

APPENDIX 1.

ANNOTATED REVIEW OF THE LITERATURE ON HOUSING WITH SERVICES FOR OLDER PEOPLE WHO AGE IN PLACE

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INTRODUCTION

This annotated review focuses on research related to programs that bring community services into existing housing to foster aging in place and maximize older people's independence in the community. Examples of these programs include service programs in Naturally Occurring Retirement Communities (NORCs), support services in public housing, and "cluster care," where a group of home care agency workers serve clients who live in close proximity to one another. Research about facilities that were originally designed to provide long-term care, such as most assisted living facilities, continuing care retirement communities, and nursing facilities, are not part of the literature review. The annotated review also includes available descriptions of prominent NORCs.

The literature for NORCs is summarized first, followed by support services in public housing programs, cluster care, and assisted living programs that bring services to existing housing. In each section, articles are presented in reverse chronological order. When articles by the same author repeat information or concepts, the repetition is eliminated.

LITERATURE RELATED TO NATURALLY OCCURRING RETIREMENT COMMUNITIES (NORCs)

Yalowitz, Nat. *NORC Supportive Service Programs: The Need for Strong and Clear Governance.* For presentation at the Joint Conference of The National Conference on the Aging and the American Society on Aging, Denver, CO. New York, NY: NORC Supportive Services Center, Inc., April 2002.

There are over 35 NORC supportive services programs (NSSPs) in five states, all of which are community based and on site at the housing units they serve. These housing units have close relationships with many existing social and health service agencies that served the communities before the coming of the NSSPs. The author uses the experience in these NSSPs to examine governance issues for service programs in NORCs.

The author emphasizes the importance of a clear, strong, workable governance structure that is committed to the principle of supporting the continued independence of the seniors the program serves. There should be an organized body of people who will take responsibility for setting the policies of the program, be accountable for finances, and will clearly set out the mission of the program. Governance objectives should be spelled out in contract language between the NSSP and the service agencies. Performance-based evaluation should be part of the program. Care should be taken that the program design and implementation cater to the seniors involved and not to the staff of the agencies. Seniors should feel empowered and should feel ownership of the program. Staff training in these principles is critical. NORC programs should be concerned with the "continued building of the community in which they are organized as well as the broader community." The article gives several examples of problems that have arisen when these principles are not followed. The author endorses the position taken by New York and Maryland legislators that there be a strong presence of housing leaders and consumer input in the governance structure of NORCs.

The Jewish Home & Hospital Lifecare System. *What We Do: Retirement Community Services (NORCs).*

<http://www.jewishhome.org/script.asp?SubCatIS=41>.

This web site describes the Community Services Division of The Jewish Home and Hospital. According to the web site, this division provides nursing consultation, health education, care management and social services to hundreds of frail elderly residing in naturally occurring retirement communities (NORCs) in New York City. The authors state that "the NORC model of providing health and social services to elders has been very successful in assisting senior citizens who wish to remain in their homes and 'age in place'."

Chicago Mutual Housing Network. *Overview of NORC Programming.*

<http://www.chicagomutual.org/level4/norc/norcprogramming.htm>.

Chicago Mutual Housing Network is using the Penn South model in a pilot NORC program at two sites funded by the Department of Housing and Urban Development and NORC Supportive Services, Inc., in New York. The web site lists services provided by month for three months.

Landsberg, Gerald, Catharine MacLaren, and Harry Schwartz. *The Accomplishments, Issues and Prospects of Supportive Service Programs in Naturally Occurring Retirement Communities*. Prepared for the Fan Fox and Leslie R. Samuels Foundation. New York, NY: Ehrenkranz School of Social Work, New York University, September 2002.

In the introduction to the report, the authors define a NORC as “an apartment building, a housing development or a neighborhood with a large concentration of older adults” (p. 1). They note that more than twice as many people live in NORCs as in housing planned specifically for the elderly. Since NORCs are not planned specifically for the elderly, they often lack supportive services. Organized programs of supportive services have been in place since the mid-1980s for NORC residents, 35 in the country of which 28 are in New York City and two in upstate New York. The authors attribute the large number of programs developed in New York City and upstate New York between 1986 and 2001 to the availability of support and funding from the state and the city. Table 1 of the report (p. 9) gives a list of the programs, the date each was established, and the number of housing units in the NORC. Table 2 (p. 13) gives for each program the number of housing units and the number of elderly (total, minority, and disabled). Table 3 (p. 14) provides selected demographics for supportive services clients, 1995 and 2000.

This report provides a summary of the programs in New York and a brief history of how they emerged, including the development of state and city funding streams. The report reviews key factors that shaped the programs and identifies lessons learned, considers programs in other states, and discusses the development of supportive services and the educational activities undertaken by the project at New York University (NYU). The report also includes extensive bibliographies on NORCs and related topics, as well as appendices with statistical materials on program performance, authorizing legislation, and other information.

The New York supportive services program has four objectives: (1) to provide a range of flexible and integrated community-based services (health, social, and allied services), (2) to stress preventive care and services that will enable people to remain at home and live independently, (3) to give consumers and their caregivers an active role in the major decisions affecting their care, and (4) to use the number and density of older people in the NORCs to facilitate care and the delivery of services. Factors shaping the supportive services program include:

- Volunteer activities were the antecedents of the program; volunteer and intern activities remain important.
- Program planning is based on resident surveys, NORC board and management, perceptions, and agency experience; outreach to residents is through flyers, work of mouth, etc.
- Staffing issues (recruitment, retention, training, pay, case loads, shortage of geriatric social workers) affect the program.
- Program governance through the board allows resident input.
- The lead agency takes the major role in organizing and operating the program but partnerships with other agencies and linkages with other resources are important, and management of the NORC is important to keep the program running smoothly.
- Financing is from city and state governments, the board, residents, grants, and users.

According to the authors, the key lessons learned have been:

- The size and compactness of the NORC facilitates service delivery, enables outreach, and encourages social interaction and mutual support among residents.
- Diversity, responsiveness, and flexibility are important characteristics of the service program. Each program is different. Resident input is important.
- Staff relationships are important; changes to staff or services can be disruptive.
- Group services, volunteer activities, and opportunities for informal help all foster the social contacts important for healthy aging.

- Housing management can play a positive role in the program.
- Collaboration with other community resources makes a wider range of services available to residents.

Programs outside New York include Services To Apartment house Residents (STAR) in Philadelphia which serves high-rise cooperatives, the Community Options program in suburban Cleveland which serves residents of four privately owned rental complexes, the Assistance-In-Living program in Greenbelt, Maryland, which serves a mixture of apartments and houses, and programs in two clusters of moderate income cooperative apartments in Chicago. A new program, the AdvantAge Initiative operated by the Visiting Nurse Service of New York, uses surveys as a tool to identify “elder friendly” housing options. This program is operating on a pilot basis in 10 communities nationwide.

The report also includes case studies of seven open NORCs in New York that were done to assess the possibility of developing supportive services programs in such neighborhoods. The goal was to identify the problems of elderly residents of these communities and the services available to them and to identify the prerequisites for developing service programs for such communities. The authors identify eight general issues from these case studies:

- Demographic and cultural changes shape the need for and use of community-based services.
- Community institutions serve as conduits for information about programs and promote social cohesion as well as providing major services, such as hospital care.
- Housing patterns and deficiencies matter, as do public services and infrastructure such as transportation and public safety.
- Chronic illness and access issues are the major health problems identified.
- Other services needed are home care, mental health care, nursing, social service coordination, transportation, and home repair and maintenance.
- Problems within agencies and between agencies can interfere with service delivery.
- Resource gaps exist including funding for local services, gaps in health insurance for home care, and reluctance of seniors to tap their own assets for personal care.

The size of the NORC shapes the scope of the program. The authors assert that the minimum number of older residents necessary to sustain a program in a service area is 1,000 over the age of 75 and a total of 3,500 over the age of 65. Based on the case studies of open NORCs and on the evaluation of the service programs for closed NORCs, the authors developed a list of prerequisites for programs in communities with large numbers of elderly residents:

- A mix of housing densities and types.
- A basic network of health and social agencies.
- Inter-agency cooperation.
- Community institutions such as churches, associations, etc.
- A key agency to take the lead.
- Resources to sustain the program.
- A suitable space that is convenient, accessible, ample, reasonably priced, and comfortable.
- Community support.

The report provides some details from various reports done on NORCs. An evaluation of four NORCs between 1994 and 1998 by Landsberg and Rock of New York University compared users and non-users of supportive services; users are more likely to be women, older than 85, and living alone. A survey of Penn South households (no date provided) described proportions of clients who used services: 8 percent used social services such as case management, 7 percent used information and referral, 4 percent used nursing services, 24 percent attended classes, 20 percent attended health screenings, and 12 percent attended lectures. Of those who did not use services, 18 percent did not like the program, 17 percent go elsewhere for services, 16 percent were not aware of the services, 9 percent did not yet need the services, and 8 percent did not need the services at all. Satisfaction was generally good for services but varied by type of service. A 1996 survey at Penn South and two other NORCs found cultural events to

be the most popular service, followed by exercise and dance classes, and health events. The report notes that residents tend to be selective in their use of services and that group services seem to be more popular than individual services.

Lyons, Beverly P., and Carol Magai. "Reducing Health Risks and Psychological Distress among Older Black Residents of Naturally Occurring Retirement Communities." *Journal of Gerontological Social Work* 35, no. 1 (2001): 53-69.

Overview

The purpose of this study was to determine if certain health and social interventions could reduce health risks or improve psychological well-being among older NORC residents. The authors defined a NORC as a housing community where at least 65 percent of residents are aged 50 years or older. The first hypothesis tested was that the experimental group would show improvements in health behavior as a result of the health intervention. The second hypothesis was that the experimental group would experience improvement in psychological well-being as a result of the social intervention. The authors expected that these improvements would continue after the end of the experiment.

Methodology

The study participants were 45 older black residents at two NORC sites located three blocks apart. The authors did not specify the minimum age for participation in the study or the location of the NORCs. Participants were drawn from attendees at a health education seminar; 19 participants were in the control group (group 2, n = 19), and 26 were in the treatment group for the eight-week study. The authors say that treatment and control groups were randomly assigned to the two buildings to prevent cross-contamination between the groups through "diffusion effects." The treatment was a program that residents attended once a week, with 45 minutes devoted to health education and the other 45 minutes devoted to facilitating socialization.

Data collection occurred from August 1999 through December 1999 in three waves--a baseline survey, a post-intervention survey at the end of the treatment, and third survey two months after the treatment ended. The third survey determined whether the treatment's effects were sustained. The researchers collected data from 24 of 26, and 17 of 19 participants in the treatment and the control groups, respectively.

Findings

The average age of participants was 79 years old and 89 percent were female. The authors report that the "median income range" for all participants was "\$4,000-\$6,999; the authors do not specify whether this is an annual figure. The first hypothesis regarding health behaviors was not supported. The treatment group had higher scores on good health behaviors than the control group for all three surveys, so the results cannot be attributed to the treatment. The second hypothesis related to psychological well-being was supported because the treatment group experienced an improvement in psychological well-being, and this improvement was sustained after the treatment ended.

Recommendations

Short-term psychoeducational interventions could improve the quality of life for older minority residents of NORCs. The implications for social work practice include the need for social workers to increased sensitivity to cultural differences, broaden the focus of their assessments of older black clients, and introduce inexpensive, innovative, and interesting interventions. However, future studies need to determine if individual, environmental, and behavior practices may prevent the onset of diseases among the black populations.

Study Limitations

The authors point out several limitations. Diffusion effects could have occurred because of close proximity of the two NORCs. The sample was small. Although study participants were representative of older blacks in New York City, this minority population may differ in other regions in the country, which may affect the generalizability of the study findings. A long-term intervention may have produced different outcomes. Finally, the health behavior measures were not widely used instruments with good psychometric properties.

Another limitation of the study is that participants came from people attending a health forum. These people might be more social by nature and inclined to participate in community life. Thus, it is not clear how programs similar to the one used in the treatment group might affect people who are more socially isolated.

Hunt, Michael E. "Settings Conducive to the Provision of Long-Term Care." *Journal of Architectural and Planning Research* 18, no. 3 (2001): 223-33.

Hunt notes the importance of a supportive social network to the well-being of older people and so asserts that environmental design should have as a goal the design of communities that are conducive to, or foster, such support networks so that people can age in place. He identifies three types of NORCs: (1) aged-left-behind localities, (2) aging-in-place localities, and (3) retirement destination localities. This article briefly describes the first two types but focuses on retirement destination localities.

Older people are attracted to retirement destination localities by a more convenient lifestyle or an amenity-oriented lifestyle. Those seeking convenience are usually the older elderly, often widowed women, looking for proximity to shopping, services, or companionship. Those seeking amenities are often the younger elderly, independent, married, and more affluent, looking for vacation or resort-type localities, or older migrants on a seasonal basis. Convenience-based NORCs are of particular interest to providers of long-term care. They show the importance of considering environmental design and social support together.

The author cites previous literature that identifies the characteristics of NORC residents, their reasons for moving to a NORC, both why they left their previous residence and what attracted them to the NORC, and their satisfaction with the NORC. He cites differences other studies found between younger and older NORC residents. He summarizes the factors that explain the attraction of apartment complexes that have become retirement destination NORCs: location, management, and design.

The NORC dilemma is how to meet the service needs of older residents without making the apartment complex less attractive to younger residents, in order to maintain the age-integration that is attractive to older NORC residents. Hunt cites three approaches identified in earlier literature. First, in the static approach, residents remain in the complex as long as their service needs do not exceed what the complex offers; when they do, they move to a more supportive environment. Second, the complex can expand services to meet the needs of residents as they age. The third approach, the balanced model, allows residents to add services for themselves but the complex expands the services it provides only to a limited degree or responds by linking residents in need with community-based services. Where the complex expands services to meet resident needs, it is likely to become known as retirement housing.

The author identifies two major lessons learned from retirement destination NORCs. First, a sense of community and the proximity of shopping combined with the availability of health care are key features of a retirement destination NORC. Second, an environment that is attractive to older people is also attractive to younger people; that is, a NORC is simply a good place to live. The possibility of social

connections is a key attribute of retirement destination NORCs. Hunt links concepts from the New Urbanism, with its emphasis on fostering a sense of community, to NORCs.

Marshall, Linda J., and Michael E. Hunt. "Rural Naturally Occurring Retirement Communities: A Community Assessment Procedure." *Journal of Housing for the Elderly* 13, no. 1-2 (1999): 19-34.

Overview

The goals of the study were to develop a diagnostic tool that communities could use to determine what type of rural NORC exists in their localities and to determine which variables are associated with the various types of NORCs. In the introduction, the authors provide an overview of the benefits of NORCs to rural areas, with a particular focus on economic benefits.

Methodology

Based on previous research, the authors identified 62 villages or townships in 16 zip codes in rural Wisconsin with a "high percentage" of older residents (the authors did not specify the percentage). The authors then obtained Census data for these 62 communities. The authors classified these areas into three types of rural NORCs: amenity (17), bi-focal (36), or convenience (9). According to the authors, this classification was based, in part, on the characteristics of certain demographic groups likely to be attracted to specific areas. For example, the authors found that young, active retirees from urban environments were attracted to amenity NORCs. The bi-focal NORCs attracted retirees wanting both the natural amenities and the ability to live in close proximity to friends and family. In addition, local residents who were relocating from a rural area to a neighboring community were often more attracted to convenience NORCs. Using the variable, NORC type, a stepwise discriminate analysis was conducted on the variables available in the Census database.

Findings

Twelve out of a set of 27 Census variables showed significant results and were subsequently used in the authors' analyses. These variables included income variables (household income, retirement income, social security income), resident characteristics (percent over 50 years of age, percent with less than a ninth grade education, percent born in Wisconsin), housing characteristics (percent of housing units vacant), and resident employment characteristics (percent employed in forestry/agriculture, construction, transportation, retail sales, or entertainment).

Relative to the other two types of NORCs, amenity NORCs had higher vacancy rates and a smaller proportion of Wisconsin-born residents. Employment patterns also differed significantly with both convenience and bi-focal NORCs showing a higher percentage of forestry and agricultural workers than did amenity NORCs, amenity NORCs showing a higher percentage of construction workers compared to bi-focal NORCs, and bi-focal NORCs showing a higher percentage of transportation workers compared to amenity NORCs.

The authors identified four variables that distinguished among the three types of NORCs: percentage Wisconsin-born residents; percentage of transportation workers; percentage of retail or sales workers; and the percentage of residents age 21 and older with less than a ninth grade education. Using these four variables, the authors accurately classified 59.68 percent of the NORCs in their sample--100 percent of amenity NORCs, 36.1 percent of bi-focal NORCs, and 77.8 percent of convenience NORCs. Because the results for the bi-focal NORCs were poor, the authors eliminated the bi-focal NORCs from the analysis and repeated it. In this last analysis, the percentage of vacant housing, per capita retirement income, and the percentage of workers employed in the entertainment industry, were significant in discriminating between the amenity and the convenience NORCs.

Recommendations

The authors assert that they can accurately identify amenity and convenience NORCs using a small group of Census variables. However, they cannot identify bi-focal NORCs because people who seek out these NORCs likely differ from other retirees on the basis of “psychographic” rather than demographic variables such as those found in Census data.

Bassuk, Karen. “NORC Supportive Service Programs: Effective and Innovative Programs That Support Seniors Living in the Community.” *Care Management Journals* 1, no. 2 (1999): 132-37.

Mutual Redevelopments Houses (more commonly known as Penn South Cooperative) was built in 1962 with union funds and tax breaks from New York City. Initially, Penn South was designed to be affordable housing for a working population in the Chelsea area of Manhattan. This complex of 10 buildings has over 6,200 residents living in more than 2,820 apartments. Seventy-five percent of current residents are age 60 or older. Most of these residents have aged in place; however, older people also have migrated into the community as supportive services became available.

The NORC has had supportive services since 1987, through the Penn South Program for Seniors (PSPS).¹ The Board of Directors of the Penn South Cooperative forged a relationship with the United Jewish Appeal - Federation (UJA-F), which became the oversight agency for PSPS, and a source of funding for it.

PSPS programs included:

- Group activities, case management, home care coordination, and nonacute nursing.
- Organized volunteer activities and support groups.
- Adult day care.
- Social model day program for seniors with dementia.
- Case management.
- Program to help residents gain financial assistance.
- Legal guidance related to routine matters.
- Psychiatric care.
- Nursing and home care.
- On-site location of a geriatric medical practice.

When PSPS was five years old, Penn South’s Cooperative Board felt that, due to their financial commitment to the program, they should have more of a management role in PSPS. In reaction, the UJA-F helped transition with fiscal oversight and responsibility to Penn South Social Services, Inc., which the Board established for that purpose. The new nonprofit corporation continues to contract with outside agencies to provide services.

The author asserts that the NORC services program saved approximately \$11 million in one year by preventing 460 hospital stays and 317 nursing home placements. It is not clear which program(s) saved money, nor is it clear how the number of prevented institutionalizations was calculated.

In 1997 through 1998, the case management team worked with 644 clients and families.² Over 50 percent of these clients were age 85 years or older and almost 25 percent were over the age of 90.

¹ West Site between 14th and 34th Street; Contact: Adeena Horowitz, 212-243-3670.

² Penn South’s group activities had about 900 members (Bassuk, p. 134).

Furthermore, nearly 30 percent were never married; 79 percent live alone; 33 percent had no family or friends to provide assistance. In 1999, PSPS provided services for over 1,200 seniors and their families. The volunteer program had 149 senior citizen volunteers that donated over 8,000 hours of services, who saved \$80,000. The total program budget was not provided.

Hunt, Michael. "Naturally Occurring Retirement Communities." In *Encyclopedia of American Cities and Suburbs* (517-18). New York: Garland Publishing, Inc, 1998.

Approximately 27 percent of Americans 55 years and older lived in NORCs (no date given). Only 5-7 percent lived in planned retirement communities. NORC design features, such as lack of elevators in multistory buildings, can prevent some residents from aging in place. The authors did not present information about their methods and analyses, which are largely described in other articles.

NORCs evolve in three ways--"aged-left-behind", "aging-in-place", and "in-migration." Residential managers find apartment NORCs ideal because older people tend to pay their rent consistently and there tends to be minimal damage to their apartments. Rural NORCs are appealing to their host communities because of the economic benefits they provide.

An aged-left-behind NORC develops when an area with an unpleasant environment experiences a significant economic decline. As a result, younger residents leave, while many older residents are unable to do so because of emotional or economic ties to the area, lack of financial resources, or the inability to move. Typically, older residents of these NORCs need medical, social, and personal services.

An aging-in-place NORC has residents who remain in their homes for many years and have a strong desire to remain in their communities. These communities can have residents with varying levels of income.

In-migration NORCs develop when older people move to an area for the convenience of its lifestyle. For example, residents may be seeking the companionship of others, proximity to shopping and services, a hospitable climate, availability of a range of activities, and a more leisurely life. Residents of some of these NORCs may live there on a seasonal basis.

Apartments and condominium complexes were consistently places of in-migration. Location, management, and design were the major factors that cause in-migration to certain housing complexes. Location mitigated the social isolation by improving proximity to friends and family. Management played a key role because referrals were important in older populations seeking hospitable environments.

Yalowitz, Nat, and Karen Bassuk. *An Intergenerational Community with Supportive Services, The NORC Model at Penn South Program for Seniors*. Presented at the American Society on Aging, San Francisco, March 1998.

In this article, the authors look at the definition of NORCs and their supportive services programs, the structure of the models developed, their financing, the clients served, and the need to see these programs as evolving entities with intergenerational issues. They emphasize the need for the models to remain flexible and to reflect the needs of the community they serve as well as the need for the community served to take major responsibility for the development of the program.

Penn South (officially the Mutual Redevelopment Houses, Inc.) is a 36-year-old, moderate/middle-income co-op in Manhattan. New York state legislation passed in 1994 established 10 NORC supportive services programs. Penn South developed into a NORC primarily through "aging-in" although there has

also been some recomposition, immigration, and congregation as described in the literature. It is an example of a closed NORC.

The New York state legislation used as its criteria for a NORC that at least 50 percent of households have one member over 60 years of age or that the complex contain over 2,500 residents that are elderly. All of the New York state programs are constructed as private/public partnerships; each housing entity must match funds provided by the state. Financial participation gives the residents a feeling of having a stake in the program, which breaks down some of the barriers to accepting social services.

The Penn South Program for Seniors (PSPS) was started with funding and oversight through UJA-F and was the model for the legislation that was later passed. The Penn South model starts with the assumption of client participation. The program offers group activities, volunteer program, case management, home care coordination, and nonacute nursing care. Social activities include classes, holiday parties, and trips. Under the case management program, social workers work with the client and, where possible, the family to facilitate acquisition and management of services. Seventy-nine percent of clients live alone; 33 percent have no family or friends to help them. The nursing services program provides Medicare and non-Medicare reimbursable care that helps prevent hospitalization or nursing home placement.

Despite the success of the program, the authors assert that there is a need to evolve in order to meet any gaps in services, to strengthen the NORC multigenerational community, and to redefine NORCs in order to remain politically viable. Examples are given in each of these areas from programs and activities at Penn South. Many of the examples on meeting service gaps focus on how to get as many services as possible for as little money as possible. Strengthening the multigenerational aspect of the program is presented as a way to promote intergenerational activities, break down ageism, and help with the long-term survival of the program. Redefining NORCs from the original definition set out in the New York state legislation is also seen as a way to assure the long-term viability of the program by promoting its spread outside of urban areas.

The authors conclude with the observation by Bruce Vladeck, Health Care Financing Administration (HCFA), that NORCs are the future of long-term care. As cost effective and efficient ways to strengthen communities while delivering services, the authors assert that the NORC model deserves broader support in order to be replicated throughout the country.

New York City Dept. for the Aging, and United States Administration on Aging. *Support Services for the Frail Elderly Residents of Federally Assisted Housing: Final Report Findings and Recommendations.* New York, NY: New York City Department for the Aging, 1997.

Program Description

The demonstration project--Vladeck Cares Program for Seniors--was designed to (1) provide coordinated services to older people, with one or more limitations in activities of daily living (ADLs), who lived in Vladeck Houses, a large public housing complex and (2) to identify minority populations who needed but were not accessing services and recommend methods of outreach to these communities. Vladeck Cares was designed to meet the first goal by linking frail older people to needed services and entitlements through provision of case management and assistance, information and referral, transportation assistance, mental health counseling, arrangement of home care, and volunteer-provided support services. The project's second goal arose from the concern that attendees at the complex's Good Companions Senior Center were generally white and Jewish and did not live in the complex; this group did not reflect the demographic profile of the complex.

The New York City Department for the Aging, the New York City Housing Authority (which owns Vladeck Houses), and Henry Street Settlement house collaborated in funding and managing Vladeck Cares. Vladeck Houses is a public housing complex of 54, six-story buildings located on 14 acres in lower Manhattan. About half of the complex's 1,700 households were led by someone age 60 or older, totaling 1,008 people age 60 and older lived in the complex. About two-thirds of these older heads of household were female, 70 percent lived alone, and 63 percent had incomes below poverty. Only 20 percent of older residents are white, 53 percent are Latino, 17 percent Asian, and 11 percent black. Henry Street Settlement House, which is a long-standing social services provider, operated Vladeck Cares.

Start-up Issues

The project advisory committee, composed of a diverse group of religious and service organizations, helped modify the project as needed, referred clients to the project, and helped recruit volunteers. The project developed *Vladeck Cares: Policy and Program Guidelines* at the beginning of the project and revised it after two years to accommodate what staff learned during the project implementation. The demonstration project found that the service coordinator and her staff did not have sufficient time to provide needed outreach and volunteer coordination or mental health services. Client intake screenings had revealed an unmet need for mental health services due to older residents' social isolation and signs of depression. Thus, the project hired two more staff; one was an outreach/volunteer coordinator and the other a bereavement/mental health counselor, both of whom reported to the service coordinator. The project also found less need for emergency home care and home delivered meals than originally thought so the project shifted emphasis to service coordination and non-Medicaid covered services. The program originally arranged for two vans to be available weekday afternoons for shopping and medical appointments, but found it more practical to arrange and provide carfare and escort services on demand.

Communication

Outreach methods to residents included print materials in English, Spanish, and Chinese, information fairs in building lobbies, articles in the housing site newsletter, and a survey distributed to all elderly Vladeck House residents. The survey appeared to be the most effective outreach method but ethnic groups varied in their responses to the other methods.

Participation

Each person contacting Vladeck Cares or the Good Companions Senior Center was offered information and referral about the project's potential benefits and entitlements. Clients potentially eligible for the program were interviewed using a client intake form and then assessed using a standard form if they appeared to be eligible for services. A professional assessment committee reviewed the project's screening and client assessment forms and made final determinations when eligibility was questionable.

Vladeck Cares projected it would have case management responsibility for up to 60 clients a year, but, by the end of the second year, project staff were serving 145 active cases. Staff conducted 1,100 office visits during the two-year demonstration project. The project recruited 14 volunteers and students to help with administrative tasks, telephone reassurance and friendly visiting for clients, assistance with instrumental activities of daily living (IADLs), and running small errands. Licensed nurses working toward their bachelor degrees did vital sign and medication monitoring, blood pressure screening, medication education, and nutrition counseling. Social work students did case management and counseling under the supervision of the service coordinator.

The program served a total of 145 clients with an average age of 75. Seventy-one percent of clients were Hispanic compared with 50 percent in the complex; Asian, white, and black populations were underrepresented in the program compared with their proportion of the elderly population in the complex. About 73 percent of clients lived alone. More than 8 in 10 self-referred to the Vladeck Cares after hearing about the program from the senior center, flyers, friends, or the survey, and 17 percent of clients heard about the program from agencies, including Good Companions Senior Center.

Evaluation/Data

The project set up a computerized client database for every client who entered the program. The first year's data indicated high penetration among the Latino senior population. Program staff felt at this point that a large number of older people were still underserved so they increased outreach to the underserved population. At the end of the grant period, 20 percent of Latino, 12 percent of African American, 11 percent of Asian, and 6 percent of white older people were enrolled in Vladeck Cares.

A survey of residents, conducted 18 months into the project, found that 71 percent of residents had not been aware of Vladeck Cares before it began outreach. Most who entered the program during the two-year grant period heard about it through the senior center or from a program flyer. Seventeen percent of clients were referred by an agency, primarily the senior center. The survey response rate was less than 20 percent. Analysis of client data showed that participation rates declined as residents lived further away from the program and as the age of residents increased.

Recommendations

The demonstration project had several recommendations for other NORC sites. Regarding cultural issues, the program must recruit advisory committee and staff members from varied backgrounds would facilitate reaching out to and working with the minority populations in a NORC. Outreach efforts should be varied and multilingual, as well as tailored to the cultural preferences of residents. The program must be flexible enough to evolve to meet the changing needs of residents and the changing environment within which the program works. The emphasis of a service program should be on coordinating and linking residents with existing community programs and services. The program offices should be as centrally located as possible when the older population lives in a geographically dispersed NORC and outreach should occur in the more remote locations. A computerized database is essential for reporting and analysis that promotes understanding of the NORC residents and their needs and for communication with funders. A resident survey should be conducted about six months after a project starts to give the program time to begin operations and work out implementation issues.

Nadeau, E.G., and David J. Thompson. "Senior Co-Op Housing: Focusing on Community, Health Care and Services." In *Cooperation Works! How People Are Using Cooperative Action to Rebuild Communities and Revitalize the Economy*, edited by Cooperative Development Services (77-94). Rochester, MN: Lone Oak Press, 1996.

Penn South is a co-operative with 2,820 units that provides a range of services. Penn South was built in the early 1960s by the International Ladies Garment Workers Union (ILGWU). The demographics changed significantly in the 1980s because many families left and the remaining residents aged in place. As they did, problems began occurring. For example, some residents needed help with financial management and others wandered without supervision.

In 1986, David Smith, board president of the Penn South co-op at the time, met with social service experts from the United Jewish Appeal - Federation (UJA-F) to discuss how to meet the needs of the aging population. Together they created the Penn South Program for Seniors (PSPS), which was a partnership between Self-help Community Services and the Jewish Home and Hospital for the Aged. Residents could access services by paying a \$15 annual fee; fees were waived for those who could not afford it. PSPS now has over 700 members. There were approximately 12 paid staff and over 100 volunteers. The PSPS program had an annual budget of approximately \$400,000 and received about \$120,000 from UJA-F, and \$100,000 from Penn South's board in 1996. The State Office of Aging, the City's Department of Aging, and foundations contributed the remaining amount.

The PSPS program has spurred the development of other programs in Coney Island, New York (Warbasse House), and the Lower East Side, New York (Co-op Village). The UJA-F created a consortium of agencies that provides a variety of services necessary for independent living. UJA-F and other co-op board organizations lobbied for the state legislation that appropriated \$1 million in 1994 to assist 10 NORCs in New York. According to the authors, this was the first state funding made available to NORCs in the United States.

Hunt, Michael, John Merrill, and Carolyn Gilker. “Naturally Occurring Retirement Communities in Urban and Rural Settings.” In *Housing and the Aging Population: Options for the New Century*, edited by W. Edward Folts (107-120). New York, NY: Garland, 1994.

The authors describe findings from their previous work on NORCs, most of which are described elsewhere in this annotated review. According to the authors, rural NORCs have a major, largely positive impact on the economy of local communities. In many rural areas, the older population’s transfer payments, dividends, interest, and rent income are major contributions to the municipality’s economic base.

According to the authors, the three main factors that affect the evolution of NORCs are location, management, and design, in order of importance. Location is the chief initial attraction of a NORC because residents are close to family or friends, shopping, and services. Management played a crucial role as well because the management’s role in maintenance can spur word-of-mouth referrals. Finally, the design of a NORC was not necessarily an attraction, but could potentially be an impediment to independent living.

Lanspery, Susan C., and James J. Callahan. *Naturally Occurring Retirement Communities: A report prepared for The Pew Charitable Trusts*. Waltham, MA: Brandeis University, Heller School, Policy Center on Aging, October 3, 1994.

This article provides a summary of the literature on NORCs, discusses the NORCs program model, presents findings from analysis of 1990 Census data, and discusses and reframes recommendations.

The U.S. population is aging, with the share of the population over 65 expected to increase to 20 percent by 2025 from the current 12.5 percent. An AARP survey in 1992 showed that 86 percent of older Americans want to age in place, compared with 78 percent in 1986. NORCs are one of the major consequences of this trend. NORCs are defined in this report as housing developments or neighborhoods where at least half of the residents or heads of households are 60 years of age or older or where a large concentration of older people live.

Factors that have led to interest in programs focused on NORCs to facilitate the delivery of health and supportive services include (1) the potential for economies of scale, (2) the successes of similar programs linking senior housing and services, (3) the extensive number of NORCs nationwide, (4) the potential to help preserve communities, (5) the strong desire of older adults to age in place, and (6) the increasing support for helping people with disabilities to remain in the community rather than moving to institutions.

The definition of NORC has changed over time. Community informants report that the impact of an aging local population begins to be felt when their share of the population exceeds about 26 percent, although density and geographic spread make a difference. The authors conclude that it is preferable to specify a range of population and density when defining a NORC. They note that NORCs are “probably

more varied than alike,” varying by physical size, population size, population characteristics, and reason for existence among other things. They may come into existence by accumulation (older people left behind as more mobile segments of the population leave), recomposition (in which older people replace other residents who are leaving) and congregation (where population inflows are of all ages, but with greater numbers of older people). Recomposition and congregation NORCs in rural areas can be further characterized as amenity NORCs (which attract older people who are generally better off in most ways and are looking for the amenities of rural life), convenience NORCs (which attract local people generally moving from a rural area to a nearby rural community for the convenience it offers), and bi-focal NORCs with characteristics of both. NORCs can also be classified by management or ownership with a closed NORC having one management entity (e.g., an apartment complex or mobile home park) as compared with an open NORC that has multiple owners or management entities. Open NORCs may also consist of one or more closed NORCs.

The number of NORCs appears to be on the rise. The only data available are the 1990 Census data and the 1993 AARP survey. Demographically, NORC residents more closely resemble non-NORC members than people in retirement housing. The latter are more likely to be widowed and to have lived less long in their current residence or area. As compared with non-NORC residents, NORC residents are likely to be older, less likely to be employed, have slightly lower incomes, more likely to own their own homes outright, and have a slightly lower level of education.

Eighty-one percent of NORC residents say their neighborhood or building is a NORC because people have lived there a long time rather than because older people have moved in. They like living in the NORC because of common interests with their neighbors and the quiet atmosphere. Table 1 of the article gives comparative demographic information on NORC and non-NORC residents. NORC residents are more likely to rate highly the usefulness of current and proposed NORC services and these ratings are consistent across a range of services. (The study does not indicate whether the differences between the groups are statistically significant.)

The article discusses various types of NORCs and NORC-centered service programs. Minnesota has developed a block nurse program. UJA-Federation in New York has sponsored a comprehensive program of social, health, and individual services at the Penn South and other moderate-income cooperative housing units. In this program, resident needs are gauged through contact with residents in various ways, and the services are financed in part by the cooperative corporations themselves. Consumer-driven residence service programs (RSPs) have been started in New Jersey and Massachusetts with the goal of providing a single point of access to services. Other efforts have begun or are being considered in Boston, Philadelphia, Connecticut, and Washington, D.C., in NORC or NORC-like areas.

The growth of NORCs is not universally applauded. For example, housing policy in Minneapolis and Rochester appears to be designed to discourage the development of NORC-like situations. Planners fear that a predominance of older residents will result in negative votes on school funding issues, will require more expensive public services, and cause zoning problems.

After presenting this background on NORCs, the authors propose a model linking NORCs and services. The key elements of the proposed model are consumer participation, a focus on resource development and service coordination rather than case management, broad involvement of stakeholders from the beginning, and cost sharing. The model is derived from a model that has worked well in senior housing based on the assumption that density will allow economies of scale, collective activities, cooperation with local businesses, geographic-specific legislation, financing through membership fees, and development of a sense of community. The differences between this model and other models of senior services are presented in a chart (pp. 22–23). In particular, the NORC population is distinguished by being all of the elder population in a targeted geographic area rather than those eligible for specific programs such as private insurance or Medicare, and financing is drawn from numerous sources including insurance, government payments, block grants, and out-of-pocket payments.

The author then delineates important factors for developing and implementing NORC programs. Specifically, there should be a clearly identified lead entity. Other factors are listed that will facilitate development and implementation including a closed NORC, a homogeneous population, a service-rich area, consumer-oriented agencies, identifiable stakeholders with an interest in cooperation, urban-like concentration, strong neighborhood or consumer groups, higher consumer income, and a relatively autonomous lead entity.

The author uses 1990 Census data to identify NORCs using a definition of at least 40 percent of householders of age 65 or more in Census block groups or those with at least 200 householders over age 65. The age 65 is used as a cutoff rather than younger ages seen in some studies for three reasons: (1) age 65 is more conservative, (2) age 65 is more convenient statistically, and (3) age 65 is the age for Medicare eligibility. The choice of a minimum of 200 householders was made because it suggests some economies of scale; it is in the mid-range of what is generally considered large enough to support a full time services coordinator in senior housing. Using these definitions, the authors found that about 10 percent of all 1990 Census block groups qualify as NORCs, representing about 3.5 million households. These NORCs show great diversity in housing age, income, and functional limitations, but single elder residents predominate over married elder residents in all but one of the identified NORCs.

The authors point out a critical difference between NORCs and integrated service networks. In the latter, a set range of services is marketed to a membership group, while in the former, the emphasis is on giving discretion and control over the types of services included to the members of the group. Services are typically of a social services nature rather than traditional health services. The authors conclude that establishing a formal linkage between NORCs and health and supportive services will have considerable benefits. In appendices the authors provide a summary of their findings and highlights from their case study.

Hunt, Michael E., D. Arch, and Leonard Ross. "Naturally Occurring Retirement Communities: A Multiattribute Examination of Desirability Factors." *The Gerontologist* 30, no. 5 (1990): 667-74.

Overview

This study analyzed the factors critical to attracting older people to NORC apartment complexes. Apartment NORCs are unique because they have become the most widespread form of alternative housing for the elderly in the U.S, according to the authors. Previous research shows that the availability of desirable supportive neighborhood services are a major attraction for older people. Furthermore, safety and proximity to services and peers also attracts this population.

Methodology

The purpose of this study is to provide quantitative measures that describe the relative importance of certain apartment complex characteristics, as identified in a previous study, in attracting older residents to non-NORC apartments. Results from a preliminary survey of NORC residents identified three critical factors that explain the desirability of NORCs: location, management, and design. The current study looked at three NORC and two non-NORC apartment complex sites located in Madison, Wisconsin. The housing was intentionally selected to vary according to location, building type, age of the housing, and management company.

A subject sample from each apartment complex was drawn from either the apartment or city directory. Of those contacted, 64.7 percent agreed to a telephone interview, and 143 people were interviewed. In order to measure the relative importance of the three NORC attributes identified in the preliminary survey, a multi-attribute scaling procedure assigned weights to various apartment complex

attributes that could affect decisions to move into the setting. These attributes were organized into a “tree” structure to compare the relative importance.

Findings

Location was the most important factor in attracting older residents to the apartment complex for both NORC and non-NORC elderly, with management and design relatively equal but less important. Location specifically included the distance to shopping/service facilities and proximity to friends, age peers, and family as well as neighborhood safety. Older NORC residents valued social factors while older non-NORC residents placed more importance on distance factors. In terms of management, which includes factors such as upkeep and resident manager, both NORC and non-NORC residents valued upkeep more than the presence of a resident manager, and both found the design of the individual unit to be more important than the complex’s design. Finally, the housing features that attracted older people were attractive to younger people as well.

Study Limitations

Some of the participants in the preliminary survey were in the final study as well. The authors did not think this posed a significant problem because the surveys occurred one year apart and used differing methodologies. It is not clear whether the authors randomly selected their pool of potential interviewees. Thus, the generalizability of these results is unclear.

Hunt, Michael E. “The Naturally Occurring Retirement Community.” In *Housing the Very Old*, edited by Gloria M. Gutman and Norman K. Blackie (161-72). Burnaby, British Columbia, Canada: The Gerontology Research Center, Simon Fraser University, 1988.

Overview

This study focuses on how apartment complex-type NORCs evolve. According to the author, NORCs in apartment buildings are probably the most common form of alternative housing in North America and house more of the older population than do planned retirement communities. In Madison, Wisconsin, there are about three times as many NORCs as planned retirement communities.

Methodology

To learn more about how these communities evolve, three NORCs in Madison, Wisconsin, were studied. Interviews were conducted with a total of 72 residents, or approximately 25 percent of residents age 60 years and older. Interviews were also conducted with a representative from the management for each apartment complex. The four major categories of questions were designed to ascertain the demographic characteristics of the older population living in the NORC, reasons for attraction to the NORC, the quality of life in the NORC, and reasons for moving away from the NORC.

Findings

The following summarizes findings from interviews conducted with residents. The majority of residents interviewed for the study were widowed women living alone (80 percent). Approximately two-thirds were age 65 to 75 at the time of the interview. About a third said they moved to the NORC when they were under 60 years of age, while half moved to the apartment community between ages 60 and 75. About a third said they had lived in the NORC between 11 and 20 years, another 23 percent said they had lived in the NORC more than 21 years. Over three-quarters had moved to the NORC from the same part of town, with about half moving after selling homes they had lived in for a long period of time.

The most frequently cited reason for moving to a NORC was that the size and maintenance requirements of their former residence were becoming problematic. According to respondents, these problems were most frequently associated with death of a spouse or cohabitant and failing health. Respondents reported that they least liked the upkeep and isolation of their former residence, but most liked the privacy and location of their home near close friends and neighbors.

Consistent with their reasons for moving away from their former residence, respondents indicated they were attracted to the NORC mainly for two reasons, its location and that friends or relatives lived there. Older residents had heard of the NORC by word of mouth and personal referrals seemed to be the predominant form of advertising.

About half of respondents said they liked life in the NORC better than where they had lived before, with more than a third rating it about the same. The most common reasons for liking the NORC better were fewer stairs, less space, and management's ability to maintain the NORC. Almost half reported socializing with neighbors more often since moving to the NORC. Although some respondents mentioned that moving to a smaller apartment was difficult, most were willing to trade-off the disliked qualities of the apartment lifestyle for its location and freedom from maintenance responsibilities.

When asked if they planned to move away from the NORC about 30 percent of respondents said "maybe" and another 10 percent said "yes." Respondents said they would move either because of a need for more health care or to lower their rental costs. Respondents also said these reasons were the primary reasons most residents moved away from the NORC. However, those who moved away reported they had left because of barriers in the design of the NORC such as stairs in the living unit and laundry room. Nonetheless, most respondents felt that nothing should be done to provide assistance to help residents live independently in the NORC, and, if residents needed more health care then they should go somewhere else where care could be provided.

Conclusions

The author finds location, management, and design to be main factors in the initial attraction to a NORC. In terms of location, a NORC's proximity to shopping and service facilities as well as family and friends are key. Residents expect that NORC will be well maintained, thus building maintenance is important. The design of a NORC can also help eliminate potential barriers to independent living.

NORCs were also found to be desirable to housing managers. Resident managers reported that older residents were desirable tenants because of their stability, which is often cost-effective, dependability with rent payments, and lack of wear and tear on the apartment itself.

Study Limitations

It is not clear whether the survey sample was randomly selected, so the generalizability of findings is in doubt.

Hunt, Michael E., and Gail Gunter-Hunt. "Naturally Occurring Retirement Communities." *Journal of Housing for the Elderly* 3, no. 3/4 (1985): 3-21.

In this study, the authors examine the evolution of NORCs and compare them to a typology of planned retirement communities (RCs) and community-based housing. According to the authors, the supportive services available in neighborhoods are the main attraction for each living arrangement.

The authors define a NORC as "a housing development that is not planned or designed for older people, but which over time comes to house largely older people" and can range from an entire neighborhood to a single apartment building. NORCs differ from planned communities in several ways:

(1) they are not specifically designed for older people, (2) they are age-integrated, (3) they are often single buildings or a small complex of buildings that house fewer than 500 people, (4) they are most often not marketed as retirement communities nor are they generally considered retirement communities by their residents, (5) they may provide few, if any, services to their residents, and (6) the residents are generally younger than residents of planned retirement communities. Given these differences, the authors propose that NORCs be added to the typology of retirement communities developed by University of Michigan researchers (M.E. Hunt et al., *Retirement Communities: An American Original*. New York: The Haworth Press, 1984).

Communities evolve into NORCs (that is, they become communities with at least 50 percent of their residents being 50 years old or older) either by aging in place (residents move in before they reach age 50 and stay until they are past that age) or by relocation (people older than 50 move into the community), or a combination of both. The authors use a case study of a NORC in Madison, WI, to demonstrate the process of becoming a NORC. The area has an array of readily accessible services (post office, medical care, banks, shops, restaurants, grocery store, and the like) and public transportation, as well as a range of housing options by type and cost. The services were present in the community before the older people settled there and may have contributed to the area's attractiveness. The apartments are well maintained and of adequate quality, and the physical environment is accessible. The large number of older people provides opportunities for companionship. Crime is low. The authors assert, "The evolutionary pattern of NORCs suggests that neighborhood and services are even more important than the housing unit itself". They note that planned retirement communities and NORCs have in common their proximity to neighborhood facilities and services.

Age heterogeneity is a major factor distinguishing planned retirement communities from NORCs. The authors state that, since people have different preferences regarding the age structure of their communities, NORCs provide an alternative to planned retirement communities. They stress the desirability of decentralizing services and planning multifamily housing around service centers; public transportation between decentralized service centers would increase access to services. Residents living in supportive neighborhoods may require fewer external services to remain independent.

Hunt, Michael, and Leonard Ross. *Naturally Occurring Retirement Communities, The Invisible Housing Alternative*. A brochure funded by the AARP Andrus Foundation, n.d.

In this brochure, a NORC is defined as a community that is not designed or planned for older people, but over time had attracted "a preponderance of residents 60 years of age." Three main factors are cited as determining the attractiveness of a NORC: location, management, and design. Location near a grocery store is particularly important. Good management, usually in the form of a resident manager, is important, as are well-maintained grounds and buildings. The design of the building, particularly the level of barriers to independence, is more often a reason that people move away rather than one that attracts them to the building. Many of the features that make a good NORC are also those that make housing desirable for all people. At the back of the brochure is a checklist of features to look for in "A NORC That's Right for You."

LITERATURE RELATED TO SUPPORT SERVICES IN PUBLIC HOUSING

Heumann, Leonard F., Ph.D., Karen Winter-Nelson, and James R. Anderson, Ph.D. *The 1999 National Survey of Section 202 Elderly Housing*. Public Policy Institute, AARP, Washington, DC (2002).

Overview

The Elderly Housing Program, commonly known by its section number, Section 202, is a federal program focused on constructing subsidized rental housing for older adults. In 1999, over 3,500 Section 202 facilities housed more than 300,000 older people. The 1999 National Survey of Section 202 housing is the third national survey of Section 202 sponsors and facility managers; previous surveys were conducted in 1983 and 1988. The survey continues to document changes in characteristics of the project, residents, consumer demand, offered services, management, and capital needs.

Methodology

The 1999 National Survey of Section 202 housing for older people involved a random sample of a third of existing projects and two different survey instruments, one for managers and another for sponsors. A total of 509 managers, (47 percent response rate), and 480 sponsors (44 percent response rate) participated in the survey. Because of the survey's focus on the effect of legislative and regulatory changes, analytic results compare project, resident, staffing, services, and financial characteristics over time. Facilities are categorized into five phases according to when they were built, these phases include: Moderate-Income Phase (1959-1974), Low-Income Phase (1974-1984), Cost-Containment or Very Low-Income Phase (1985-88), Transition Phase (1989-1994), and the Project Rental Assistance Contract (PRAC) Phase (1993-present).

Findings

The following is a summary of findings on staffing and management, service availability and usage in Section 202 elderly housing. Since authorization of professional service coordinators in 1990, more than a third of facilities (37.4 percent) in 1999 had professional service coordinators on staff. Another 43.8 percent of residents had access to community-based service coordination. Managers with service coordinators on staff report that service coordinators have increased the range of services (90.5 percent), increased the quality of services (78.3 percent), and allowed residents to stay independent longer (81.1 percent). There was a 17 percent increase in total staff hours per unit between 1988 and 1999, averaging 2.1 hours a week, while services hours increased 57 percent to an average of 1.1 hours per week. In the past decade, the number of part-time managers, working less than 30 hours per week has increased from 22 to 27 percent. This trend is concentrated mostly in small facilities.

Facilities that are more likely to provide supportive services to elderly residents tend to be older with large numbers of units, more residents over the age of 80, a higher percentage of frail residents, residents that pay for services, and large communal spaces for group services and activities. Section 202 projects reporting lower levels of full or partial congregate support (i.e., meals and housekeeping) were more likely to be developed between 1985 and the present. Higher levels of congregate support were reported from older projects developed between 1959 and 1985. Some projects (10.9 percent) extended services to nonresidents from the surrounding community.

Sources of funding differed by type of service. Resident funds were the primary source of income for group meals for 81.3 percent of moderate-income facilities and 57.9 percent in the other four phases. Medicaid was the most common source of income for personal care services in all phases, except for the moderate-income phase. For other services such as transportation or visiting nurse services resident

funds were used by 63.8 percent of moderate-income facilities, and 42.8 percent of facilities in the other phases.

Services such as group dining, social work and counseling, and social and recreational activities were most likely to be provided by on-site staff. Personal care, housekeeping, care management, medication management, and religious services were most likely provided by external agencies or contractors, while transportation and money management are services most likely provided by family and friends. Support from family and friends remained unchanged across all Section 202 phases, suggesting that program changes or use of outside agencies had little effect on the use informal support networks.

Conclusions

Legislative and regulatory changes have improved the Section 202 program since 1988. For example, legislative changes in the early 1990s allowed facilities to hire service coordinators. Service coordinators have increased the range and quality of services as well as allowed residents to stay in their individual units longer. Residents in Section 202 housing are older and more likely to be frail than in previous surveys. In 1983 the average resident age was 72, compared with an average age of 75 in 1999. As residents continue to age in place, facilities are setting up congregate services or converting to assisted living to accommodate residents' needs. But, facilities built in the past decade are much smaller, on average, than those in previous years with fewer staff and services. It may be less economically efficient for these facilities to serve a smaller number of residents.

Recommendations

There are two important issues to examine in future research. The first is the need to address resident satisfaction and perceptions about the quality of federally subsidized housing and care. The second is to address quality of care issues in facilities providing support services, where currently there is no data about the adequacy or appropriateness of support services in elderly subsidized housing. It is also recommended that HUD improve its databases for the inventory of projects serving older people and people with disabilities, besides establishing a regular process for updating information in this survey.

Cox, Beth Madvin. "Linking Housing and Services for Low-Income Elderly: Lessons from 1994 Best Practice Award Winners." *Journal of Housing for the Elderly* 15, no. 1-2 (2001): 97-110.

Overview

This study identified the characteristics of HUD's Best Practice Award winners for subsidized multiunit housing facilities that offered supportive services program to older residents. Supportive housing was designed to provide services at a new site or pre-existing facility to an aging population, where the services increase as the population ages. Facility management typically developed supportive programs by providing direct services or securing community resources. Charitable organizations also provided supportive services to federally subsidized housing facilities.

Methodology

The author used data from 117 applications for the HUD 1994 Best Practice Award competition, and compared the 23 winners with the other 94. The purpose of this competition was to recognize and award HUD subsidized multiunit housing facilities.

Findings

The best practice sites had more access to supportive, clinical, and ancillary services, and astutely utilized community resources. The winners of the 1994 HUD Best Practice award provided linkages to a greater number of supportive services ($p < 0.01$), and were more likely to provide on-site nursing services ($p < 0.01$), mental health services ($p < 0.05$), and security services ($p < 0.05$). Winners used outside providers more often in the provision of service coordination ($p < 0.05$), congregate meals ($p < 0.05$), and mental health services ($p < 0.05$).

Recommendations

These characteristics would be imperative in the continued development of comprehensive aging-in-place programs for older adults with low incomes. Winners were also more likely than non-winners to be located adjacent to community centers.

Ficke, Robert C., and Susan G. Berkowitz. *Report to Congress: Evaluation of the Hope for Elderly Independence Demonstration Program and the New Congregate Housing Services Program*. Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research, 2000.

Overview

This report presents the evaluation results from two Department of Housing and Urban Development (HUD) programs, the HOPE for Elderly Independence Demonstration program (HOPE IV) and the Congregate Housing Services Program (CHSP). Both programs combine housing assistance with case management and a range of supportive services for the frail, low-income elderly population. The purpose of evaluating these programs is to provide information and support in legislation, programs, and policies that address the housing and service needs of elderly individuals in federally assisted housing.

Background

Section 802(1) of the National Affordable Housing Act of 1990 mandated an evaluation of HOPE IV and the new CHSP. The objectives of the two evaluations were to provide a comprehensive description of each program, assess the effectiveness of the two programs in providing supportive services to frail elderly with the goal of maintaining their independence, and compare HOPE IV with the new CHSP. Although both programs provide similar services with the same goal, one major difference is that HOPE IV is tenant-based and CHSP is project-based. The HOPE IV program combines Section 8 rental vouchers with case management support services to enhance elderly residents' quality of life and prevent unnecessary institutionalization. These services are provided either in the tenants home or in other community locations. To be eligible for HOPE IV the person must have been at least 62 years of age, have income not exceeding 50 percent of the median for their area or be willing to move to a private rental unit that meets HUD's Section 8 standards, not participating in Section 8 or other housing assistance programs, and need assistance with personal care or home management activities.

The CHSP program provides a combination of housing and supportive services to low-income frail elderly or nonelderly with disabilities to encourage maximum resident independence, improve management's ability to assess service needs, and ensure delivery of needed services. Services are delivered in the resident's apartment or in the development's common areas (i.e., dining room, activity center). For eligibility to both HOPE IV and CHSP programs, HUD required that participants need assistance in three or more HUD defined ADLs: eating, bathing, dressing, grooming, and home management activities (e.g., housework, shopping, laundry).

Another difference between the two programs is in recruitment and participation. Participants for the HOPE IV program were recruited by grantees, but could not have been receiving HUD housing assistance before applying to the program. CHSP participants came from HUD-assisted congregate housing sites, many of them having lived in these communities for several years. One key feature of both programs was the establishment of a service coordinator position responsible for designing and implementing a system of case management and supportive services to their frail elderly residents.

Methodology

HUD awarded grants to 16 agencies or grantees for HOPE IV housing projects ranging from 25 to 150 residents during a five-year demonstration period. Grantees represented state-level agencies, county jurisdictions, and municipalities across the nation including states in the West (California, Colorado, Washington), Southwest (Arizona, Oklahoma, and Texas), Midwest (Iowa, Ohio), South (Kentucky), and East and Northeast (Maine, Massachusetts, New Hampshire, New Jersey, and Pennsylvania). Thirteen of the 16 grantees reported serving suburban, rural or small town communities.

Another 39 grants were awarded to fund CHSP projects in 45 developments with the number of participating residents in each development ranging from less than 10 to 100. These projects existed in various types of federally subsidized housing including Section 202, Public Housing Authorities (PHAs), Rural Housing Service, Section 236 and Section 8. Most of the CHSP developments were located in urban or metropolitan areas, only four were in nonmetropolitan areas. CHSP projects were concentrated geographically in the Midwest (12 developments) and Northeast (11 developments). West and Midwestern developments were located mainly in large metropolitan areas, while Northeastern developments were in moderately sized metropolitan areas, and Southern developments were mostly moderate-sized metropolitan areas to nonmetropolitan areas.

The service coordinator and professional assessment committee (PAC) were key parts of the HOPE IV and CHSP programs. The service coordinator's responsibilities included recruiting and formal case management, educating resident and staff, building a network of providers and service agencies, and linking participants to those providers and services. The PAC worked in conjunction with the service coordinator to determine eligibility, help develop the case plan for services, and monitor participants' condition.

Services provided to participants under HOPE IV and CHSP included: meals, housekeeping, grooming, dressing, maintaining personal hygiene, transportation, nonmedical supervision, wellness programs, preventive health screening, personal emergency response systems, and other supportive services approved by HUD. Grantees either provided services directly or through contract agencies or providers. HUD paid 40 percent of the program costs, the grantees paid an added 50 percent, and participants paid for the remaining 10 percent with a cap up to 20 percent of their income.

The report discusses program design, implementation, and operation. Subsequent chapters compare and contrast the demographic profile and functional health status of participants in each program. There is a discussion of the informal and formal assistance, social support, and service utilization of program participants and comparison of the effect of the two programs on measures of well-being and exit patterns (e.g., nursing home placement, mortality). Finally, the authors present conclusions, policy implications, and recommendations for how HUD and Congress might address the needs of the frail elderly in federally subsidized housing through housing and supportive services.

Findings

Program Implementation. Because of differences between CHSP and HOPE IV models, recruitment of HOPE IV participants took considerably longer than CHSP. Almost all HOPE IV grantees reported difficulty in recruiting and placing eligible applicants in subsidized rental housing, with 40 percent of applicants having to relocate to a qualifying apartment to receive the programs services. Public housing authorities had to make considerable changes to their Section 8 application and placement policies and procedures to accommodate the frail elderly in applying and finding subsidized housing as

well as balance the implementation activities with supportive service requirements for participants. Because of the implementation requirements in the HOPE IV program, the role of the service coordinator developed differently from the CHSP program. Throughout the five-year demonstration period, HOPE IV service coordinators continued to work on efforts to recruit and retain participants, while CHSP service coordinators were able to focus on more case management activities. In follow-up surveys HOPE IV and CHSP participants reported they were satisfied with their service coordinators' help in providing information and linkages to services. HOPE IV participants stressed their role in finding housing and rental assistance, while CHSP participants focused on the personal and interactive relationship with the service coordinator.

Participant Characteristics. Most of the participants in the HOPE IV and CHSP programs were widowed, white females, living alone. Over half were 75 years of age or older, while the median age of CHSP participants was higher than HOPE IV (82 years versus 74 years). Half the HOPE IV participants changed residence within one year of enrollment, compared with 12 percent of CHSP residents, partly caused by the design differences of each program. All HOPE IV participants were new to HUD housing assistance, while CHSP participants were already living in HUD assisted congregate housing. In terms of ADL limitations, HOPE IV and CHSP participants were considerably frailer than the elderly population as a whole but less frail than people who receive, or are eligible, for institutional care. HOPE IV and CHSP participants report having many chronic health conditions. The most frequently reported chronic conditions were heart conditions, diabetes, arteriosclerosis, and stroke. A greater percentage of HOPE IV participants indicated they sought medical care because of falls during the past year compared with CHSP (22 percent HOPE IV, 12 percent CHSP), however a similar proportion (9 percent HOPE IV, 7 percent CHSP) reported they were hospitalized for more than one day due to a fall during that period. More than a third of participants in both programs reported that they had stayed overnight in a hospital over the past year, twice the rate of the elderly as a whole. But, a majority reported they had not been confined to a bed or chair during the month before the baseline interview.

Social Support and Service Utilization. HOPE IV and CHSP participants differed in their social support and interaction. HOPE IV respondents reported contact with family members in-person or on the phone at one or another extreme, either frequently (several times a week or more) or infrequently (less than once a month). More than a quarter (25 percent) of HOPE IV participants reported seeing their child more than three-times a week and 12 percent reported they saw their child every day, while 47 percent reported they saw a child less than once a month. The distribution of family contact with CHSP participants was much more even across categories. Participants in both programs reported similar levels of loneliness (20 percent HOPE IV, 21 percent CHSP). Not surprisingly, a greater proportion of CHSP participants compared with HOPE IV participants were receiving formal services before entering their program. However, the core services received by participants were similar across programs with almost four-fifths of participants in both groups reporting they received housekeeping services, slightly less than a half indicated they received transportation services, and about a third received personal care. Participants reported they were satisfied with both the program and the amount and types of services received.

Outcomes. A separate comparison group of frail elderly receiving Section 8 rental assistance but not enrolled in HOPE IV was part of the evaluation to determine what the level of services might be without the program. Both participant and comparison groups were interviewed at two points in time, during a baseline and follow-up survey two years apart. The evaluation found that HOPE IV participants received considerably more services than the comparison group, a disparity that continued to increase over time. At follow-up 32 percent of the comparison group reported receiving no services compared with 7 percent of the HOPE IV participants. HOPE IV service recipients scored higher on mental health measures (anxiety, depression, loss of behavioral/emotional control, and psychosocial well-being), social functioning, vitality, and other measures of social well-being. However, there was no statistical difference in the rate of nursing home placement, mortality, or exiting Section 8 housing between the HOPE IV participants and comparison group. Similarly there is no independent effect of receiving one specific individual CHSP service on continued participation in the CHSP program. Twenty-four months after the baseline study, half the residents were still in their respective programs. Nine percent had left the program but remained in their subsidized housing either because they were not eligible, were dissatisfied,

or obtained services from some other source. More CHSP participants had moved into a nursing home compared with HOPE IV participants (25 versus 9 percent), possibly because of their higher median age. Another 14 percent of participants in both programs had died.

Conclusions

The HOPE IV and CHSP service coordinators played a key role by providing case management services to participants, educating PHA staff and building managers, and linking community agencies with each other and the low-income elderly population in federally assisted housing. Linking federal, state, and community-based programs on aging was a key factor in the programs success. According to service coordinators, information sharing among grantees on the stages of initial development across programs would have provided them with the ability to build on existing conceptual designs and avoided duplication of models. Shared information on client assessment instruments and procedures for selecting participants would have also been useful. The evaluation showed a high level of frailty and unmet need for services among current HUD housing residents, patterns that are likely to exist in other communities. Long waiting lists for congregate housing and limited availability of Section 8 rental vouchers leaves barriers to expansion of HUD's housing assistance programs for the frail elderly. Although the evaluation demonstrated high satisfaction among participants, turnover was also high between the two-year baseline and follow-up period suggesting that increasing levels of frailty even with supportive services may preclude elderly residents from participation. Finally, the HOPE IV and CHSP program models are complementary and respond to different population needs, with the tenant-based approach responding to those frail elderly living in scattered-site housing that meet HUD housing quality standards and the project based-approach to those living in subsidized congregate housing. The authors also note that the HOPE IV and CHSP models are similar to and correspond with the Medicaid waiver and assisted living programs professionals are using in the development of alternative long-term care policies.

Recommendations

The following are recommendations for action from the lessons learned from the evaluations of HOPE IV and CHSP. These recommendations include, in the absence of funding, expanding the congregate service coordinator's role to support tenant-based HUD programs. This would create some central organization for the recruitment, placement, and arrangement of supportive services to frail elderly tenants. To facilitate this expanded role for the service coordinator, HUD could encourage formal links with other federal, state, and community-based programs that provide these services. Also, Congress and HUD can encourage the dissemination and utilization of the evaluation results and information about the specific design, implementation, and operation of these programs through HUD's Office of Policy Development and Research, national conferences, and publication of journal articles. Congress and HUD should also provide incentives for public housing authorities to set aside vouchers for the frail elderly or offer additional vouchers to meet demand for Section 8 and congregate housing. This effort might encourage public housing authorities to set up supportive services or offer additional money to service coordinators as incentives to congregate housing sponsors who include supportive services. It is recommended that HUD continue monitoring HOPE IV and CHSP grantees after the program ends to determine how successful grantees were in continuing the program using alternative resources. Further promotion of the adoption of the HOPE IV and CHSP models by Congress and HUD would help toward the increasing demand for housing assistance and supportive services programs. Finally, HUD policies must ensure that a range of housing assistance options, both tenant-based and project-based, exists for the frail elderly.

Schafer, Robert. *Housing America's Seniors*. Cambridge, MA: Joint Center for Housing Studies of Harvard University, 2000.

Overview

This study examined the housing choices of the elderly population and the public policy challenges innate to housing for the elderly.

Methodology

This study analyzed a recent survey conducted by AARP in *Understanding Senior Housing, (1996)* as well as the 1993 AHEAD survey, the 1995 American Housing Survey, the 1997 American Housing Survey, and the 1997 Current Population Survey

Findings

About 80 percent of older people prefer to remain in their own homes, and this percentage increases with age, with almost all people age 85 and over preferring to remain in their homes. However, 39 percent of American changed residences after they reach the age of 60, with most moves being local. Typically, about one percent of the elderly moved across a state boundary, and even these moves were within the same metropolitan region.

In 1993, three-fourths of the nation's population age 70 and over lived in conventional housing, whereas 5 percent of this group live in supported housing (i.e., where "seniors receive assistance from outside the home from a nonfamily member or an organization"). Seniors who chose supported housing normally had difficulties with activities of daily living, but continued to have good cognitive ability. Younger, married seniors preferred conventional housing, particularly those with children in the home or nearby. Three percent of those age 70 and older in 1993 lived in the most expensive living arrangement-assisted communities (i.e., "age-restricted communities that provide some assistance"; this category includes assisted living communities and continuing care retirement communities). The housing choices were influenced by age, need for assistance, and availability of children. Assisted communities without income limitations resulted in out-of-pocket costs for the average resident of \$1,461 monthly. Then the order was shared housing (\$442), conventional housing (\$351), and supported housing (\$328). These figures do not include the cost of purchased support services.

Seniors frequently need environmental modifications to accommodate their disabilities, but only 20 percent of conventional housing have bathroom grab bars; only five to eight percent of such housing has call devices, railings, and ramps.

Study Limitations

The differences in the definitions of assisted communities and supported housing are not distinct. The 1993 data probably does not reflect the major shift to assisted living facilities and other group housing that has occurred during the last decade.

Sheehan, Nancy W. "Resident Services Coordinator Program: Bringing Service Coordination to Federally Assisted Senior Housing." *Journal of Housing for the Elderly* 13, no. 1-2 (1999): 35-49.

Overview

The author reviewed the role of service coordinators in six state-assisted housing developments for the elderly by analyzing a two-year federally funded, on-site program in Connecticut called the Resident Services Coordinator Program.

Methodology

The evaluation included: key informant interviews with property managers, resident services coordinators (RSCs), and management company representatives; case studies of elderly residents at risk of entering a nursing facility; RSCs' weekly activity logs; and, pre-test and post-test interviews with elderly residents in the six demonstration sites and random samples of residents living in two other senior housing sites, which were included for comparison purposes. Post-test interviews were conducted eight months after the program began at each site.

Findings

The typical resident was white, female, and living alone. About half of those residents in the demonstration sites characterized their health status as fair or poor, compared with less than 40 percent in the comparison sites. Levels of disability also differed among the six sites.

The RSCs expressed concerns about being able to maintain the confidentiality of communications with residents with respect to the on-site property managers who wanted to know about residents' needs and circumstances. Working relationships between RSCs and property managers could be somewhat problematic; part of the issue was that RSCs believed that they needed on-going supervision from someone who had the training necessary for supervision.

Property managers believed that the RSCs improved the quality of life for residents, reduced residents' risk of entering nursing homes, and resulted in savings due to lower apartment turnover, and vacancy rates as well as better upkeep of the apartments. RSCs also freed property managers from trying to meet the support needs of elderly residents.

Frail older people in the demonstration sites reported significant improvement in perceived health status in comparison to their peers as well as functioning related to activities of daily living and instrumental activities of daily living between the pre-test and post-test interviews. There were no changes among frail elderly people in the comparison sites.

The majority of residents said that the RSCs had benefited them through providing emotional support, help with problems, and information and referral. As a result, participation in social activities and housing satisfaction had increased significantly for residents, regardless of their level of disability.

Study Limitations

The authors state that key informants might have been reluctant to criticize a program that benefited them and responses might have changed if interviews had been conducted later in the life of the programs. Since the authors could not match residents from the demonstration and comparison sites, the conclusions that can be drawn from comparing these results are limited. Finally, one third of residents who received help from the RSCs did not participate in the pre-test interviews.

Park, Jungwee, and Jean Burritt Robertson. "Mental Health Needs and Supportive Services for Elderly and Disabled Residents." *Journal of Housing for the Elderly* 13, no. 1-2 (1999): 79-91.

Overview

This study examined the effects of the provision of supportive services on the mental health and quality of life of older adults, including those with mental disabilities, living in 12 housing developments for older people and people with disabilities.

Methodology

The authors interviewed 205 residents of 12 housing projects in Rhode Island, who were interviewed at baseline and six months after they began receiving chore, homemaker, and personal care services. Of these residents, 44 reported that they had or were "known to have" mental health conditions. The majority of services that residents received fell into the chore and homemaker categories.

During both interviews residents completed an assessment designed to measure their cognitive and affective functioning as well as their psychosocial well-being. The assessment was drawn from items in several recognized assessment tools, such as the Mini Mental Health Status Exam.

Findings

At baseline, there were significant differences related to cognitive and affective functioning, but not psychosocial well-being, between the full sample and the 44 residents with reported mental health conditions. Six months after support services began, there were no significant differences in any of the three areas of functioning between the entire sample and the subset of 44. The authors conclude that the provision of supportive services to residents with mental illness led to increases in their cognitive, affective and psycho-social scores, and that such services may be more important for those with mental illness than for those without.

Recommendations

The authors speculate that reminders to take medications may have contributed to improvements in the functioning of the 44 with reported mental health conditions. The authors also contend that the program was less expensive than personal care programs in congregate housing settings.

Study Limitations

The subset of 44 people may well have had mental health conditions but the authors did not supply information on diagnosis or the level of cognitive impairment. And, the cost savings estimates are not methodologically sound.

Howe, Judith L. "Linkage House: A Case Study Highlighting the Challenges and Opportunities in Linking Housing and Programs for Older Adults." *Care Management Journals* 1, no. 2 (1999): 138-45.

Program Description

The Mount Sinai Medical Center, New York City and three community-based organizations sponsored supportive services programs in the Linkage House, a 70-unit building with low-income residents, using a capital grant under HUD 202 program. The Linkage House program fostered an environment of communal living and the formation of support networks, while enabling a resident to

maintain his/her privacy. The model for the Linkage House program was dynamic, thus enabling it to adapt to the changing needs of its residents. In 1991, the Department of Geriatrics and Adult Development at Mount Sinai Medical Center commissioned New York Community Trust to do a feasibility study of the program. By 1992, Mount Sinai began to include leaders from the East Harlem community in development of the Linkage House program. According to the author, it was difficult to achieve successful aging in place, primarily because there was separate housing and health & social service funding streams. However, health programs, including health education and on-site medical care, were critical to the Linkage House success.

Participation

The continuum of care covers a broad range from services for healthy adults to those with chronic or acute health conditions that need more assistance. The Linkage House model included a full-time, bilingual social worker with graduate level education to provide care and service coordination for the residents. Furthermore, the residents must be at least 62 years of age and meet federal income guidelines. For example, a single person household cannot have more than \$17,100 in annual income from all sources, and a two-person household cannot have more than \$19,600. Furthermore, potential residents must be either homeless, have poor housing, have difficulty paying the rent, or documentation of elder abuse.

Barriers

According to the authors, there was difficulty in securing funding for the program at the Linkage House because the HUD Section 202 program provided support only for construction costs, operation, and rent subsidies.

Environment

Other elements of the program included building design. The building was designed to create space for examination and consultation rooms for the health programs. Additional space was created for furnished common areas and meetings places for tenants. Five one-bedroom apartments were grouped around each common area to promote socialization.

Long-Term Viability

According to the author, securing funding and the hiring of an on-site social services coordinator were critical to the program's success.

Lanspery, Susan. *Service Coordination in Senior Housing: Roles, Problems, and Strategies: A Guide for Aging Network and Other Professionals*. Los Angeles, CA: National Resource and Policy Center on Housing and Long Term Care, University of Southern California, Andrus Gerontology Center, 1997.

Overview

This guide reviewed the role of service coordinators in state-assisted housing developments for older people, the challenges they faced, and alternatives they could use to address these challenges. Many housing developments have added service coordination to manage daily activities in housing developments to improve the quality of life and minimize early institutionalization.

Methodology

The methods were not described in the guide.

Findings

The guide asserts that the five most common functions service coordinators perform are: advocacy with community agencies for services, mediating disputes among residents, advocacy with housing management for supportive services, assisting resident organizations, and assisting residents with financial management. The challenges they faced were lack of funding, unresponsive agencies, "turf" issues, varying syntax, minimal monitoring, and fragmentation with the supportive services delivery system.

Recommendations

Two major factors influenced success, namely the level of involvement of residents in meaningful ways and the nature of the collaboration among the entities involved in the housing development. According to the author, the service coordinators could develop new services, establish an interagency group, promote volunteer programs, and possibly work with agencies to find new sources of funding to combat the challenges they face.

Study Limitations

Since this is a practice guide, there is no emphasis on research methods. However, the lack of information on methods makes it difficult to judge the guide's conclusions.

Schulman, Abbott. "Service Coordination: Program Development and Initial Findings." *Journal of Long-Term Home Health Care* 15, no. 2 (1996): 5-12.

Overview

The study's purpose is to describe the development and one-year evaluation of a service coordination program designed to help older people and people with disabilities experience an improved quality of life and to minimize institutionalization.

Methodology

Service coordinators served residents of 20 Section 202/8 housing projects in 12 states and Puerto Rico. The 20 Service Coordinator programs were implemented during the first 10 months of 1993. The service coordinator had four major functions: (1) to identify the needs of residents, (2) to arrange for supportive services to cover residents' needs, (3) to monitor the quality of those services, and (4) to reassess the residents' needs. Assessment of residents' needs has varied by program. The needs driven assessments used the medical model, where the service coordinator made an evaluation prior to determining what services were needed, where the resident had little input. The consumer driven model did not have an assessment, and the service coordinator marketed the services available, and then allowed the residents to choose what services they want to purchase.

The author selected 25 randomly chosen residents who had used service coordination from each of the 20 properties, totaling 500 individuals. The residents were then asked to complete a survey of 12 true-false statements about their perspectives on the Service Coordinator program in their projects. The service coordinator distributed the survey and asked residents to complete it at their leisure. About 458 people responded, 120 of whom were men and 338 were women, but not all respondents answered all questions.

Findings

Due to the cost of the services offered by the service coordinator, and fear of possible rent increases or evictions from their apartment, many residents were afraid of approaching the service coordinator. About 75 percent of male and 72 percent of female respondents believed that the service coordinator involved their families in their care. While over 98 percent of both male and female respondents saw the service coordinator as being available when needed, 15 percent and 11 percent, respectively, thought the service coordinator was too busy to see them when they desired. About 90 percent of the respondents had used the service coordinator to help them avoid loneliness. Over 93 percent in both populations believed that they benefited from the service coordinator's support.

Recommendations

The author believed this survey showed the importance of a service coordinator's role and made some assertions regarding such things as delayed institutionalization that were not supported by the research conducted.

KRA Corporation, and Office of Policy Development and Research, U.S. Department of Housing and Urban Development. *Evaluation of the Service Coordinator Program*. Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research, 1996.

Overview

The Housing and Community Development Act Amendments of 1992 authorized HUD to administer the Service Coordinator Program (SCP). The program is designed to meet the needs of people with disabilities living in HUD-assisted housing by directly funding service coordinators who are to coordinate provision of supportive services for this group. Service coordinators (SCs) determine the needs of eligible residents, identify available community services, link residents with needed services, monitor and evaluate services used, and carry out other functions as needed; coordinators are prohibited from direct service provision. Projects eligible for SCP are Section 202, Section 8, Section 221(d), and Section 236 projects; Section 811 projects are not eligible. The goals of the study were to describe the Service Coordinator Program and the residents served, assess resident satisfaction with programs, as well as to identify implementation problems and recommendations for improvement in the programs.

Methodology

The reported data came from two sources: (1) information from application forms from 645 programs that received HUD funding. These data were only used to describe programs and residents; and (2) site visits to 18 SCP projects during 1995. Site visits involved interviews with service coordinators and HUD project managers, as well as resident focus groups. The 18 sites were selected to represent the variation in characteristics of HUD projects, service coordinator type, and geographic location of programs sites. However, the sample cannot be considered nationally representative.

Findings

Of the 645 projects that received funding, about one-third had 100 or more units, one-third had 50-99 units, and one-third had fewer than 50 units. The projects were located in all but three states. In 99 percent of the projects, at least one-quarter of residents had disabilities. Similarly, in 17 of the 18 case study sites, 25 percent or more of residents had disabilities. The majority of residents at all sites were elderly, at least two-thirds of all but one site's residents were female, 11 projects were majority white and two projects majority black. Thirteen projects had part-time service coordinators, 11 coordinators worked at more than one SCP, and three projects contracted with other agencies for coordinators. Most

coordinators had bachelor degrees and relevant prior work experience. All but one coordinator had received some type of training.

Service coordinators in the 18 sites worked with autonomy but coordinated with project directors when planning activities. More than half the coordinators had contacts with 90 percent or more of the project residents and case loads ranged from 7 to 112 residents, which represented between 10 and 96 percent of residents. Coordinators' outreach to residents consisted of print materials and presentations at resident meetings. Coordinators in the 18 sites arranged for services to come into the project; transportation and housekeeping were the most frequently provided services. Other services included health screenings, exercise programs, and budget assistance. Service coordinators sometimes provided services themselves despite the HUD prohibition against doing so; services included transport to medical appointments and housekeeping chores. Half of coordinators said that more transportation was needed at their sites; other needed services included housekeeping, financial counseling, errand services, and eye and dental services.

Residents in the 18 sites reported that SCP linked them to services and that the coordinator was someone to confide in about their problems and made them aware of how to access available services. The 18 sites did not report serious obstacles to program implementation, but seven sites reported inadequate office space primarily due to lack of privacy, and one site required residents to climb stairs to access the office.

Recommendations

Sites recommended improvements to the SCP program including: ensuring that the SCP office is accessible and that SCs do not share office space with project staff so that SC conversations with residents can be confidential. Additionally, the SC office should be located where residents tend to congregate such as mailboxes, the dining room, lounges, or community rooms. SCs also believed that they should be able to provide some services themselves where services are not readily available, including transportation in rural areas and social activities planning, and that HUD could fund these activities through the SCP. SCs would welcome HUD identification of training opportunities in rural areas and HUD development of materials such as assessment and service tracking and monitoring forms. SCs also made recommendations for changes to the annual reporting form.

Study Limitations

The 18 case study sites cannot be considered representative of the 645 sites in existence at the time of the study.

Nachison, Jerold S. "The Housing Programs of the Department of Housing and Urban Development: Description and Issues." In *Housing and the Aging Population: Options for the New Century*, edited by W. Edward Folts (83-104). New York, NY: Garland, 1994.

Program Description

The Congregate Housing Services Program (CHSP) provides grants to various public housing programs to enable them to purchase supportive services for their residents who are aging in place. The federal Department of Housing and Urban Development (HUD) provides up to 40 percent of funding for services, the users of services pay 10 percent of the cost of services, and funding must be raised from other third parties to cover 50 percent of the cost of services. Funding is available in Section 8 and Section 236 HUD housing projects for the older population, Farmers Home Administration projects; states, Indian tribes and local governments also can seek this funding. Projects must accept food stamps

as full or partial payment for meals, and a service coordinator must provide case management and service coordination to program participants.

National Eldercare Institute on Housing and Supportive Services, and U.S. Administration on Aging. *Linking Housing and Services: Six Case Studies*. Los Angeles, CA: National Eldercare Institute on Housing and Supportive Services, Andrus Gerontology Center, University of Southern California, 1994.

After consultation with key informants, the authors chose six study sites that represent a range of approaches to linking housing with services. This paper provides descriptive information about six program sites, focusing on how they “operationalize” the housing and supportive services linkage and address challenges unique to each services program. It then offers advice for replication of similar program types.

The Housing Authority of St. Paul, Ravoux and Valley Hi-Rises, in St. Paul, Minnesota, is a HUD CHSP and the first national program linking housing and services. The program’s staff credit its success to several key skills the CHSP Supervisor demonstrates, such as flexibility, creativity, knowledge of community services, and good organizational skills. Other factors that have contributed to the program’s long-term success are community education and involvement and resident support. The program faces several challenges including long-term funding viability and a changing resident population that includes a frailer elderly population, a growing younger disabled population, and a more culturally diverse resident profile.

The Southern California Presbyterian Homes, Los Angeles, California, is a Section 202 federal housing site with a “circuit rider” approach to community service coordination. The program staff links frail residents with available community services. The only program cost is staff salaries, which are currently funded by HUD. The paper identifies limitations to this model as service gaps or lack of service providers, which can restrict resident’s choices, and the lack of ability to monitor the quality of care provided.

The State of Maryland, Office on Aging, Multi-Family Senior Assisted Housing (SAH) Program operates in several public and private senior facilities. The SAH program provides a package of services that allows frail elderly residents to remain in their own homes, potentially avoiding any Medicaid costs that would incur due to premature institutionalization. Payment for services is on a sliding scale. The SAH program has faced several challenges, including residents’ resistance to having to pay for services, the meals component of the service package is somewhat inflexible, maintaining high enrollment across the state has been difficult, and limited funding has been a problem. Additionally, there is still an independent living “mind set” that is difficult to overcome with housing managers and some of the more independent residents.

The Silsbee Tower’s Supportive Services Program in Senior Housing in Lynn, Massachusetts, is a large national program linking housing with supportive services that began as a national demonstration funded by the Robert Wood Johnson Foundation (RWJF). The program is now privately funded, although it takes public support when available, and is currently being replicated through the national No Place Like Home program, also funded by RWJF. According to the authors, the program has been successful because of its close connection to the Area Agency on Aging (AAA), ongoing communication with residents through surveys and meetings, and the service coordinator’s ability to balance different stakeholder agendas, including the building manager, residents, and AAA.

The Area Agency on Aging Senior Home Care Services, Inc. in Gloucester, Massachusetts, allows the agency to take advantage of economies of scale in offering alternatives to nursing home placement by providing supportive services to residents of senior housing. The program’s success has been attributed to good communication and willingness to collaborate, good planning and management, and willingness to learn from other programs that link housing and services. Obstacles include lack of funding

and flexibility, “turf issues” that may lead to service duplication, and an emphasis on process rather than outcomes.

One key component of the On Lok program in San Francisco, California, is the On Lok House, a HUD Section 202 building, which has demonstrated that very frail elderly can live in their own apartments with health and supportive services provided by a capitated managed care program based on an adult day care model. While the program does not provide skilled nursing care, the program has found it difficult to distinguish itself from a nursing home. Staff also face the challenge of determining when a resident is too frail to live independently at On Lok House.

Nenno, Mary K. “Public Housing: A Pioneer in Housing Low-Income Older Adults.” In *Housing and the Aging Population: Options for the New Century*, edited by W. Edward Folts (61–81). New York, NY: Garland, 1994.

Program Description

This article provides a brief history of public housing programs and policies for low-income elderly in the United States. Starting with the development of programs initiated in the 1930s that spurred the Housing Act of 1956, which first recognized the elderly as a distinct population needing public housing assistance. Then, the Housing and Urban Development Act of 1970 authorized the use of about 10 percent of all public housing development for the elderly, displaced, and handicapped. The next major development occurred in 1978: the Congregate Housing Services Program, which was a demonstration program for 33 public housing agencies and 30 HUD Section 202 nonprofit housing sponsors. Subsequently, the National Affordable Housing Act of 1990 restructured the Congregate Housing Services Program and expanded its coverage. As the elderly public housing program continued to mature, a medley of structure types evolved.

Participation

By 1989, over 1.4 million households headed by an elderly person lived in federally subsidized housing. A subset of 517,000 resided in public housing, which comprised 38 percent of national public housing occupancy. By the late 1970s and early 1980s, the proportion of public housing occupied by elderly households leveled off at about 45 percent.

Evaluation/Data

Congress directed HUD to carry out a CHSP evaluation, which was designed as a four-year evaluation involving three types of evaluation: process, performance, and impact. The CHSP evaluation denoted missed success and was devoid of positive outcome during the first 14 months.

Long-Term Viability

According to the author, there are four areas that need considerable attention for public housing to remain a viable housing option. First, many of the public housing developments are over 30 years of age and need significant renovation. Second, many of the elderly developments have not designed or made accommodations for community space and other types of support services. Third, support services are only available on an ad-hoc basis. In the future, long-term and integrated resources must be made available. Finally, the author suggests that new housing policy must emerge to resolve issues of grouping the elderly with handicapped people. Ultimately, public housing will need to develop and hone an integrated system of support services, and provide adequate information about the various types of housing in all areas of the country.

King, Nancy Koury, Janet Hofmann, Ohio Department of Aging, and the U.S. Administration on Aging. *Supportive Services in Federally Assisted Housing for the Elderly*. Columbus, OH: Ohio Department of Aging, 1993.

Overview

This report discusses findings from several evaluation components of the Ohio Department of Aging's (ODA) Supportive Services in Federally Assisted Housing for the Elderly Project, a two-year grant program awarded by the U.S. Administration on Aging. The project's purpose was to develop a model to promote supportive services to the elderly in federally assisted housing by linking community-based services to public housing, thus allowing elderly residents greater access to support services. Specific program objectives include improving housing managers' ability to work with elderly tenants, linking housing providers with local assessment and delivery systems, developing programs that encourage volunteerism and integration of the facility into the local community, and managing current resource needs with available funding while advocating for future funding. Project activities were designed to address the development, implementation, and evaluation of the program's objectives. These activities included development of a working agreement between the ODA and other state agencies, a survey of Ohio's public housing managers, and a problem indicator resource tool for housing managers. Other activities included development and implementation of a training program and resource manual for housing managers, and improvement of a computer database program for Ohio's Area Agencies on Aging (AAAs) to use in maintaining directories of elderly housing facilities.

Methodology

Public housing facilities in two pilot sites, Portsmouth, a rural area in southern Ohio, and Cleveland, an urban area in northeastern Ohio, were selected for program implementation. Both pilot sites developed and facilitated a coalition of organizations concerned with older adults in public housing. Coalition members collaborated to plan new services for the elderly tenants. The manager training and resource manual was revised. The housing manager-training program, a two day Train the Trainer course, was implemented in each of Ohio's 12 planning and service areas (PSAs).

Evaluations of the new programs for elderly residents at pilot sites were conducted. The pilot site evaluations contained two components: (1) results of each site's needs assessment survey, and (2) a qualitative evaluation of each site's activities. A sample of residents age 60 and older in the Miles Elmerge public housing facility in Cleveland were surveyed in-person to determine their characteristics and service preferences, 67 of the 139 residents living in Miles Elmerge were interviewed. In Portsmouth, Ohio, 95 older adults were interviewed in their apartments.

Findings

The following summarizes findings from a survey of housing managers in pilot site facilities, evaluations of the housing manager training program, resource manual and train the trainer program, and evaluations of the pilot site activities. According to findings from the housing managers' survey few housing facilities offered services other than housing, about a quarter (24 percent) had social or recreational activities, 10 percent offered congregate meals, 5 percent housekeeping, and 2 percent transportation. Managers perceived that medical and or physical health problems were the main functional or health difficulty, and transportation the major service requested by residents age 62 and older. Managers indicated they spend an average of 15.7 hours per week of staff time on personal, family, or health problems associated with residents. The majority of managers (88 percent) referred residents to social services agencies. However, more than half of managers (60 percent) report that residents' capabilities are assessed when problems arise.

Managers stated their biggest challenges were meeting the needs of residents aging in place, developing services for residents, and understanding mental health issues. This need for assistance was

indicated by awareness of senior services such as homemaker services and meals on wheels, but lack of referrals to these services. Also there was limited awareness of Ohio's PASSPORT program, a statewide Medicaid waiver program for in-home community services for older adults, a potential benefit to managers and residents. Housing managers also expressed a desire for more information about dealing with the challenges of elderly residents.

Post-program evaluation results of the housing manager training program indicated that housing managers viewed both the training program and housing resource manual as useful, relevant, and effective. Housing managers improved their knowledge about aging related issues, and confidence in their ability to identify residents at risk, address problems, develop policies and procedures for action, and work with the appropriate service agencies in the aging services network. Overall, participants in the train the trainer program were satisfied with each components of the course.

Cleveland Pilot Site. The majority of residents were female (66 percent), African-American (98 percent), living alone (68 percent), and either active (10 percent) or interested (50 percent) in volunteering. Slightly more than a third (37 percent) reported health problems that limited their functional ability, and 60 percent rated their health as "fair." The majority of respondents (82 percent) indicated they could turn to relatives for help. Respondents were frequently unaware of many support services such as legal services, companionship visiting, personal care services, mental health counseling, exercise and adult education classes, and information and referral services. The most desirable services for respondents were transportation, homemaker, personal care, meals, and social clubs.

The program augmented many of the services Cleveland residents identified as desirable such as transportation, adult education, social activities, meals, information and referral, and nursing services. Other services such as homemaker and home health aide were identified but not strengthened other than increasing housing managers' awareness of resident service needs. The community coalition met monthly to address service access to the elderly in public housing and played an instrumental role in improving communication between the aging services network and housing community. The coalition has committed itself to continue efforts toward meeting the needs of elderly in public housing. At the request of housing managers, the Cleveland pilot site went beyond the ODA's housing manager training program and implemented a series of workshops on dealing with mental health issues. The coalition will continue to meet beyond the grant period, plan future training programs for housing managers, and retain many services such as educational opportunities, transportation, food distribution, and health promotion programs.

Portsmouth Pilot Site. Transportation, cleaning, shopping, and laundry were the activities respondents reported having most difficulty with. Transportation services (36 percent), house keeping (27 percent), the senior center (21 percent), and home delivered meals (18 percent) were other supportive services for which respondents indicated high usage. Although the survey did not ask residents about preferences for supportive services, respondents were asked about their interest in a variety of activities. Respondents most frequently requested music and wellness programs.

Besides the ODA's housing manager training program, a first aid and CPR class was conducted and the aging sensitivity training program became available to all Portsmouth Metropolitan Housing Authority (PMHA) employees. The coalition helped in overseeing the needs assessment, developing welcome baskets for new tenants, conducting a health fair, working with the senior center to improve transportation, assist the tenant council, and oversee resident programs. With added community resources and continued involvement from the coalition, welcome baskets, social activities, and first aid/CPR classes will continue along with blood pressure screening and blood sugar checks for residents and scheduled visits from a mobile mammography unit.

Conclusions

The Ohio Department of Aging's public housing manager survey was useful in understanding the needs of both public housing managers and tenants. Managers felt more knowledgeable and confident in dealing with issues involving their elderly tenants. AAAs were able to customize training programs to individual communities and provide networking opportunities for training participants and key stakeholders in the community. Involving the management of the local housing authority in planning and implementation of the training program was instrumental in gaining participation among housing managers.

Both pilot sites were able to successfully recruit a broad based group of local support services including social services, health service providers, housing groups, and community leaders. These coalitions were able to target attention on specific problems facing the elderly in federally assisted housing in their communities and find creative solutions. These community coalitions will continue to collaborate with residents of public housing and their communities to target needed services and programs to the elderly resident population.

Recommendations

For those considering development of similar or related projects, the authors recommend that AAAs develop a more complete understanding of the housing authority structure and role of housing manager. Future research and training should emphasize mental health issues, the role of the housing manager, and integration of the young person with mental health conditions into senior housing. Furthermore, the project should strengthen efforts to form broad-based community coalitions that include residents, community leaders, besides social service providers. There is also a need to address barriers in public housing's design and environment that may prevent elderly residents from living independently, and nonaging social problems that impact the elderly in public housing.

Lynn Greenleaf, Sheila Malynowski, and the New Hampshire Housing Finance Authority. *Increasing Service Availability to Seniors in Housing: Final Report.* Bedford, NH: New Hampshire Housing Finance Authority, 1993.

Overview

This report describes an Administration on Aging (AoA) grant project directed by the New Hampshire Housing Finance Authority (NHHFA). The project expanded the NHHFA's model of supportive services programs, originally developed for seniors living in privately owned, subsidized housing (Section 8 housing), to seniors living in public housing. The primary purpose of the program was to establish closer linkages between the network of state and local services for seniors and those older adults living in federally subsidized housing to prolong their ability to live independently in the community. Objectives of the study included allowing seniors to determine which services they wanted and providing increased service delivery to seniors in public housing for those identified services.

Methodology

The NHHFA chose six public housing authorities in New Hampshire as pilot sites to develop supportive service programs. Each housing authority was responsible for designing and implementing supportive services programs to best meet the needs of their residents with the goal of financial self-sufficiency over the long-term. Services included transportation, meal preparation, light and heavy housework, and personal care. Service coordinators also helped residents apply for eligible entitlement benefits. Pilot sites implemented community-building programs that included social and recreational activities, and informational programs for elderly residents. The NHHFA provided technical assistance and oversight.

The NHHFA also developed and implemented a pilot statewide, telephone network between the housing and service provider network called Senior Care Connections (SCC). For an annual subscription fee, the service provided housing managers with a master's level social worker to help housing providers find and help residents access services.

Findings

Senior Care Connections, the pilot statewide, telephone network, faced several implementation challenges. Faced with lower participation than expected, focus group discussions were conducted with housing managers to determine the participation barriers and identify potential candidates for the program. Feedback from the focus groups identified management agents who are the best candidates for the program. These management agents are typically interested in supportive services, unable to hire a service coordinator, or have a service coordinator that requested social work support. Barriers to participation that were identified include a complex's financial constraints, a service coordinator with extensive experience or a background in support services, and managers who believed they could handle things on their own. Because of low demand, the program was cut by 50 percent for the second year of the grant and marketing efforts were enhanced. Face-to-face meetings with managers were determined to be the best marketing strategy during the program's second year.

Senior Care Connections enrolled 11 management companies representing 786 senior housing units in over 20 complexes. This represented about 25 percent of the potential market share. The program handled a total of sixty-one service requests and 46 follow-up contacts over the two-year grant program. The majority of requests involved assistance with mental health issues, followed by assistance with medical problems, and suspected abuse or self neglect. A follow-up program evaluation survey was developed and completed. The survey found that managers believed they were supported by the service, that the service relieved stress, enhanced their skills and abilities, and prevented resident situations from worsening.

The project helped 731 residents at the six pilot sites in getting services such as light and heavy household chores, shopping, transportation, meals, and personal care. The following table shows the number of residents who received assistance by service type.

Support Services	Number of Residents Receiving Assistance
Light/heavy household chores	141
Transportation	246
Meals	59
Personal care	41
Managing finances or filling out forms	152
Reassurance call/visits	248
Total	887*
NOTE: Some residents received more than one service.	

Interviews were conducted with 503 residents by NHHFA staff in four of the six public housing authorities chosen as pilot sites to determine residents' demographics and service needs. Laconia and Somersworth Housing Authorities opted to use preexisting information on support services programs rather than a survey to form the basis for designing their program expansion. Respondents to the resident market/needs assessment survey were overwhelmingly female (80 percent), single (85 percent), and living alone (84 percent). About half of respondents (47 percent) were 75 years of age and older. About half of respondents said they had lived in their complex six or more years, 10 percent had lived there more than 15 years, indicating the "aging in place" phenomenon. Most of the respondents had low incomes with 68 percent having gross annual incomes of \$7,500 or less. Respondents rated their health favorably compared with others their age with 77 percent reporting excellent or good health. But, 27 percent reported putting off needed health care in the past year, with the most frequently reported reason

being lack of financial resources followed by lack of transportation. It is important not to generalize from the resident market/needs assessment survey because the surveys were not from a random sample of resident.

The number of reported residents receiving services varied by complex, as did the number of reported residents in need of such services. The following table shows the ranking of services residents reported most needed compared with services reported most wanted. Except for shopping and transportation, what residents needed ranked closely with what they most wanted.

Ranking	Most needed	Most wanted
1	Heavy household chores	Transportation
2	Shopping	Heavy household chores Service coordination
3	Service coordination	--
4	Transportation	Personal emergency response system
5	Light household chores	Shopping
6	Personal emergency response system	Light household chores Meal preparation
7	Meal preparation	--
8	Personal care	Personal care

Long-Term Viability

According to the authors, the supportive services pilot programs in senior public housing were successful, however, they do not state how the program's success was measured. Housing managers and residents benefited from the programs developed. The supportive services programs not only improved the quality of life for many seniors but allowed seniors to remain in their homes. All the supportive services programs developed under the AoA grant continued beyond the end of the grant, however, the funding came from a number of sources and future funding is uncertain. Education at the federal level is needed to ensure that supportive services programs in senior housing are valued and that funds are appropriated to HUD for inclusion of the program as part of a housing complex's regular operating expenses.

The Senior Care Connections telephone consultation service provided support to managers and service coordinators in need of social work services. Education of management agents about the benefits of a social worker led to increased participation in the SCC program during the second year of the grant. Although the SCC program had difficulty becoming financially self-sufficient, the program is continuing on past the end of the grant with slight increases in the enrollment fee and funding support by the parent organization, the Crotched Mountain Foundation. The service might be more successful in areas with larger markets of management agents for subsidized senior housing. Combining the SCC program with other services requiring social work staff might improve the program's financial situation.

LITERATURE RELATED TO CLUSTER CARE

Lanspery, Susan. *Clustering Services at Senior Housing Sites: A Technical Assistance Guide for the Aging Network*. Los Angeles, CA: National Resource and Policy Center on Housing and Long Term Care, University of Southern California, Andrus Gerontology Center, 1997.

Housing is a vital element in long-term care, however its priority is often minimized. Often senior housing residents only receive shelter assistance, but lack services. Finally, residents in assisted housing are often older, more isolated, less well off, and frailer than other seniors in other settings. Service clustering is a strategy to minimize costs by taking advantage of economies of scale; clustering involves consolidating the fragmented services of many clients. Many programs, such as HUD's Congregate Housing Services Program, the RWJ Supportive Services in Senior Housing, and No Place Like Home, have combined housing and services. The benefits of service clustering can include: more people receiving assistance, residents finding more support, housing sponsors having better staff and resident morale, managers focusing more on managing the property, and all parties benefiting from lower costs. Typical activities included congregate meals, care management and crisis management, planning and advocacy, and participating in inter-organizational groups or task forces.

Service coordinators in public housing primarily assist residents in finding needed services; coordinators also provide information and advocacy, and organize activities. Some see this coordination as unnecessarily duplicating aging network activities. Technically, the service coordinators should complement the aging network's coordination efforts. Some aging network staff assume that housing managers are ready to evict residents who need assistance, while network staff see themselves as advocates for older people. Some aging network staff believed that older people who live in senior housing have more support than older people who do not. To ensure long-term viability of service clustering the following factors are important: the extent to which the program promotes aging in place, how the program coordinates services, the development of new services, the extent of environmental modifications, and how much resident input would be used.

The factors that need to be examined in promoting aging in place are: supply and demand for services in the community, laws and regulations that restrict a program's ability to provide services, what services residents may use, characteristics of the physical setting of the housing, and the applicable financing streams for housing and services. Aging networks, as expected, had limited budgets.

The guide provides examples of service clustering. The New Jersey Congregate Housing Services Program provided supportive services to eligible frail, low-income residents of subsidized housing. In Massachusetts, the Managed Care in Housing and Group Adult Foster Care programs targeted low-income older people, primarily residents of multiunit housing, who were at high risk of losing their independence. The Massachusetts programs incorporated a clustering approach to service delivery and provided a range of services. The New York State Office for the Aging established the Resident Advisor Program, which helps assisted housing developments in hiring service coordinators.

Feldman, Penny H., Eric Latimer, and Harriet Davidson. "Medicaid-Funded Home Care for the Frail Elderly and Disabled: Evaluation the Cost Savings and Outcomes of a Service Delivery Reform." *Health Services Research* 31, no. 4 (1996): 489-505.

Overview

This article evaluates New York City's Cluster Care demonstration, a model where one home care agency serves a number of Medicaid beneficiaries with disabilities living in the same senior housing site. Cluster care was tested as an alternative to the City's one-on-one attendant care system (i.e., traditional care). The differences between cluster care and traditional care were: (1) under cluster care, a single agency provided services at one site, rather than multiple agencies delivering services in one site as in traditional care; (2) teams of workers served people whose apartments were close to one another under cluster care, rather than one aide serving one client at a time under traditional care; and (3) in cluster care, clients' service schedules were based on the tasks that clients needed accomplished compared with attendants delivering services in blocks of four, eight, or 12 hours under the traditional care system. The demonstration was designed to test cluster care's potential to reduce costs by reorganizing delivery of traditional agency home care services. The evaluation addressed cost issues as well as client well-being, which was measured by functional status, mortality, depression, and satisfaction with services.

Methodology

The experimental group consisted of Medicaid beneficiaries who lived in seven senior housing sites with an on-site social worker or a senior center. Clients were not included in cluster care if their physical health condition made it unsafe for them to be alone, if they could not provide access to their apartments, or if they were psychotic. The control group was Medicaid clients receiving traditional care at four other senior housing sites. The study design involved comparing 229 clients at seven cluster care demonstration sites to 175 clients at four comparison sites. Medicaid clients in the experimental and control groups were interviewed in-person before and 16 months after the demonstration began. Home care agency and Medicaid records were used for the cost analysis and agency records were accessed to determine what happened to clients who were not available for follow-up at 16 months.

Measured variables included clients' average hours of home care used and the average cost of their home care per week in the 36 weeks preceding the intervention; post-intervention hours of care per week and home health costs per quarter; mortality; functional status using a scale of 10 ADLs and IADLs; a depression scale; a client satisfaction scale; severity of illness based on the number of classes of drugs that a client used, and the client need trajectory (the rate of change in the clients' use of hours of home care prior to the intervention).

Findings

On average, clients at cluster care sites used six fewer hours of care a week or 300 fewer hours a year than traditional clients. The reduction in hours was a result of reductions in hours of care for clients with higher functional needs at baseline. Clients in cluster care and traditional care sites with four or fewer limitations used about the same number of hours of care per week on average. Those with five to 10 limitations in cluster care sites used 7 fewer hours per week or 350 hours fewer per year than their counterparts in traditional care.

The lower hours of care in the cluster care sites resulted in cost savings. Controlling for differences in client characteristics, those in cluster care cost on average \$720 less per quarter or \$2900 less per year than clients in the traditional sites. Savings were achieved largely among those with 5 to 10 limitations in daily activities. The cluster care clients with this level of disability cost, on average, \$4600 less per year than similar clients in traditional care. There were no significant differences in mortality, functioning, or depression between the experimental and control groups. However, when measuring functional differences, those with four or fewer limitations in cluster care sites had better functioning at

follow-up than those at traditional sites and those with five to 10 limitations at baseline in cluster care fared worse than people with same level of disability in traditional sites. Client satisfaction at cluster care sites was lower than at traditional sites.

Study Limitations

The authors do not say whether they attempted to match the experimental and control groups on demographic or functional characteristics. There were significant differences between the two groups that were controlled for in the multivariate regression analysis.

LITERATURE RELATED TO ASSISTED LIVING

Wilden, Robert, and Donald L. Redfoot. *Added Assisted Living Services To Subsidized Housing: Serving Frail Older Persons With Low Incomes.* Washington, DC: Public Policy Institute, AARP, 2002.

Overview

The purpose of this study is two-fold, the first being an examination of research on the potential demand for assisted living services in federally subsidized housing and the ability to provide such services, and the second, a discussion of findings from case studies of subsidized housing projects that have developed assisted living services.

Methodology

This study first examines the existing research on the issues related to assisted living services among older residents in subsidized housing, including a summary of the research on supportive services provided in subsidized housing, specifically the service coordinator program and the federal Congregate Housing Services Program (CHSP). The second approach uses a case study method to examine policy and management issues. Interviews were conducted with 17 sponsors of subsidized housing for the elderly in nine states. Sponsors were chosen in states that provide Medicaid funding for assisted living services, such as New Jersey and North Carolina, and states that do not provide such funding, such as Connecticut. Other states, such as Maryland and New Hampshire, were chosen because of their substantial experience with state or federal Congregate Housing Services Programs. In-person interviews with sponsors in seven states (CT, KY, MD, NJ, NH, NC, and VA) were conducted between October 1999 and January 2000. Six interviews with sponsors were conducted by telephone or mail. Sponsors were mailed a project interview schedule before the interviews to obtain relevant data. The annotated review reports only the case study findings as the findings from the literature are covered in other sections of this review.

Findings

The findings from the case studies of 17 projects that provide assisted living services to the elderly cover financial issues, service delivery issues, state efforts and housing types, management, and other issues. Funding sources vary among subsidized housing sponsors, and are often an array of public and private sources. Among the 17 projects, 16 have funding from residents, nine from Medicaid, and six have private funding. Other funding includes other federal, state, and county sources. Funding limitations often result in low staff pay and high staff turnover.

Most projects have assisted living residents scattered throughout the building rather than concentrated in one location. Sponsors for grouping assisted living residents in one location argue that clustering creates economies of scale and saves staff time. Others feel that assisted living residents should not feel stigmatized or isolated from other residents, allowing residents to obtain services without having to move. All of the 11 sponsors visited on-site have managed to incorporate assisted living services while retaining a residential environment. Although most sponsors contract out some of their assisted living services, some owners find that providing services directly can save money. Other owners feel they lack the necessary skills to administer such programs and contracting out services may provide some liability protection. Most sponsors provide individual "a la carte" services rather than bundled services. Sponsors who provide "a la carte" services feel this allows residents to maintain decision-making power and focus on their individual needs. Other sponsors find it easier to structure a system of bundled services, however, those tend to be the larger projects that provide services directly through project staff. Section 202 policy changes have prevented newer housing projects built in the 1980s from establishing mandatory meals, thus, these projects and smaller sponsors, who often lack a commercial

kitchen or central dining room, and have more difficulty developing meals programs for assisted living residents

Conclusions

Findings from case studies show that assisted living services can be successfully integrated with subsidized housing for seniors with funding, training, and coordination of housing and service staff major obstacles for implementation. States that have funded such services have also played a key role in development of assisted living services in subsidized housing. But, state efforts to regulate and monitor specific assisted living services will become more common as they begin to address the issue of developing way to monitor and enforce quality. Further research is needed to develop models and strategies for continued expansion and improved quality of assisted living services in subsidized housing for elderly.

LITERATURE RELATED TO GENERAL HOUSING AND POLICY

Robert, Stephanie A. "Community Context and Aging, Future Research Issues." *Research on Aging* 24, no. 6, (2002): 579-99.

This article was written as the introduction to a special volume of *Research on Aging* addressing "Community Context in Aging Research." It provides an overview of the issue of community context and a brief summary of the four articles on the topic in the volume. It begins with a review of definitions of community. Community can be defined by the physical space in which people live, by political boundaries, or other physically delineated spaces; or it can be defined by social rather than physical boundaries such as shared interests, identity, or interactions. The community context is crucial in life-course and aging research because of the need to consider the spatial distribution of the aging population and the implications that this distribution has for meeting the needs of the aging population. In addition, community can be the repository for social capital and social inequalities that may require response through services.

Different communities may attract different types of older adults with different needs and different capacities for contribution to the community. Some communities made up predominately of older adults were formed primarily through the in-migration of older adults and others primarily by the out-migration of younger adults, which may have implications for the characteristics of the older adult population. Furthermore, although racial and ethnic diversity of communities is increasing, segregation is still the norm, which may affect individual well-being.

The problems that communities face may depend on the community context. Specifically, some areas may be looking at the best way to attract healthy and wealthy older adults while others may be struggling to determine how to best meet the needs of the population they already have. The rate of growth of the community may determine the rate of growth in the need for services. The devolution of responsibility from the Federal Government to the states and from the states to local communities means that communities must balance services across age groups and service groups. There is a great diversity in the ability of communities, both within states and across states, to accept publicly funded services at home rather than in nursing homes.

There is growing popular and scientific interest in the role of community in individual well-being. For example, there is interest in how income inequality within the community affects individuals in the community even when they are not poor, or in whether older individuals are seen as resources for the community or drains on community resources.

The availability of survey data has had the effect of focusing attention on the individual outside of the community context. The four articles summarized in this article all extend research to the effects of the community on the individual. Cotter, Hermser, and Vanneman discuss the contribution of the structure of the labor market on employment patterns. Specifically, they consider whether metropolitan areas with higher demand for female labor lead to narrower gender variation in employment rates, if the shifts made to accommodate female labor market participation makes workplaces more amenable to older female workers and differences in individual and community expectations of women's roles. Extensions to this research might include looking at whether "gendered labor markets" are associated with quality of life in retirement, particularly for women.

Kim and Lauderdale look at the determinants of living arrangements of older adults with a particular focus on the Korean-American immigrant community. They find that differences in living arrangements in metropolitan areas are partly explained by co-location of Korean ethnic businesses and subsidized housing. They conclude that government-subsidized housing provides Korean-American older adults,

who on average have lower incomes, the opportunity for independent living. They suggest that the acceptability of services may vary by cultural preferences.

Lee and Robert look at the role of race differences in the community context in explaining health disparities at older ages. They show that older black adults tend to live in socially and economically disadvantaged communities compared with non-black older adults of similar income and education and that the observed health differences are only partly explained by individual socioeconomic status.

Lawrence and Schigelone look at community coping responses to the stressors of aging in a continuing care retirement community. They describe communal responses to problems such as the institution of a buddy system to check up on community members and provide social support.

Finally, this introductory article proposes the research approach of trying to look at old problems in new ways and also to look at new problems in new ways. The author asserts that the four articles in this volume show that community characteristics provide additional information useful for explaining individual level outcomes.

Lawler, Kathryn. *Aging in Place, Coordinating Housing and Health Care Provision for America's Growing Elderly Population*. Joint Center for Housing Studies of Harvard University and Neighborhood Reinvestment Corporation, 2001.

In this paper, Lawler discusses the relationship between health and housing and their roles in addressing the needs of a growing elderly population. The author argues that the bureaucratic separation of services and the lack of coordination between health and housing combine to deter seniors from successfully aging in place. She advocates a customized care model of service delivery, that is, one that can be tailored to the needs of the individual, rather than the current production model of service delivery that can lead to either "overcare" or "undercare." The author asserts that aging in place allows individuals to maintain their social support network, can limit the negative effects of relocation and transitions, and may lead to cost savings by minimizing the provision of inappropriate care. She cites results from a survey conducted in 2000 by AARP suggesting that the majority of seniors wish to remain in their current residence for as long as possible. However, the current system of public subsidy for housing and health care services presents structural barriers that prevent the coordination of these services for those in need. These barriers include separate federal funding sources, separate administrative jurisdictions (state vs. locality), and separate regulatory standards (medical vs. construction and development). Additionally, the eligibility criteria for health care and housing services differ and often conflict with each other.

Using information from a series of 60 interviews the author conducted with senior service providers across the nation between June and August of 2001, the author identifies four key elements consistently present in most successful aging-in-place programs: a choice of health care and housing options; flexibility in the range of services offered; the ability to maintain mixed generation communities; the ability to provide ongoing assessments of health-service needs in order to identify the appropriate level of services and make any adjustments. She also identifies challenges to developing and maintaining an aging-in-place program, which include: differences between rural and urban settings; lack of understanding of the elderly community's perceptions of alternative residential care settings; the physical deterioration of housing stock; and different skill sets of housing and service providers. She notes that the different skill sets may also create opportunities for partnership.

Several opportunities exist for the coordination of health and housing services at the federal, state, and local levels, in particular, aligning HHS and HUD programs and funding streams toward one another. Programs that HHS and HUD have initiated in the last few years that the author feels should be continued and expanded include the HUD Service Coordinator Grant, the HUD Assisted Living Conversion Program, and the HHS-sponsored PACE Program. Alternatively, a program that pulls funding from both

federal health and housing streams could be developed in one agency. The 1999 Supreme Court-issued *Olmstead v L.C.* ruling, which requires states to develop an Olmstead Plan that redirects services from institutional settings to community-based alternatives, presents states with an opportunity to address housing and health-service needs within the long-term care delivery system.

Numerous opportunities already exist for better coordinating the health and housing needs of seniors. Community development corporations and community-based nonprofits can play a large role in identifying housing and health service needs of elderly residents in the community. Naturally Occurring Retirement Communities (NORCs) offer models for service delivery based on the concept that a neighborhood or apartment building with a high density of seniors aging-in-place affords the opportunity to bring services to seniors instead of transporting or relocating seniors to the services or to alternative residential settings. Community-based organizations can serve elderly residents aging-in-place by offering paraprofessional support services that are often less costly than the services of licensed medical or housing professionals. These organizations are also helpful in facilitating the organization of long-range community planning efforts and development issues that address the needs of elderly residents aging-in-place. Furthermore, community efforts to encourage and support aging-in-place can be linked with goals to build community stability or revitalize neighborhoods by focusing on rehabilitating the housing stock, encouraging diverse resident demographics, and promoting home ownership since most seniors own the homes they live in.

The author summarizes findings from case studies of three different projects that offer ways state and local governments can combine health and housing services for seniors. The first case study focused on Atlanta, Georgia, and used GIS technology to locate communities with a high density of seniors, communities with seniors at risk, and communities with diverse age structures. The location of health services and housing services were also mapped. This information was designed to assist government officials in planning services to meet the needs of a growing elderly population.

The second case study focused on the Penn South NORC, a cooperative housing arrangement of 2,820 units and 6,200 residents. In 1985, more than 75 percent of Penn South's resident population was 60 years old or older. At that time, Penn South's board organized to develop services programs to forestall nursing home placement and encourage the elderly to remain in their own homes. The cooperative organized various social and health-related community organizations to provide care coordination, group recreation, cultural and artistic programs, home-care coordination and non-acute nursing care, volunteer opportunities, and preventive health and education services among other programs.

The third case study focused on Florida's Elder Community Program, which offers communities within the state of Florida the opportunity to assess their own facilities, services, housing stock and recreational activities. The program was a grassroots effort with the state providing the framework and assessment tools and residents doing the work, thereby affording residents the opportunity to design their own programs and plan changes to create more Elder Friendly Communities. This program offered communities the flexibility to decide how much or how little to spend to improve transportation, recreation, and housing. Currently 23 communities are participating in the program, and one grocery chain has become an elder friendly business.

National Investment Center for the Seniors Housing and Care Industries. *NIC National Survey of Adult Children: How They Influence Their Parents' Housing and Care Decisions.* Annapolis, MD: National Investment Center for the Seniors Housing and Care Industries, 2000.

Overview

The goal of this study was to ascertain the roles, knowledge, and decisions that influence adult children who may have responsibility for their parents' housing and care.

Methodology

The study employed a telephone survey of approximately 1,500 adult children between the ages of 45 to 64. Two-thirds of this population had a parent who did not currently need supportive care. However, 14 percent were responsible for a parent who had received professional care services within the past two years at home. About 7 percent had a relative residing in an "assisted living" community. Finally, 3.5 percent had a relative residing in an "independent living" community.

Findings

Many adult children were uninformed about independent living and assisted living options. Only 40 percent were familiar with independent living and 27 percent with respite care services. Many adult children found the terminology about senior housing and care to be confusing and irregular. Despite the fact that 73 percent of the respondents stated that their older relative has less than \$25,000 annual household income, 77 percent of adult children had not discussed the costs of seniors housing with that relative. Physicians' recommendations were most often used for decisions about home health care services. Furthermore, the authors believed that seniors housing and care providers needed to educate other professionals about the benefits they offer. Finally, adult children provided financial support for senior housing and care services.

Recommendations

The authors suggested a massive campaign to educate consumers about their options, as well as changing the perception of financial affordability.

Pynoos, Jon, and Phoebe S. Liebeg. *Housing Frail Elders: International Policies, Perspectives, and Prospects.* Baltimore, MD: Johns Hopkins University Press, 1995.

Overview

The authors of this study analyzed past and current housing program policies for frail elders in industrialized societies, and compare them to the United States.

Several efforts over the past two decades have tried to improve integration of services into government-assisted housing for the elderly. For example, Congress in 1978 created the Congregate Housing Services Program (CHSP) to provide service coordinators and a variety of services to older tenants in public and Section 202 housing. While the program began in 63 sites, controversy existed over whether HUD's should be responsible for payment of services. Additionally, an evaluation of the CHSP created further disagreement; OMB argued that CHSP did not save money, and the money would have been better spent on nursing-home care. However, Congress insisted the CHSP program continue, but because of budget constraints and lack of enthusiasm for support among the Reagan and Bush

administrators, it was limited to the same number of participants at the same sites. The second phase of the CHPS involved more restrictive targeting.

Findings

The experience of the CHSP demonstrates how political and bureaucratic influences can make it difficult to create a strong housing and services relationship. The authors cite three major structural changes that prompted the transition of the United States toward a system of residentially based long-term care. First, private markets and consumer preferences favored residential care. Second, state governments had limited resources, yet growing demands for services as a result of federal mandates. Finally, budget implications had a major impact on current efforts to reform federal housing and long-term care policy.

AARP. "Understanding Senior Housing for the 1990s, An American Association of Retired Persons Survey of Consumer Preferences, Concerns, and Needs." Washington, DC: AARP, 1990.

Overview

This study reports results of an AARP housing study on emerging housing trends for older adults. Notable findings include the preference for aging in place is more prevalent in the current survey (1989) than in 1986 (86 versus 78 percent), there is more receptivity to age-segregated housing (40 versus 32 percent), more awareness among older people of the need for help around the house (65 versus 40 percent), and more anticipation of the need for help in the future (55 versus 33 percent). Over half of respondents reported that they have done little or no planning for their future housing needs, especially among those over 75 years of age, with lower incomes, and those not currently married. As a result, the most vulnerable older people are those who have done the least planning for the future and are most susceptible to being forced out of their homes because of a crisis.

Methodology

The survey updates a 1986 AARP national survey. The sample included 1,500 adults age 55 and older interviewed by telephone in 1989 about (1) current housing arrangements, (2) community preferences, (3) preferences for housing options and related services, (4) household activities, (5) housing costs, (6) safety and security concerns, and (7) planning for future housing needs. Results were analyzed by gender, age (55-64, 65-75, and 75 and over), income, marital status, race, home ownership, health limitations (no limitations, some limitations, or a great deal of limitations), mobility (moved within the past five years or not), planning (planned a lot or a moderate amount for future housing needs, or planned a little or none) and community type. Community type consisted of the following categories: retirement housing or buildings planned for older adults, communities or buildings where the majority of residents are 60 and older (NORC), and communities in which the majority are under 60 (non-NORC). The questionnaire is provided as an appendix to the report.

Findings

With respect to community type, 5 percent lived in a retirement community or building and 27 percent live in a NORC. Of those in a NORC, 80 percent said the older people had lived there a long time rather than having moved in recently. Most residents of NORCs or retirement communities like living in communities with a majority of older residents; only 11 and 7 percent of residents of retirement communities and NORCs, respectively, would prefer a better mix of ages. Social activities were mentioned by 10 percent of those living in communities composed predominately of older people as a positive attribute of their living situation; those in retirement buildings or communities were twice as likely as those in NORCs to mention this (20 versus 9 percent).

With respect to housing option preferences, 32 percent of older Americans are considering moving to an apartment that provides meals, housekeeping, transportation, and social activities, and 17 percent are considering moving in with a family member. Those limited by health were the most likely to be interested in board and care homes and were more likely to be interested in age-segregated housing.

With respect to help with household activities, both heavy and light household chore help was the most frequent help used (23 to 30 percent, depending on the chore), followed by light housekeeping (9 percent) and grocery shopping (9 percent). These percentages more than double when older adults talk about expected future assistance needed. In addition, 14 and 11 percent expect to need help with cooking and personal grooming, respectively, in the future.

More than 8 in 10 older people do not want to leave their current home. Those living in NORCs are more likely to want to stay. Over one-fifth expect to move but only 13 percent say they want to move. Most would like to live in a neighborhood with people of all ages but in a household of people of the same age. Residents of NORCs were less likely than residents in retirement communities or buildings to have moved in the past five years (23 versus 53 percent).

Conclusions

In conclusion, the report states that those who least want to leave their homes are those who are most vulnerable and who may lack a support system, presenting a challenge to policy makers that want to help these individuals remain at home and to providers of services for such people.

Newman, Sandra, and Raymond J. Struyk. "Housing and Supportive Services: Federal Policy for the Frail Elderly and Chronically Mentally Ill." In *Building Foundations: Housing and Federal Policy*, edited by Denise DuPasquale (435–64). Philadelphia, PA: University of Pennsylvania Press, 1990.

Overview

There was not a strong market response to the dearth of housing for the frail elderly and chronically mentally ill because typically these households have lower incomes, and developers lack the experience needed to meet the needs of these groups. These populations have a high demand for supportive services and could require environmental features to enable independent living. The largest disparity between the two groups was that characteristics of care varied and the median age drastically differed.³ Coupled with differences in informal support, this fostered different living environments to sustain independent living.

Approximately, 9 percent of the elderly needed assistance in physical activities due to the chronic health problems. Most of this requires help with toileting and getting in and out of bed or a chair. In 1985, about 400,000 people in elderly headed households were at risk of being institutionalized. The author anticipated that the number of households headed by an elderly person would remain stable until the baby boom generation reaches retirement in the early part of the 21st century, where it would then increase drastically. Institutionalization could be averted if people received varying levels and types of nonmedical supportive services where they lived. However, obtaining this help was difficult and expensive. The primary challenge was to create a cost-effective program that still provided valuable services. The author reviewed various housing programs created by the government.

³ The median age of a sample of CMI at NIMH's Community Support Program was 42 years of age.

Housing with Support Services

There were three types of housing with support services. The first type consisted of projects designed for use by physically impaired people. The second type provided support services to people living in government-subsidized housing. The third type was the small Congregate Housing Services Program, which is used to delay the need for institutional placement of its residents. Several states have launched congregate housing programs, which were “mixed income” and primarily financed by state housing bonds and insured under the FHA 221 (d)(4) program. Since 1980, the number of additional households assisted each year had dropped notably, and the composition of the funded units has been shifted from constructing homes to rent supplements or housing vouchers. Moreover, funds were being appropriated only for the elderly and handicapped by the Section 202 program.

Housing in Relation to Long-Term Care Policy

Housing and long-term care policies were technically not linked because the United States had no articulated long-term care policy. The current legislation through two clauses enabled the expansion of community-based services. First, it could occur through the “creative use of coverage options in the state Medicaid plans.” Second, another possibility was through the Section 2176 “waiver program.”⁴ Furthermore according to the authors, community-based programs have not been able to effectively prove that they minimize costs because many experimental programs have not been able to define the appropriate target population. The targeting issue would need to be a grave concern in designing new housing initiatives.

Future Policies

Housing-based options were packages of assistance that combine supportive services with a housing-based solution, such as the CHSP. A long-term care based option was where housing assistance was added as necessary to community-based long-term care assistance.

Housing-Based Options

CHSP. In 1985, the monthly cost of supportive services received by CHSP participants was about \$340.⁵ The authors then derived the approximate cost of the housing services and housing subsidies and concluded that total rent was \$430 per month and federal outlays were \$274 per month. Therefore, the full cost of services was \$770 and the subsidy component was \$614 per month.⁶

Intermediate Care Facilities. The authors claimed this costs approximately \$45 per day, or \$1,350 per month, where residents received assistance through Medicaid and paid all their income except \$35 per month for this care. The authors then estimated the monthly cost of Medicaid to the government to be \$890.

Targeting and State Interest in Congregate Housing

Two major considerations arose about congregate housing as a substitute for nursing homes care. The first concern was how to determine the appropriate margin of error in selecting low-income tenants for congregate facilities, such that congregate care would not cost more for each person who has not entered the nursing home. Secondly, the interest of the states in congregate housing programs was crucial because the cost sharing varied and could foster a strong interest on the part of the states to forestall or delay institutionalization. According to the authors, if congregate housing services could

⁴ States could apply to HCFA, now CMS, for permission to substitute such services for institution-based services.

⁵ This includes costs directly paid for by the program and matching services provided by the housing facility.

⁶ This was based on two assumptions: (1) the income of the elderly receiving this assistance was the same as that of all elderly receiving housing assistance; (2) the cost in public housing and Section 202 projects was the same as the average outlays under the entire Section 8 program.

demonstrate effectiveness in reducing institutionalization, then states should be more willing to share in the cost of a federal congregate housing program.

LTC-Based Options

Life Care at Home (LCAH) and Social/Health Maintenance Organizations (S/HMO) were new long-term care insurance and service delivery models primarily for middle-income households. LCAH combined financial and health security of a CCRC with the freedom and independence of living at home. LCAH pooled the risk of its enrollees and enabled more individuals to participate it. This was currently done in Philadelphia. The S/HMO relied heavily on HMOs as the service provider, where the provider assumed responsibility for a full range of services

Conclusions

Congregate housing according to the authors was considered to be the most promising housing-based approach. However, the complexity and types of support services offered must be studied and altered continuously to continue program effectiveness. States should have a genuine interest in creating a joint federal-state congregate housing program, since congregate programs could possibly reduce overall long-term care costs by minimizing entry into nursing homes and reliance on Medicaid. In addition, the authors suggested that a stronger working relationship was needed to evolve between HUD and HHS to improve cost savings and services.

SUPPORTIVE SERVICES PROGRAMS IN NATURALLY OCCURRING RETIREMENT COMMUNITIES

PDF Files Available for This Report

Main Report <http://aspe.hhs.gov/daltcp/reports/NORCssp.pdf>

APPENDIX 1: Annotated Review of the Literature on Housing with Services for Older People Who Age in Place <http://aspe.hhs.gov/daltcp/reports/NORCsspA1.pdf>

APPENDIX 2: NORC Site Visit Summaries
<http://aspe.hhs.gov/daltcp/reports/NORCsspA2.pdf>

APPENDIX 3: Comparison of the Conceptual Model by NORC Sites
<http://aspe.hhs.gov/daltcp/reports/NORCsspA3.pdf>