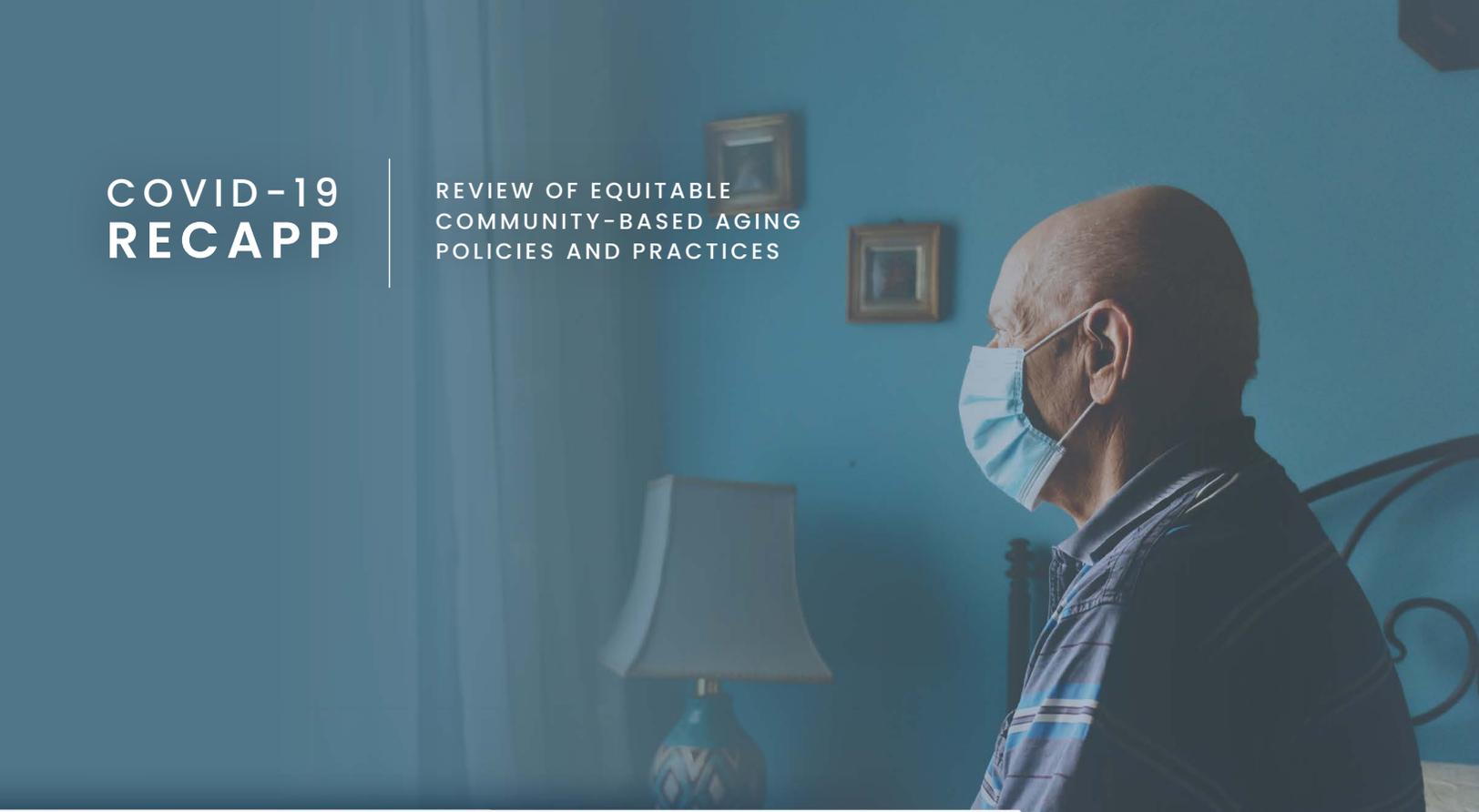


COVID-19 RECAP

REVIEW OF EQUITABLE
COMMUNITY-BASED AGING
POLICIES AND PRACTICES



ADVANCING HOUSING AND HEALTH EQUITY FOR OLDER ADULTS:

PANDEMIC INNOVATIONS
AND POLICY IDEAS



ADVANCING HOUSING AND HEALTH EQUITY FOR OLDER ADULTS: PANDEMIC INNOVATIONS AND POLICY IDEAS

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PHOTO CREDITS

Photos in this report come from the Centre for Ageing Better, The New York Academy of Medicine, Getty, and Shutterstock.

PRINCIPAL FUNDING FOR THIS REPORT WAS PROVIDED BY RRF FOUNDATION FOR AGING

The authors would like to thank the representatives of organizations and agencies who contributed to the research through interviews and case studies, as well as members of the Housing, Public Health, and Aging Network for their thoughtful contributions through all phases of research and development of this report.

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Thank you also to Lillian Picou and Aashna Lal for helping with the research for this report.

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For more information on the COVID-19 Review of Equitable Community-Based Aging Policies and Practices (RECAPP) project, visit our website at www.jchs.harvard.edu/research/aging/covid-19-recapp.

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EXECUTIVE SUMMARY

As the COVID-19 pandemic upended daily life around the globe, older adults, who were at highest risk for severe illness and death, faced disruptions in social routines and access to food, medications, and services. Organizations that support low- and moderate-income older people dwelling in the community—including housing and service providers, voluntary organizations, and government agencies—improvised solutions to address these challenges, while also emphasizing the importance of stable housing itself.

These responses offer lessons for improving housing and housing-related services over the long term. We explored these responses in COVID-19 RECAPP (Review of Equitable Community-based Aging Policies and Practices), a project of the Joint Center for Housing Studies and The Hastings Center. Drawing from more than 200 examples of housing-focused responses nationwide, and informed by a diverse network of policymakers, practitioners, advocates, and researchers, we developed the following observations and recommendations:

- Interorganizational networks, particularly those with a focus on aging, played a foundational role in response by facilitating information sharing, conducting advocacy, and delivering goods and services. Nurturing networks and leadership development at trusted local organizations can benefit older adults in typical times as well as emergencies.
- Engaging older adults in planning processes and collaborating with them on responses enhanced effectiveness and equity. Local organizations are well-positioned to solicit input and engage older adults, but often need support to sustain their work.
- Flexible regulations and adequate funding expanded access to programs that fulfilled older adults' needs. Demand for resources including affordable housing, nutritious food, and medical care predated the pandemic and persists today. Additional research is needed to assess the potential for extending temporary administrative relief over the long term.
- Service delivery to the home demonstrated the value of locating supports where older people live.

In senior housing, service coordinators played a crucial role in identifying older residents' evolving needs and connecting them to information, goods, and services. The benefits of high-quality residential service coordination should be made available to more older adults living in the community.

- During the pandemic, the physical home was a vital link to resources. Going forward, age-focused housing design and community planning must be informed by an expanded concept of accessibility, acknowledgement that internet access is now a basic utility, and neighborhood design that is inclusive of older adults and caregivers.
- Despite progress, barriers to coordination and collaboration among the housing, social service, and healthcare sectors remain. This has resulted in a patchwork of programs that often only partially meet the needs of low- and moderate-income older adults. Greater collaboration is needed to serve goals such as creating an adequate supply of affordable housing for older adults.

The COVID-19 RECAPP project employed a “housing lens” to reflect the importance of homes and neighborhoods to older adults' health and wellbeing. A housing lens focuses on the affordability, accessibility, safety, and suitability of the home, including services provided there. It highlights the difficulties many face paying for both housing and care and the practical challenges involved in remaining in one's home and community. By advocating for the use of a housing lens in policy analysis and development, we hope to reframe our collective narrative on aging to recognize the social and health implications of the home in an aging society.

CHAPTER ONE

INTRODUCTION



In addition to its devastating effects on health and mortality, the COVID-19 pandemic produced a complex and interconnected set of social challenges across the United States that continues to evolve today. In the early months of the pandemic, physical distancing helped to reduce disease transmission but increased social isolation and produced economic hardships through shuttered businesses and lost wages. Solutions to these difficulties—which were typically improvised quickly—often led to new challenges. The expanded use of telehealth, for example, reduced risks of exposure to COVID-19 but required home access to broadband and computer or smartphone technologies, as well as the ability to learn how to use new applications with limited technical support. Equitable access to healthcare during the pandemic has thus required addressing disparities in digital access that existed long before March 2020.

Older adults (in this report, those age 65 and over) were particularly at risk for severe illness, hospitalization, and death from COVID-19 and also susceptible to the disruptions it created. For those dwelling in the community, obtaining food, medication, and other basic goods in the early days of the pandemic may have involved paying for shopping and delivery services; relying on neighbors, family, or community groups; visiting stores with special shopping hours; or all of these. Older adults who relied on home health aides and other in-home assistance experienced care disruptions when workers were unable to leave their own homes due to illness, quarantine, or caregiving responsibilities, or when managers of senior housing restricted access by non-residents. Social isolation, a problem before the pandemic, was exacerbated by physical distancing guidelines. Other longstanding challenges, including the lack of affordable, accessible, safe, and suitable housing for older adults, became more difficult to address under pandemic conditions and with the rising costs of housing and building materials.

Responding to the needs of older adults at home during a prolonged public health emergency revealed anew the deep disparities in access to housing and supports in America's aging society. Millions of older adults with limited income had few resources with which to ease the strain of social isolation, ensure delivery of needed goods and services, or weather financial shocks to their own households or those of family. This includes the vast “middle” population of older Americans who struggle to pay for both their housing and their unreimbursed care—services and supports not covered by Medicare or private insurers—yet who do not qualify for subsidies designed for low-income households.¹

Organizations involved in meeting the needs of older adults residing in the community—including housing providers; service providers; age-focused departments of state, regional, and local governments; community groups; and coalitions such as age-friendly initiatives—had to innovate to respond to new needs during the pandemic as well as underlying inequities.

The goal of this report is to capture lessons from these efforts. **What can we learn from the promising practices that emerged from this crisis to support older adults at home?** How should we study and apply these temporary fixes and policies going forward to meet the long-term housing needs of all older adults? Because many responses required creative workarounds to administrative barriers and lack of coordination between housing and service programs, we also sought to identify ongoing challenges that frustrate effective and equitable support for those aging with modest financial resources.

Below we describe the research approach and key concepts informing this report. Subsequent sections describe the “stress test” effect of the pandemic on housing, care, and community infrastructure, focusing on impacts for older adults; how public and private sectors responded to these needs; and lessons we have drawn from these responses. We offer recommendations targeted to service providers, public and foundation funders, and other actors concerning practical courses of action to support the housing and housing-focused services our society needs. We also discuss ongoing impediments to building a more equitable future for older adults, including ways of thinking about housing that stymie progress. Throughout, we offer examples of pandemic-era practices drawn from our research. Finally, we conclude with a set of deep dives into several responses that informed the report.

RESEARCH APPROACH

This report focuses on practices and policies that emerged during COVID-19 to respond to the needs of community-dwelling moderate- and low-income older adults. While an array of responses benefited people of all ages, such as eviction moratoriums, we focus on those designed primarily to meet the needs of older adults. We also look specifically at housing-focused policies and programs, including services delivered to people in their homes to help them meet their day-to-day needs. Thus, our analysis covers programs to deliver food and other necessities, provide medical care in the home, support caregivers, improve in-home internet access, and offer social engagement opportunities. We also examine how preexisting programs altered their practices to continue under pandemic conditions.

Our research began in 2021 with a scan of materials describing practices and policies put in place around the United States (but including examples from Canada and other nations) that addressed the needs of older adults during the pandemic. We excluded examples from nursing homes, assisted living facilities, and other residential care settings.² The scan covered “gray literature”—publicly available materials such as reports, working papers, e-newsletters, policy guidance, and program descriptions from websites, social media, and webinars that are not typically indexed in academic databases. In our case, relevant materials were often created by nonprofit and government housing and service providers, philanthropic organizations, think tanks, and community groups. We conferred with policymakers and practitioners to gather information about programs and policy approaches across different settings and regions, especially rural areas.

Our search also included academic literature relevant to our topic, although most of the practices and policies we were learning about had yet to be formally studied. This work resulted in an archive of approximately 200 descriptions of pandemic interventions.

The timing of our scan enabled us to capture descriptions of programs and policies put in place at the height of stay-at-home orders and shutdowns, as well as some practices which emerged after the introduction of vaccines. It concluded at the end of 2021. Beginning in January 2022, we closely analyzed these descriptive materials to identify the problems they sought to address, the populations they served, the types of interventions they utilized, and any data on outcomes. In consultation with our Housing, Aging, and Health Research Network (see box to the right), we extracted lessons for public and private sector organizations at the federal, state, and local levels. The Network further supported the drafting and refinement of actionable recommendations for post-pandemic policymaking and practice.

For a detailed description of methods, see [Appendix A](#).

THE HOUSING LENS: RECOGNIZING THE CENTRALITY OF HOUSING TO EQUITABLE AGING

We approached our research using a **housing lens**, a concept that recognizes and focuses on residential settings as critically important to older adults' overall wellbeing, including their physical and mental health, financial security, and social engagement.³ Residential setting includes a person's housing, their neighborhood and community, and the significance of those spaces to the individual, including the meaning of "home" itself.

THE HOUSING, AGING, AND HEALTH RESEARCH NETWORK

The Housing an Aging Society program of the Joint Center for Housing Studies (JCHS) at Harvard University and the Bioethics for Aging Societies program of The Hastings Center, an independent research institute, share a commitment to understanding how housing, community, and the built environment shape health and wellbeing for older adults and to translating knowledge into recommendations and resources for policy and social innovations that meet the needs of America's aging society (Berlinger, de Medeiros, and Girling 2021). One outcome of this ongoing collaboration was the creation, in May 2020, of the Housing, Aging, and Health Research Network as a standing working group of experts on age-focused research, practice, and policy relevant to the housing needs of older Americans. This publication reports on the first full research collaboration of these institutions and the Network.

DEFINITION

Affordable, accessible, safe, and suitable housing is important for people of all ages. Here, **affordability** broadly indicates housing costs that are sustainable in relation to household income and to spending on food, healthcare, and other necessities. **Accessibility** and **safety** refer to a home environment that residents can enter, navigate, and exit without difficulty or fear of physical injury or harm. **Suitability** includes other aspects of a home that satisfy residents' preferences and needs. See [Appendix B](#) for a glossary of terms.



Research has established the positive health effects of safe and affordable housing, neighborhood amenities, and access to services like transportation.⁴ For older adults, the residential environment influences opportunities to engage socially and live independently. The home itself may take on new roles as needs evolve, including as a site of care and a platform for receiving services and supports.

The pandemic further highlighted the importance of the “housing-health connection,” and of living in a place that supports one’s wellbeing and does not pose risks to health. This connection was particularly salient prior to the rollout of vaccines, when people of all ages limited risk by remaining at home. Certain types of housing were associated with increased risk of COVID-19 infection, notably nursing homes, shelters and other congregate facilities, and overcrowded, often multigenerational households.⁵ At the same time, as lost income imperiled housing stability for millions of households, the implementation of eviction moratoriums conveyed the immense risks to life and health that could result from loss of housing during a pandemic. The housing lens underscores how housing can support—or undermine—health and wellbeing, and highlights inadequacies and inequities in our nation’s approach to housing and supporting America’s aging society.

Aging in place, which generally refers to a desire to remain as long as possible in one’s current home or community and to avoid institutional care, is a widely shared goal among older adults. However, many older adults cannot afford the housing and services they need to age in place, such as assistance with household tasks or personal care, which are not always covered by medical insurers or government programs (Davis 2021; Forsyth and Molinsky 2021).⁶ A housing lens centers the affordability, accessibility, safety, and suitability of the home, including services provided in the home, in our understanding of aging in place. It highlights the connections between a person’s housing, their care needs, their ability to afford housing and care, and other practicalities involved in remaining in one’s home and community.

A housing lens also helps focus attention on disparities in people's capacities to live securely and safely in older age, many of which result from unequal access to housing across generations. A long history of racial discrimination in the real estate market and housing finance—often codified through government policies—have restricted housing options and housing quality for Black Americans, while white Americans have received more opportunities to buy homes in communities where housing increased in value. These policies, along with subsequent patterns of public investment and disinvestment that prioritized white communities and withdrew resources from communities of color, have resulted in nationwide residential segregation and vast socioeconomic disparities between geographically close neighborhoods (Rothstein 2017). Policies that limited access to mortgages and investment in neighborhoods of color also limited Black Americans' ability to use homebuying as a tool for investment, inhibiting intergenerational wealth transfer and resulting in starkly different financial resources in late life by race (Oliver and Shapiro 2013). These housing-related factors are crucial to understanding and responding to health disparities which disproportionately impact people of color (Diez Roux and Mair 2010; Swope and Hernández 2019).

Data also show how disadvantages accumulate during a person's working life. Lack of access to jobs with pensions, to "good" health insurance, or to the savings and financing needed to buy a home will profoundly affect a person's options in late life. Chronic disease and disabilities can reduce earnings and increase medical expenses, impeding economic security (Thorpe et al. 2017). Health disparities and longevity itself are shaped by where people live and the networks to which they have access (Abramson 2016). When developing policy, designing programs, or studying outcomes to better meet older adults' needs, a housing lens reminds us to start by recognizing the role of residential setting in health and access to resources—over a lifetime and in old age—and the

inequities that leave millions struggling to secure affordable housing and care. The goal of "healthy longevity" will be elusive for many older Americans so long as these impediments remain.⁷

Policymakers and practitioners involved in housing advocacy, policy, and research, or in its design, development, and operation, likely already use a housing lens in their work. They begin with residential setting when they consider the needs of individuals, and perhaps even more commonly, households. Readers who are not "housers" will also benefit from this perspective. Policymakers, practitioners, and researchers in public health, health policy, geriatric healthcare, and other fields can use the housing lens to better understand how place, and the specifics of housing and neighborhood, support or undermine health and wellbeing in late life.

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

As noted, the goal of this project was to identify lessons from pandemic responses that might reduce well-documented disparities in access to suitable housing, services, and supports that enable people to remain in the residential setting of their choosing for as long as possible. The pandemic also highlighted needs that deserve greater attention going forward. These include gaps in home-based services and safe, accessible housing, as well as roadblocks to progress like the mismatch between housing and service programs and policies.

Our lessons reflect broad observations about pandemic responses, as well as the factors that facilitated or impeded their implementation, that are useful to all types of actors. These are followed by forward-looking recommendations aimed more specifically at funders (including government agencies and philanthropic organizations), housing and service providers, advocates, and community groups.

TABLE 1. SUMMARY OF OBSERVATIONS AND RECOMMENDATIONS

OBSERVATIONS	MAIN ACTORS	RECOMMENDATIONS
Networks and partnerships were essential to efficient and equitable response	Funders (including government agencies and foundations)	<p>Nurture the development of networks</p> <ul style="list-style-type: none"> • Value networks in funding decisions • Support inclusive network-building • Fund and support innovative partnerships, particularly those emerging from pilot projects • Reconsider restrictions on funding advocacy activities that may be necessary to support equitable aging in community <p>Invest in leadership development and organizational stability of trusted local organizations</p>
Collaboration with older adults contributed key perspectives and supported civic participation	Public, private, and nonprofit entities engaged in planning; funders	<p>Include older adults, people with disabilities, and caregivers in planning for foreseeable emergencies</p> <ul style="list-style-type: none"> • Solicit public input through trusted local organizations and inclusive outreach • Support leadership training for older adults • Inform planning efforts with accurate data on older residents' needs
Pandemic responses relied on flexibility in regulations and funding	Government agencies	Study outcomes of regulatory and administrative flexibility under emergency conditions; make permanent changes where they will support improved outcomes under typical conditions
Successful responses brought services to the home	Federal agencies, state and local networks of housing and service providers	<p>Prioritize coordination of services</p> <ul style="list-style-type: none"> • Adequately fund service coordination in publicly-assisted housing • Explore lessons around service coordination from publicly-assisted housing for community-dwelling older adults • Leverage networks to build “no wrong door” approaches to service access
Design of homes and neighborhoods shaped access to resources	Funders, planners, architects, developers, providers of housing	<p>Build accessibility and equity considerations into the design and renovation of homes and neighborhoods</p> <ul style="list-style-type: none"> • Expand concepts of accessibility • Consider broadband access a basic utility • Focus on inclusive neighborhood infrastructure
Barriers to coordination and collaboration across housing, social service, and healthcare sectors impeded effective responses	Federal agencies, state and local agencies, grantmakers, research centers	<p>Strengthen the connections between housing, healthcare, and social service programs</p> <ul style="list-style-type: none"> • Create forums for collaboration, shared data and analysis • Coordinate subsidies and incentives • Change the narrative

CHAPTER TWO

THE PANDEMIC AS STRESS TEST



The pandemic stress-tested all systems of housing and housing-related supports for older adults, exposing gaps and often exacerbating existing disparities. This section reviews major challenges that existed before the pandemic in three interrelated areas: housing, community infrastructure supporting older adults, and access to different forms of care provided in the home. It also examines how the pandemic made these challenges more urgent.

HOME

The US lacks a comprehensive approach to housing its aging society. There is broad recognition that most older adults want to “age in place.” However, our public policies, and the community-level decisions involving public and private actors that shape how housing is planned and built, are not sufficiently coordinated or robust to ensure that our nation’s housing stock meets the needs of millions of low- and middle-income older adults.

AFFORDABILITY AND STABILITY

According to analysis by the Joint Center for Housing Studies, as of 2019, over 10 million households headed by an individual age 65 or older spent more than a third of their income on housing. This phenomenon is often referred to as being housing cost-burdened. Half of these households paid more than 50 percent of their income for housing costs. Rates of cost burden are higher among older households headed by a person of color, as well as renters and those with low incomes. Cost burdens are also more prevalent among people in their 80s and above, as incomes decline and housing costs—including rent or mortgage payments as well as utilities and, for owners, property insurance and taxes—may rise. Older renters, often on fixed incomes, are

particularly at risk from rising housing costs, and in recent years, housing costs have risen faster than Social Security cost-of-living adjustments (Joint Center for Housing Studies 2018). Renters also have a much smaller personal safety net than owners: in 2019, the median older renter had a net wealth under \$6,000.⁸

At last measure in 2019, over 2.2 million older, very low-income renter households (those earning under 50 percent of the area median income) had “worst case housing needs,” defined as having severe cost burdens, living in severely inadequate housing, or both (Alvarez and Steffen 2021). Yet housing subsidies are not guaranteed: in 2020, only 39 percent of older adults who qualified for rental assistance through federal subsidies based on low income received it (PAHRC 2021).⁹ Those who qualify but do not receive housing assistance often pay excessive rents compared to their income, double up with others, or live in housing poorly suited to their needs.

The pandemic exacerbated affordability challenges for many older households that lost income as the economy slowed in 2020. As of 2019, 11 million older adults had been employed in the labor force at some point in the prior year (Hermann and Molinsky 2020). This included 2.8 million people who worked in sectors most at risk of losses during COVID-19, such as retail, transportation, and personal service.

Many older workers lost income during the pandemic, either through cuts to their own wages or those of household members, with disproportionate losses among older households of color (Generations United 2021; Gould 2021).

People who struggled to pay for housing during the pandemic also often faced food insecurity and difficulty covering other expenses (Hu 2022). Beyond the direct health implications of being unable to afford food or out-of-pocket medical expenses, being behind on housing payments or having low or no confidence one will be able to pay for housing in the next month has been associated with psychological distress and poor self-rated health (Linton et al. 2021).

“I’m an outdoor person and I’m used to getting out. It’s so confining to be here and not be able to do anything. I can’t walk down the steps well now and I’m not getting enough exercise. The pain has gotten worse during the pandemic because I can’t get out and move around as much.”

OLDER WOMAN, DETROIT



THE PHYSICAL HOME

Beyond housing affordability, two features of a physical home that are integral to aging in place are accessibility and safety. Accessibility features can support independent living for older people who are frail or have disabilities. At the last available count, less than 4 percent of US housing units offered three basic accessibility features: a no-step entrance into the home, a bedroom and bath on the main living floor, and extra-wide hallways and doors that allow passage of a wheelchair (JCHS 2014). Older adults, particularly those over age 80, report the most difficulty entering, navigating, and using different spaces in their homes (Scheckler, Molinsky, and Airgood-Obrycki 2022). The pandemic hampered efforts to respond to accessibility problems. Some organizations dedicated to repairing and retrofitting the homes of low-income older adults had to put projects on hold to minimize contagion risk (see [Deep Dives](#)) (Habitat for Humanity n.d.). Renovations to improve accessibility and make other upgrades in senior housing had to be rethought to protect residents’ health (T. E. Perry et al. 2021).

Safety issues such as broken heating equipment, exposed wiring, lack of a working smoke detector, missing handrails on stairs, or the presence of pests or mold can increase the chance of fall or injury, affect respiratory health, and have other deleterious effects. Indoor air quality has become an issue of growing importance as climate change has increased the incidence of flooding—which can lead to mold and mildew—and wildfires, which can lead to higher levels of particulate matter indoors. Older adults, who are more likely to have respiratory disease, can be more susceptible to these events.¹⁰ The pandemic highlighted other ways the physical home affects health. By the summer of 2020, scientists had recognized the importance of effective indoor ventilation and air filtration to reduce the spread of COVID-19 and the Centers for Disease Control and Prevention had issued guidance for improving infection control in multifamily housing settings (Morawska et al. 2020; CDC 2021).



Researchers and housing advocates have long noted significant disparities in access to accessible and quality housing among older adults. According to *Worst Case Housing Needs: Report to Congress 2021*, in 2019, 131,000 low-income renter households headed by someone age 62 or over lived in severely inadequate housing (Alvarez and Steffen 2021). The pandemic underscored other gaps, such as in access to open space and fresh air. Many older adults living in high-rise apartments do not have operable windows or easy access to the outdoors. Indeed, older adults living in apartments, as well as Hispanic and Black older adults, those with fair or poor health, and those with incomes under \$30,000, were least likely to report access to green space within walking distance or even a view of nature from their homes during the pandemic (Malani et al. 2021). Lastly, the layout of housing drew attention, particularly in apartment complexes designed for older adults, for its role in facilitating physical distancing while supporting community life (MASS Design Group 2020).

COMMUNITY INFRASTRUCTURE

The home sits within a physical neighborhood that shapes access to amenities and resources including parks, libraries, grocery stores, and transportation. As Forsyth et al. note, the ideal environment beyond the home itself supports people with a range of abilities and needs, has clean air and safe streets, provides access to healthcare and other resources, and supports healthy behaviors like physical activity (Forsyth, Molinsky, and Kan 2019). The social connections within a neighborhood and larger community are also critical for informal support, including during periods of crisis (Heid et al. 2021). During the pandemic, the physical neighborhood and social community were critical factors in how well older adults could access fresh air, engage socially even while physically distant, and obtain needed goods and services. Those in better-resourced areas may have been able to overcome challenges posed by the pandemic and even seek out new forms of social and other supports, while others struggled to maintain their health and wellbeing in poorly-resourced settings

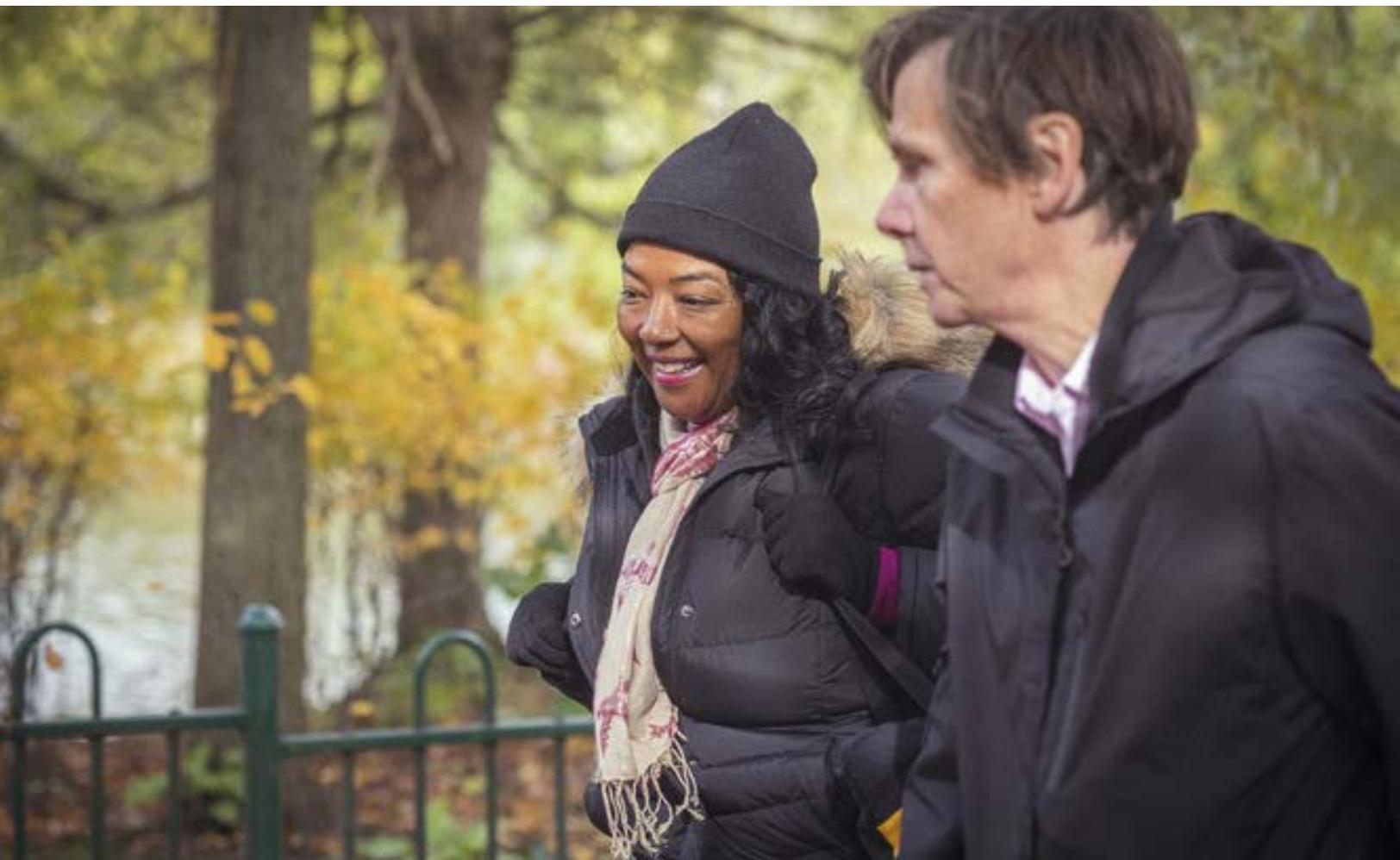
NEIGHBORHOOD AMENITIES

The infrastructure of a neighborhood, town, or city can play a crucial role in supporting or diminishing older adults' independence and health. For those who are unable to drive or do not own a car, public transportation and walkable streets offer important connections to doctors' offices, shopping, banking, and opportunities for social engagement, and have been shown to have positive effects on older adults' health (Levasseur et al. 2015). Essential services located in the vicinity matter as well; for instance, public health researchers have found that people living in "food deserts"—neighborhoods with few or no options for buying fresh, healthy, and affordable food—are more likely to experience food insecurity, particularly older people with limited transportation options (Fitzpatrick, Greenhalgh-Stanley, and Ver Ploeg 2016; Lee, Shannon, and Brown 2014).

Before the pandemic, it was already clear that neighborhood amenities were unevenly distributed. Research based on AARP's 2018 Livability Index, which

measures dimensions of a community's housing and neighborhood infrastructure, transportation, environment, health, engagement, and economic opportunity, showed that most older adults in the US did not live in places with the highest livability scores (Molinsky et al. 2020). Analysis of AARP data also revealed that access to specific amenities varied, with availability of resources and services related to health, engagement opportunities, and clean natural environments notably lower in neighborhoods with higher shares of people of color.

Although our understanding of how the pandemic altered access to community resources for older adults is still developing, initial evidence suggests that effects were severe (D'cruz and Banerjee 2020; Heid et al. 2021). The crisis strained public transportation networks across the country, greatly affecting those who relied on them (de la Garza 2020). Ride-share options presented the risk of infection or may have been inaccessible to older adults and other populations unfamiliar with smartphone apps.



Those living in areas without green spaces, sidewalks in good repair, or excellent air and water quality likely suffered health-wise, particularly if they were not able to reach outdoor resources outside their neighborhoods. Issues of inadequate housing, transportation, and other amenities likely coincided for many households, placing a heavy burden on middle- and lower-income older adults.

DIGITAL EQUITY

While internet access has become increasingly important in a digitally connected society, the pandemic dramatically increased reliance on technology once in-person activities were restricted. Programs, services, and social life moved online: religious services were livestreamed, doctors and patients met via telehealth visits, book clubs took to Zoom, and families gathered virtually. Digital access and knowledge also became important for everyday tasks many older people previously conducted in person, such as buying groceries or medications. Many welcomed the convenience brought by these changes.

Yet not all benefited from the move to digital platforms. According to a study reflecting 2019 Census data, 18 percent of adults 65 and above did not have internet access at home (Amin et al. 2020). The digital divide also falls disproportionately on low-income households, rural residents, people of color, and residents of affordable housing, including older adults in these populations (Amin et al. 2020; Ellison-Barnes et al. 2021; Swenson and Ghertner 2020). Factors that contribute to this divide are both structural and personal. Older adults' buildings or residential areas may lack broadband internet due to lack of public and private investments (Asher, Arnold, and Nassau-Brownstone 2021). Individuals may also be unable to purchase or use computer equipment, smartphones, and other devices without financial, technological, or linguistic support (gonzález-rivera and Finkelstein 2021).

DEFINITION

The **digital divide** is the gap between those who have access to online resources and those who do not due to the lack of a strong internet connection, technology, and/or the training to use it. These issues may be related to affordability, availability of coverage, and other factors. Addressing at least some of the causes of this divide would improve **digital equity**.



The digital divide worsened during the pandemic as the public lost access to community resources such as computers in libraries or shared spaces in senior housing. In addition, some of those hardest hit by the pandemic could no longer afford internet service despite its increased importance to daily life (University of Washington Bothell 2021).



PROVISION OF CARE

Care encompasses multiple practical expressions of human interdependence within households, social institutions, and societies. While it is common to associate older adults' care needs with medical care for age-associated health conditions, this leads to an incomplete picture of both older adults and of care. A broader concept of care encompasses the many ways in which housing providers, service providers, age-friendly community groups and other volunteers, neighbors, friends, and family members provide support and assistance to older adults for a range of daily activities. Care also includes medical services provided in the home as well as in clinical settings. Inadequate access to these different forms of care, when combined with poorly-resourced home and community settings, can compound inequality among older adults (Abramson 2016).

HEALTH AND HOME CARE

According to the National Health Interview Survey, 22 percent of people age 65 and over reported “a lot of difficulty” or “cannot do/unable to do” when asked about seeing, hearing, walking or climbing stairs, communicating, remembering or concentrating, or caring for oneself. Nearly 46 percent of people age 85 and over report a disability in these domains (Federal Interagency Forum on Aging-Related Statistics 2020). Over 39 percent of Medicare beneficiaries report limitations in activities of daily living (ADLs, which include bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet) or with instrumental activities of daily living (IADLs, including using the phone, housework, meal prep, shopping, and managing money). Analysis of the Health and Retirement Survey showed that fully 60 percent of older people dwelling in the community reported needing help with ADLs or IADLs.¹¹

In the US, a great deal of home care for older adults is unpaid and provided by family members, typically spouses and children. Yet the pool of unpaid family caregivers available to older adults is shrinking—baby boomers had fewer children than previous generations and more women, to whom care responsibilities have traditionally fallen, are in the workforce (JCHS 2014). Meanwhile, low wages and other structural issues have led to shortages of paid health workers (Weller et al. 2020; Graham 2022). This shortage is especially troubling given the rising number of older adults with dementia, a progressive condition that requires increasing levels of care. Most people with dementia live in the community and not in nursing homes (Population Reference Bureau n.d.).

Medicare provides limited coverage for home healthcare services such as skilled nursing care or physical therapy. It does not cover homemaker services (such as grocery shopping or cleaning) or personal care services (such as assistance with bathing) (CMS n.d.). Some older adults are dually eligible for Medicare and for state-level Medicaid insurance, either because they were already eligible for Medicaid due to low income or because they “spent down” their assets to qualify for services funded by Medicaid, including home care services and long-term care in a nursing home. Yet for those not dually eligible, Medicare’s limited home care provisions and income restrictions provide no ready way to pay for care.



Research published in 2019 estimated that by 2029 there will be over fourteen million middle-income older adults with high healthcare and functional needs and/or mobility limitations, and that over half of this group will be unable to pay for residential care provided in settings such as assisted living facilities (Pearson et al. 2019). As noted earlier, millions of middle-income older adults already have trouble paying for housing alone. The gap between an older adult’s resources and the price of both housing and care is especially stark for Black Americans due to the cumulative effect of lifetime disadvantages affecting income and housing (Abramson 2016). Efforts to solve housing problems through healthcare financing streams have tended to focus on supportive or transitional housing as a source of stability for people with complex medical and related social service needs, such as severe chronic illness or homelessness, or on making housing safer through home modifications (Taylor 2018). While important, this does not solve the growing problem of affordability among older people.

The pandemic stress-tested existing housing and insurance systems that were already inadequate for the needs of an aging society in which many older adults struggle to pay for both housing and for care (Bailey 2020; Gleckman and Favreault 2021). Shortages of paid health workers worsened during the pandemic, and with many adult children working remotely, older adults relied more heavily on family caregivers if they could; others had higher unmet needs (Graham 2022; Kent, Ornstein, and Dionne-Odom 2020). The pandemic also highlighted the economic precarity of professional care workers, who often face difficulty finding affordable and safe housing for themselves and their families. The shortage of health workers affected many settings where older adults live and receive care, especially nursing homes (Weller et al. 2020). These impacts in turn intensified interest in aging in the community, including in the homes of family (Abelson 2021).

DEFINITION

Service-enriched housing refers to housing that includes services on-site that are provided and/or managed by trained staff.

A **Service Coordinator** helps residents access services and supports that help them remain self-sufficient and socially connected.



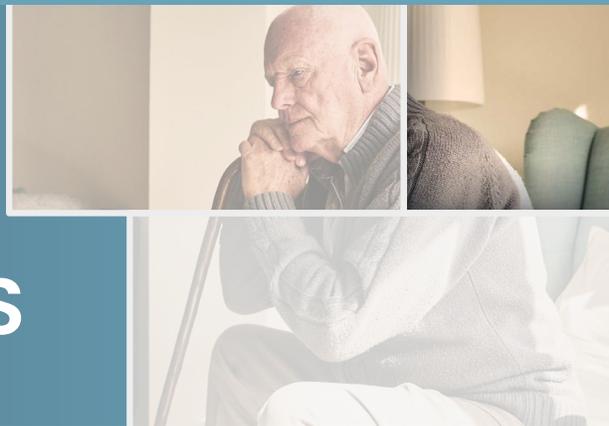
SOCIAL AND OTHER SUPPORTS

Another element of “care” relates to informal support found among family, friends, and others in the community. Older adults’ social networks vary due to personal preferences and structural factors. Pre-pandemic, some community-dwelling older adults, including those who live alone, were well connected to friends and neighbors. Older adults in affordable housing complexes might also rely on resident **service coordinators** for social support and connection (Scheckler and Molinsky 2020). In **service-enriched housing**, additional trained staff who specialize in service delivery may provide other kinds of support. On top of this, grassroots age-friendly programs support social engagement in some communities. However, these resources are unevenly spread across the many settings and neighborhoods in which older adults live. Many community-level social supports for older adults rely on volunteers and access varies greatly by building or neighborhood. Even the support that resident service coordinators are able to provide can vary depending on funding and staff-to-resident ratios in service-enriched housing.

The pandemic strained older adults’ connections to social and other resources; the suspension of congregate meals, recreation and exercise programs, and in-person access to support resulted in greater isolation and loneliness (Heid et al. 2021; Berg-Weger and Morley 2020). People living in buildings with resident service coordinators received social support and help with practical problems such as accessing technology and groceries (Scheckler and Molinsky 2020), and age-friendly and grassroots organizations provided similar forms of aid. However, disparities in access left many without support and assistance. While research has yet to fully assess unmet need by residential setting, older adults in under-resourced urban communities and rural locations may have faced greater challenges (Henning-Smith 2020).

CHAPTER THREE

OVERVIEW OF PANDEMIC RESPONSES



The pandemic put further stress on housing, care systems, and community resources that older adults depend upon, and in many cases deepened existing disparities. Yet it also produced a great deal of creative thinking and practical innovation on the part of service agencies, housing providers, community organizations, and advocacy groups whose value is not limited to the crisis context of the pandemic.¹²

The housing-focused responses we studied fall into three categories. “Direct services and supports” focused on the health and wellbeing of community-dwelling older adults. These programs were often made possible by emergency funding streams created and administered by public agencies and private philanthropies, or by partnerships between service organizations. “Service provider network building” involved coordination among service organizations, which rapidly activated and expanded their networks to share information and evolving practices. The third category, “structural shifts,” covers changes made to service delivery, reimbursements, eligibility requirements, or other aspects of policies that affected large numbers of older adults in different types of housing.

TABLE 2. CATEGORIES AND EXAMPLES OF HOUSING-FOCUSED COVID-19 RESPONSES TO THE NEEDS OF OLDER ADULTS

CATEGORY	DESCRIPTION	EXAMPLE
Direct services and supports for community-dwelling older adults	Policies or programs that directly respond to needs and challenges such as food insecurity, social isolation, the digital divide, access to healthcare, barriers to transportation, housing insecurity, housing accessibility, and housing safety.	Area Agencies on Aging and other organizations adopted new practices to support mental health in the context of physical distancing. Phone and video calls were used to conduct wellness checks and build social connections (engAGED n.d.).
Service provider network building	Interventions that strengthen systems serving older adults by expanding organizational capacity, sharing information, or supporting caregivers.	An age-focused advocacy group held weekly calls to share public health updates and best practices with affordable housing providers (Stone, Sanders, and Magan 2020).
Structural shifts	Changes in policy and programmatic landscapes that create, expand, improve, or broaden eligibility for different types of supports and services.	California expanded state Medicaid coverage (Medi-Cal) for undocumented immigrants age 50 and above, who are excluded from the federal Medicare program, as part of its long-term goal of universal health coverage regardless of immigration status (DHCS 2022).

Many organizations implemented multiple interventions spanning different categories. For example, a nonprofit service provider may have conducted wellness checks by phone, created online programming, and trained clients on how to use computers and software. The same provider may also have shared information with or referred clients to public agencies or other nonprofit organizations providing rental assistance or home modifications. Though these different types of responses were often implemented by the same entity, they offer distinct lessons for practice and policy.

Geographically, direct supports and services were often developed within a city or a county in response to local conditions and needs. Service provider network building frequently occurred across a state or region, and structural shifts often took place at a federal or federal-state level. However, there were exceptions to these trends. In particular, state and regional-level actors were flexible in terms of developing and supporting different types of interventions.

The relationships among these three broad categories of pandemic interventions informed our analysis, along with insights from a closer examination of specific examples (see [Appendix A](#) for more detail). From this work, we drew two main conclusions.

- First, progress toward sufficient housing and housing-focused services and supports for moderate- and low-income older adults requires **significant collaboration over time** across domains (housing, health, aging), among stakeholder groups (policymakers, practitioners, advocates, providers), and within and between policymaking levels (federal, state, local/regional). Evidence of

collaboration involving state and local levels is encouraging, especially when the pace of federal policy action is slow or unpredictable. However, progress on serving the multifaceted needs of older adults requires ongoing collaboration at the federal level, particularly between the Department of Housing and Urban Development and the Administration for Community Living within the Department of Health and Human Services.

- Second, sustaining collaboration requires **shared knowledge, trust, and communication channels**. The pandemic responses that “worked” often did so because there had been prior investment in building diverse stakeholder networks within communities, regions, and states. This investment—often the legacy of a prior effort to improve age-focused services—had nurtured personal relationships, identified shared goals, and established communication channels and informal networks that could be reactivated. Identifying regulatory and other structural barriers to collaboration is also important, as we discuss in the following section.

This project’s findings from the pandemic align with prior scholarship on crisis response. Whether events such as pandemics are called “transboundary,” “turbulent,” or “wicked,” large-scale problems with sprawling, unforeseen consequences will continue to occur, requiring more flexible, collaborative responses, or what some term “transformative governance.”¹³ Mindful of the complexity of social change in the interests of older adults and all citizens of our aging society, we offer the following observations, followed by recommendations for specific audiences.



CHAPTER FOUR

OBSERVATIONS AND RECOMMENDATIONS



Six broad observations emerged in our review of COVID-era policies and practices. Each is accompanied by examples of policies and practices (see [Appendix C](#) for a complete list) and followed by actionable recommendations developed by our team in consultation with our advisory network.

1. NETWORKS AND PARTNERSHIPS WERE ESSENTIAL

At the state, regional, and local levels, pandemic interventions frequently involved collaborations among government agencies, nonprofit housing providers, healthcare providers, advocacy groups, businesses, and other entities to share information, advocate for the needs of older adults, and deliver goods and services. In many cases, these collaborations were rooted in existing networks created to advance age-friendly agendas.¹⁴

Drawing on frameworks from the World Health Organization, AARP, and others, age-friendly initiatives pursue interlinked policies and programs supporting the social participation and inclusion of, as well as respect toward, older adults, along with practical improvements to domains such as housing, transportation, and healthcare (WHO n.d.). Age-friendly efforts recognize the centrality of place, including the built environment, social networks and opportunities, and services available in a given location (Greenfield, Pestine-Stevens, and Scher 2022). Becoming an age-friendly community or state requires working across traditional policy silos that separate social services, housing, transportation, health, and other domains. AARP maintains a Network of Age-Friendly States and Communities in the United States, which included over 660 communities and nine states as of July 2022.

The age-friendly designation recognizes existing cross-sector collaborations, and it can also strengthen or result in new partnerships. For instance, two years after California's governor released his executive order mandating a master plan for aging, the state government made a commitment to become an age-friendly state (McCaslin 2021). The process of writing the state's aging plan—which sets concrete objectives for affordable housing, healthcare access, and caregiver support—amplified the voices of grassroots organizations and continues to spur community outreach efforts under the **Together We EngAGE** Campaign (see [Deep Dives](#)).

DEFINITION

As used in this report, a **network** is “three or more organizations connected in ways that facilitate achievement of a common goal” (Provan, Fish, and Sydow 2007).

NETWORKS FACILITATED INFORMATION SHARING AND ADVOCACY

Networks of organizations that focused on age-friendly initiatives proved to be crucial two-way vectors for communication by disseminating information “downward” from government agencies to older adults and sharing experiences of older adults “upward” to decision makers. Convening organizations were critical in supporting this function. For example, in Massachusetts, four state and quasi-public agencies regularly shared information and guidance with affordable senior housing communities during the pandemic (Stone, Sanders, and Magan 2020). Additionally, **LeadingAge Massachusetts**, a membership organization of not-for-profit providers of healthcare, housing, and services for older adults, hosted weekly calls in which members discussed effective strategies for meeting older adults’ needs and identified emerging challenges. These meetings were attended by over one hundred affordable housing providers.

Another network, convened by **The New York Academy of Medicine’s Center for Healthy Aging**, organized monthly Zoom meetings with representatives of neighborhood-based age-friendly organizations, elected officials, and service providers in New York City to share strategies for meeting older adults’ needs around food access, social isolation, and access to information and technology (see [Deep Dives](#)). In New Jersey, members of the **North Jersey Alliance of Age-Friendly Communities** served as communications brokers, sharing information with residents, partners, and public agencies. This included surveying community-dwelling older adults about their needs and sharing results with local age-focused organizations, as well as sharing updates about services and supports with organizations and older adults (Greenfield, Pestine-Stevens, and Scher 2022; Rutgers University School of Social Work 2021).

Established networks also advocated for older adults and helped ensure they received needed goods and services. For example, **Senior Housing Preservation-Detroit (SHP-D)**, a coalition that promotes stability

of housing for low-income older adults, mobilized to alert city officials, fellow advocates, and philanthropists about the challenges facing senior housing residents during the pandemic (see [Deep Dives](#)). Of particular concern were infection prevention in common areas such as laundry rooms and elevators, delivery of food and supplies, social isolation, communication of public health guidance, and ways older people could seek help under pandemic conditions (Archambault, Sanford, and Perry 2020). Detroit lacks a local department of aging, making the established SHP-D coalition and its productive relationship with city officials vitally important to swift mobilization.

PARTNERS WITHIN NETWORKS DELIVERED GOODS AND SERVICES

Responding to older adults’ needs during the pandemic often required multiple organizations working together to deliver or scale up services. For example, Honolulu’s **Kūpuna Food Security Coalition** was created in 2020 by the City and County of Honolulu Elderly Affairs Division with AARP Hawaii and other members of the area’s existing age-friendly network to address food security for older adults. The coalition emerged out of a network of age-friendly organizations convened by the Hawaii Public Health Institute. In its first year of operation, the coalition delivered 1.2 million meals. The coalition has since evolved the model to work on other drivers of health, producing the **Kūpuna Collective**, a network of organizations engaged in incubating and implementing new approaches to address critical aging issues with the support of the Hawaii Public Health Institute and University of Hawaii Center on Aging.

DEFINITION

A **partnership** involves close cooperation between two or more organizations to achieve a concrete objective and can include members of the same network.

These efforts were not without challenges. Existing funding structures often mean that service providers work only within their own silos. Coordination with other organizations, or even going beyond the organization's typical scope of work to fulfill additional needs, can be constrained by limited staff capacity, time, and funding. In the case of the Kūpuna Collective, the pandemic created such immense need that it did spark new practices and has led to advocacy to improve response systems going forward.¹⁵

Partnerships to deliver food and services often emerged out of relationships among members of formal and informal networks, though some included

organizations recruited for a specific service. For example, in **Florida**, the **Department of Elder Affairs** partnered with the state's Department of Business and Professional Regulation, the Florida Restaurant and Lodging Association, and Area Agencies on Aging (AAAs) throughout the state to prepare and deliver nutritious meals to older adults. These partnerships met a new need for contactless meal provision and provided employment to restaurant industry workers (ADvancing States 2021a). **Arizona's Rural Transportation Incubator** was initially funded as a two-year project emerging from the state's age-friendly initiative, helping nonprofits in twelve communities provide rides to low-income older adults (Age Friendly Arizona 2022). The Incubator's work involved peer-to-peer meetings to support program development, which facilitated partnerships and cooperation among member organizations. During the pandemic, the incubator helped members pivot from providing rides to delivering meals to homebound older adults.¹⁶

Many organizations partnered to provide technology access. Early in the pandemic, volunteer groups across the country collected tablets, smart speakers, and other devices to donate to senior housing and agencies supporting older adults. Efforts also included training for older adults and upgrades to internet service in addition to device distribution. For example, in New York City, the nonprofit **OATS (Older Adults Technology Services)**—now an affiliate of AARP—partnered with the New York City Housing Authority and T-Mobile to provide tablets, internet service, and technology support and training to ten thousand older residents of public housing. In addition, older residents could contact a support hotline to ask how to accomplish online tasks, such as ordering food (OATS 2021a; OATS 2021b).



“Zoom programs are great. Coffee hour, church services, and lunch groups on Zoom, and... exercise classes. Better than driving for some gatherings, especially at night! Zoom family-oriented church parties. Classes on Zoom.”

OLDER RESIDENT IN HOUSING WITH SUPPORTIVE SERVICES, MASSACHUSETTS

TRUSTWORTHY LOCAL ORGANIZATIONS WERE CRITICAL TO NETWORKS

Effective pandemic responses frequently involved trusted local organizations who communicated directly with older adult populations. Reaching older adults in underserved communities was challenging for government agencies seeking to disseminate public health information, understand older adults' needs, and provide services. Trust in government, particularly concerning vaccine safety and effectiveness, was low in some communities. The digital divide and language barriers posed further challenges.

Local organizations that had already earned the trust of older adults were the linchpins of successful information dissemination efforts. In some places, age-friendly initiatives fulfilled this role (Rutgers University School of Social Work 2021). **Kingdom Care Senior Village** in Washington, DC, engaged ambassadors at local churches to reach out to older adults regarding vaccines and services (see [Deep Dives](#)). In other places, the trusted local organization was not age-focused but was well-situated to reach older adults. For example, **GreenRoots**, a community-based environmental justice organization in Chelsea, Massachusetts, undertook extensive efforts to contact older residents in the early months of the pandemic. Staff members ensured written materials were available in multiple languages and partnered with members of the local Somali Bantu community to disseminate information in a non-written language (Clarke, Oomer, and Tavarez 2020).

In Georgetown County, South Carolina, healthcare provider **Tidelands Health** partnered with the local branch of the **NAACP** to help people with limited internet access make COVID-19 vaccination appointments. Strategies included door-to-door outreach, postcards, and phone calls, as well as an educational session that addressed vaccine hesitancy. The share of Black Americans receiving



“It took a crisis to bring folks together and collaborate on a higher level—to mobilize, be nimble, and act to solve a problem. It shook up our existing systems, funding mechanisms, and policies so that we could build better ones—and we are still learning how to do this better.”

CHRISTY NISHITA, CO-COORDINATOR, KŪPUNA COLLECTIVE AND AGE-FRIENDLY HONOLULU

vaccines from Tidelands rose from 5 to 16 percent from February to April 2021, possibly as a result of the initiative (Phillips 2021; Tidelands Health 2021).

A study of the **Leeds Neighbourhood Network (UK)**, which includes thirty-seven grassroots groups run with older adults' involvement, highlights the support local organizations need to do this important work (Dayson et al. 2020). Before the pandemic, organizations in the Leeds network offered activities and services supporting older adults' health and wellbeing as well as their social connections. During COVID-19 they pivoted to delivering food and medication to homes and providing social support to older adults. An evaluation by the Centre for Ageing Better in 2022 found that to function well, the neighborhood organizations needed a stable workforce, effective leadership, a supportive policy environment, and reliable funding (Dayson et al. 2022).

RECOMMENDATIONS

For Strengthening Networks, Partnerships, Local Organizations, and Leaders

- **Policymakers and funders should nurture the development of networks.** Investment in networks pays off through the products of collaboration, such as new policies or programs that support older adults, and also through the creation of “connective tissue”—the shared knowledge and trust characteristic of effective networks (Butler and Maguire 2022). Existing networks can foster time-limited or periodic collaborations, such as partnerships between community health centers and senior centers to host vaccine clinics during flu season. Networks can also give rise to longer-term collaborations, such as local coalitions of businesses and age-friendly initiatives that advocate for improved safety and accessibility for older adults and other pedestrians. During a crisis, when new needs arise and supplies must be coordinated and distributed efficiently, trusted networks with the capacity for rapid collaboration and mobilization are essential.

“Organizations and communities that had existing connections from previous work were able to leverage those relationships and quickly collaborate to meet the needs of older adults throughout the pandemic. These partnerships allowed for innovation and creativity in providing services and increasing connection.”

ROBIN LIPSON, DEPUTY SECRETARY OF
ELDER AFFAIRS, MASSACHUSETTS

Government agencies, such as departments and councils focused on aging at state, county, or local levels, and grantmaking foundations can nurture the development of networks by:

- Valuing networks in funding decisions, including asking grant-seekers to describe their formal and informal networks and collaborations that have resulted from these networks;
- Supporting network-building by offering workshops showcasing products of network collaborations;
- Ensuring age-focused networks reflect the diversity of older adult populations, with representation and participation (as possible) of older adults with mobility, cognitive, or other impairments, as well as caregivers;
- Funding and supporting innovative partnerships, particularly those emerging from pilot projects. For example, the Connecticut-based **Donaghue Foundation’s** “R3” funding mechanism encourages research grantees to seek partnership opportunities and apply their findings to practice (Yedlin 2018);
- Supporting research into the characteristics of effective networks and partnerships working on behalf of older adults, including their leadership and membership, and the conditions that enable them to activate and pivot in times of crisis; and
- Reconsidering restrictions on funding advocacy activities that may be necessary to support equitable aging in community. For example, meeting a community’s needs for affordable and accessible housing often requires organizing around objectives such as changing restrictive zoning or countering claims that new housing will negatively affect quality of life.

- **Grantmakers and other conveners should invest in leadership development and organizational stability of trusted local organizations.**

Grantmakers and other organizations that play convening roles can ensure that opportunities for organizational capacity-building are accessible to smaller or new groups as well as to those that are larger or more established. Coalitions of age-friendly initiatives and emerging dementia-friendly initiatives are well positioned to identify organizations in a community or region that are involved in supporting community-dwelling older adults, whether or not an organization's mission is age-focused.

Family foundations and donor-advised funds interested in supporting grassroots groups or social justice work, often regionally, are well positioned to support valuable local organizations through training and technical assistance in leadership development, in project design and evaluation, and through long-term operating support.

- **Government and nonprofit service providers can leverage lessons learned during the pandemic regarding outreach to older adults.** Examples of successful outreach conducted by networked organizations can serve as a guide for ongoing efforts to ensure older adults are aware of programs and benefits for which they are eligible, from housing assistance to nutrition support. Barriers to the use of public benefits often include lack of awareness about programs or eligibility, fear of stigma, and a need for assistance with applications, including access to technology (Cheyne and Vollinger 2022; Pew Fund for Health and Human Services 2017).



2.

COLLABORATION WITH OLDER ADULTS CONTRIBUTED KEY PERSPECTIVES AND SUPPORTED CIVIC PARTICIPATION

Many of the innovative pandemic responses we identified reflected the insights of older adults. Information on older adults' needs collected before the pandemic was often insufficient to guide rapid planning to meet new needs. In Columbia, South Carolina, city officials and the nonprofit **SC Thrives** partnered with youth volunteers to reach out to older residents, asking about their needs and connecting them with resources (Cities of Service 2021). The program resulted in an online portal, Thrive Hub, to support connections between older adults and their city.

Other efforts directly engaged older volunteers. As the pandemic strained nonprofits' resources in Saint Paul, Minnesota, the multi-city **Experience Matters** program helped recruit nearly 200 older volunteers to aid in food preparation and delivery, administrative support, and more (Cities of Service 2021). The **Tufts Health Plan Foundation** (now part of the Point32Health Foundation) awarded grants in December 2020 to community organizations working to engage older adults in the development and promotion of policy solutions, including issues highlighted by the pandemic. For example, the **Senior Agenda Coalition of Rhode Island** supported older people advocating for improved home care options under Medicaid. Another grant, to **Massachusetts Way Finders, Inc.**, supported older people advancing age-friendly initiatives (Tufts Health Plan 2020).

A key lesson from the COVID-19 pandemic and from other recent, often climate-related public health emergencies is that community-level emergency planning should include the needs and perspectives of community-dwelling older adults, people with disabilities regardless of age, and caregivers. Here we draw on The Hastings Center's framework for ethical leadership during public health emergencies, which was developed to advise healthcare organizations in the early days of the pandemic: "plan" rather than wait for crises, "safeguard" vulnerable populations, and "guide" responders through explicit instructions and other support whenever possible (Berlinger et al. 2020). Ethical leadership during or in preparation for emergencies of all types requires knowledge of which populations in a community may be at greater risk. Planning and response must necessarily be informed by the expert insights of diverse vulnerable populations. Examples such as **disability justice advocates'** mobilization during a 2019 power grid disruption in the Bay Area—which drew attention to the needs of people who rely on electricity for medical and transport equipment—help point the way toward better practices (Green 2019).

These lessons can be applied more broadly to planning in general, where inclusive outreach and engagement, as well as reliable data, helps ensure that local comprehensive plans, state housing plans, and similar efforts meaningfully include the full population.

RECOMMENDATION

For Engaging Older Adults: Planning for Community Needs and Preparation for Foreseeable Emergencies Should Include Older Adults, People with Disabilities, and Caregivers

- **Planning processes must include strategies for equitable public participation by older adults and other marginalized communities.** City planners, disaster response teams, and others can work with trusted local organizations (religious organizations, nonprofits, others) to conduct outreach and make sure older adults have ways to offer their perspectives and ideas. At the state or regional level, planning efforts can leverage Older Americans Act-mandated planning and other processes to facilitate outreach. Details matter: planning teams should consider the location of gatherings if in person, digital access if virtual, the food provided, translation options, and speakers and facilitators. The rapid shift to virtual meetings necessitated by the pandemic revealed new ways to expand participation in public processes for people for whom travel is difficult. We now need to clarify and share best practices for hybrid and online communication, e.g., captioning to support participation by people with hearing loss, image description to support participation by people with low vision, and appropriate support for people with impairments that affect thinking or speech so that they can share insights.
- **Older adults involved in community-based organizations and coalitions may benefit from technical assistance and other forms of support as they take on leadership roles** (Kiyota et al. 2015). Although its activities were put on hold at least temporarily during the pandemic, Boston's **Senior Civic Academy** provides an example of how local governments can help foster greater advocacy among older adults.¹⁷ Emerging from Age-

Friendly Boston, the six-week program introduced participants to local officials and advocates, and trained them to make a case for issues they cared about (University of Massachusetts Boston Gerontology Institute 2020). Expanding the reach of these programs, and making them more inclusive, can spur greater public participation among older adults of different backgrounds. “Unpausing” leadership programs put on hold during the pandemic should be a priority.

- **Planning efforts must be informed by accurate data about older populations.** At a local or regional level, this might mean government agencies and service providers developing a more detailed understanding of where older adults live and how they might face specific risks based on location or housing type (e.g., loss of electricity during a storm can strand older or disabled residents in high-rise apartments). City and county agencies often maintain voluntary registries of people who may need assistance during crisis events; Area Agencies on Aging may also keep such registries. These can include lists of locations where residents require a stable supply of electricity to power medical equipment, and of residents who would need assistance evacuating or accessing food and other supplies in an emergency. Reliable data is also useful for broader planning efforts, helping planners and policymakers understand population trends such as the share of residents with dementia (Bayakly 2020). There are ample opportunities for collaboration among data-gathering agencies to share and merge data: often health and housing information is collected in different systems that make it difficult to holistically understand older adults' needs and experiences.

3.

SUCCESSFUL RESPONSES BROUGHT SERVICES TO THE HOME

In the first year of the pandemic, stay-at-home policies led to rapid social innovation to provide older adults with essential goods and services where they lived. Staff at community-based affordable housing for older adults, including senior housing apartments and congregate living communities that include shared meals and social activities, pivoted to support residents who were now under physical distancing guidelines. Older adults living in the community without support from residential staff often relied on family and neighbors as well as local organizations. As discussed previously, the shift to online services and social engagement produced initiatives to equip households with internet upgrades, device access, and training, underscoring how digital technologies have become integral to home infrastructure.

A key variable in service delivery at home is the residential setting itself. We therefore discuss lessons specific to senior housing, including independent and congregate living and service-enriched housing, and to housing for older adults who do not reside in age-restricted buildings or communities.

SERVICE COORDINATION WAS KEY IN SERVICE-ENRICHED SENIOR HOUSING AND CONGREGATE HOUSING INCLUDING OLDER ADULTS

Housing providers played a pivotal role during the pandemic in ensuring older residents received the care and services they needed. In congregate and service-enriched housing, the presence of trusted, experienced service coordinators enabled swift response and adaptation to pandemic conditions.

Providers of service-enriched senior housing faced stark challenges given the severe risks of COVID-19 to their communities. At **2Life Communities** (see [Deep Dives](#)) and in other service-enriched housing for older adults, resident services coordinators were integral to pandemic response. Service coordinators reported stepping beyond their usual duties to ensure that residents were supplied with prepared meals, groceries, household supplies, and medication, and to devise new opportunities for physically distanced social engagement (Bratt 2022; Scheckler and Molinsky 2020). Crucially, service coordinators served as residents' IT support at a moment when older adults and others needed both access and training to use telehealth and to communicate with family members. When visitors were barred from buildings to reduce contagion risk, service coordinators also supported family members by providing information on residents' health and wellbeing (Scheckler and Molinsky 2020).

Service coordination shows again the power of networks and partnerships. Service coordinators leveraged relationships with food pantries, restaurants, pharmacies, public libraries, health providers, and other community partners to arrange donations, deliveries, and transportation. Service coordinators' experience with everyday troubleshooting on behalf of individual residents helped them to pivot into innovation on behalf of the entire community (Scheckler and Molinsky 2020).

Staff who worked on-site as part of building management or in another capacity also provided support to residents. In Canada, staff at the publicly-funded **Toronto Community Housing Corporation's Seniors Housing Unit** began to call or knock on the doors of their approximately fifteen thousand tenants starting in March 2020.¹⁸ Staff members connected residents to needed services, including food or medication deliveries. This initial outreach helped the team to better target aid to tenants with the greatest need and later to administer door-to-door COVID-19 tests and vaccinations. Currently, the Seniors Housing Unit (now Toronto Seniors Housing Corporation) is building upon relationships with regional partners, established during the pandemic, to better align health and social support services for older adults with complex needs in some of the neighborhoods where their buildings are located.

OLDER ADULTS OUTSIDE SENIOR HOUSING RELIED ON A WIDER RANGE OF SERVICE DELIVERY METHODS

Older adults who do not live in senior housing or other service-enriched housing lack the built-in support of a resident services coordinator or formalized support network. They may face barriers to learning about available services and their eligibility for them. They often need to initiate requests for services rather than being asked what they need. During the pandemic, their access to information may have relied on outreach by a local health department, an age-friendly initiative, a building manager, or a co-op or condo board, which may have resulted in less regular and less personally tailored communication.

Naturally occurring retirement communities, or NORCs, are places—such as apartment buildings, complexes, or neighborhoods—in which a significant percentage of residents are older. In many locations, NORCs house organizations that support long-time residents seeking to age in place. For example, the management or tenants' association of a building that constitutes a NORC may partner with a local department of aging to offer services such as

wellness checks or fitness classes, or to distribute health information. An example of a site with a well-developed urban NORC is **Penn South** in Manhattan, an affordable co-op community with over 2,000 residents age sixty and older. Pre-pandemic, Penn South provided social services, recreational opportunities, and other programs to older residents, including access to discounted home health and housekeeping services (Penn South Social Services n.d.). During the pandemic, the co-op recruited volunteers to make check-in calls to older residents and help with errands (Penn South 2020).

In some communities, an age-friendly program supporting social engagement or a membership-based **village program** connecting older adults with volunteers and services, adjusted their operations or expanded to provide pandemic-related services. Other place-based organizations serving older adults also pivoted. For example, the **Community Aging in Place—Advancing Better Living (CAPABLE)** program (see [Deep Dives](#)), which operates in multiple sites in twenty-three states, relies on a nurse, an occupational therapist, and a home renovation professional to improve the accessibility and ease of use of the home. When CAPABLE had to partially suspend operations during the pandemic, program staff in some locations were able to procure personal protective equipment (PPE) to conduct safe home visits and disseminate public health updates to their clients. During a time of widespread misinformation, CAPABLE staff functioned as a trusted source of information about COVID-19 and best practices for safety.

Access to programs such as CAPABLE is the exception rather than the norm in the US. Because resources differ by location and the nation's aging population is so diverse, there is no one-size-fits-all approach to providing older adults who are living independently with the services and supports they need. Learning from these programs, and from service-enriched housing, will help housing and service providers to understand how these benefits might be brought to a broader population.

RECOMMENDATIONS

For Service Delivery in the Home: Prioritize Coordination of Services

- **Government agencies should adequately fund service coordinators in publicly-subsidized housing, where community-dwelling older adults can benefit greatly from services and supports.** Currently, funding for some service coordinators in Section 202 housing—the only HUD program designated to serve people 62 and older—is sourced from the operating budget, which allocates money for tasks such as building maintenance (HUD n.d.). Establishing stable funding for service coordinators in Section 202 and other types of public housing, including resources for professional training and networking, will make service coordination available to more older and disabled residents of HUD-subsidized properties. These changes can improve access to community and medical resources and increase people’s ability to navigate complex public benefits systems (Sally, DuBois, and Burnstein 2021; Ewen 2021).
- **Explore how service coordination that may exist in age-restricted housing and in NORCs can inform efforts to serve older adults in dispersed housing in the community.** What economies of scale are needed to make service coordination successful? Answering this question may involve increasing funding for, modifying, and learning from existing health and housing-related initiatives such as village programs or CAPABLE. It can also include pilots and studies of new models for service delivery.

- **Consider how networks can support a “no wrong door” approach, in which an older adult reaching out for assistance with one issue (e.g., home repair, food insecurity) can find information about programs and benefits in other domains.** Older adults may be unfamiliar with entities such as local or state departments on aging or area agencies on aging that provide a range of services. Building up support for networks and trusted local organizations is an important first step toward connecting older adults to the services they need through the organizations they know.

“Owners of service-enriched housing have been telling us that while they appreciate the outpouring of grants and tablets to enhance older adults’ digital access, it’s not really that helpful unless there is a service coordinator on site who is trained to help older adults use the technology.”

MEGHAN ROSE, GENERAL COUNSEL AND CHIEF GOVERNMENT AFFAIRS OFFICE, LEADINGAGE CALIFORNIA

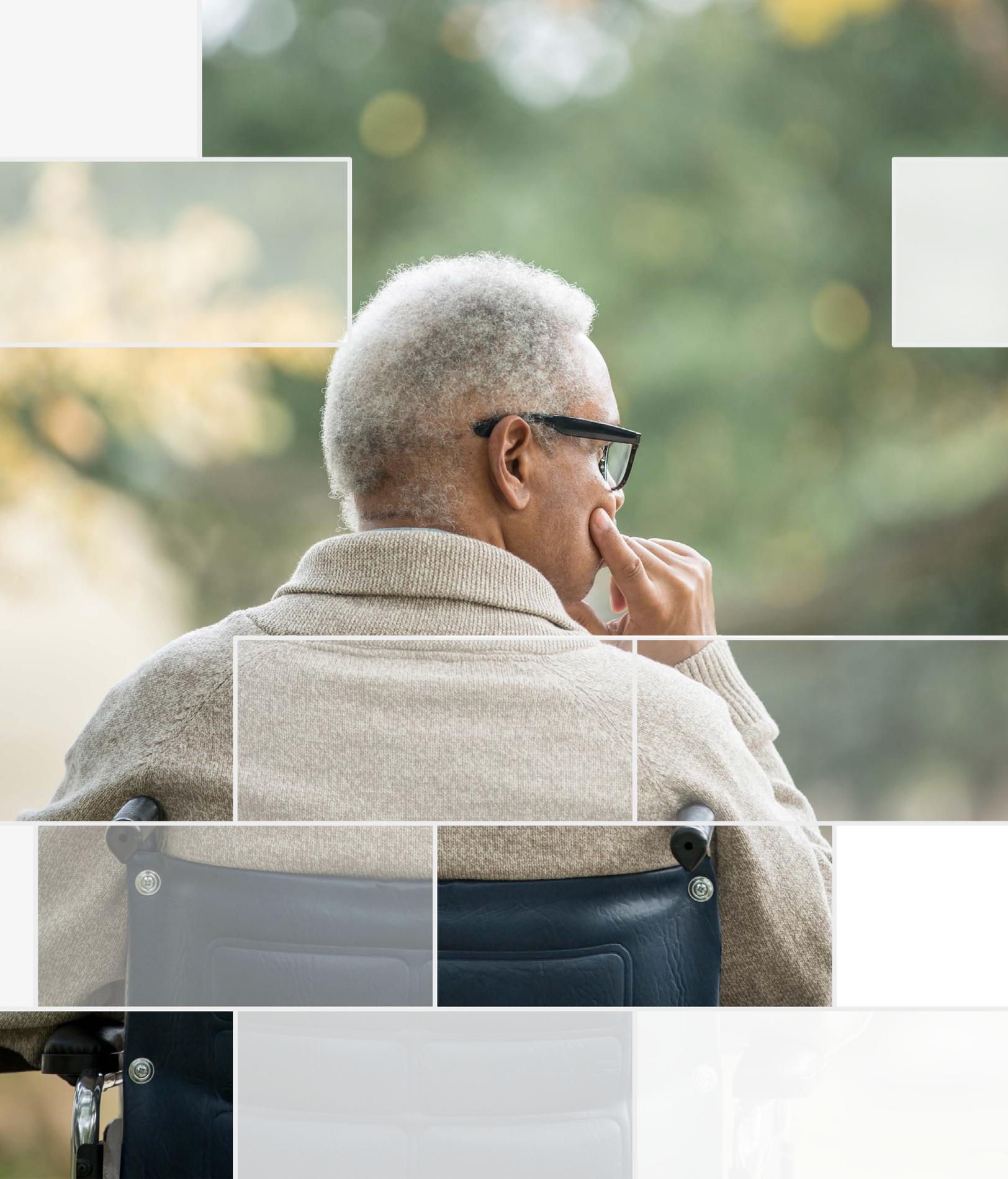
As people of all ages spent more time at home during the pandemic, housing and neighborhoods became even more important to health and wellbeing. As outlined in *The Pandemic As Stress Test*, the pandemic highlighted deficits in access to the outdoors, adequate indoor ventilation, and accessibility inside the home for people with disabilities, as well as issues with infrastructure at the neighborhood level. Pandemic-related safety risks and supply chain problems delayed housing upkeep and retrofits. At the same time, the crisis reinforced the importance of maintaining and enhancing the physical design of housing and neighborhoods to support health and wellbeing for all ages.

- **Access to nature and fresh air:** The pandemic highlighted the need for connections to nature and opportunities for fresh air, including for those in high-rise multifamily housing, where operable windows and balconies can provide direct access for each unit (MASS Design Group 2020; Poon 2020). Improved filtration and ventilation systems, including air cleaners and HVAC filters, in homes and other shared spaces were also found to reduce infection risk (EPA 2022). However, it is unclear how many residential settings have been able to adopt these best practices.
- **Accessibility:** Efforts to improve home accessibility for older adults (and other residents) with disabilities—such as widening entrances, adding ramps, or bathroom remodels to allow wheelchair access—were hampered during the pandemic due to safety concerns that limited or halted work. Currently, labor and materials shortages, as well as rising costs, continue to impede improvements that would instantly enhance residents' safety, independence, and quality of life. A recent survey of over one hundred municipal home repair programs, which often help lower-income homeowners, showed that over one-third offered accessibility modifications; however, many of these programs serve fewer than one hundred homeowners per year (Mayes and Martín 2022).
- **Digital equity:** A broadband connection should be recognized as a basic utility and part of housing infrastructure given its ever-growing importance in accessing healthcare, banking, education, social services, social programming, and civic participation opportunities. Bridging the digital divide—including gaps based on geography, cost, access, training, and comfort—will require significant capital investments and public-private collaboration. At the same time, the pandemic has shown that phone and in-person services remain crucial given the challenges of achieving digital equity and given that some people, including some older adults, will always need alternatives to digital tools.
- **Flexible spaces in the home:** During the pandemic, many households used interior spaces in new ways—for schooling and home offices, for example. Extra rooms or small units independent from a main house (called “accessory dwelling units”), when available, accommodated people in quarantine, caregivers, or family members who had lost income during the pandemic's early days. The broad lesson here is that flexible spaces that can be reprogrammed as needs evolve can help support older adults as well as multigenerational households.
- **Neighborhood design:** Design and infrastructure of neighborhoods can facilitate access to open space and fresh air, local services and shops, and a sense of social connectedness for those who might feel isolated in their homes. The pandemic saw roadways and parking lots transformed for dining and recreation uses. These spaces can continue to facilitate intergenerational gathering, with attention to space-sharing considerations involving sidewalks and bike lanes. Community-level efforts to increase safety, health, comfort, and wellbeing for people of all ages and abilities can include increasing crossing times at intersections, adding maps and other wayfinding aids to streets, and giving thought to the placement of benches and other amenities.

RECOMMENDATION

For More Inclusive Homes and Neighborhoods: Build Accessibility and Equity Considerations into New Construction and Renovations

- **Support accessibility, safety, and community.** Many resources already exist to help architects, developers, planners, and building managers create accessible, safe residential spaces for older adults. After the onset of the pandemic, **MASS Design Group** released a guide containing general principles for designing housing that can protect older residents' health while allowing for safe social interaction (MASS Design Group 2020). Although much of their research predates the pandemic, the **University of Florida's Project Re-envision** has created a variety of resources for improving the residential experiences of people with disabilities. These include a Design Guidebook containing specific suggestions for redesigning the interiors of existing public housing stock (Cantrell et al. 2021). **The Center for Inclusive Design and Environmental Access** at the University of Buffalo also offers resources for universal design, while advocacy group **The Kelsey** offers a broad set of recommendations in their *Housing Design Standards for Accessibility and Inclusion*. These standards cover the design process, building components, interiors, and operations (The Kelsey and Mikiten 2021; Steinfeld and Maisel 2012). The last element, operations, highlights the fact that accessibility for people with disabilities, including older adults, can be supported by not only physical but also service-related aspects of the home.
- **Improve digital equity.** *The Cost of Connectivity 2020*, a report by the **Open Technology Institute**, lays out several recommendations that could benefit households of all ages (Chao, Park, and Stager 2020). These include requiring internet service providers (ISPs) to make internet prices more transparent, legalizing affordable municipal networks across all states, and reducing the practice of "digital redlining," where ISPs fail to provide high-speed internet services in lower-income neighborhoods. While the authors mostly call on federal government to implement changes, policymakers at other levels can also play a role in reducing the digital divide. In addition, housing providers can directly partner with telecom companies to provide low-cost internet, as in the **Connected for Success** program which expanded eligibility in three Canadian provinces during the pandemic (King 2021).
- **Improve neighborhood infrastructure.** Numerous resources also exist to help design and improve community infrastructure for older adults (including those with dementia) and others, particularly in the wake of the pandemic. For instance, a recently published **Smart Growth America** report addresses spatial inequalities which impact health with a particular focus on transportation networks and public spaces (Thakkar et al. 2022). Similar to our recommendations above, it points out the importance of community engagement for improving public infrastructure in an equitable way, as well as recognizing the diverse needs of people living in different residential settings. These principles can be adopted and used not only by city officials and planners, but also policymakers at the state level, developers, community groups, and advocacy organizations.



5. PANDEMIC RESPONSES RELIED ON FLEXIBILITY IN REGULATIONS AND FUNDING

Another major theme across pandemic responses, reflected in efforts by actors from federal agencies to grassroots organizations, is that flexibility in program administration increased effectiveness. The expanded availability of telehealth is a key example of administrative flexibility. Prior to the pandemic, the Centers for Medicare and Medicaid Services (CMS) and providers of services reimbursed by CMS had been working toward getting telehealth on a footing equivalent to in-person visits. The pandemic gave a huge push to these efforts; the cancellation of in-person clinic appointments in the interest of infection control meant that telehealth was often the sole way for providers and patients to connect.

Other administrative changes, often granted at the request of states, had the effect of streamlining or updating processes. CMS fielded numerous requests from states, including calls to permit electronic sign-offs on required documents and allowances for virtual or telephone service delivery (CMS 2020).

In another example of administrative flexibility, state Medicaid programs allowed more family caregivers to receive payment in response to staffing shortages and concern over infection (Murray et al. 2021). In Massachusetts, where Medicaid recipients were allowed to hire family and friends as personal care workers prior to the pandemic, this flexibility helped staff at one **Program for All-Inclusive Care for the Elderly (PACE)** site meet the heightened need for individualized, at-home care (Quintal, Stanik, and Perry 2021). Though the pandemic exacerbated workforce issues, longer-term trends in population growth and age-associated health needs make clear that supporting caregivers will remain vitally important in the future.

Funding for and direct provision of resources were also critical. The COVID-19 responses discussed above relied on financing or direct provision of food, technology, transportation, and other goods and services. Stimulus checks to households and Emergency Rental Assistance under the American Rescue Plan Act benefited many older adults. The same act also enabled over thirty states to expand their home and community-based services through Medicaid (ADvancing States 2021b). In addition, expansion of funding for the Supplemental Nutrition Assistance Program (SNAP) helped older adults access more food options and pay for other necessities (Beaudoin 2022). Administrative waivers granted by the US Department of Agriculture supported states as they managed increased demand (USDA 2021). These measures helped households bridge the disruptive effects of the pandemic on household income and demonstrated the value of meeting basic needs.

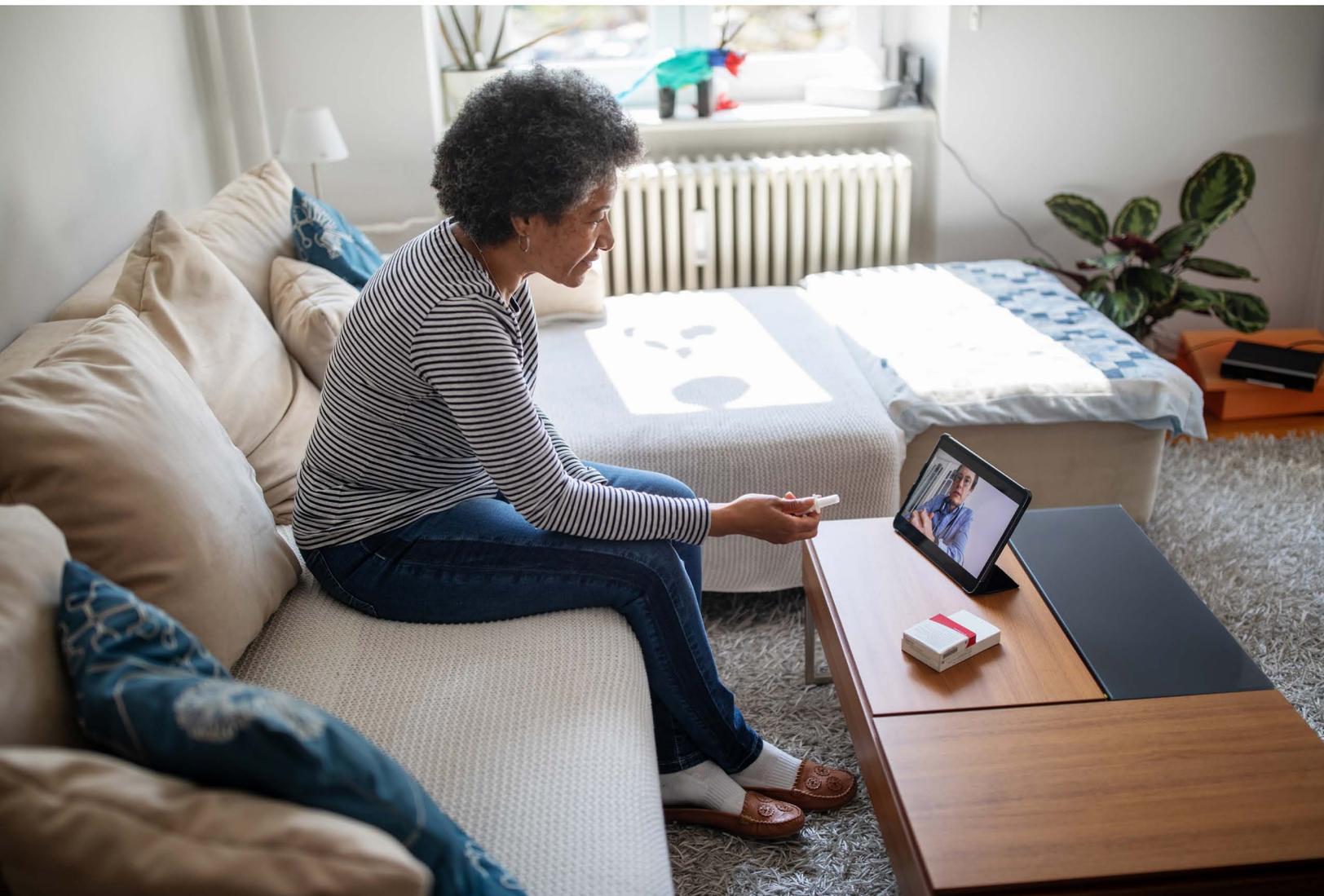
Short-term emergency measures cannot resolve the chronic problems, such as food insecurity, housing cost burdens, and lack of internet access, that many older adults faced prior to the pandemic. Once a sense of emergency about the pandemic has receded and emergency funds have been expended, what will it take to make progress on meeting the basic needs of older adults, particularly those from marginalized populations? The end of SNAP Emergency Allotments, for example, portends what the Food Research and Action Center calls a looming “hunger cliff” and an average household loss of \$82 in monthly SNAP benefits, with some standing to lose more (FRAC 2022). Projections such as these underscore the fact that many older adults faced crises before the pandemic and will continue to do so if current benefits are not continued or expanded.

RECOMMENDATION

For Improving Flexibility in the Long Term: Learn from Outcomes Under Emergency Conditions

Regulatory and administrative flexibility, while not a substitute for additional funding, can help alleviate some barriers to effective delivery of services to community-dwelling older adults. Going forward, there are ample opportunities for researchers to evaluate the long-term potential for flexibility in the use of funding to push forward public policy goals. Research is also needed on the ways that changes to systems—though intended for efficiency and

access—may inadvertently foreclose opportunities for some, as the move to telehealth did for those with limited access to technology or broadband. With this information, program administrators can better adjust existing programs that impact the lives of older adults. Finally, extending the federal Emergency Rental Assistance Program, expanding SNAP, and similar actions would help low-income and food-insecure households in need.



BARRIERS TO COORDINATION AND COLLABORATION ACROSS HOUSING, SOCIAL SERVICE, AND HEALTHCARE SECTORS IMPEDED EFFECTIVE RESPONSES

While the pandemic fostered innovation, it also highlighted barriers to progress in meeting the housing needs of America's aging society, including housing-focused services and supports. Many of these barriers result from the different approaches, funding streams, agencies, and policies underpinning housing assistance and supportive services. Yet given that individuals often need both in concert to age well in the place they choose to live, enhancing coordination is critical. This is true at several levels.

ELIGIBILITY CRITERIA ARE MISALIGNED ACROSS PROGRAMS AND SECTORS

One area of misalignment concerns eligibility criteria for affordable housing, social services, and healthcare. An older adult may be income-eligible for rental assistance through the Department of Housing and Urban Development (HUD) but not income-eligible for Medicaid, which could impede access to long-term services and supports. State policymakers and housing and social service providers are familiar with the **“trapped in the gap”** problem in which older adults are eligible for housing assistance but not for the services they need to live safely and comfortably. Greater flexibility in Medicaid eligibility for services and supports received in the home could help resolve this problem.

That federal housing assistance is not an entitlement and serves only a fraction of those who are eligible complicates these issues even more (Bailey 2020). Medicare, the universal healthcare insurer of Americans ages 65 and older, provides limited rental assistance through Medicare Advantage plans for enrollees with chronic, complex medical conditions who meet certain requirements (CMS 2021). Some states and localities have experimented with using

state Medicaid dollars to support housing for people with complex medical, mental health, and other needs who have been or are at risk of becoming homeless (Tompkins 2022). While these programs have limited overlap with the housing needs of many older adults, they may be a source of insight about how to develop, implement, and evaluate pilot programs to serve the housing and health needs of older adults eligible for both Medicaid and Medicare. A broader insight is that using state-level health insurance programs as sources of housing entitlements is itself a workaround for inadequate federal funding of housing assistance programs.

HOUSING, HOME CARE, AND WORKFORCE POLICY REMAIN DISCONNECTED

The pandemic highlighted the interrelationship of housing, home care, and caregiver support. For many older adults, suitable housing, access to transportation and other services, and care provided by paid and unpaid care workers make the difference between living in the community or in a residential care setting. Acknowledging how different forms of housing-focused care make aging in place possible involves advancing the interests of the home care workforce. Paid home care workers, an overwhelming majority of whom are women, need living wages, training and career-building opportunities, and affordable, safe housing (PHI 2022). Family members who provide care need support as well. While provisions for payments to family caregivers exist in state Medicaid programs and in Veterans Health, most family caregivers are unpaid (AARP and National Alliance for Caregiving 2020).

RECOMMENDATIONS

For Strengthening Connections Between Health and Housing Policy

Policymakers in federal, state, and local agencies, grantmakers, and/or researchers should:

- **Promote policy and social innovation among housing, healthcare, and social service programs that serve older adults and adults approaching old age.** This report has explored how the pandemic highlighted the interrelationship of housing and health, and also of housing policies and health policies. A post-pandemic goal of both fields should be to reduce barriers to coordination through collaborations that include social service and housing providers.

Strengthening the “connective tissue” needed to align housing and health policymaking sectors is a process that starts with sharing knowledge and building trust (Butler and Maguire 2022). Breaking down budget silos that stymie collaboration requires high trust and a willingness to share data typically viewed as sensitive. At the federal level, agencies such as HUD, HHS, and CMS should work together to better coordinate subsidies and incentive programs to support equitable access to affordable, service-enriched housing throughout the US. At the local, regional, and state levels, grantmakers, research centers, and other conveners can create forums for collaborative analysis of misaligned or insufficient policies, with the goal of identifying feasible, sustainable solutions. Finally, at the building level, differences in regulations and eligibility can inhibit collaboration, but personnel can take an active role in overcoming these barriers. As Sheppard et al. note, confusion about the roles of each party, staff turnover, and a lack of understanding of the connection between housing and health among those on the housing side can frustrate efforts at collaboration (Sheppard et al.

“I think there’s a new premise, which is the interconnectedness of us all...we can’t get our work done in the same way because we are so interconnected. And it just was this moment of realization. ”

TAM PERRY, ASSOCIATE PROFESSOR,
WAYNE STATE UNIVERSITY

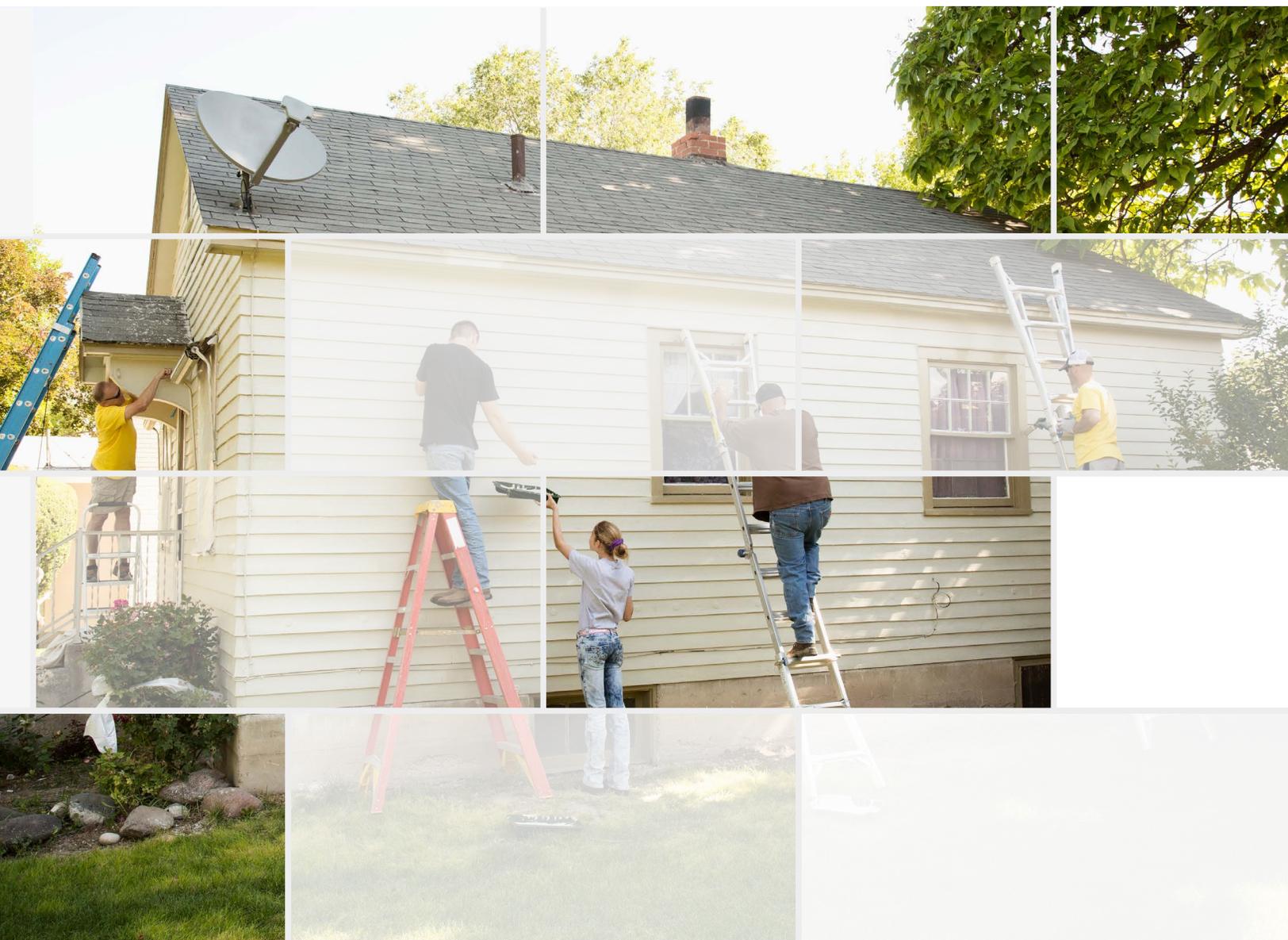
2022). Although some of these factors may not be under their immediate control, local leaders in health and housing can be mindful of these barriers when initiating collaborations.

- **Recognize housing disparities in policies focused on delivering care at home.** Aging in the community can be supported by trends in healthcare that were accelerated during the pandemic, including telehealth and even acute care in the home. However, housing disparities may mean that older adults with unstable, inadequate, or inaccessible housing, or without family caregivers or access to professional supports, are left behind. Policies that aim to expand access to home care should be recognized as housing-focused proposals because they depend on the home, its resources, and its capacity to function as a site of care and of employment; such policies should include provisions for upgrading infrastructure, addressing inaccessibility, and training and supporting family caregivers (Molinsky et al. forthcoming).

- **Adequately fund critical programs.** Recognizing the value and interconnectedness of programs and policies which serve older adults' housing, health, and other needs should lead to adequate funding and backing for such initiatives. On top of the recommendations we have listed above, this should include expanding existing housing assistance to eliminate long waiting lists and ensure that all who are eligible have access to safe housing they can afford. Public resources such as Area Agencies on Aging or public libraries can also be utilized to expand older adults' digital connectivity and literacy.

“We can’t leave funding for innovative programs to private philanthropy alone, as important as that is. Equity, sustainability, and impact through community-based social innovations for aging requires public support alongside private resources.”

**EMILY GREENFIELD, PROFESSOR,
RUTGERS UNIVERSITY**



CONCLUSION

The pandemic is not yet over and will have lasting effects. Social isolation has taken a toll on physical and mental health as older adults have had to forgo exercise and socializing outside the home. Long COVID means some people will continue to struggle. People with preexisting conditions or who are immunocompromised may remain isolated. Meanwhile, the homes of older adults may have suffered from lack of maintenance, increasing safety risks. Some inequities have increased, despite the creative responses highlighted in this report. In other words, the need has never been greater to provide adequate housing and support for America's older adults.

In the spirit of not letting a crisis go to waste, we must learn from the efforts of thousands of community organizations, public agencies, and housing and service providers, as well as millions of older adults, in order to better address the long-term needs of our aging society. Certainly the pandemic has offered insight into crisis response, but it has also shown us examples of collaboration and creativity that are useful in “normal” times. It has also shown more clearly the barriers we must address and the deep value of some existing approaches such as service coordination.

A final recommendation is that **we must change our collective narrative around how to support aging in place to recognize the crucial importance of housing itself. How we frame challenges shapes how we perceive potential solutions.** Issues concerning older adults are often framed in terms of health, because the biological process of aging produces a range of health effects that begin in mid-life and continue for

decades until death. For nearly sixty years, our society has acknowledged the health consequences of aging through the federal Medicare program, the universal insurer of Americans ages 65 and older. It is time to make a similar commitment to housing our aging society. This means recognizing how housing supports health and wellbeing whether or not an older adult is “healthy,” and imagining housing and community as integral to a good life in late life.

As a tool for analyzing problems and solutions, the housing lens focuses on older adults' homes in relation to every domain of health and wellbeing, including financial security, social engagement, physical safety, and access to services and supports. The housing lens also disrupts dominant narratives about aging that center the healthcare system, reminding us that while many health conditions are age-associated, older adults are more than their illnesses and clinical experiences. Additionally, the housing lens helps illuminate the economics of aging in America, where financial security requires affordable housing as well as affordable care.

It is difficult to change collective ideas about any topic (Davidson 2022). Yet we must try. The importance of housing in the COVID-19 pandemic, and the range of innovations and policy ideas that arose from the urgent need to keep people safe at home, can be the foundation of a new narrative about housing as the linchpin of wellbeing for older adults. Highlighting the place in “aging in place” may help us see with greater clarity how affordable, accessible, safe, suitable housing supports health, and how care and support are integral to home.

DEEP DIVES

DEEP DIVE #1

KINGDOM CARE SENIOR VILLAGE

Faith-Based Outreach to African American Communities in Washington, DC

BACKGROUND

Kingdom Care Senior Village belongs to a nationwide network of grassroots organizations founded by and serving older adults in their communities. In 2017, Kingdom Care launched as a result of a local government push to establish a village (see definition in [Appendix B](#)) in predominantly African American neighborhoods. Director Kathy Pointer drew on her relationships with her church community and her project management experience to secure funding, establish the village, recruit members as well as volunteers, and provide services.

THE AGE-IN-PLACE DC PROGRAM

In January 2022, thanks to greater public awareness of racial inequity, the support of the DC Village consortium, and funding from the local department of aging and community living, Pointer launched the pilot program “Age-in-Place DC” to expand outreach. “Ambassadors” at eight churches reach out to congregants and nearby residents to check in and provide assistance. Ambassadors’ familiarity with older residents and their needs helps them convey information about vaccines, transportation, programs for food delivery or home modifications, and referrals to home health aides and other professionals.

Through Age-In-Place DC, Kingdom Care expanded the number of people reached: in the fourth month of the pilot, Kingdom Care impacted 132 older adults. The new program allows older adults who are not official Kingdom Care members to receive an array of services, including check-in calls and visits, help with groceries or errands, food preparation, technology assistance, and transportation. Ambassadors also connect older adults with resources offered by city government, such as a program which provides free home modifications for safety reasons. So far older adults have responded positively to these interventions.

MAINTAINING VOLUNTEER-RUN EFFORTS

Although Kingdom Care has made great progress in serving communities of color—it is the only village in DC to focus on doing so—it still faces the issue of sustainability. Like many villages, it has no full-time staff. This limits its geographic range and ability to launch new initiatives. Through advocacy over the last few years, however, Kingdom Care and other DC-based villages have secured a high level of support from city government. During the pandemic, Kingdom Care also received supportive funding from a local foundation to address food insecurity. Other strategies for sustainability include documenting program impact, building up organizational infrastructure, developing partnerships, and mentoring volunteers for potential leadership roles.

CONTACT

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THE NEW YORK ACADEMY OF MEDICINE

Convening Age-friendly Groups for Neighborhood Change in NYC

BACKGROUND

The Center for Healthy Aging at The New York Academy of Medicine (NYAM) works to improve the health and wellbeing of current and future aging populations. The Center aims to achieve this work through four mechanisms: 1) convening for policy and practice change, 2) promoting data-driven planning and policy, 3) providing strategic assistance for policy implementation, and 4) contributing to the evidence base for healthy aging interventions.

In 2010, NYAM developed the “Age-friendly Neighborhood Organization” (AFNO) model in partnership with the World Health Organization to develop targeted solutions to neighborhood-level issues and to support emerging grassroots efforts driven by older people to improve neighborhoods. Working with both new and existing AFNOs, this model advances age-friendly priorities through local planning, community, and economic development efforts by soliciting feedback from older New Yorkers and partnering with community leaders and organizations.

CREATING AN AGE-FRIENDLY NETWORK

In response to the pressing needs of older adults during COVID-19, NYAM initiated a series of virtual convenings consisting of approximately 20 AFNOs as well as elected officials and local aging service providers to connect with each other, identify challenges and solutions, and exchange resources. Topics of focus included food access and distribution, access to information, communication

and technology, access to healthcare and behavioral health services, and the prevention of social isolation during physical distancing.

These convenings occurred monthly from July through September in 2020 and 2021, and were made possible by two private foundations, New York Health Foundation and New York Community Trust. Invited speakers included New York City Mayor Eric Adams (serving as Brooklyn Borough President at the time), Manhattan Borough President Gale Brewer, and experts who work at the intersection of aging and technology, affordable housing, civic engagement, and local business.

In addition, NYAM administered grants of up to \$3,000 to AFNOs that applied to work on projects of their choosing that addressed COVID-related needs in their neighborhoods. These included equipment and supplies to make virtual or in-person programming possible. For instance, Southbridge Fitness in Central Brooklyn began an intergenerational wellness program which included health assessments using FIT-3D (a health metric tracker) and facilitated educational grocery shopping trips to share sources of fresh and healthy produce. The grants also funded infrastructure improvements: in one example, Harlem Advocates for Seniors installed Wi-Fi at two sites as part of a larger program to expand technology access.

LIMITATIONS OF THE DIGITAL DIVIDE

These monthly convenings could be attended only by individuals who had digital access and sufficient knowledge to use video meeting platforms such as Zoom. In addition, these convenings relied on limited private, one-time funding to operate.

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SENIOR HOUSING PRESERVATION-DETROIT

Partnerships to Protect Subsidized Housing Residents

BACKGROUND

Senior Housing Preservation-Detroit (SHP-D) was formed in 2013 to address displacement of older adults from HUD-funded housing as building contracts expired. Against a backdrop of decreasing financial support for public housing and pressure from gentrification, this coalition of advocates, nonprofit housing providers, and researchers has worked continually to raise awareness among civic leadership of the needs and concerns of older adults living in low-income senior buildings (Perry et al. 2015; Perry, Archambault, and Sanford 2017; Perry et al. 2021). To do so, the coalition has worked with local government and provided input on Michigan's plan on aging.

As the extent of the pandemic's impact became apparent, SHP-D extended its focus beyond preserving affordable housing to protecting the health and wellbeing of residents and staff in senior housing. The coalition held additional meetings and addressed concerns including acquiring personal protective equipment, conducting public health education, and carrying out important renovation projects planned before the pandemic (Perry et al. 2021).

SAFETY ISSUES DURING RENOVATION

During the pandemic, renovations confronted older residents with the risk of infection as well as displacement. The health crisis added another level of complexity to existing concerns about the health and wellbeing of residents. For example, if residents live in the same unit throughout construction, dust

and noise could exacerbate existing health concerns, particularly asthma. SHP-D drew attention to the importance of mitigating these factors when planning for renovations. In addition, the coalition emphasized that information should be communicated keeping in mind residents' literacy levels, languages spoken, and preferred modality (email, paper delivery under door, signs posted in hallways, telephone calls).

PRODUCING GUIDANCE FOR THE FUTURE

Among other health-related concerns, SHP-D aimed to raise awareness of safety during renovations to developers and city officials. The coalition raised this topic via a public meeting in partnership with the City of Detroit's Housing and Revitalization Department on March 2, 2021. The coalition also produced a journal article (Perry et al. 2021). Using case studies, the coalition suggested multiple ways renovations have to be tailored, including accounting for the digital divide in information dissemination strategies, tracking visitors for contact tracing, possibly separating entrances for residents and tradespeople, and clearly designating responsibility for cleaning. By offering specific details, these case studies shed light on the importance of careful planning which incorporates the perspectives and health concerns of residents and staff as well as public health guidelines. By building a dialogue around renovation, SHP-D and similar advocacy groups can attract greater attention toward the quality of life and individual needs of those living in senior housing.

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TOGETHER WE ENGAGE CAMPAIGN

California's Public Outreach Process for the Master Plan for Aging

BACKGROUND

In June 2019, Governor Gavin Newsom signed Executive Order N-14-19 calling for the development of the California Master Plan for Aging (MPA) (California Executive Department 2019). The MPA is a ten-year, cross-sector initiative to further age- and disability-friendly goals.

Between September 2019 and October 2020, the California Department of Aging oversaw the Together We EngAGE campaign, which collected input from the public, stakeholders, and partners through pledges, surveys, meetings, webinars, and legislative and community roundtables. To help guide the process, a Stakeholder Advisory Committee (SAC) and two subcommittees were formed. Together, they include nearly eighty stakeholders representing local government, healthcare and service providers, health plans, labor, community-based organizations, academia, and consumers.

LAUNCHING A STATEWIDE CAMPAIGN

The Together We EngAGE campaign was intentional about reaching a diverse audience, particularly older Californians and their caregivers who had not engaged in government advocacy in the past. To do this, the public was offered many opportunities to provide comment through formal written comments, a public comment portal, numerous webinars, and stakeholder meetings (California HHS 2019a). With the arrival of COVID-19, all meetings were moved to web-based platforms. This enabled Californians from across the state to participate, including individuals who would otherwise not have been able to travel for in-person meetings. Stakeholders drove the meeting

schedules, helped set agendas, and recommended subcommittees and workgroups. The administration created a cabinet-level workgroup, which served to elevate the visibility of stakeholder recommendations to the highest levels of state government.

OUTCOMES AND FUTURE WORK

Throughout the Together We EngAGE campaign, the California Department of Aging received over 240 policy recommendation letters submitted by stakeholder organizations and over one thousand public comments through the online comment portal. Housing was cited as the number one issue across the public comments, totaling 19 percent of the comments received and topping issues such as health and wellness, long-term services and supports, information and assistance, family caregiving support, economic security, transportation, and elder abuse (California HHS 2019b). As a result, housing was identified as one of the top issues in the SAC recommendations in fall of 2020, as well as in the state's plan, released in January 2021.

Overall, Together We EngAGE brought aging and disability rights policy topics to the forefront of California's public discourse. This has been particularly true in housing and homelessness policy, where the MPA is leading to increased policy focus on the unique housing needs of older adults and people with disabilities. Stakeholder engagement continues in 2022 through public events such as webinars, regional roundtables, and public stakeholder meetings, now featuring targeted multilingual outreach to underrepresented communities (California Department of Aging 2022).

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2LIFE COMMUNITIES

A Resident-Centered Approach Toward Service Delivery

BACKGROUND

In the Greater Boston Area, 2Life Communities owns and manages five campuses—including over one thousand units—providing a range of service-enriched housing for extremely low-income and low-income older adults.

As the pandemic began, 2Life had many organizational strengths, including a highly experienced leadership team; strong rapport among staff; relationships with private donors, service providers, and other nonprofit, for-profit, and government actors; and a decades-long commitment to residents' health and wellbeing (Bratt 2022). As a result, the organization is able to provide extensive services, including social programming, and responsive on-site staff.

STRATEGIES FOR FINANCIAL INDEPENDENCE

2Life's strengths are bolstered by significant financial reserves. To build its finances, 2Life was strategic in utilizing HUD funding programs and regulations prior to the pandemic. HUD restricts how nonprofit developers of subsidized elderly housing can use "excess" revenue (meaning positive cash flow at year end). 2Life shifted ownership of its properties to for-profit limited liability corporations which were wholly owned by the nonprofit parent. 2Life also made use of another HUD rule that allowed it to raise rents, with all of the increase being paid through federal housing subsidies. At the same time, tenant rent payments were capped at the HUD limit of 30 percent of

income. Revenue from these sources has fueled service innovations and created critical reserves which were partially used to fund 2Life's pandemic response.

EXPANDING SERVICES DURING THE PANDEMIC

As the public health crisis evolved, 2Life was able to provide flexible, comprehensive supports. Even before a HUD mandate, based on emerging information, leadership decided to restrict outside visitors and partner with residents, who were awarded the title of "community heroes" after they agreed to remain in their apartments and to follow other COVID-related protocols. Staff kept tenants updated through a combination of phone calls and emails in their native languages. To help residents access a wide range of online programming it created during the pandemic, 2Life purchased and then loaned digital devices to residents, provided help setting them up, and delivered free groceries, personal items, meals, mail, and laundry services. These far-reaching efforts required the trust and support of staff and tenants.

Flexible funds, aggressive outreach, and strong relationships with external actors were key in setting up an on-site COVID-19 testing program in the fall of 2020. All of the above factors helped facilitate 2Life's efforts to educate and vaccinate virtually all its residents and staff (over 90 percent by March 2021). Despite the difficulty of implementing new processes across five campuses, 2Life succeeded in prioritizing the safety and wellbeing of residents and staff during the pandemic.

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COMMUNITY AGING IN PLACE—ADVANCING BETTER LIVING FOR ELDER (CAPABLE)

Adapting a Home Modification Program to Prevent Infection

BACKGROUND

The Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program is a home-based intervention to increase mobility, function, and capacity for older adults to “age in community.” CAPABLE consists of a series of ten home visits over the course of five months from an occupational therapist, a registered nurse, and a handy worker.

The CAPABLE program partners with more than forty organizations nationwide to implement the program. These include the Johns Hopkins Home Care Group (JHHCG), which provides comprehensive options to help individuals manage their health from home. While some CAPABLE sites paused services due to COVID-19, JHHCG continued throughout the pandemic.

KEEPING STAFF AND CLIENTS INFORMED

In the beginning of the pandemic, there was a lack of direction and consistent information regarding safety measures from federal and state government. JHHCG’s relationship with Johns Hopkins Medicine allowed CAPABLE staff access to reliable, evidence-based information: CAPABLE staff met regularly with healthcare specialists, and a virtual meeting was conducted between Dr. Anthony Fauci and the Johns Hopkins community. From these resources, CAPABLE staff were able to develop protocol to implement safety measures for clients and staff, such as wearing masks, hand hygiene, and holding internal staff meetings online.

CAPABLE clinicians were often a client’s primary contact for health information during the pandemic. To counteract misinformation about COVID-19, information sheets were developed and provided to CAPABLE clients. During in-person visits, staff also provided guidance on COVID-19 safety measures.

In addition, algorithms were developed to screen for clients’ exposure to COVID-19. These algorithms were updated periodically as new information became available. COVID-19 tracking procedures were also established to track client exposures, symptoms, and positive test results to determine appropriate quarantines.

CONDUCTING HOME VISITS SAFELY

Acquiring PPE was a universal challenge in the early days of the pandemic. The JHHCG CAPABLE manager worked to identify legitimate supplies to secure PPE for program staff, including N95 masks, gloves, hand sanitizer, and face shields. With the shortage of PPE, volunteers worked in shifts to provide CAPABLE field staff with hand sanitizer, gloves, face shields, and other supplies. Protocols and training were also developed to provide information to CAPABLE clinicians on how to safely perform an in-person visit, including instructions on how to sanitize PPE equipment. For clients reluctant to schedule home visits, clinician procedures for virtual visits were developed and training was provided to optimize virtual visits.

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APPENDICES

APPENDIX A: APPROACH AND METHODS

We used a variety of methods to explore the landscape of housing-related policies and practices which emerged as part of pandemic response. Given the breadth of our scope as well as the ever-evolving nature of the pandemic, we used an iterative process for information-gathering and analysis. Key elements included a broad scan of academic as well as “gray literature” and collaboration with a network of subject experts and practitioners. Our findings informed the important concepts and takeaways highlighted in the body of this report.

Starting in the summer of 2021, we sought out promising policies and programs that developed or changed during the pandemic to address the needs of older adults living in the community. We interpreted “housing-related” in a broad sense to include interventions which were delivered to or in the home. Our network members helped identify eight key topics for our initial search of gray literature:

Home-based improvements

- Housing affordability - minimizing the burden of housing payments
- Housing safety - reducing health and safety risks
- Housing accessibility - adapting infrastructure to suit residents’ needs

Connecting home to services

- Access to health - connecting people to healthcare and health-related information
- Supportive services - providing other essential in-home services
- Neighborhood supports - strengthening community networks
- Social isolation - addressing mental health needs
- Digital divide - overcoming barriers to internet access

The goal of the search was not to create a comprehensive survey of all COVID-19 responses in these categories, but

to scope out a variety of solutions that could be applied to community-dwelling older adults in a post-pandemic United States. Sources included news articles, e-newsletters, organizational updates, reports, white papers, and journal articles. We began with general terms such as “COVID housing older adults” and moved on to more targeted searches. We also drew on online repositories of pandemic-era best practices such as n4a’s annual Aging Innovations & Achievement Awards. As other scholars have found (Adams et al. 2016), expanding our scan beyond academic databases gave us a much more comprehensive view of COVID-19 responses.

From these results we created an archive of promising policies and practices that addressed needs related to COVID-19. To ensure we had a wide variety of solutions, we categorized them based on location, organizational type, target populations, date of implementation, and, if publicly stated, size of impact. As of March 2022, we had collected over 200 examples which fit the criteria outlined above.

With the help of our network, we singled out certain kinds of policies and practices as especially promising. Keeping in mind the diversity of older adults and the neighborhoods in which they live, we interviewed and emailed some practitioners who managed or developed innovative interventions. In the spring of 2022, we also invited network members to present on their own work at a series of focus groups centered around different residential settings. This additional data collection resulted in some of the Deep Dives and examples scattered throughout the report.

Discussions with the entire network helped solidify and refine overarching themes that emerged from our findings, which we present in Observations and Recommendations. These conversations also brought up additional gaps in housing and service provision which often predate the pandemic and have not yet been adequately addressed, as explained in The Pandemic As Stress Test. Finally, our team further developed the housing lens as we considered the potential of the COVID-19 crisis to bridge existing fields and allow for new ways of cooperation.

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APPENDIX B: GLOSSARY

Aging in place – A desire to remain as long as possible in one’s current home or community and to avoid institutional care. Requires attention to housing accessibility, affordability, safety, and suitability (see definitions below), as well as adequate provision of care (see definition) and in-home services.

Community-based living or living in the community – Refers to living in private households (including in owned, rented, service-enriched, and/or age-restricted settings) outside of institutional settings such as nursing homes.

Care – Actions which help maintain a person’s physical and mental health, typically provided by other people. Includes healthcare administered through institutions and by paid workers as well as services provided by volunteers, friends, and family members. Examples range from social calls and wellness checks to help with cooking, bathing, and administering medication.

Digital divide – The gap between those who have access to online resources and those who do not due to the lack of a strong internet connection, technology, and/or the training to use it. These issues may be related to affordability, availability of coverage, and other factors resulting from structural inequalities.

Digital equity – A state in which all have the option of internet access and, if they wish, the ability to use it. Initiatives that increase the affordability and availability of digital connections, internet-enabled devices, and technological know-how contribute toward this outcome, as do programs which address the underlying causes of the digital divide.

Housing lens – A tool for reframing how we consider older adults’ health, emphasizing the importance of homes and communities. Underscores how residential setting affects physical and mental health, financial security, access to needed services, and opportunities for social engagement.

Housing accessibility – A home environment that a resident can navigate, enter, and exit without difficulty. This may change over time depending on a resident’s level of ability or the condition of the home.

Housing affordability – A state in which housing costs (including utilities) are sustainable in relation to household income and to spending on food, healthcare, and other necessities. Can be measured by metrics such as housing cost burden (spending more than 30 percent of one’s income on housing). We also use “affordable housing” to refer to various models and programs in which housing is subsidized or relatively low-cost; however, residents of “affordable housing” may still struggle to pay for it.

Housing safety – A home environment that does not pose the risk of physical injury or harm for its residents. Risks may include lack of adequate ventilation, heating or cooling, or adaptation for natural disasters. Safety may be related to features of the home as well as its surroundings.

Housing suitability – Related to housing accessibility, affordability, and safety, this term encompasses other aspects of the home that satisfy residents’ preferences and needs. Depending on the individual or household, this may include natural lighting, an adequate number of bedrooms, and proximity to needed transportation and services.

Naturally occurring retirement communities (NORCs) – Apartment buildings, complexes, or neighborhoods that are not age-restricted but house a significant number of older residents. May have organizations on site, such as building management or a tenants’ association, which support aging in place. One example is Penn South (see [Appendix C](#)).

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Network – “Three or more organizations connected in ways that facilitate achievement of a common goal” (Provan, Fish, and Sydow 2007). Cooperation may include sharing information, resources, and support. Some networks are formal, with members and conveners, while others are informally convened and may expand or contract as needed (Provan, Fish, and Sydow 2007).

Partnership – Close cooperation between two or more organizations to achieve a concrete objective. Can include members of the same network.

Service coordinator – A service coordinator helps residents access services and supports that help them remain self-sufficient and socially connected.

Service-enriched housing – Service-enriched housing refers to housing that includes services on-site that are provided and/or managed by trained staff. Includes housing subsidized through public as well as private sources. 2Life Communities (see [Deep Dives](#)) is an example.

Services and supports – Similar to “care,” refers to a broad range of activities that support people’s physical and mental health, as well as independent living. This report focuses on services and supports delivered to older adults’ homes.

“Trapped in the gap” – A shorthand term referencing the misalignment of eligibility criteria for assistance with housing and services and supports. For instance, someone who qualifies for federal rental subsidies based on their income might not be eligible for Medicaid. This can make it more difficult for affordable housing providers to fund services for all their tenants.

Village program – Membership-based local nonprofits, often grassroots, which provide programming, resources, and services to improve quality of life for community-dwelling older adults. Frequently rely on volunteers for service delivery, but may also receive funding from public sources. One example is the Kingdom Care Senior Village (see [Deep Dives](#)).

APPENDICES

APPENDIX C: POLICY AND PROGRAM INDEX

NAME OR DESCRIPTION OF POLICY OR PROGRAM	LOCATION	PRIMARY ACTOR(S)	PAGE
Expansion of Medi-Cal to undocumented older immigrants (California SB 56)	California	State Senate and Assembly members, Health4All coalition	19
Weekly calls with healthcare, housing, and service providers	Massachusetts	LeadingAge Massachusetts	23
Documentation and analysis of age-friendly community work	Northern New Jersey	North Jersey Alliance of Age-Friendly Communities	23
Meal delivery and advocacy for older adults	Honolulu, Hawaii	Kūpuna Food Security Coalition, Kūpuna Collective	23
Partnerships to deliver meals to older adults	Florida	State departments, Florida Restaurant and Lodging Association, Area Agencies on Aging	24
Rural Transportation Incubator	Arizona	Maricopa Association of Governments, Age Friendly Arizona, funders	24
Provision of tablets, internet, and support for public housing residents	New York City, NY	Local housing authority, Older Adults Technology Services (OATS), T-Mobile	24
Multilingual public health outreach	Chelsea, MA	GreenRoots	25
Outreach to address vaccine hesitancy	Georgetown County, SC	Tidelands Health, NAACP	25
Grassroots provision of services and supports	Leeds, United Kingdom	Leeds Neighbourhood Networks	25
R3 funding for partnerships and applied research	Connecticut	Donaghue Foundation	26
Outreach and support for older residents	Columbia, SC	SC Thrives, city government	28
Experience Matters program	Various cities (US)	Johns Hopkins University's Cities of Service, AARP	28
Funding for efforts to engage older adults	Connecticut, Massachusetts, New Hampshire, Rhode Island	Tufts Health Plan Foundation (now part of Point32Health Foundation)	28

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NAME OR DESCRIPTION OF POLICY OR PROGRAM	LOCATION	PRIMARY ACTOR(S)	PAGE
Mobilization of older adults as healthcare policy advocates	Providence, RI	Senior Agenda Coalition of Rhode Island	28
Support for older advocates in age-friendly initiatives	Springfield, MA	Way Finders, Inc.	28
#Powertolive campaign	Bay Area, California	Grassroots volunteer group	28
Senior Civic Academy	Boston, MA	University of Massachusetts Boston's Gerontology Institute	29
Door-to-door check-ins and vaccine delivery	Toronto, Canada	Toronto Community Housing Corporation Seniors Housing Unit	31
Volunteer-run check-ins and help with errands	New York City, NY	Penn South	31
Connected for Success	Ontario, New Brunswick, Newfoundland and Labrador, Canada	Rogers, various public partners	34
Expansion of reimbursable telehealth	United States	CMS, state Medicaid programs	36
Support for family and friends as personal care workers	Massachusetts	Medicare/Medicaid, state government	36

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ENDNOTES

1. Housing assistance is not an entitlement for any age group; while households may qualify for assistance based on income, housing or rental assistance is not guaranteed. There is also no housing entitlement equivalent to Medicare for which older adults qualify on the basis of age.
2. The experience of nursing home residents during the pandemic is the topic of other reviews, including a 2021 report by HHS (Clarke-Whyte et al. 2021).
3. Rebecca Bentley and Emma Baker also use the term “housing lens” to describe the importance of home and community for health outcomes (Bentley and Baker 2022). Their discussion focuses on implications for researchers. We develop and use this term in the context of policymaking and practice, with attention to research and its translation in these areas.
4. For example, see Shaw 2004; Eibich et al. 2016; PRB 2017; Sanders 2020; and Oswald et al. 2007.
5. See Varshney, Glodjo, and Adalbert 2022; Husain et al. 2021; and the Centers for Disease Control and Prevention Nursing Home COVID-19 Data Dashboard.
6. There is no standard definition of “aging in place.” For some, the term may refer to remaining in a longtime home while for others, it may refer more broadly to living in any residence outside institutional settings (Forsyth and Molinsky 2021). In this report, we use the term in the broadest sense, focusing on older adults dwelling in the community. This includes those living in a longtime home or one that is new to them, regardless of whether it is their own home or that of another person.
7. The National Academy of Medicine’s Global Roadmap for Healthy Longevity notes lack of affordable and accessible housing as a barrier to this goal (National Academy of Medicine 2022).
8. Except where otherwise noted, data in this paragraph are from Joint Center for Housing Studies tabulations of the US Census Bureau’s 2019 American Community Survey and the Federal Reserve Board’s 2019 Survey of Consumer Finances.
9. Federal agencies are the main provider of rental assistance for low-income households, including older households (Couch 2020). Assistance may take the form of public housing, vouchers, or subsidies to incentivize lower-cost housing development.
10. See for example Bunker et al. 2016; Carter et al. 1997; Clayton et al. 2017; Crimmins et al. 2016; Gamble et al. 2013; Kenny et al. 2010; and McDermott-Levy Ruth et al. 2019.

ENDNOTES

11. Joint Center for Housing Studies tabulations of the Health and Retirement Study 2018. This analysis excluded respondents to the HRS survey who had spent any time in nursing homes in the previous two years.
12. This review largely excludes housing- and service-related responses that addressed the needs of people of all ages such as eviction moratoriums, mortgage foreclosure moratoriums, mortgage forbearance, stimulus payments, and other programs and protections that helped stabilize living conditions for those otherwise unable to pay for housing due to lost wages. These programs and approaches are well-examined elsewhere and therefore not the focus of this report. See, for example, Reid, Manji, and Rosenberg (2021) on hotel conversions, and Gerardi et al. (2022) for lessons for US housing policy. It should also be noted that during the pandemic, the Black Lives Matter movement drew increased attention to the racial dimensions of health and housing inequities, leading to greater focus on developing effective programs (such as vaccine outreach) informed by the needs and concerns of specific populations (Corallo, Artiga, and Tolbert 2021). In some places, calls for racial justice in housing and concern over rapidly rising housing costs contributed to conversations about amending zoning and other land use regulations to permit greater density and encourage more housing options, including smaller units at lower prices. These shifts are helping to expand housing choice for people of all ages and are covered in depth in other reports and articles.
13. Ansell, Sørensen, and Torfing 2021; Boin 2009; Willi et al. 2020; Witkowski et al. 2021.
14. Networks are useful in times of crisis, providing “organizations with the opportunity and benefit of shared resources and information and the capacity to adapt and adjust to changing environments” (Tao and Zhang 2020). Interorganizational networks play an important role in disaster response (Kapucu and Demiroz 2017). Critically, individuals within organizations often drive networking (Provan, Fish, and Sydow 2007).
15. Correspondence with Christy Nishita, University of Hawaii, July 2022.
16. Interview with Amy St. Peter, Maricopa Association of Governments, August 2022.
17. Correspondence with Caitlin Coyle, University of Massachusetts Boston, July 2022.
18. Interview with Jaipreet Kohli, Toronto Community Housing Corporation, February 2022.

