age of 65) and this share is projected to increase.

Chief Components of the Elder Friendly Initiative

Key to the success of the program is the input of all community members, particularly the elderly. Through its Department of Elder Affairs the state facilitates the process, but the community carries out the bulk of the assessment and planning. The state acts as a catalyst and provides residents and local officials with the tools they need to assess their community, assists in the development of a proactive plan to resolve any elder "unfriendly" elements and issues an elder-friendly designation when the plan is carried out.

The community members and their elected officials are the motivating force behind the survey of facilities and determination of community priorities. A standing committee or Office of Elder Affairs is developed at the local level to organize the elder-friendly plan. An open meeting is held to explain the purpose and value of an elder-friendly designation. The local governing body must then pass a resolution stating the community's intent to become an elder-friendly community.

A survey instrument is developed which measures the impact of taxes, housing, utility costs, air and water quality, health-care costs and accessibility, and the rate of crime on elderly residents. Volunteer residents then measure the quality of life for seniors in the community by examining:

- Accessibility;
- Timing of traffic lights;
- Location and adequacy of parking (including handicapped parking);
- Taxi services;
- Public transportation service;
- Location of bus stops;
- Adequacy of street lighting;
- Pedestrian concerns (presence of benches and sidewalks, condition of sidewalks, well-marked crosswalks); and
- Land use and zoning procedures.

These measurements capture the different needs of both well and frail elders in an urban setting. Additional criteria are set for rural communities that include an evaluation of home-health services, caregiver services, availability of adult day-care centers, and assisted-living facilities.

Residents then work with the Department of Elder Affairs and local officials to report their findings and identify what the city or county needs to have in place to become Elder Ready. When those plans are complete, the state verifies that the community is Elder Ready and issues the Elder Ready designation.

The Elder Friendly Communities program is continuing to spread throughout Florida, and the state is well on its way to achieving the goal of 100 percent Elder Friendly Communities by 2006. The program will continue to evolve as more communities participate and add their input and experience to the assessment, planning and implementation process. Florida provides a compelling example of how a state or regional body can empower communities and local governments to improve the quality of life for their senior residents and to facilitate the programs and services needed to allow residents to age in place.

Conclusion

The vast majority of Americans wish to remain in their homes and their communities as they age. Keeping seniors in place maximizes their independence and capacity for self-help, maintains the social and economic value seniors contribute and decreases the inefficiencies of production-model care. As the elderly population continues to grow at a rapid pace, and in particular the frail elderly segment of the population (those over 75) triples in size, the current systems of elderly health and housing services will be heavily taxed. Better coordination of services and more efficient use of funds are essential to meet the growing demand.

The current systems of housing and health programs can be altered and turned around, conflicts can be ironed out and eligibility requirements can be sharpened to allow the separate funding streams to work in tandem. A more comprehensive approach would require reshaping the funding streams to reflect the interrelationship of health and housing services. A series of specific changes could begin the reorientation of health and housing funds toward, rather than away from one another.

- Create a resource pooling agency to combine health and housing resources at the state or local level.
- Eliminate major regulatory barriers that prevent the overlap of health and housing.
- Include housing in each state's Olmstead planning process.
- Recognize the assets of community-based organizations in coordinating health and housing services at the local level.

The stage is set for alternative long-term care strategies and solutions. Both health and housing providers articulate the need for each other. The challenge lies in finding the cost-saving incentives to bring the two sectors together in a unified service-delivery system that preserves the dignity and independence of seniors. If on the federal, state and, most importantly, local level we begin to look at health and housing, not as separate sectors which occasionally overlap, but as integral parts of a unified system, the growing number of seniors who desire to live in their homes and their communities will be able to.

Appendix: Range of Interventions Which Overlap Health and Housing Services

There are a number of models and terms used to describe programs that combine both health and housing services, some of which occur in segregated facilities and others, which provide services in an individual's residence.

Independent Living: Self-contained houses, townhouses or apartments which seniors either own or rent and where they function as members of the wider community. If they do receive any formal care and support such as homemaker service, home nursing, or Meals on Wheels, they (or a family member) make this decision themselves and organize the support.

Independent Living Supports: Programs that assist senior citizens in overcoming barriers to remaining in their own homes. These barriers include excessive housing expenditures, inadequate home maintenance and a low rate of home modifications to accommodate health or mobility limitations. Home-repair and -modification programs can eliminate or reduce the barriers to aging in place. In addition, they offer an effective means of avoiding or delaying costly institutional care while helping to preserve a community's valuable housing stock.

Facility Care: Living in a room, not a self-contained dwelling, and eating three meals a day communally. Typically bathrooms are shared and doors to residents' rooms cannot be locked. Facility care includes a full package of services, including nursing, housekeeping, laundry and meal service, and this package is rarely negotiable. Facility members are generally not members of a larger community.

Supportive Housing: Fills the gap between independent living and facility care. In the broadest sense it includes an array of housing with different support options. The essential features are security and help with everyday tasks when needed. Some types of supportive housing:

Homesharing: An arrangement by which a senior opens his or her home to another person wishing to share the accommodation and provide support and companionship. A third party usually matches the home provider and home sharer. Homesharing has the advantages of using the existing housing stock, providing affordable rental accommodation, and offering security to older people living alone.

Accessory Apartments: Apartments built into or onto existing housing stock. They can serve the needs of seniors who wish to live close to but not with their adult children. They have the advantages of both privacy and security. Zoning restrictions, however, have made the construction of accessory apartments illegal in many communities.

ECHO (Elderly Cottage Housing Opportunity): Small manufactured or constructed houses with one bedroom, which are placed on the property of a "host house"

whose water and electricity supply they tap into. They are intended, like the accessory apartments, to house the elderly relative of the occupant of the host house.

Naturally Occurring Retirement Communities (NORCs): The phrase "naturally occurring retirement community," coined in the 1980s by Michael Hunt and colleagues at the University of Wisconsin-Madison, originally referred primarily to areas that attracted, but were not planned for, older immigrants. More recently, the term has evolved to mean any building or neighborhood where more than 50 percent of the residents are over 60, or where a disproportionate number are over 60.

Assisted Living: Each state defines assisted living differently and many states do not recognize assisted living as a regulated form of supportive housing. In general, however, assisted living can be categorized as residential care that combines rental housing with supportive services. These supportive services can include personal care, linen services, housekeeping, meals, 24-hour oversight and medication supervision.

Selected Bibliography

Burkhardt, John. "Mobility Needs in a Maturing Society." *Coming of Age, Federal Agencies and the Longevity Revolution,* 1999.

Campbell, Jennifer. "Health Insurance Coverage." *Current Population Reports.* US Census Bureau, October 1999.

Chu, Gary and Jocelyn Pan. "Comprehensive Care for the Elderly: Is PACE the Answer?" *Harvard Health Policy Review,* Vol. 2, No. 1, Spring 2001.

Coleman, Barbara. "Trends in Medicaid Long-Term Care Spending." AARP, January 1999.

Department of Housing and Urban Development. *Housing Our Elders.* November 1999.

Feder, Judith, Harriet Komisar and Marlene Niefield. "Long-Term Care in the United States: An Overview." *Health Affairs,* Vol. 19, No. 3, May/June 2000.

Federal Committee for the International Year of Older Persons. "Coming of Age: Federal Agencies and the Longevity Revolution." White House, 1999.

Fox-Grage, Wendy. *The States' Response to the Olmstead Decision: A Status Report.* National Conference of State Legislatures, March 2001.

Golant, Stephen. "Housing the Poor and the Vulnerable Elderly." *Shelterforce,* January 2000.

Heumann, Leonard, et al. *1999 National Survey of Section 202 Elderly Housing.* AARP, January 2001.

Kaiser Commission on Medicaid and the Uninsured. *Medicaid Eligibility for the Elderly.* May 1999.

Kane, Rosalie. "Long-Term Care and a Good Quality of Life: Bringing Them Closer Together." *The Gerontologist,* June 2001.

Kassner, Enid, et al. *Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community-Based Waiver and Nursing Home Services.* AARP Public Policy Institute, April 2000.

Kennedy School of Government. "Elder CHOICE." Innovations in American Government summary of awards, 1995.

Knack, Ruth. "Gray is Good." *Planning,* August 1996.

Kochera, Andrew. *A Summary of Federal Rental Housing Programs.* AARP Public Policy Institute, May 2001.

Kutty, Nandinee. "Aging-in-Place Strategies." Paper prepared for the Twenty-first Annual Research Conference of the Association for Public Policy Analysis and Management, November 1999.

Louie, Josephine. *Home Modifications for Disabled Elderly Households.* Harvard University Joint Center for Housing Studies, W99-8, September 1999.

National Center on Health Statistics. *Health Insurance Coverage.* Fact sheet.

Newman, Sandra. "Housing Policy and Home-Based Care." *The Milbank Quarterly,* Vol. 7, No. 3, 1995.

Newman, Sandra, et al. *The Effects of Supports on Sustaining Older Disabled Persons in the Community.* AARP, September 1995.

————. "Overwhelming Odds: Caregiving and the Risk of Institutionalization." *The Gerontology Society of America,* Vol. 45, No. 5.

Raetzman, Susan and Susan Joseph. "Long-Term Care in New York: Innovation in Care for Elderly and Disabled People." *The Commonwealth Fund,* September 1999.

Schafer, Robert. *America's Elderly Population and Their Need for Supportive Services.* Harvard University Joint Center for Housing Studies, W99-3, January 1999.

————. *Housing America's Elderly Population.* Harvard University Joint Center for Housing Studies, W99-4, January 1999.

Schneider, Andy. *Medicaid Eligibility for the Elderly.* Kaiser Commission on Medicaid and the Uninsured, May 1999.

Smith, Gary, et al. *Understanding Medicaid Home and Community Services: A Primer.* Department of Health and Human Services, October 2000.

Smith, Ray. "Assisted Living Firms Grapple with Oversupply." *Wall Street Journal,* April 18, 2001.

Stanfield, Rochelle. "Aging of America." *National Journal,* July 20, 1996.

Tu, Trang. *Market Study for Affordable Assisted Living in Dorchester, Massachusetts.* Codman Square Community Development Corporation, September 1996.

Author Interviews

All interviews were conducted by the author between June 15 and August 25, 2001.

Alani, Dina
Commission on Affordable Housing and Heath Facility Needs for Seniors
Washington, DC

Apfel, Ken
LBJ School of Public Policy
Austin, Texas

Aquil, Askia Muhammad
St. Petersburg Neighborhood Housing Services
St. Petersburg, Florida

Ball, Scott
Community Housing Resource Center
Atlanta, Georgia

Belling, Browyn
AARP
Washington, DC

Bellware, Carrie
Atlanta Jewish Family and Career Services
Atlanta, Georgia

Bluth, Dora
New York State Medicaid Office
Albany, New York

Brice, Barbara
Georgia Division of Aging
Atlanta, Georgia

Clingman, Elaine
St. Mary's Development Corporation
Dayton, Ohio

Cohn, Jodi
SCAN Health Plan
Los Angeles, CA

Creeden, Frank
Massachusetts Housing Finance Authority
Boston, Massachusetts

Ellwood, David
Kennedy School of Government
Cambridge, Massachusetts

Faigan, Jenn
Cambridge Housing Authority
Cambridge, Massachusetts

Feder, Judy
Georgetown Public Policy Institute
Washington, DC

Feidlander, Joy
Housing Partnership
West Palm Beach, Florida

Ferris, Jim
Housing Resource Group
Seattle, Washington

Friedman, Evelyn
Nuestra Comunidad Development Corporation
Roxbury, Massachusetts

Galdera, Fran
Nursing Home Without Walls
Honolulu, Hawaii

Garcia, Rose
Tierra Del Sol Housing Corporation
Las Cruces, New Mexico

Garvin, Marianne
Long Island CDC
Centreach, New York

Gilette, Robert
American House Senior Living Residences
Bloomfield Hills, Michigan

Goldfarb, David
Goldfarb & Abrandt
New York, New York

Haas, Matthew
National Equity Fund
Chicago, Illinois

Holder, Gerard
Comission on Affordable Housing and Heath Facility Needs for Seniors
Washington, DC

Hollies, David
HomeConnections
Silver Spring, Maryland

Jenkins, Robert
NCB Development Corporation
Washington, DC

Justa, Francine
Neighborhood Housing Services of New York City, Inc.
New York, New York

Katz, Bruce
Brookings Institute
Washington, DC

Kleyman, Paul
American Society on Aging
San Francisco, California

Kliger, Cheryl
Goddard Riverside
New York, New York

Knepper, Sydelle
Knepper & Associates
New York, New York

Lay, Tom
Neighborhood Housing Services of Boise, Inc.
Boise, Idaho

Lewis, Teresa
CSP of West Alabama
Tuscaloosa, Alabama

Lowe, Eugene
U.S. Conference of Mayors
Washington, DC

Mason, Jeff
Healing Homes
Tiverton, Rhode Island

Maxwell, Kathleen
Rural Ulster Preservation Company
Kingston, New York

McNickles, Larry
American Association of Homes and Services for the Aging
Washington, DC

Merels, Peter
Southeast Senior Housing Initiative
Baltimore, Maryland

Mollica, Bob
National Academy for State Health Policy
Portland, Maine

Mull, Brenda
Department of Housing and Urban Development
Atlanta, Georgia

O'Neill, Kevin
Housing Resources of Columbia County
Hudson, New York

Overton, Julie
Ethel Percy Andrus Gerontology Center

Payne, Jack
Department of Housing and Urban Development
Washington, DC

Pepper, Pat
Campbell Stone Apartments
Atlanta, Georgia

Pepper, Cliff
Campbell Stone North
Atlanta, Georgia

Preede, Kevin
American Senior Housing Association
Washington, DC

Puckett, Ann
University of Georgia
Athens, Georgia

Reavis, Bob
Department of Housing and Urban Development
Atlanta, Georgia

Rhymer, Robbie
Symbion Health Services
Atlanta, Georgia

Rosenburg, Barbara
Atlanta Jewish Family and Career Services
Atlanta, Georgia

Rothman, Max
Center on Aging at Florida International University
Miami, Florida

Sackman, Bobbie
Council of Senior Services
New York, New York

Slotzberg, Claudia
U.S. Department of Health and Human Services
Washington, DC

Smith, David
Mutual Redevelopment Houses, Inc.
New York, New York

Sprague, Diane
Minnesota Housing Finance Agency
St. Paul, Minnesota

Spurgeon, Ned
University of Georgia
Athens, Georgia

Valdez, Rosa
Cen-Tex Certified Development Corporation
Austin, Texas

Williams, Aretha
Department of Housing and Urban Development
Washington, DC

Yaltowitz, Nat
Mutual Redevelopment Houses, Inc.
New York, New York

Neighborhood Reinvestment Corporation
1325 G Street, NW, Suite 800
Washington, DC 20005
(202) 220-2300
www.nw.org

Joint Center for Housing Studies
Harvard University
1033 Massachusetts Avenue
Cambridge, MA 02138
(617) 495-7908
www.jchs.harvard.edu