



One of the greatest needs of people wishing to age in place, reliable and affordable transportation options connect aging adults to services and amenities in their communities.

*Newton at Home*

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## Aging in Place: Facilitating Choice and Independence

In the coming decades, increasing life expectancy, a declining birth rate, and the aging of the baby boom generation will dramatically increase the number and proportion of the U.S. population over the age of 65. This aging of the population presents a number of challenges and unanswered questions, including where people will live and how they will obtain the support and care they will need as they age while retaining as much independence as possible.

Most seniors indicate that they would prefer to age in place, either staying in their current home or choosing from a range of affordable, age-appropriate housing options within their community. A 2010 AARP survey found that 88 percent of respondents over age 65 wanted to remain in their homes for as long as possible, and 92 percent said they wanted to remain in their communities.<sup>1</sup> To make these options viable, we must adapt homes and communities to

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# Editor's Note

Although aging in place was once the norm in U.S. society, modern land use trends and housing stock design make this goal increasingly difficult to achieve today. This edition of *Evidence Matters* hits close to home for many families as they or their relatives age and consider their evolving needs. By examining the demographic shifts and preferences of the elderly population, we aim to provide a backdrop for the challenges that confront communities across the country.

The feature article, "Aging in Place: Facilitating Choice and Independence," reviews the trends underpinning the issue and looks at the federal, state, and local programs and policies for the elderly that are accommodating a shift away from institutional living and toward aging in place with supports. The Research Spotlight article, "Measuring the Costs and Savings of Aging in Place," examines efforts to measure the potential health cost savings (as well as improvements in well-being) to families and the government when individuals are able to age in their homes with assistance, reinforcing the argument that housing matters. Finally, grassroots efforts to aid the elderly in their communities and provide practical solutions for the supportive services necessary to age in place are examined in the In Practice article, "Community-Centered Solutions for Aging at Home." Readers may find that the issues involved in creating aging-friendly communities have much in common with the issues involved in building livable communities, such as the role that density and transit systems can play in providing access to neighborhood amenities.

Together, these articles give a sense of the breadth of housing and community development issues associated with the graying of America while also identifying the significant and ongoing need for further research. On this front, the Office of Policy Development and Research (PD&R) has partnered with the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to fund a proposal for a demonstration to test models for subsidized aging in place. (For more information, see "Demonstration Will Evaluate Subsidized Models for Aging in Place," p.17.) Of course, like HUD and HHS, every federal agency and state government will need to come to terms with the effect that the aging American population will have on the programs and services they provide. Join us on January 9, 2014, when we will explore this issue as part of PD&R's Quarterly Update.

I hope you find this issue of *Evidence Matters* enjoyable and thought-provoking. Our next issue will focus on vacancy and the reuse of vacant land. As always, please provide any feedback at [www.huduser.org/forums](http://www.huduser.org/forums).

— Rachelle Levitt, *Director of Research Utilization Division*



meet the changing needs of aging residents, make available affordable housing options suitable for aging residents, and connect seniors to the services they need in the places that they live.

A combination of public policies, public and private strategic initiatives, and marketplace developments seek to meet the health and housing needs of the rising senior population by facilitating aging in place and by using housing as a platform for accessing medical and nonmedical services.<sup>2</sup>

## Demographics and Economic Consequences

Demographers project that by 2040, the U.S. population aged 65 and older will double to 80 million and their share of the total population will rise from 13 to 20 percent.<sup>3</sup> Driving this fundamental demographic shift is a confluence of factors. First, as the baby boom generation (those born between 1946 and 1964) ages, the growth rate of the portion of the U.S. population over age 65 will accelerate significantly. Experts are quick to point out, however, that the aging of the population is not “all about the baby boom.” Rather, rising life expectancy coupled with a reduced birth rate is driving a long-term change in the age composition of the U.S. population.<sup>4</sup>

The U.S. Census Bureau forecasts continuing increases in life expectancy, from 79.5 years for a baby born in 2015 to 84.8 years for one born in 2060 (compared with 68 years for a baby born in 1950).<sup>5</sup> In addition, a National Research Council report projects that the average years of life remaining for males who reach age 65 will rise from 17.5 years in 2010 to 22.2 years in 2050; for females, these numbers will rise from 19.9 years in 2010 to 24.1 years in 2050.<sup>6</sup> Considerable debate exists, however, over how to project life expectancy and years remaining, considering the uncertain implications of developing trends such as the rise in obesity rates.<sup>7</sup>

## Highlights

- A combination of demographic and economic shifts is creating a large and growing need for affordable and age-appropriate housing opportunities.
- Most seniors would prefer to age in place; home modifications are critical to this process, but the costs can be prohibitive.
- Many organizations are using housing as a platform to provide supportive services that adapt to the needs of seniors, allowing them to remain at home and continue to engage with their communities.

In addition to increasing life expectancy, researchers have explored the concept of “compression of morbidity,” meaning that people can live actively and largely free of disease and disability until shortly before death.<sup>8</sup> Although the topic is still the subject of debate, most research suggests that a compression of morbidity occurred in the 1980s and 1990s that has since leveled off.<sup>9</sup> As with life expectancy, it is unclear how to project compression of morbidity. Some research suggests that, compared with the cohort that preceded them, baby boomers are in poorer physical and mental health as they enter retirement and therefore will have higher rates of disability as they age.<sup>10</sup> Exactly how people will live their lengthened lives — with compressed or extended morbidity — has a significant effect on their ability to age in place.<sup>11</sup>

Other demographic influences will shape the dynamics of aging in place in ways that are not yet fully understood. Experts project increasing ethnic diversity in the older population. The share of the population aged 65 and older who identify as Hispanic, for example, is expected to increase from 7 percent in 2010 to 20 percent by 2050.<sup>12</sup> Such diversity may add to the challenges of aging in place because ethnic and racial minorities may have different needs, preferences, or understandings regarding issues such as death or dementia.<sup>13</sup> Growth in the populations of ethnic and racial minorities that, because of socioeconomic differences, are more likely to encounter barriers to services, have a higher prevalence

of disability, and have less wealth than whites of the same age will also shape the challenges of aging in place in the future.<sup>14</sup> According to a recent study by the Institute on Assets and Social Policy at Brandeis University, 76 percent of African American and 85 percent of Latino seniors “do not have sufficient financial resources to meet projected lifetime expenses.”<sup>15</sup>

Although the financial circumstances of these African American and Latino seniors are especially insecure, the Center for Retirement Research’s National Retirement Risk Index predicts that 53 percent of all working households are “‘at risk’ of being unable to maintain their pre-retirement standard of living in retirement.”<sup>16</sup> Stagnant incomes and unstable sources of wealth underlie this financial insecurity. Using 2007 dollars, the median income of people aged 45 to 54 rose only marginally between 1989 and 2007, from \$62,100 to \$64,200. Because these households hold most of their savings in home equity, their net worth is subject to the volatility of local and national housing markets.<sup>17</sup>

Low incomes contribute to the financial insecurity of older households. In 2011, the median income of households with at least one person over age 65 was \$33,118, only 60 percent of the median income of younger households.<sup>18</sup> Much of this income is devoted to health care and housing. In 2010, for example, households enrolled in Medicare devoted nearly 15 percent of their annual spending to health care-related expenditures.<sup>19</sup> And in

2009, 48.1 percent of homeowners with a mortgage and 58.6 percent of renters aged 65 and older spent 30 percent or more of their income on housing and utilities.<sup>20</sup> These factors pressure the budgets of many older households and are particularly challenging for those with the lowest incomes, including the 8.7 percent of people aged 65 and older who were living below the federal poverty level in 2011.<sup>21</sup>

These demographic changes and characteristics will have wide-ranging implications for society and policy. The aging population will strain the capacity of government programs that support seniors (and, by extension, federal, state, and local budgets) and will increase demand for affordable and age-appropriate housing. At the federal level, the portion of the budget devoted to Social Security, Medicare, Medicaid, and interest payments on the federal debt will increase from 44.4 percent in 2010 to a projected 61.8 percent in 2020.<sup>22</sup> This spending increase will likely constrict funding for other federal programs, including those that support housing for the low-income elderly. State and local governments will also face heightened

demand for services for older residents. Compounding these problems, the changing age structure will mean that fewer workers will support the growing number of retirees. Although older people may work longer in the future, according to current projections, only 3 potential workers (those aged 15 to 64) will exist for every 1 retiree (aged 65 and older) in 2050 compared with 5.2 in 2010 and 8 in 1950.<sup>23</sup>

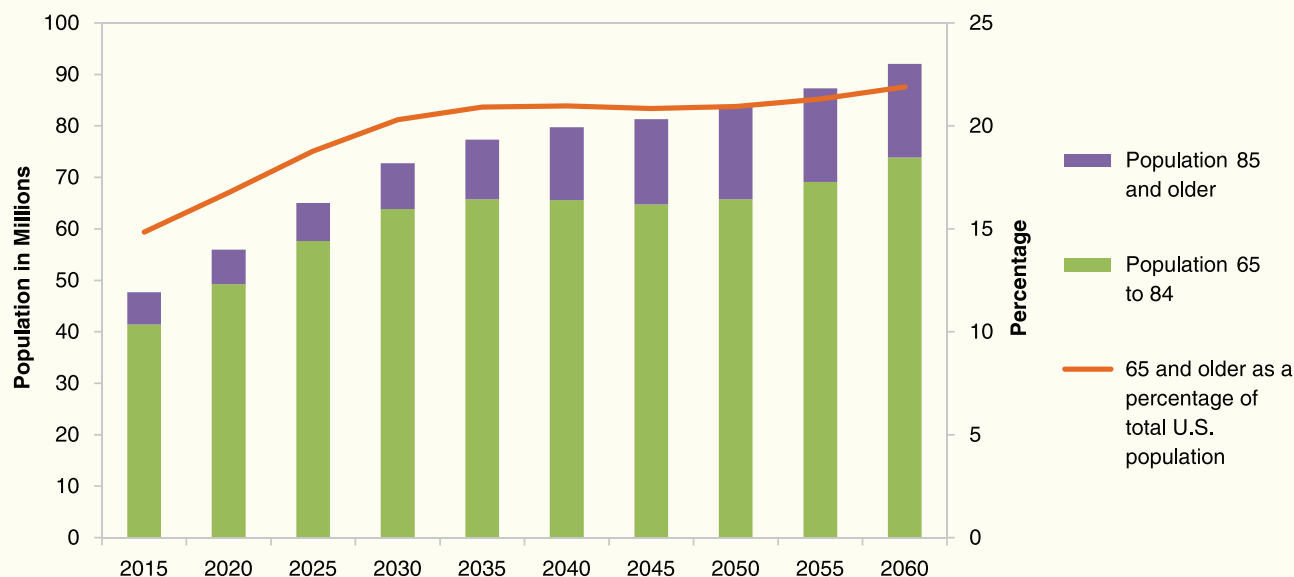
State and federal governments will be especially burdened by the expanding demand for Medicaid-funded services. Long-term care is a matter of particular concern for state policymakers because it constitutes nearly one-third of all Medicaid spending.<sup>24</sup> Although it constitutes a decreasing share of total expenditures, institutional care continues to account for more than half of Medicaid expenditures for long-term care services.<sup>25</sup> Helping seniors delay or avoid institutionalization by facilitating aging in place has the potential to significantly reduce public spending on long-term care. Kaye, Harrington, and LaPlante estimate that supporting a resident in a nursing home costs five times more than in a

community setting.<sup>26</sup> Critical to unlocking this potential savings, then, is meeting the housing and health needs of seniors in their current homes and communities.

## Aging in Place

The overwhelming majority of older adults prefer to age in place, remaining in their current homes or communities. Most seniors — 93 percent of Medicare enrollees aged 65 and older in 2009 — are already aging in place in traditional communities.<sup>27</sup> But as Robyn Stone, executive director of the LeadingAge Center for Applied Research, puts it, “Most people are doing that until they aren’t doing it... it’s only when they reach either a crisis or a change in their condition or functional status or in, many times, their family support” that they can no longer remain in their homes.<sup>28</sup> Such a crisis or change often happens after age 85. In 2009, only 7 percent of Medicare enrollees between the ages of 75 and 84 resided in long-term care facilities or community housing with services compared with 22 percent of those aged 85 and older.<sup>29</sup> The aging-in-place initiatives that successfully keep seniors from entering

## Population Projections by Age



Source: U.S. Census Bureau, Population Division. 2012. "Table 12. Projections of the Population by Age and Sex for the United States: 2015 to 2060 (NP2012-T12)."



Chris Hartlove

Simple modifications such as the installation of a handrail can make homes more aging-friendly for residents like Carol Glover, pictured here. Glover participated in the Community Aging in Place—Advancing Better Living for Elders (CAPABLE) pilot conducted by researchers at the Johns Hopkins School of Nursing, which tested an intervention that combined occupational therapy, nursing, and handyman visits.

institutional long-term care facilities will likely be those that target this most vulnerable and high-need group.

In tension with both the strong desire to age in place and the reality that many already do so, many seniors feel that their current homes are not well suited for aging. Slightly less than half of the respondents to an AARP/Roper Public Affairs and Media group of NOP World poll reported that their home would not fully meet their physical needs as they age.<sup>30</sup> A home environment that does not meet physical needs — one that lacks a bathroom and bedroom on the first floor, for example — is just one of several barriers to aging in place. Community features, housing affordability, and accessibility of services all contribute

to the ability of seniors to successfully age in their current homes and neighborhoods.<sup>31</sup> Several current initiatives aim to improve home and community environments that are ill-suited for aging residents as well as increase the range of affordable housing options. To the extent that these efforts can succeed, housing can be a platform for accessing needed medical and other services that facilitate aging in place.

### Home Modification

Home environments that do not meet the changing needs of aging residents can prevent successful aging in place. “In houses,” says Jon Pynoos of the University of Southern California, “we are still stuck with the old models that will not easily accommodate

to the changes that can accompany getting older.”<sup>32</sup> In a national AARP survey, 23 percent of respondents aged 45 and older reported that someone in their household was very or somewhat likely to have difficulty getting around their home in the future.<sup>33</sup> Various modifications can make it easier for aging residents to navigate through and live in their homes, including brighter lighting, handrails, stair lifts, and accessible workspaces. New technologies are also being harnessed to help people age in their homes. A project developed at the University of Missouri, for example, helps caregivers monitor seniors in their homes using sensors to detect falls and other emergency situations and to track changes in functional ability. The sensor system,



Aljoia Thornton Place, an Era Living retirement community.

Part of a retrofit of the Northgate Mall and its surroundings, Aljoia Thornton in Seattle offers residential options for seniors within a walkable, mixed-use neighborhood with access to public transit.

which includes monitoring of bathing and cooking activity as well as time spent in bed, has been tested in a community-based setting and is being developed for in-home use.<sup>34</sup>

These home modifications can range in cost from a few dollars for a brighter light bulb to thousands of dollars for significant remodeling.<sup>35</sup> The National Association of Home Builders (NAHB) reports that 80 percent of aging-related home modifications are paid for out of pocket — a significant obstacle to aging in place for the poorest elderly, who both have the highest levels of disability and tend to live in older housing stock.<sup>36</sup> Some form of public assistance may be necessary to support modifications for this high-need population. The U.S. Department of Energy’s Weatherization Assistance Program, which makes homes more energy efficient to reduce utility costs for low-income families, could be of help to seniors as well as serve as a model for home modification programs

that adapt housing for the low-income elderly.<sup>37</sup>

A more cost-effective (although long-term) solution for promoting aging-friendly housing is to ensure that new construction includes accessible features and is designed with future modifications in mind, such as blocking for future railings and grab bars or stacking closets for a future elevator. Two design standards — visitable and universal — promote accessibility and provide benefits to users of all ages. On the lower end of the spectrum, visitability creates a standard of accessibility for disabled visitors, including zero-step entryways, wide doorways, and a first-floor bathroom. Universal design is a higher standard that would also include, for example, having a bedroom on the first floor. These design standards already incorporate many aging-friendly modifications and provide greater ease of access and use to people of any age and ability.<sup>38</sup>

A handful of local jurisdictions, including Atlanta and Austin, require visitability in all publicly funded homes. Other jurisdictions, such as Pima County, Arizona, require visitability in all publicly (and at least some privately) funded homes. Generally, however, visitability and universal design are voluntary standards, although some jurisdictions encourage their use through public incentive programs, such as the tax credits offered by Georgia, Virginia, and Pennsylvania.<sup>39</sup> At the federal level, Green and Painter suggest that universal design could be required for the Section 202 Supportive Housing for the Elderly program and other HUD programs.<sup>40</sup>

To promote the adoption of accessible design principles in the private market, AARP and NAHB created a Certified Aging-in-Place Specialist program that trains and certifies housing professionals in aging-friendly design, and the Andrus Gerontology Center at the University of Southern California offers an Executive Certificate in

Home Modification.<sup>41</sup> Pynoos notes that adoption of universal design “has a ways to go,” but could become more commonplace “once consumers and builders understand that it is not really any more expensive in the long run and can look attractive. Moreover, it helps families with young children as well as older people, making everyone’s lives easier.”<sup>42</sup> Whether they are accomplished through retrofitting older homes or designing accessible new homes, aging-friendly modifications can adapt to people’s changing needs, allowing them to age in their homes more successfully.

## Community Adaptation

As with home modification, the community environment can be adapted to facilitate aging in place both through retrofitting and new design. Most households with residents aged 65 and older are located in a suburb.<sup>43</sup> Suburbs, however, with their widely spaced residences that are often distant from grocery stores, doctors’ offices, and other services and amenities, are ill-suited for seniors, especially those who cannot drive.<sup>44</sup> Ellen Dunham-Jones and June Williamson, authors of *Retrofitting Suburbia*, suggest that suburban spaces can be repurposed to meet the needs of aging residents — for example, a vacant strip mall could become a “medical mall” as a one-stop destination for medical services.<sup>45</sup> Similar adaptations are also appropriate for rural and urban areas.

Community planners envision the design of “lifelong neighborhoods” that are consistent with smart growth principles and that can accommodate residents of all ages by incorporating connectivity, pedestrian access and transit, neighborhood retail and services, and public spaces for social interaction. Planning for lifelong neighborhoods includes flexible zoning ordinances that can expand potential avenues for aging in place such as accessory dwelling units (self-contained living units adjacent to or within a single-family dwelling), co-housing, and multifamily housing and

would allow residential and commercial areas to be situated closer together.<sup>46</sup>

Public transit offers a potential solution to seniors’ mobility barriers, but traditional transit systems are typically geared toward the needs of commuters. According to an AARP analysis of the 2009 National Household Travel Survey, people over age 65 made only 2.2 percent of their trips by public transit compared with more than 87 percent by car and 8.8 percent by walking.<sup>47</sup> Paratransit services — door-to-door, demand-responsive services required by the Americans with Disabilities Act — could be an alternative to public transit, but an estimated 58 percent of older people do not qualify for ADA paratransit services because they do not have a serious disability.<sup>48</sup> These services are also very expensive; in 2011, the average cost of a one-way paratransit trip was \$34.59.<sup>49</sup>

When residential and commercial uses are separated and communities lack connectivity, walkability, and adequate public transportation, seniors become dependent on their ability to drive or receive rides from others.<sup>50</sup> Without

dependable and affordable transportation options, seniors can have difficulty accessing necessary goods and services and can become socially isolated.<sup>51</sup> A 2004 study found that older Americans who do not drive make 15 percent fewer trips to the doctor, 59 percent fewer trips to shopping and restaurants, and 65 percent fewer trips for social or religious activities than those who do drive.<sup>52</sup> Programs that provide transportation through volunteer drivers or taxi subsidies — or that help seniors continue driving safely for as long as possible — can help older Americans overcome mobility barriers even in communities that are not particularly walkable or well-served by public transit.<sup>53</sup>

“[S]trategies of improving existing homes, of incorporating universally useful features in new homes, of building thoughtful new communities, and of retooling existing neighborhoods must be broadly integrated into our community-building strategies at the local level across the United States,” writes former HUD Secretary Henry Cisneros.<sup>54</sup> All of these interventions, and likely more, may be necessary to meet the diverse needs and increasing demands of an aging population.



MEND, a nonprofit housing development organization, converted the former Springside School into 32 senior apartments in Burlington Township, New Jersey. Another 43 units will be added to the development, which exemplifies community adaptation to meet the growing demand for senior housing.

# HUD Programs Support Aging in Place

HUD's Section 202 Supportive Housing for the Elderly (Section 202) program has supported the construction of approximately 263,000 units in 8,000 properties that are currently serving low-income elderly households (defined as those with at least one member over age 62 and earning no more than 50 percent of the area median income). Demand for Section 202 housing is very high, with wait list times averaging a year or longer.<sup>1</sup> Although eligibility for the Section 202 program is age specific, other HUD initiatives also serve seniors, including approximately 440,000 elderly families who receive housing choice vouchers, 492,000 elderly families who participate in the Project-Based Rental Assistance (Section 8) program, and 325,000 elderly individuals who live in public housing.<sup>2</sup> In addition, in 2006 an estimated 30 percent of properties receiving low-income housing tax credits primarily served older residents, including 14 percent that were explicitly restricted to residents over age 55.<sup>3</sup>



HUD also stimulates the supply of assisted living units through the Assisted Living Conversion Program, which provides grants to private, nonprofit owners to convert some or all of a multifamily building into assisted or service-enriched housing. The exact level of assistance can vary from state to state, but HUD sets minimum standards for construction (requiring accessible bathrooms and a community kitchen and lounge or recreational facilities) and programming (requiring 24-hour crisis response staffing and the provision of three meals per day).<sup>4</sup> In 2012, HUD awarded \$26 million to 11 conversion projects in 9 states.<sup>5</sup> Similarly, Section 231 of the National Housing Act allows HUD to insure mortgage loans for construction or rehabilitation of rental housing for elderly and disabled renters.<sup>6</sup> Other Federal Housing Administration programs such as Mortgage Insurance for Rental and Cooperative Housing may also increase the supply of housing for seniors, although these are not age-specific programs.

A number of programs facilitate the coordination of services for residents of HUD-subsidized housing. The first of these programs, beginning in 1978, was the Congregate Housing Services Program (CHSP), which provided meals, transportation, and other services to frail residents of participating Section 202 and public housing developments. Legislation passed in 1990 specifically authorized the use of CHSP funds to hire service coordinators. Although no new contracts have been awarded under this program since 1995, some existing funds continue. CHSP has been eclipsed by the Service Coordinator program, through which owners of HUD-subsidized multifamily housing can hire a service coordinator to connect residents with services such as meals, transportation, housekeeping, and medication management. Service coordinators can be funded through competitive grants or from the property's excess income or residual receipts. A separate program, the Resident Opportunity and Self-Sufficiency (ROSS) Service Coordinator program, offers similar services.<sup>7</sup> A study of ROSS programs in Seattle shows evidence of reduced social isolation, increased likelihood of treatment for chronic conditions, and longer tenure for residents compared with those without ROSS services.<sup>8</sup>

HUD is engaged in ongoing efforts to evaluate its programs' effectiveness at using housing as a platform to improve quality of life. For example, HUD is collaborating with the National Center for Health Statistics to match HUD's administrative records for assisted renters with data from the annual National Health Interview Survey. This effort will, for the first time, make available reliable, nationally representative health statistics about health outcomes and health care access for assisted renters as well as disparities relative to other populations. This evidence will inform policy about cost-effective health interventions for assisted renters, allowing policymakers to better employ housing as a platform to improve quality of life while conserving public resources.

<sup>1</sup> Melisa Vandawalker, Gretchen Locke, and Ken Lam. 2012. "Evaluation of the Section 202 Demonstration Predevelopment Grant Program," Abt Associates and U.S. Department of Housing and Urban Development, 2.

<sup>2</sup> U.S. Department of Housing and Urban Development. 2012. "Public and Indian Housing: Tenant-Based Rental Assistance, 2013 Summary Statement and Initiatives," and "Housing: Project-Based Rental Assistance, 2013 Summary Statement and Initiatives;" Shaun Donovan. 2011. Remarks at Leading Age Annual Washington DC Conference, 13 April.

<sup>3</sup> Andrew Kochera. 2006. "Developing Appropriate Rental Housing for Low-Income Older Persons: A Survey of Section 202 and LIHTC Property Managers," *AARP Public Policy Data Digest* 2.

<sup>4</sup> Libby Perl. 2010. "Section 202 and Other HUD Rental Housing Programs for Low-Income Elderly Residents," Congressional Research Services, 18–9.

<sup>5</sup> U.S. Department of Housing and Urban Development. 2012. "HUD Awards \$26 Million to Convert Apartments into Assisted Living or Service-Enriched Senior Housing," 20 December press release.

<sup>6</sup> U.S. Department of Housing and Urban Development. 2013. "Mortgage Insurance for Rental Housing for the Elderly: Section 231."

<sup>7</sup> Perl, 16–7.

<sup>8</sup> Collin Siu. 2009. "Impacts of Nutrition and Human Services Interventions on the Health of Elderly and Disabled Persons in Public Housing," Congressional Hunger Center, 18.



## Paying To Age in Place

To age in place, seniors must be able to either afford to remain in their current homes, making any necessary aging-related modifications, or choose from affordable residential options in their communities. Wealthier households may have sufficient personal savings and assets to self-finance aging in place. As previously noted, however, many households are financially insecure; for low-income households and even many middle-income households, paying to age in place is a serious challenge. Middle-income households that do not qualify for Medicaid home and community-based care services or subsidized housing support services may not be able to afford to pay for in-home care, home modifications, or Village membership dues to help them stay in their homes or for assisted living or continuing care retirement communities to remain in their communities. (See “Community-Centered Solutions for Aging at Home,” p. 20). Although numerous government programs support low-income seniors, they do not meet the current demand for services. Communities will need a wider range of affordable housing options to help middle-income households age in place.

For those who may be able to self-finance aging in place, economists Richard K. Green and Gary D. Painter suggest that “the most likely method for allowing elderly homeowners to remain in their homes is to ensure that they have a path to using their home equity to do so.”<sup>55</sup> Reverse mortgages allow homeowners to age in place by accessing the equity of their homes as income, either in monthly payments or in a lump sum, before the home is sold. A downside of this approach, which discourages its broader use, is that neither the homes nor their equity can be left to heirs unless they pay the debt in full. Nearly all reverse mortgages are supported by the Federal Housing Administration’s (FHA’s) Home Equity Conversion Mortgage (HECM) program.<sup>56</sup> Under HECM, FHA insures reverse mortgages, encouraging lenders

to offer these loans without concern for the risk that homeowners will outlive the value of their homes.

In recent years, however, stagnant or declining home values, changing loan and borrower characteristics, borrowers’ inability to keep up with property tax and insurance costs, and increasing numbers of homes left to be sold by FHA rather than by the borrower have caused the HECM program to sustain heavy losses.<sup>57</sup> The Reverse Mortgage Stabilization Act of 2013 aims to put HECM on firmer financial footing, but FHA’s new financial assessment criteria

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## Successful aging in place depends on access to needed supports and services, both medical and nonmedical.

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may restrict the terms and availability of these mortgage instruments. “The challenge for HUD,” says Ohio State University’s Stephanie Moulton, “will be to set the threshold for the financial assessment criteria and tax and insurance set-asides in a way that mitigates risk while not unnecessarily excluding homeowners from the program who would have otherwise been able to meet these obligations.”<sup>58</sup> Moulton and her colleagues are currently gathering information about HECM borrowers that can help HUD set these new criteria.

Without the ability to draw on home equity, renters have more limited options for self-financing aging in place. High housing cost burdens make residential stability difficult to achieve, and a lack of affordable housing choices may force these seniors to move out of their communities. Cost burdens

and affordability issues are most severe for low-income households. Of those renters in the lowest income quartile, 72 percent pay more than 30 percent of their income toward housing and nearly half pay more than 50 percent.<sup>59</sup> In addition, much of the rental housing stock lacks the accessibility features that make residences more aging friendly; only 36.3 percent of renter-occupied units have wheelchair-accessible bathrooms, only 15.5 percent have handrails or grab bars in bathrooms, and only 6.3 percent have extra-wide doors or hallways.<sup>60</sup> Several HUD programs, such as the Section 202 Supportive Housing for the Elderly program and public housing designated for elderly tenants, provide assistance to these low-income elderly renters (see “HUD Programs Support Aging in Place.”). Overall, 37 percent of HUD-assisted households are headed by a person over age 62.<sup>61</sup>

Despite the range of available programs and the considerable number of seniors they serve, HUD assistance is insufficient to support all those in need. Only 35.6 percent of all renter households consisting of low-income seniors with no children receive federal rental assistance.<sup>62</sup> These programs, which are unable to meet current demand, will be further pressed as the older population — and their need for services — grows.

## Housing as a Platform for Access to Services and Supports

Successful aging in place depends on access to needed supports and services, both medical and nonmedical. A number of current models connect seniors with services and amenities in their homes and communities, but these may not be sufficient to meet growing demand.

The primary means of connecting seniors to the support and care they need is through informal caregivers — friends, family, and neighbors — with just an estimated 5 percent of older people supported only by paid caregivers.<sup>63</sup> The AARP Public Policy



Shoshana Herndon

Bob Harrison, 85, makes himself a snack in his kitchen while sensors mounted on the wall behind him monitor his activity to alert caretakers to emergency situations such as falls. The sensor technology is part of an experimental program at the University of Missouri.

Institute estimates that the economic value of unpaid caregiving reached a staggering \$450 billion in 2009.<sup>64</sup> Research shows that informal caregiving allows seniors to delay or avoid institutionalization even as their need for care grows.<sup>65</sup>

Although these findings support the assertion that informal caregiving can help seniors age in place, other research suggests that excessive caregiver stress often leads to admission of a care recipient to a nursing home.<sup>66</sup> Policymakers may be interested in supporting informal caregivers to reduce their stress. Studies show that such support should focus on teaching coping skills to deal with “problem behavior” of the care receiver, and they also indicate that additional supports may need to differentiate between caregivers who are adult children and those who are spouses.<sup>67</sup> Some existing programs, such as the United Hospital Fund’s Transitions in Care – Quality Improvement Collaborative, recognize the critical role of the family caregiver in the transition from institutional to home or community settings and aim to better integrate

caregivers into the transition process through needs assessment and education.<sup>68</sup> The stress of caregiving that now falls on many baby boomers may also have ramifications for their own health as they age. One study finds an association between caregiving and poor health behaviors among caregivers that puts their long-term health at risk.<sup>69</sup> Some studies also suggest that the baby boom cohort will be less likely to have a spouse or adult children to provide informal care and therefore will be more likely to require nursing home care.<sup>70</sup>

Although nearly all seniors receive support from informal caregivers, some choose housing options that include paid caregiving. Continuing care retirement communities and assisted living facilities require seniors to move from their current residence, but they can allow seniors to remain in their communities and enter a housing arrangement that includes medical and support services. These options can offer more independence than a nursing home facility while still providing customized medical and daily living support as needed. In 2010, there were 31,100 such

state-regulated residential care facilities nationally with a total of 971,900 beds. Of these facilities, 82 percent were private, for-profit institutions and 38 percent of them were chain affiliated.<sup>71</sup> But with a mean national monthly cost per resident of \$3,550 in 2012, assisted living is unaffordable for many seniors.<sup>72</sup> Two alternative models that connect seniors with services in their current homes are naturally occurring retirement community support service programs (NORC SSPs) and Villages. (See “Community-Centered Solutions for Aging at Home,” p. 20, for more on these models for aging in place).

Services such as the Centers for Medicare and Medicaid Services’ (CMS) Home and Community-Based Services and Program of All-Inclusive Care for the Elderly also contribute to aging in place by supporting home- and community-based care and reducing unnecessary institutionalization.<sup>73</sup> As many as 5 percent of Medicare enrollees aged 65 and older who live in long-term care facilities have no functional limitations, suggesting that relatively modest interventions could mean the difference between staying at home and institutionalization.<sup>74</sup> One study finds that states that invest more in community-based services — home-delivered meals in particular — have fewer seniors with few or no functional limitation and little or no cognitive impairment in nursing homes.<sup>75</sup> The national average annual rate for a semiprivate room in a nursing home reached \$81,030 in 2012, indicating that states can realize considerable savings by delaying or avoiding institutionalization.<sup>76</sup> In fact, a significant shift in Medicaid spending away from institutional long-term care has already occurred, with spending on home- and community-based care increasing from 13 percent in 1990 to 43 percent in 2009.<sup>77</sup> Federal initiatives including Medicaid waivers, Money Follows the Person, and the Community Living Program have helped states facilitate this shift, often called “rebalancing,” as well as other efforts to divert seniors from nursing homes.<sup>78</sup>

One example of an effort to link housing and health services for seniors aging in place is Vermont's Support and Services at Home (SASH) program. Cathedral Square Corporation, a Vermont nonprofit that provides affordable housing to seniors, forged SASH as a set of partnerships to use housing as a platform for health and other services. The program supplies a SASH service hub, which includes a service coordinator, nurse, and possibly other staff, for each 100 participants. Care is provided in participants' homes, and the SASH team also addresses community needs through a Community Healthy Aging Plan. During SASH's initial one-year pilot phase, participants had fewer hospital admissions, fewer falls, and improved nutrition. The program is funded by a combination of public and private sources.<sup>79</sup>

The widespread recognition that integrating housing and health services is critical for successful aging in place suggests the need for greater coordination of health and housing policy, breaking down the silos that have historically kept them separate.<sup>80</sup> A current study jointly supported by HUD and the U.S. Department of Health and Human Services (HHS) seeks to demonstrate the potential gains of greater coordination in the provision of affordable housing and medical services between the two agencies.<sup>81</sup>

## Research and Policy: Looking Ahead

The demographic shift to an older population is imminent, yet we still do not fully understand what this change will mean. Researchers are still uncertain about whether advances in health care and assistive technology will continue to increase life expectancy and quality of life, or whether recent trends such as the obesity epidemic will curtail or reverse these gains. Researchers are also unclear about how the increasing diversity of the aging population will affect its members' needs and preferences considering that racial and ethnic minorities experience a higher prevalence of disabilities, lower incomes and wealth, and greater barriers to services compared with whites.

Most seniors want to age in place, remaining in their homes and communities as they grow older. But as Andrew Scharlach of the University of California at Berkeley says, "We don't really have a good understanding of what are the primary factors that allow people to age in place. And we don't have very good information about the relative effectiveness of the different innovations or initiatives or programs" that have been designed to facilitate aging in place.<sup>82</sup> Academics, practitioners, and other stakeholders have suggested and implemented various interventions, including aging-friendly home

modification and design, community adaptation and planning, and a range of methods of connecting seniors with medical services in their homes and communities.

"Theory and evidence support a role for safe and accessible housing and services as a way to maintain maximum health, functioning, and independence in the older population and potentially delay or avoid nursing home placement, which is least preferred by older people and very costly for public programs," write Spillman, Biess, and MacDonald.<sup>83</sup> A handful of empirical studies find evidence of improved health outcomes, enhanced productive engagement, and public cost-savings attributable to various interventions that encourage aging in place.<sup>84</sup> "Where you have evidence," says Stone, "is in some specific models for specific problems, but there is nothing that is fully integrated."<sup>85</sup> Spillman et al. concur that "[m]ore research is needed to confirm and quantify the costs and benefits of public policies to improve access to affordable and accessible housing and services."<sup>86</sup>

Ongoing evaluation of existing initiatives and new programs is necessary and is already underway. Aging in place has become a "focal concept in the scholarly field of gerontology," numerous academic institutes and think tanks are devoting attention to aging issues, and — in another sign of the issue's salience — three of the five recipients of MacArthur Foundation How Housing Matters grants in 2012 are conducting studies related to the housing of older adults.<sup>87</sup> For its part, HUD is currently evaluating Vermont's SASH program, the abovementioned HUD and HHS effort to coordinate HUD and CMS data, and the Seniors and Services Demonstration project, which evaluates the effectiveness of models for connecting seniors in subsidized housing with supportive services. HUD's Office of Policy Development and Research has also identified evaluating the demand for and supply of affordable housing



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The University of Missouri's experimental in-home sensor system exemplifies the potential of adaptive technology to help people age safely and comfortably in their own homes.

with supportive services as a critical topic in its *Research Roadmap*.<sup>88</sup>

Given the demographic dynamics of population aging, research and evaluation will have to continue alongside innovation and practice in the provision of age-appropriate housing and supportive services. More rigorous research will be needed to identify the most beneficial and cost-effective programs to facilitate aging in place. If successful, such initiatives will enable seniors to remain in their homes and communities, use housing as a platform for health and other services, improve health and overall quality of life, and reduce the public cost of long-term care. [EM](#)

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## Definitions of Terms

**Disability:** The Americans with Disabilities Act of 1990 defines disability with respect to an individual as "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment...."<sup>1</sup>

**Medicaid:** "Medicaid is a jointly-funded, Federal-State health insurance program that helps many people who can't afford medical care pay for some or all of their medical bills."<sup>2</sup>

**Medicare:** "Medicare is a Federal health insurance program for people 65 years or older, certain people with disabilities, and people with end-stage renal disease."<sup>3</sup>

**Morbidity:** "A diseased state, often used in the context of a 'morbidity rate' (i.e., the rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state, including diagnosis and complications is referred to as morbidity."<sup>4</sup>

**Universal Design:** Coined by Ronald L. Mace, founder of the Center for Universal Design at the North Carolina State University, universal design refers to "the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design."<sup>5</sup>

**Visitability:** "Visitability is a movement to change home construction practices so that virtually all new homes — not merely those custom-built for occupants who currently have disabilities — offer a few specific features making the home easier for mobility-impaired people to live in and visit."<sup>6</sup>

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# Measuring the Costs and Savings of Aging in Place

With the United States' ongoing demographic shift toward an increasingly older population, along with the fact that 89 percent of Americans over age 50 wish to remain in their homes for as long as possible, conversations about the benefits and costs associated with aging in place will become increasingly critical. Recent research on home-based health programs suggests that aging in place can yield potential cost savings at the individual, state, and federal levels. Although the current body of research is limited, these studies demonstrate the benefits of aging in place — benefits that extend beyond cost savings to include social and emotional benefits to both seniors and the broader community.

## Individual Cost Savings

The choice to either age in place or enter institutional care is a complex and deeply personal decision that hinges on factors such as the amount of health care needed and the availability of family assistance. However, one reason most older adults choose to age in place for as long as they are able is simply because doing so is the most economical option. Some older people — 21 percent of those aged 65 to 74 and 18 percent of those aged 74 to 84 — own their homes outright and thus no longer have mortgage expenses.<sup>1</sup> Others are enrolled in the Federal Housing Administration's Home Equity Conversion Mortgage (HECM) program, which helps elderly homeowners age in place by allowing them to access the equity of their homes as income.<sup>2</sup> (For more information about HECM, see "Aging in Place: Facilitating Choice and Independence," p. 1).

Even when seniors are ready to move, selling their homes can be difficult. Their homes tend to be older and are

- Evidence suggests that programs that support aging in place may yield cost savings for families, government, and health systems.
- More extensive research is needed to better account for all costs involved, because existing evidence often relies on small-scale case studies.
- Aging in place has also been shown to have health and emotional benefits over institutional care.

less likely to have been updated, making them less desirable to potential buyers, especially in a slow housing market. A 2008 survey from the American Seniors Housing Association found that nearly a quarter of seniors have not improved their homes in 10 years, and 41 percent say they won't spend money to attract a buyer.<sup>3</sup> These findings are starkly different from the 57 percent of all homeowners who made home improvements in the 3-year period from 2009 to 2011.<sup>4</sup>

for a private room rose 3.8 percent, which exceeded the rate of inflation.<sup>6</sup> Approximately one-fifth of nursing home bills are paid either primarily or entirely out of pocket. In 2009, 94 percent of people aged 65 and older paid for health care out of pocket.<sup>7</sup> Out-of-pocket spending is much greater for institutional than for noninstitutional services. For example, among those who needed assistance with activities of daily living, out-of-pocket expenses were



Nursing home expenditures are more than three times those of noninstitutional long-term care services, and approximately one-fifth of nursing home bills are paid out of pocket.

High nursing home costs mean that aging in place could yield significant cost savings for the elderly. From 2004 to 2007, in 2009 dollars, the median monthly payment for noninstitutional long-term care was \$928 compared with \$5,243 for nursing homes. Expenditures for nursing homes are more than three times those for noninstitutional long-term care services, and these rates are continuing to rise.<sup>5</sup> Between 2011 and 2012, the average daily rate

\$554 and \$1,065 in 2009 dollars for non-institutional and institutional services, respectively.<sup>8</sup>

## Potential Cost Savings to Medicaid and Medicare

In addition to saving money for seniors, promoting aging in place may also create systemic cost savings for the Medicare and Medicaid programs. Medicare is a federal health insurance program primarily for people aged 65 and older,

whereas Medicaid is a joint federal and state assistance program that helps cover medical costs for some people with limited income and resources.<sup>9</sup> Rules and eligibility for these programs vary by state; some individuals are “dual eligible,” meaning they can receive both Medicaid and Medicare coverage.<sup>10</sup>

Together, Medicaid and Medicare pay for the majority of long-term care. Of the \$203 billion spent in 2009 for nursing home, home health care, and other long-term services and supports, 62 percent was paid through Medicaid, 4 percent was paid through Medicare, and 23 percent was paid by individuals out of pocket. The remainder was paid by private insurance.<sup>11</sup> Medicare has more restrictive guidelines for home and community-based services (HCBS) than does Medicaid: Medicare’s home health program is designed for acute illnesses and averages approximately 24 days, and the individual must have orders from a physician to qualify. Longer-term HCBS care is covered through Medicaid for those who meet the program’s eligibility requirements.<sup>12</sup> Because of rising demand and seniors’ desire to age in place, Medicaid HCBS spending has greatly increased. In 2007, total Medicaid HCBS spending rose to \$41.8 billion, a 95 percent increase from 1999 levels.<sup>13</sup>

States have also been encouraged to expand their HCBS waiver programs. These waiver programs, such as those authorized under section 1915(c) of the Social Security Act, allow states to provide medical and nonmedical services to individuals who are eligible for institutional care.<sup>14</sup> The waiver programs must demonstrate cost neutrality, meaning that the state’s average per-person spending on HCBS waiver participants cannot exceed Medicaid’s average per-person spending for the type of institutional care for which they are eligible.<sup>15</sup> States have the discretion to set financial eligibility criteria and specify the target group served and geographic coverage.<sup>16</sup> States often prefer

to provide HCBS services using waiver programs because controlling costs is easier through these programs than with other methods, such as Medicaid’s optional Personal Care Services State Plan benefit, which must be applied uniformly throughout the state and made available to everyone who qualifies.<sup>17</sup>

The federal government sponsored several demonstrations in the late 1970s and 1980s to evaluate the cost-effectiveness of home-based care compared with nursing home care. These tests were experimental prototypes for the Medicaid HCBS waiver program, but many of the demonstrations found that expanding community-based care did not reduce long-term care expenditures because of what was called the “woodwork effect,” meaning that people who would not have received institutional care would “come out of the woodwork” to apply for community-based care (see “The Woodwork Effect”).<sup>18</sup> Although the expansion of home-based care services benefits the public, serving more people can offset any savings achieved through these programs. The existence and impact of the woodwork effect has been a source of debate, however, and it is still being studied.<sup>19</sup>

Despite the woodwork effect, these early demonstrations also found that narrow targeting and emphasizing services provided in alternative facilities, such as community centers and senior centers, can result in budget neutrality.<sup>20</sup> More recent studies, beginning in the mid-1990s, offer further support for these administrative cost-control techniques. Kane et al. even suggest that to a certain degree, the woodwork effect is necessary to achieve long-term cost savings. Researchers in Oregon found that 2.6 people needed to be served by HCBS to eliminate one nursing home bed. Therefore, serving more people can result in systematic reform and savings in the number of nursing home beds created and maintained.<sup>21</sup> More recent studies confirm this finding and even demonstrate cost savings. These studies, along with HCBS waiver requirements, have led most to accept that per-person costs for HCBS are lower than those for institutional care.

One study that analyzed state-by-state Medicaid long-term care spending from 1995 to 2005 found that expanding HCBS created a short-term spending increase that was followed a few years later by long-term care savings and a

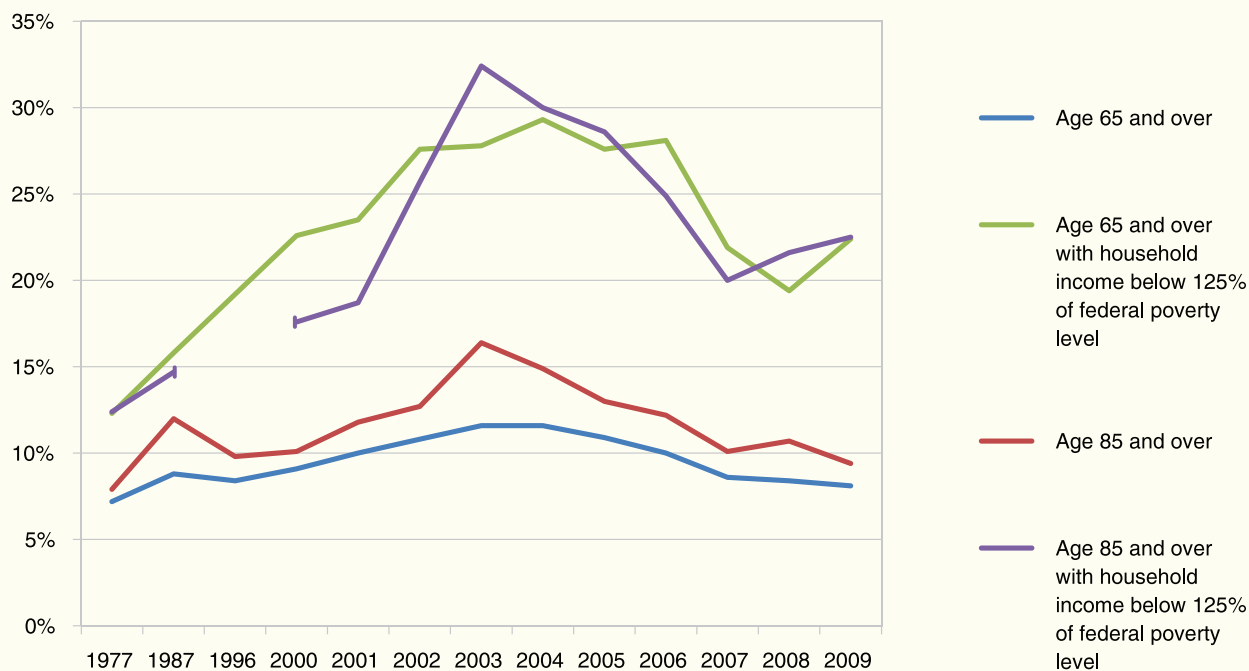
## The Woodwork Effect

In health policy terms, the “woodwork effect” describes the increase in enrollment that can occur after programs are expanded or changed, encouraging eligible participants to “come out of the woodwork” to enroll in them. For home-based care programs, this enrollment increase can lead to increased costs if the expense of treating more participants outweighs the cost savings from avoiding or delaying institutional care.<sup>1</sup> The extent of the woodwork effect and its true risks are the subject of considerable debate. Some policymakers and budget officials believe that the woodwork effect’s increased costs are unacceptable, whereas others believe that these costs are ethically justified by the increased number of people who receive needed services in their homes and communities. Because “woodwork effect” has a negative connotation, some researchers and advocates prefer to call it the “welcome-mat effect,” which more positively conveys the process of providing a program’s services to eligible individuals who were not previously enrolled.<sup>2</sup>

<sup>1</sup> Mitchell LaPlante. 2013. “The Woodwork Effect in Medicaid Long-Term Services and Supports,” *Journal of Aging & Social Policy*, 25:2, 161–80.

<sup>2</sup> Julie Sonier, Michel H Boudreaux, and Lynn A. Blewett. 2013. “Medicaid ‘Welcome-Mat’ Effect of Affordable Care Act Implementation Could Be Substantial,” *Health Affairs* 32:6, 1319–25.

## Out-of-Pocket Health Care Expenditure as a Percentage of Household Income



Source: Federal Interagency Forum on Aging-Related Statistics. 2012. "Older Americans 2012 Key Indicators of Well-Being," table 33b, 142–3.  
 Note: The 1996 datum for age 85 and over households with incomes below 125% of the federal poverty level is missing.

reduction in institutional spending. Spending growth was greater for states that offered limited HCBS services than it was for those that already had established noninstitutional programs. For example, in states with established high-expenditure HCBS programs, nursing home spending declined by 15.3 percent and overall long-term care spending declined by 7.9 percent.<sup>22</sup> In states that were expanding their HCBS programs, nursing home spending remained fairly stable for three years following the expansion and then declined in each subsequent year.<sup>23</sup> These results suggest that expanding HCBS may require an initial increase in spending that will decrease after the HCBS programs become established, potentially creating cost savings.

Kitchener et al. examined 2002 data to compare per-participant expenditure costs for Medicaid HCBS waiver

programs with those for institutional care. The researchers found that HCBS waivers produced a national average public expenditure savings of \$43,947 per participant for that year.<sup>24</sup> In a 2005 survey by the Centers for Medicare and Medicaid Services (CMS), 165,276 nursing home residents indicated that they would like to return to their communities; if they received HCBS waivers to do so, the public could see annual savings of \$2.6 billion.<sup>25</sup> While it is not feasible for all residents who expressed the desire to return home to do so, the savings would still be significant. However, this study did not attempt to examine whether waiver programs save the state money overall because such savings depend on several factors, including the previously mentioned woodwork effect as well as other research and data issues.

## Case Studies

Although the studies described above analyzed systemwide Medicare and Medicaid cost data, other studies have evaluated the cost savings of specific programs. For example, the Arizona Long Term Care System (ALTCS) emphasizes HCBS and provides incentives to avoid institutional placement. This program has decreased the state's LTC Medicaid expenditures by 16 percent and lowered the growth rate of these expenditures.<sup>26</sup> One reason for this program's success is its high level of coordinated care. Some HCBS programs suffer because Medicaid does not reimburse states for the extra care and time needed to coordinate care, especially the transition from acute to long-term care. For this reason, states such as Arizona have initiated capitated systems for Medicaid payments.<sup>27</sup> A capitated system, based on patients and not on services, allows providers (or



Program Contractors, as ALTCS calls them) in similar programs to avoid breaking down separate Medicare and Medicaid expenses. Instead, they are paid blended rates each month based on the number of people enrolled in the program.<sup>28</sup>

The federal government has also experimented with different home-based care programs using capitated payment systems. The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid state option program for those who are eligible for nursing home-level care but can safely reside in the community. The program integrates both acute and long-term care, amounting to a continuum of both medical and social services. In addition to better clinical outcomes through shorter hospital stays, lower mortality rates, and better self-reported health and quality of life, costs for PACE enrollees are estimated to be 16 to 38 percent lower than Medicare fee-for-service costs for the elderly population and 5 to 15 percent lower than costs for comparable Medicaid beneficiaries.<sup>29</sup>

Despite these favorable outcomes, the PACE program was slow to expand in its

early years. Reasons for the slow growth included a lack of funding for non-profit providers to develop PACE sites, a shortage of for-profit providers, the unwillingness of older adults to leave their primary care provider to enroll in PACE, poor marketing; inadequate state support, and the high cost of participation for middle-income older adults not eligible for Medicaid.<sup>30</sup> As the program has expanded to rural areas and become better known, the number of PACE programs has grown, more than doubling between 2007 and 2012. Currently, 29 states offer 88 local PACE programs, which are run by nonprofit or for-profit providers and monitored by CMS and the program's home state.<sup>31</sup> However, many of the issues that caused PACE's initial slow growth continue to prevent the program from spreading nationwide.<sup>32</sup>

Using the idea of coordinated care, the Sinclair School of Nursing at the University of Missouri developed its own Aging in Place (AIP) program. AIP employs nurse care coordinators to manage the delivery of both Medicaid HCBS and Medicare home health services. A distinguishing feature of this program is that the same care

personnel, including nurses, therapists, and home health aides, deliver both Medicaid and Medicare services. Not only did AIP participants have statistically significant better clinical outcomes than those in nursing homes, but an evaluation also found that total Medicare and Medicaid average costs were \$1,784 lower for AIP participants than for nursing home residents. Most of these savings came from reduced Medicaid costs. The evaluation estimates that enrolling only 10 percent of Americans needing long-term care in AIP or a similar program could save nearly \$9 billion.<sup>33</sup>

These studies demonstrate the benefits of coordinated and integrated care in community settings. Although multiple factors explain the successes and cost savings of these programs, service integration is perhaps the most important one. Integration benefits both patients, who can receive uninterrupted Medicare and Medicaid services in their home or community, and providers, who are often paid for their coordination time and, in capitation programs, enjoy a simplified reimbursement process. These models merit further study and evaluation in the continuing discussion of aging in place.

## Demonstration Will Evaluate Subsidized Models for Aging in Place

An abundant supply of service-enriched affordable housing will be needed to help a growing number of older, low-income adults remain in their communities and live independently. As discussed throughout this issue of *Evidence Matters*, many experts suggest that providing sufficient supports to allow older adults to age safely in place can reduce the need for costly institutionalized care (which often must be paid for by the government) and improve residents' housing and quality of life. Although researchers have attempted to prove the efficacy of aging in place over the years, definitive evidence has been difficult and costly to obtain. A recently completed report prepared by the Lewin Group under contract to the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation, with support from HUD's Office of Policy Development and Research, proposes a demonstration to answer this question and others that have eluded researchers.

The report outlines design options for the demonstration based on recent case study findings for exemplary programs that provide supportive housing to low-income older adults. The demonstration will determine whether publicly subsidized multi-unit properties can serve as an effective platform for meeting the health and service needs of the low-income elderly, which of the models tested result in the best outcomes, and what services and supports maximize these positive outcomes. Core outcomes to be measured include the number of hospital and emergency room visits, number of falls, number of medications, presence of depression, community tenure, and quality of life. Although funding for the demonstration described in the report is still uncertain, HUD is optimistic.

The report will be available this winter at [www.huduser.org](http://www.huduser.org).



Ninety percent of aging-in-place adults rely on help from family, friends, and volunteers.

## Research Issues

Although the studies discussed in this article provide some evidence of the multiple benefits of aging in place for individuals, families, taxpayers, and state and federal governments, more research is needed. Most of the studies to date have been small and have evaluated specific programs over a short period of time. Other studies have found insufficient evidence to draw conclusions about potential cost savings.<sup>34</sup>

Costs comparisons of long-term care are challenging for several reasons. Often only Medicaid expenditures are considered without also examining Medicare and private insurance spending. Studies should also include

expenditures by other public programs such as Social Security, the Supplemental Nutrition Assistance Program, and others to measure the true effectiveness of aging-in-place initiatives.<sup>35</sup> Such efforts could help governments avoid shifting expenditures from one program to another or between state and federal funds.<sup>36</sup> However, these data are very difficult to obtain and cross reference. Reporting requirements for various home-based care programs are not uniform, making comparisons across programs and states difficult. Furthermore, researchers often do not have access to consumer information and claims data.<sup>37</sup>

Researchers must also consider the potentially significant costs of aging in

place for individuals and their families.<sup>38</sup> About nine-tenths of those aging in place who need long-term care rely on a family member, relative, friend, or volunteer as their primary source of help with daily activities.<sup>39</sup> This informal care can be paid or provided in kind and, although estimates vary widely, AARP puts the value of this work at \$450 billion in 2009, up from \$375 billion in 2007. Informal care can have an enormous effect on cost studies if it is considered,<sup>40</sup> but measuring and monetizing these informal contributions is difficult. In addition, personal accounts of caregiving often do not distinguish between familial relationship activities (visiting relatives and supplying food) and more formal care activities (administering medicine or checking blood pressure).<sup>41</sup>

## Beyond Costs

In addition to these research challenges, some researchers and aging-in-place advocates argue that policymakers' focus on controlling costs is having a detrimental effect on the quality and availability of HCBS care. Harrington et al. argue that the cost containment strategies of some HCBS waivers are doing more harm than good.<sup>42</sup> Cost controls, including service limits, geographic limitations, hourly limits, and fixed expenditure ceilings, can lead to elderly people not receiving the services they need and premature or unnecessary institutionalization for those who fall outside the state's constraints — for example, those living outside of the target area or requiring services that fall above the hourly limits or fixed expenditure ceilings.<sup>43</sup> Researchers estimate that more than 15 percent of those living in nursing homes are there inappropriately, and addressing this issue requires considering more than just the cost of care.<sup>44</sup>

Others argue that those who spend so much time and energy examining how to reduce costs are focusing on the wrong area; instead, they should be emphasizing the emotional, social, and health benefits of HCBS and aging in place.<sup>45</sup>

Aging in place also helps protect social connections. Social isolation is a major problem among the elderly, and relationships that are found in a community are important to maintain throughout life. Aging in place allows people to better maintain their social relationships. In a recent AARP survey, 41 percent of those who want to remain in their community stated that their primary reason for staying was their friends, followed by family, safety from crime, and a pleasant neighborhood/community.<sup>46</sup>

In addition to preventing social isolation, allowing older people to stay involved in their communities has been found to have health benefits. Civic engagement and volunteering can reduce mortality; increase physical function, muscular strength, and levels of self-rated health; reduce symptoms of depression and pain; and increase life expectancy. An evaluation of Missouri's AIP program showed that participants had better outcomes in the areas of cognition, depression, activities of daily living, and incontinence than those in nursing home care. This finding led Marek et al. to suggest that maintaining independence in one's home contributes to more positive outcomes.<sup>47</sup> These improved health outcomes can, in turn, lead to cost savings.<sup>48</sup>

Because of these emotional, social, and health benefits, LaPlante recommends creating a cost-benefit framework that takes into account the quality of life differences between aging in a nursing home and in the community. This framework would also define independence as more than simply living outside an institution. True independence for the elderly involves control over their own lives and meaningful participation in the community; receiving services at home or in the community can play a large role in gaining this independence.<sup>49</sup> A cost-benefit framework would allow more accurate comparisons between institutional care and HCBS.

The costs of aging in place will continue to be an issue for years to come. Researchers estimate that expenditures on community long-term care services could surpass nursing home expenditures as soon as 2015 or 2016.<sup>50</sup> Costs are always important, especially in tight budget climates, and the potential cost savings from expanding HCBS programs predicted by some studies are promising. However, more research is needed that takes into account all the costs and benefits of aging in place. **EM**

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# Community-Centered Solutions for Aging at Home

Many older members of our society wish to age safely in their homes and neighborhoods but have limited financial means, are unaware of community supports and services that could help, and lack the travel options that allow them to move about freely and to participate fully in community activities. The results are undesirable: social isolation, economic hardship, declines in health and well-being, and the loss to the community of one of its richest resources — its elders.

Among the many initiatives to facilitate aging in place, two prominent community-centered models that have emerged are Naturally Occurring Retirement Community Supportive



Newton at Home

Newton at Home members organize affinity groups around common interests like kayaking. Such social activities build community among members and enrich their daily lives.

Services Programs (NORC SSPs) and Villages. NORC SSPs and Villages developed to address the discrepancy between how communities are designed and what older adults need to age in place. Because of their location or cost, Villages and NORC SSPs are not accessible to all who might benefit from them due to location or affordability

## Highlights

- Naturally occurring retirement communities (NORCs), such as the East Point NORC in the Atlanta suburbs, offer supportive services to neighborhoods with high concentrations of seniors, including transportation assistance, health and wellness programs, home repairs, and social and educational programs.
- Villages such as the Newton at Home program in Massachusetts are membership-based organizations with paid staff who coordinate access to services through trained volunteers, referrals to screened vendors for complex jobs and needs, and affinity groups led by community members.
- Some Villages, such as the Concierge Club in San Diego, offer a tiered membership structure with more intensive engagements to help seniors with greater needs remain in their homes.

and they are not the complete solution to the burgeoning needs of an aging cohort. These models, however, raise seniors' awareness of available supportive services, fill service gaps to prevent or delay moves to institutional settings, and engage elders as active community members.<sup>1</sup> This article briefly discusses each model and examines a NORC SSP and two types of Villages.

### NORC SSP Model

In the mid-1980s, naturally occurring retirement communities (NORCs), characterized by a predominantly older population, emerged throughout the United States. These communities are not planned or designed for elderly residents but rather arise naturally, often as a result of people remaining in the homes in which they have raised their families. This concentration of older adults makes it possible to deliver elder-specific services using economies of scale and the NORC SSP model, defined as a “community-based intervention designed to reduce service fragmentation and create healthy, integrated communities in which seniors living in NORCs are able to age in place with greater comfort and security in their own homes.”<sup>2</sup> Typically, NORC SSPs are initiated and governed not by the elders they serve but by community service providers.<sup>3</sup>

The NORC SSP model promotes independence and healthy aging by

engaging seniors and addressing their changing needs as they age; coordinates health care, social services, and group activities onsite through partnerships that integrate the efforts of housing entities, residents, service providers, government agencies, and philanthropies; involves seniors in the program's development and operation; and fills service gaps resulting from inadequate or uncoordinated services provided by the Administration on Aging, the Centers for Medicare and Medicaid Services, state agencies, and other community-based services.<sup>4</sup>

NORC SSPs also facilitate change to make communities more livable for aging residents. Penn South, the original NORC SSP launched in 1986 in New York City with private philanthropic support, exemplifies this proactive approach to aging in place. The advocacy of the residents and founders of the SSP in this moderate-income cooperative of 10 high-rise apartment buildings led both New York State (1995) and New York City (1999) to institute public policies and legislation that provide ongoing funding for NORC SSPs.<sup>5</sup>

Building on the success of this model, the Jewish Federations of North America (JFNA) advocated for federal funding to expand the number of NORC SSPs. Between 2002 and 2010, Congress funded the first 3 years of nearly 50 different demonstration SSPs in 26



East Point NORC

Increased social and physical activity are goals of East Point NORC.

states. These NORC SSPs were led by JFNA’s National NORCs Aging in Place Initiative and administered by the Administration on Aging.<sup>6</sup> A national evaluation of these demonstrations in 2007 concluded that NORC SSPs effectively facilitated aging in place. The results showed the following:

- Socialization increased and social isolation declined among NORC SSP participants, 88.1 percent of whom agreed or strongly agreed that participation led to talking to more people than in the past.
- NORC SSPs were effective at linking older adults to services that enabled them to age in place; 95.4 percent of participants agreed or strongly agreed that they had learned more about community services.

- NORC SSPs can improve volunteerism among older adults; 48.1 percent agreed or strongly agreed that they volunteered more frequently as a result of program participation.
- NORC-SSP participants felt healthier (70.5%) and more likely to stay in their community (88.1%) as a result of the program.<sup>7</sup>

### East Point NORC’s Supportive Services Program

Penn South has served as a prototype for many NORC SSPs, including in East Point, a suburb of Atlanta, Georgia. East Point’s population of 36,000 is 75 percent black and has a median household income of \$41,622. Today the area, composed mostly of single-family homes, has a large concentration of seniors, many of whom

are homeowners living on limited incomes in aging homes built in the 1950s and 1960s or earlier.<sup>8</sup> In 2003, the Jewish Federation of Greater Atlanta (JFGA), the Atlanta Regional Commission (ARC), and the Fulton County Office for Aging, acting on a shared interest in helping local elders successfully age at home, collaborated to organize East Point NORC’s SSP.<sup>9</sup> These partners began by surveying 1,200 older adults and found that, rather than traditional services such as home care or home-delivered meals, seniors wanted broader community support that would enable independence and aging in place. Through focus groups, door-to-door surveys, and community mapping, the “pulse of the community was taken,” according to Regine Denis, program manager of aging services for Fulton County. The priority needs of East Point’s

seniors were identified as access to information and referral services, safety, transportation, and home repair.<sup>10</sup> Annual surveys to assess needs and a Participant Advisory Committee that advises JFGA and the county about the needs and interests of older residents help keep the program relevant.<sup>11</sup>

Today, JFGA serves as an umbrella agency; coordinates with other NORC sites in Georgia; and assists with fundraising, advocacy, marketing, and impact evaluation. The Fulton County Office for Aging is the lead agency that manages East Point's efforts, secures needed services for residents, and develops partnerships to enhance its programs.<sup>12</sup> One of Fulton County's community centers is located in East Point and is not only a focal point for many senior activities but also the site of the NORC

SSP office; the office's outreach coordinator is over 60 and has lived in the neighborhood since 1975.<sup>13</sup>

Membership in the East Point NORC SSP is free for city residents who are over 60. New members are recruited through word of mouth recommendations from other members and through community organizations, neighborhood groups, and churches that have contact with older adults.<sup>14</sup> Members receive a community newsletter, information about volunteer opportunities, and notices about upcoming events and services available to seniors.<sup>15</sup> As of June 2013, East Point's membership totaled 1,153; the average age of members was 68, 74 percent were female, and 53 percent lived alone.<sup>16</sup> The types of services available to East Point members reflect the

program's priorities and are adapted to the needs of the community's senior residents. East Point's services include the following:

- Transportation assistance.
- A walking club.
- Monthly workshops on senior health and safety topics.
- A health and wellness program, including vision and hearing clinics, foot clinics, health screenings, a farmers' market, and an annual Seniors Partnering with Artists Citywide event.
- A neighbor-to-neighbor program to maintain contact with those living alone or who are shut in.



East Point NORC sponsors educational and social events for its members, such as a gathering to celebrate Black History Month.

- Home repairs provided by volunteers or, for major jobs, through referrals to other community partners such as Rebuilding Together Atlanta. Residents pay for materials and volunteers facilitate, if necessary.
- Group activities such as exercise classes and a book club for elders cosponsored by the public library.<sup>17</sup>

Social and educational activities, transportation, and information and referral services are used most frequently.<sup>18</sup> Mobility for seniors is a pressing need in Fulton County, which has significant transportation challenges. To meet this need, East Point NORC's partners have successfully implemented a transportation coupon program for seniors. East Point members may buy a transportation coupon booklet worth \$100 for the price of \$10. Purchasers needing to travel find their own driver, who can be anyone who does not reside with the senior, including a friend or a family member. East Point outreach coordinator Diana Stevens explains that the price for the trip, agreed on by the senior and the driver ahead of time, is \$10 an hour for the first 3 hours and \$5 per hour after that, plus a set mileage rate. Stevens says, "The senior pays the driver with a coupon. The driver fills out a voucher for a completed trip, which the senior must review and sign to approve." NORC program staff collect and review the voucher and then approves payment to the driver, which JFGA makes using grant funds set aside for this purpose. This program has proven to be a popular and cost-effective means for enabling older adults to remain mobile and age in place. As Denis points out, "It's a win-win for all seniors to be able to move about freely and go where they want to go." This simple, innovative way of delivering a service is possible through continued partnerships with JFGA as well as ARC, which has replicated the transportation coupon program elsewhere in its service area.<sup>19</sup>

One half-time and one full-time county employee coordinate the community partners and volunteers who provide most of East Point NORC's services. One challenge in operating this program, Denis reports, is maintaining an adequate pool of volunteers to provide services and conduct surveys to stay in touch with needs of the city's aging residents. Fortunately, Hands on Atlanta, a program partner and nonprofit organization that connects volunteers to service opportunities, helps East Point NORC build its volunteer pool.<sup>20</sup>

Office for Aging is the program's lead agency. Instead, the state NORC logo, featuring a friendly streetscape, is used to market the East Point NORC SSP as a broad, community-driven initiative.<sup>22</sup>

The program relies heavily on volunteers, community partnerships, and in-kind contributions. All costs incurred are met through fundraising for particular service initiatives, funds from philanthropies, and sometimes from the state, although state funds are not guaranteed because there is

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## Local partnerships and collaborations, in combination with numerous East Point NORC volunteers, produce an integrated community effort that supports seniors wishing to age in place.

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Local partnerships and collaborations are key to leveraging existing resources and offering services, states Denis. She says that East Point NORC's strength is that it is a true community effort, with numerous partners who provide space, support, expertise, and in-kind contributions. These partners include the public library, Hands on Atlanta, home health services, the local fire and police departments, places of worship, ARC, and local higher education programs such as Brenau University, which sends occupational therapy students to help with home assessments and programming for safety and fall prevention.<sup>21</sup> In addition, East Point's public leaders appreciate the program and attend its events.

One lesson learned from East Point's seniors is that some elders distrust government programs and associate them with handouts that erode self-respect. To avoid this stigma, the program does not use the county's logo on any of East Point NORC's promotional materials even though the Fulton County

no ongoing legislative commitment. JFGA is advocating for a state statute to make the NORC program model a permanent part of Georgia's strategy to enhance aging friendliness as the population of seniors grows.<sup>23</sup>

JFGA is using program outcome data to support its advocacy efforts. In 2006, JFGA partnered with Georgia State University to make a baseline assessment of East Point residents' health, physical activity, mental health, socialization, perceptions of the environment and the community, and feelings about aging in place. Annual followups are conducted with a random sample of East Point members, and data are entered into a program management system to allow monitoring and reporting.<sup>24</sup>

The researchers emphasize simple ways to measure the results of the East Point NORC SSP, such as demonstrating that members have increased their activity levels, used more community services, gone when and where they

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## NAH governance is provided by members and community residents who form a board of directors that lends expertise and energy to planning and programming activities.

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could not go before, practiced healthy behaviors, shown progress in achieving weight and blood pressure goals, felt safer at home and in the community, and felt more confident that they will be able to age in place. For the 12 months ending in June 2013, the numbers show that large majorities of East Point seniors have become more mobile, more socially active and engaged, healthier, and more able to avoid falls, hospitalizations, and emergency room visits.<sup>25</sup>

The East Point NORC SSP reflects the efforts of a broad spectrum of the community. Its success, suggests Denis, lies in the integration of so many individuals and groups who, as stakeholders, participate in making East Point a city where seniors can age in place and remain actively engaged in their community.

### Two Kinds of Villages

As with NORCs, Villages promote access to services, strengthen older adults' social relationships, reduce social isolation, promote members' contributions to community, and help communities become more aging friendly. The Village model emerged as an alternative to traditional approaches that relied on private social services or government agencies. Government programs tended to target the very poor or disabled and were often unavailable to those with relatively more resources. To the founders of the first Village, Beacon Hill in Boston, assisted living, continuing care communities, and nursing homes seemed too "regimented, expensive, and isolating." Instead, Beacon Hill Village organizers

preferred to "design their own lifestyles and create their own futures" as they crafted the support systems needed to successfully age in place.<sup>26</sup> The founders realized that everything they needed to age in place was available somewhere in the greater Boston area. Rather than replicate existing community services, Beacon Hill Village organizers chose to consolidate and arrange access to services for members through strategic partnerships with service providers. Programs were designed for the whole person — that is, to meet the emotional, intellectual, physical, social, and spiritual needs of individuals — by building community around shared interests, addressing member service and information needs, and promoting healthy aging. Since 2002, when the Village was first organized, Beacon Hill's model has been adopted in more than 100 localities nationwide and in Canada, Australia, and the Netherlands, with another 123 Villages in development.<sup>27</sup>

To promote the development of aging-friendly communities, Beacon Hill Village produces a manual for grassroots groups to use to establish their own Villages. In addition, Beacon Hill has joined with NCB Capital Impact, a national community development financial institution, to create a peer network to encourage communication between Villages and assist new Village startups.<sup>28</sup> Approximately 85 percent of existing Villages belong to this Village to Village (VtV) Network.<sup>29</sup>

Villages have structured themselves in diverse ways, although the model's main components are common to

most. Some Villages operate as a division or program within a parent organization, while a majority of Villages (77%) are freestanding with their own governance or advisory board and staff.<sup>30</sup> An example of the former is the Concierge Club, a program of Elder-Help of San Diego, whereas Newton at Home, located in a community near Boston, exemplifies the latter. Both Villages are members of the VtV Network.

### Newton at Home: A Freestanding Village

Newton at Home (NAH) is a freestanding Village conceived by longtime residents of Newton, Massachusetts, who created a community support system that would enable city residents to remain in their homes as they grew older. Fully operational since April 2011, NAH is a membership-based, 501(c)(3) nonprofit organization with 178 members.<sup>31</sup>

Governance for NAH is through a board of directors composed of 14 NAH members and interested community residents with diverse backgrounds, including a physician, a social worker, a retired microbiology professor, and an economist. The board engages in a continuous planning process delegated to active committees that work on programming, health and wellness, fundraising, marketing and communications, and technology support. NAH devotes significant energy to planning and programming activities such as an annual Intergenerational Senior Walk, museum trips, and concerts. Popular affinity groups formed by members who share similar interests foster such activities as attending book clubs, dining out, kayaking, seeing films, visiting museums, painting, and attending cultural events. Village members form and run the affinity groups while staff arrange for necessary transportation and publicize dates, times, and locations. Communication with members is a constant challenge for NAH staff. Although the Village's website maintains a schedule of events,



Maureen Grannan, NAH's director, says communications with members can be challenging if members suffer from memory impairment or do not use a computer.<sup>32</sup>

Three paid staff members arrange services for NAH members through a centralized information and referral contact point. NAH membership benefits include access to services provided primarily by screened and trained volunteers, resources to help members navigate the health care system, and referrals to screened vendors for complex jobs such as roofing, construction, gutter replacement, and landscaping. These vendors frequently offer discounts to NAH members. NAH staff selects and vets vendors so that members can be confident of their honesty, reliability, and quality of work. The type of screening depends on the vendor's type of work and may include criminal background, license, and insurance checks. NAH staff also follows up after jobs are completed to make sure that members are satisfied.<sup>33</sup>

Members request and receive many services, including light in-home maintenance projects, health and fitness activities and classes, daily telephone check-ins, transportation, convenience services (such as dog walking, house sitting, or waiting for a delivery or service person when a member is not at home), technology assistance and education, and gardening advice and help. Many requests are for help with seasonal chores like installing window air conditioners in the summer and putting them away for the winter. Transportation is the most frequently requested service. Local rides are free, and round-trip rides into Boston cost a flat \$10. All parking fees are paid by members; volunteers cover fuel expenses, which are tax deductible.<sup>34</sup>

NAH's volunteer-first philosophy means that the Village attempts to identify a volunteer who can meet member requests before making a referral to a paid vendor. As a result, 98 percent of services are provided by a pool of about 110 volunteers that includes more than a third of NAH members, which builds community. All volunteer candidates are interviewed,

receive criminal background checks, and participate in a comprehensive orientation program before their first service assignment. "We are always looking for volunteers," says Grannan. "It's a multipronged approach. We work closely with a group called Soar 55 that places retirees in volunteer positions, we put out emails on listservs from which we get many responses, and we recruit at schools." NAH especially encourages youth volunteers and has local athletic teams, Boys and Girls Clubs, and Boy Scout troops providing support.<sup>35</sup>

An essential component of NAH's existence is its collaboration with agencies and community organizations that already serve older adults. NAH avoids duplicating services and works to add value to its partnerships. One example of such collaboration is a recently developed partnership with Newton-Wellesley Hospital to help prevent rehospitalization of Medicare patients within 30 days for the same diagnosis (for which the hospital cannot be reimbursed). As Grannan explains, "We can help discharged, at-risk individuals stay at home just by doing the kinds of things we do for our members: daily home visits, grocery shopping, putting the trash out for pickup, delivering prescriptions, taking them to doctor appointments." The hospital pays \$180 for a 30-day membership for the released patient, NAH supplies the necessary patient support, and everyone benefits. The patient stays at home, and the hospital saves a significant amount of money by avoiding a nonreimbursable readmission.

NAH enjoys community support from the mayor's office, numerous nonprofit partners, and many businesses that make in-kind contributions such as the local hardware store, which donates rakes and leaf bags for the autumn leaf removal. NAH members can also receive carpentry and auto repair services from volunteers at one of the town's high schools. In addition, a nonprofit group called Food to Your



Newton at Home

Recruiting volunteers young and old, Newton at Home encourages intergenerational interactions.



Newton at Home

With volunteer drivers using their own cars and paying for gas, Newton at Home coordinates free local travel for members.

Table goes to the local farmers' market every Tuesday afternoon to collect unsold produce; these vegetables and fruit are bagged and delivered for free to Village members. "We also work closely with an elder affairs officer in the police department on safety issues for our members. To sustain Newton at Home, this kind of continued community support is essential," says Grannan.

Annual membership fees for Newton residents aged 60 and older are \$660 for an individual living alone and \$780 for a household. A limited number of reduced-fee memberships are offered to modest-income residents. Newton also offers a six-month trial membership at a reduced rate and a BreakAway Membership plan that prorates the annual fee if a member spends at least three consecutive months a year away from their Newton home.<sup>36</sup> Membership dues cover about 60 percent of NAH's \$165,000 budget; donations

from businesses, individuals, foundations, and an occasional grant account for the remainder of revenue. Salaries for three full-time staff members, modest rent for a one-room office, technology costs, and postage account for most of the program costs.<sup>37</sup>

Fundraising is crucial, says Grannan. She has several volunteers who help with grant writing. Currently, an assisted living facility, a physical therapy business, and NAH are collaborating on a grant application to fund a fall prevention program to safeguard members and clients, prevent hospital stays, and save the health care industry money in the long term. The president of NAH's board of directors assumes the responsibility of chief fundraiser. Membership continues to grow, and Grannan stresses that to be sustainable, NAH will need more money to hire additional staff, rent a larger office space, and acquire additional technology and a van for event transport.

NAH is a grassroots initiative, and many of its members are invested in Village activities that also build community. Although NAH's volunteer-first philosophy effectively meets a variety of service requests and its membership is growing, the organization is labor intensive for staff. To remain sustainable, NAH must continue to secure and maintain the necessary resources, energies, and investments of members, staff, volunteers, and community partnerships.

### **The Concierge Club: A Parented Village**

ElderHelp of San Diego, a nonprofit with decades of experience in providing services to seniors, became increasingly aware of a need for affordable support for frail seniors who wish to live independently in their own homes. In 2009, ElderHelp launched the Concierge Club, which is patterned on the Village model. Membership in the Concierge Club is open to seniors

aged 60 and older who live in a service area covering much of mid-city San Diego and a small portion of the East County region. Most Club members are relatively homebound and have limited resources.<sup>38</sup> Deb Martin, Concierge Club's chief executive officer and executive director, states that "about 50 percent of our members pay nothing, and the rest pay on a sliding scale from \$25–\$300 per month for services, depending on income level and choice of services. Less than two percent of our members pay the maximum monthly fee."<sup>39</sup> The average annual membership fee paid in 2011 was \$377, whereas the average value of assistance received by each member was \$4,156 per year.<sup>40</sup> Donated funds and services cover most of the difference between membership dues collected and total expenses.

The Concierge Club offers three levels of member services, explains Anya Delacruz, member services director for the Club.<sup>41</sup> The first consists of information and referrals requested by members who call in for a quick resource. The second level is any kind of volunteer service that members need. The greatest demand is for drivers, but other volunteer services are also available to members who choose to take advantage of them: housekeeping, grocery shopping, bill minding, budgeting, home repair, gardening, social visits, and pet care.<sup>42</sup> In 2011, Club members received 10,627 hours of volunteer services valued at \$10 to \$29 per hour.<sup>43</sup> The third level of member services includes care management and coordination plus volunteer services, meaning that, if needed to allow aging in place, members receive personal care management, monitoring, and assistance as indicated by an in-depth biopsychosocial assessment.<sup>44</sup> Club staff provided 4,500 hours of such care management at a value of \$115 an hour in 2011.<sup>45</sup>

Approximately 310 volunteers provide the bulk of direct services to about 250 Club members at any one time, and 6 or 7 staffers recruit members,

find and train volunteers, match volunteers with members, perform ongoing care coordination, and oversee member services.<sup>46</sup> Concierge Club personnel connect members with needed volunteers and, as at NAH and most other Villages, the Club screens providers and arranges for member discounts. Delacruz says their network of preferred providers consists of "community partners who provide services that we don't so that we can offer a more comprehensive set of services, knowing that we can't be everything to everyone." These partners are thoroughly vetted through interviews, applications, license verifications, and checks on their standing with the Better Business Bureau. Delacruz says, "We really try to take the guesswork out of things for members so they're not just looking through the Yellow Pages or Craigslist, but can know these are trusted people in the community."

Members are also able to purchase in-home care services at \$19 per hour, a discount of 14 percent from the standard rate of \$22 per hour, and Lifeline medical alert services are available from a preferred provider at a discount of 27 percent.<sup>47</sup>

Club membership offers seniors more than just access to needed services. The University of California at Berkeley completed an 18-month evaluation of the Concierge Club in 2012 that identified additional social and economic benefits for members that could lead to improved quality of life. The study indicates that after joining the Club, members who were "very confident" that they would be able to remain in their own home as they age increased from 24 to 71 percent. Forty-four percent of members found it easier to take care of their home. After six months of membership, the number of



Concierge Club volunteers help members pursue interests such as gardening.

ElderHelp Staff and Volunteers

# The Original NORC Supportive Services Program

In June 2013, members of the Penn South Program for Seniors (PSPS) joined friends and neighbors to sing, dance, perform monologues and group sketches, and otherwise publicly showcase their talents at the Hudson Guild Theatre in New York City. This talent show launched a monthlong display of visual artworks, The Second Acts Gallery Exhibit, also created by PSPS members.

The talent show is but one of many activities engaged in by older residents of Penn South, the first officially recognized Naturally Occurring Retirement Community, or NORC, in the nation. Penn South is a limited-equity cooperative in the Chelsea neighborhood of Manhattan, built by the International Ladies' Garment Workers Union in the 1950s to accommodate the affordable housing needs of 2,820 moderate-income families, many of whom were garment workers. As the children of these families grew up and moved away, many of the adults stayed. By 1985, more than 75 percent of Penn South households had a member who was aged 60 or older.<sup>1</sup> Increasingly, older residents were asking co-op management for assistance "with problems such as inability to read or understand paperwork received from the co-op, losing keys several times and going to the security office for help, or simply wandering and being unable to find their apartment. Some people forgot to pay their monthly charges."<sup>2</sup>

Although their needs had changed, most Penn South senior residents preferred to age in their homes rather than move to an assisted living community or a nursing home. As a result, the Penn South co-op board implemented PSPS, a prototypical NORC SSP now replicated in many localities.<sup>3</sup> A separate nonprofit organization, Penn South Social Services, was established and charged with sponsoring comprehensive services that enable elderly residents to stay in their homes and avoid nursing home placement. The PSPS program offers social and health services, educational and cultural programs, trips and holiday celebrations, recreational and exercise classes, referrals for legal and mental health services, and care coordination, all in the interest of wellness and wellbeing in later years. A recently added amenity, Home Organized Personal Services, offers steep discounts on products and services classified as out-of-pocket expenses not covered by insurance, such as eyeglasses, home health aides, and hearing aids.<sup>4</sup>

<sup>1</sup> Kathryn Lawler. 2001. "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.

<sup>2</sup> PENNSOUTHLIVE. 2011. "About PSPS." Accessed 9 September 2013.

<sup>3</sup> A 2010 survey of NORCs by B. J. Bedney et al. reported in "Aging in place in naturally occurring retirement communities," *Journal of Housing for the Elderly* 24, 304–21, identified 84 operational NORC Supportive Services Programs.

<sup>4</sup> PENNSOUTHLIVE. 2011. "About PSSS." Accessed 9 September 2013.

seniors who often felt socially isolated, lacked companionship, or felt left out declined by approximately two-thirds. The Club also improved members' health outcomes and addressed their safety concerns. For example, the number of home hazards that might cause injury declined from an average of 1.43 to 0.76 per home and the number of falls experienced in the previous 6 months declined from a total of 28 down to 4.<sup>48</sup>

Although Club staff use these findings to support its grant submissions and reports, they are still exploring how to use them to enhance Club programs and to reduce social isolation. "We're trying to translate a lot of our services into measurable medical health benefits and cost savings," says Martin. "When unmanaged chronic illness worsens for a socially isolated

individual, there's an increase in serious functional and mental debilitation that overburdens the health care system. What we do directly correlates with reducing isolation among seniors and all of the health and medical problems that occur when they are left alone." The Club believes the services its volunteers provide, such as transportation to medical appointments and the pharmacy, home and safety improvements, and fall prevention, translate directly into health benefits for seniors and health cost savings.

Although the organization constantly tries to diversify its revenue streams, its funding comes primarily from foundations and donations from individuals and corporations, with a very small percentage coming from membership fees. Martin says that "fundraising is always going to be a challenge in this day

and age with thousands of nonprofits out there. But we have a unique model, we've done this job well for a long time, and our reliance on volunteers keeps things affordable." To be sustainable in the long term, however, Martin emphasizes that the Club must find ways to increase revenue. The Club's original membership structure fails to cover program costs, and the organization is exploring how to attract people who can afford to pay for services to subsidize those who cannot.<sup>49</sup>

Another key to sustainability, says Martin, is to retain and continually build alliances and partnerships. "At the same time, we try to increase our capacity, which is contingent on the number of volunteers we can recruit. They are both our growth and our limit." One of the Club's biggest challenges is to meet members' demand

for transportation; keeping up with all of the rides requested is possible only because of help from a nonprofit partner who has vans, including wheelchair-accessible ones. Finally, Martin stresses the importance of controlling costs and overhead and ensuring that the Club is able to retain experienced, skilled staff.

## Issues and Challenges for NORC SSPs and Villages

The objectives and types of services that seniors need in East Point, San Diego, and Newton are markedly similar. All experience heavy member demand for transportation services. The amount and nature of member activity and involvement varies across these NORC SSP and Village examples — high and multifaceted in NAH's Village, a grassroots, self-governed initiative in a relatively well-educated community; curtailed by health and frailty, as are many Concierge Club members; and constrained by limited economic resources, as are the members of East Point NORC's SSP and the Concierge Club. An additional constraint for the Concierge Club's program is its large service area, which makes recreation and socializing activities logistically difficult (although it has successfully planned some excursions to museums, the wild animal park, and musical performances). The Club provides the bulk of its services in members' homes, which has resulted in meaningful relationships between volunteers and Club members.<sup>50</sup>

Both Villages and NORCs are challenged with securing funds to sustain their programs. NAH and the Concierge Club depend on revenue from membership fees but also require additional operating funds. NAH depends most on membership fees and has diversified its membership options while also seeking grants and gifts. The Concierge Club plans to restructure and broaden its membership base but also relies heavily on fundraising.

East Point NORC's two largest revenue sources are government grants and

contracts and contributions from businesses and private philanthropies, sources that are always accompanied by a degree of uncertainty. JFGA hopes to secure a state legislative commitment in Georgia that would provide more certain funding, just as Penn South accomplished in New York through its advocacy. Villages, too, often rely on fundraising to compensate for insufficient revenue from membership fees, which is why VtV Network members seek help to recruit and reach target populations able to benefit from Village membership.<sup>51</sup> Having extensively researched the Village model, Scharlach et al. posit that Villages may be a workable solution for middle-income households if more stable funding can be assured and if affiliation and partner networks can be sufficiently strengthened to secure access to needed resources.<sup>52</sup>

These issues and challenges are similar to those found in a national study of NORC and Village programs by Greenfield et al. despite significant variation in their "unique development histories." The specific services delivered, the populations served, how services are provided, and how they are financed are the primary dimensions of these programs, according to Greenfield et al. Factors affecting these dimensions include the characteristics of the program's geographic service area, population density, health status and needs of participants, degree of participant engagement, coordination and involvement of community groups, and the fiscal status of the participants.<sup>53</sup>

Finally, NORCs and Villages increasingly need outcome-oriented data, such as those gathered by Concierge Club program evaluators, to compete successfully for grants and donations that help support staff, transportation, information dissemination, education, and volunteer programs. Stakeholders want to know whether these initiatives are reducing costs and are socially beneficial, underscoring the critical role of good research and program evaluation in securing an adequate flow of revenue.<sup>54</sup>

Obtaining such data also makes it possible for others to replicate successful programs.

Fredda Vladeck, director of United Hospital Fund's Aging in Place Initiative, stresses that data also help create and strengthen the community infrastructure necessary to support aging in place.<sup>55</sup> Vladeck has shown how data-driven initiatives have identified and closed gaps in health and social services, improving clinical outcomes for NORC SSP participants with diabetes. This evidence is significant for the individuals involved but also reinforces the essential role that effective collaboration has in sustaining the aging friendliness of a community.<sup>56</sup>

Vladeck also points to having collected baseline data on the health status and risks for older adults living in NORCs. Subsequently, interventions were designed and implemented to address prevalent health risks (heart disease, diabetes, and falls) in these populations. Over the next 18 months, the interventions resulted in improvements, such as increased percentages of quarterly blood pressure readings taken and blood pressures that were under control.<sup>57</sup> "The value of these studies," Vladeck notes, "is that the conversation is no longer about one case or individual at a time but about a whole population. For example, when health care organizations know that 42 percent of seniors living in two communities are diabetic, it offers a unique opportunity for providers to partner with other community agencies to improve management of diabetes and prevent numerous emergency room visits and amputations."<sup>58</sup>

## Conclusion

Membership in a community is a vehicle for self-fulfillment for people of all ages. To avoid social isolation, older adults must "have a community to belong to that supports their needs and gives meaning to their lives," explains Ann Bookman, a social anthropologist from the University of Massachusetts at Boston.<sup>59</sup> East Point NORC, Newton at

Home, and the Concierge Club are helping seniors remain in their own homes, independent and socially engaged. While these organizations are respecting the housing choices of aging individuals, they are also creating better integrated communities by closing service gaps, building partnerships among organizations and institutions, and — in one case — intentionally adding cross-generational engagement by actively recruiting youth volunteers.

The evidence suggests that both seniors who wish to age in place and their communities can benefit from Village and NORC SSP initiatives as well as other models that attempt to integrate individual and community health needs, such as Vermont's SASH program (see "Aging in Place: Facilitating Choice and Independence," p. 1). Questions remain as to how resources can be aligned to provide more certainty and long-term stability for these programs and how a wider spectrum of consumers can be included. Stakeholders are also interested in learning whether efforts to facilitate aging in place will be instrumental in reducing the health care costs associated with aging. A rigorous research agenda designed to identify outcomes of programs, as well as the conditions under which working Villages and NORC SSPs are most effective in helping particular groups and subgroups of older adults to successfully age in place, could answer these questions and guide the way forward.<sup>60</sup> EM

<sup>1</sup> Ann Bookman. 2008. "Innovative models of aging in place: Transforming our communities for an aging population," *Community, Work & Family* 11:4, 419–38.

<sup>2</sup> Ibid.; The Jewish Federations of North America. 2013. "What is a NORC SSP?" defines a naturally occurring retirement community (NORC) as comprised of a significantly large proportion of older residents whose needs have changed with aging and are no longer adequately met by the physical and social environment.

<sup>3</sup> Emily A. Greenfield, Andrew Scharlach, Amanda J. Lehning, and Joan K. Davitt. 2012. "A conceptual framework for examining the promise of the NORC program and Village models to promote aging in place," *Journal of Aging Studies* 26, 273–84.

<sup>4</sup> Center for the Advanced Study of Aging Services. 2010. "Compendium of Community Aging Initiatives, 67.

<sup>5</sup> Kathryn Lawler. 2001. "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, 42–4.

<sup>6</sup> United Hospital Fund. 2013. "9 Frequently Asked Questions about NORCs." Accessed 21 August 2013; Emily A. Greenfield, Andrew E. Scharlach, Carrie L. Graham, Joan K. Davitt, and Amanda J. Lehning. 2012. "An Overview of Programs in the National NORCs Aging in Place Initiative: Results from a 2012 Organizational Survey," Rutgers University School of Social Work.

<sup>7</sup> Barbara Joyce Bedney, David Schimmel, Robert Goldberg, Laurence Kotler-Berkowitz, and Debbie Bursztyjn. 2007. "Rethinking Aging in Place: Exploring the Impact of NORC Supportive Service Programs on Older Adult Participants," presented at Joint Conference of the American Society on Aging and the National Council on the Aging, March 7–10; United Jewish Communities. 2007. "NORCs National Evaluation."

<sup>8</sup> United States Census Bureau. 2013. "State and County QuickFacts" and "2007–2011 American Community Survey 5-Year Estimates," DPO4 and DP05. Accessed 5 September 2013; Atlanta.net. 2013. "About East Point." Accessed 5 September 2011.

<sup>9</sup> Jan M. Ivery and Deborah Akstein-Kahan. 2010. "The Naturally Occurring Retirement Community (NORC) Initiative in Georgia: Developing and Managing Collaborative Partnerships to Support Older Adults," *Administration in Social Work* 34:4, 329–43.

<sup>10</sup> United Hospital Fund. 2012. "East Point NORC Program, Atlanta, Georgia." Accessed 8 August 2013.

<sup>11</sup> City of East Point, Georgia. n.d. "What is a NORC?" Accessed on 16 July 2013.

<sup>12</sup> Jewish Federation of Greater Atlanta. 2013. "How Does NORC Help Our Community?" Accessed 8 August 2013.

<sup>13</sup> Interview with Diana Stevens, East Point Outreach Coordinator, August 2013.

<sup>14</sup> Ivery and Akstein-Kahan.

<sup>15</sup> Interview with Regine Denis, August 2013.

<sup>16</sup> Jewish Federation of Greater Atlanta. 2013. "NORC Evaluation Report 2012–2013." Unpublished, provided by JFGA.

<sup>17</sup> Jewish Federation of Great Atlanta. 2012. "East Point NORC." Accessed July 2013.

<sup>18</sup> "NORC Evaluation Report 2012–2013."

<sup>19</sup> Regine Denis interview; United Hospital Fund. 2012. "Custom-Tailored Transportation." Accessed July 2013.

<sup>20</sup> City of East Point, Georgia.

<sup>21</sup> Ivery and Akstein-Kahan.

<sup>22</sup> United Hospital Fund, 2012. "Establishing a Brand"; Interview with Regine Denis.

<sup>23</sup> Jewish Federation of Greater Atlanta. 2013. "What About Funding?" Accessed 8 August 2013.

<sup>24</sup> Ibid.; "Is the NORC Model Working?"; Ivery and Akstein-Kahan; "NORC Evaluation Report 2012–2013."

<sup>25</sup> Ibid.

<sup>26</sup> Susan McWhinney-Morse. 2009. "Beacon Hill Village," *Generations* 33:2, 85–6.

<sup>27</sup> Village to Village Network. "About the VtV Network." Accessed 10 July 2013.

<sup>28</sup> Ibid.; Beacon Hill Village. 2013. "Thinking About Starting a Village?" Accessed 10 July 2013.

<sup>29</sup> Emily A. Greenfield, Andrew E. Scharlach, Carrie L. Graham, Joan K. Davitt, and Amanda J. Lehning. 2012. "A National Overview of Villages: Results from a 2012 Organizational Survey," Rutgers University School of Social Work, 6.

<sup>30</sup> Ibid., 2–3, 5.

<sup>31</sup> Newton at Home. 2013. "Living in your community — staying in your home." Accessed 3 July 2013.

<sup>32</sup> Interview with Maureen Grannan, August 2013.

<sup>33</sup> Newton at Home. 2013. "Membership Services"; Interview with Maureen Grannan.

<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> Newton at Home. 2013. "How You Can Become a Newton at Home Member."

<sup>37</sup> Interview and email communication with Maureen Grannan.

<sup>38</sup> ElderHelp. 2013. "Concierge Club."

<sup>39</sup> Deb Martin interview, August 2013.

<sup>40</sup> Center for the Advanced Study of Aging Services. 2012. "Results of Evaluation of Concierge Club." Internal document provided by ElderHelp.

<sup>41</sup> Interview with Anya Delacruz, August 2013. According to Greenfield et al., this is a typical service delivery structure for Villages.

<sup>42</sup> ElderHelp. n.d. "Caring Services In Your Own Home." Concierge Club brochure.

<sup>43</sup> Center for the Advanced Study of Aging Services.

<sup>44</sup> Interview with Anya Delacruz. The biopsychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery.

<sup>45</sup> Center for the Advanced Study of Aging Services.

<sup>46</sup> Interview with Deb Martin.

<sup>47</sup> Center for the Advanced Study of Aging Services.

<sup>48</sup> Ibid.; Andrew E. Scharlach, Carrie L. Graham, and Clara Berridge. 2012. "ElderHelp Concierge Club Evaluation Final Report," University of California, Berkeley Center for the Advanced Study of Aging Services. Copy provided by lead author.

<sup>49</sup> Deb Martin interview.

<sup>50</sup> Ibid.

<sup>51</sup> Andrew Scharlach and Christabel Cheung. 2010. "The Village Movement: Data Collection & The Practical Application of Data," 27 October webinar.

<sup>52</sup> Andrew Scharlach, Carrie Graham, and Amanda Lehning. 2012. "The Village Model: A Consumer-Driven Approach for Aging in Place," *Gerontologist* 52:3, 418–27.

<sup>53</sup> Emily A. Greenfield, Andrew E. Scharlach, Amanda J. Lehning, Joan K. Davitt, and Carrie L. Graham. 2013. "A Tale of Two Community Initiatives for Promoting Aging in Place: Similarities and Differences in the National Implementation of NORC Programs and Villages," *The Gerontologist* (April), 1–11.

<sup>54</sup> Jean C. Accius. 2010. "The Village: A Growing Option for Aging in Place," AARP Fact Sheet.

<sup>55</sup> Fredda Vladeck. 2006. "Testimony before the Subcommittee on Retirement, Security and Aging of the Health, Education, Labor, and Pensions Committee, United States Senate," 16 May.

<sup>56</sup> Corrine Kyriacou and Fredda Vladeck. 2011. "A new model of care collaboration for community-dwelling elders: findings and lessons learned from the NORC-Health Care linkage evaluation," *International Journal of Integrated Care* 11 (29 April), 1–20.

<sup>57</sup> Fredda Vladeck. 2011. "A New Role for Senior Serving Community Based Organizations in Chronic Care Management," United Hospital Fund Research Symposium PowerPoint presentation, 13 October, and accompanying notes provided by the presenter.

<sup>58</sup> Interview with Fredda Vladeck, July 2013.

<sup>59</sup> Bookman.

<sup>60</sup> Greenfield et al., "A Conceptual Framework."

## Additional Resources

- “A Profile of Older Americans: 2012,” developed by the U.S. Department of Health and Human Services’ Administration on Aging, incorporates the latest data from the American Community Survey, the Medicare Current Beneficiary Survey, and the National Center for Health Statistics on the characteristics of seniors over age 65. [www.aoa.gov/Aging\\_Statistics/Profile/index.aspx](http://www.aoa.gov/Aging_Statistics/Profile/index.aspx).
- “An Overview of NORC Programs in New York: Results from a 2012 Organizational Survey” (2012), by Emily A. Greenfield et al., reports survey data that describe NORC programs in the state of New York. [www.agingandcommunity.com/wp-content/uploads/2012/12/NY-NORC-FINAL.pdf](http://www.agingandcommunity.com/wp-content/uploads/2012/12/NY-NORC-FINAL.pdf).
- “Home and Community-Based Long-Term Services and Supports for Older People” (2011), by Enid Kassner, is an AARP Public Policy Institute Fact Sheet that relays information about the resources available to older adults and people with disabilities who wish to remain in their homes. [www.aarp.org/health/health-care-reform/info-05-2011/fs222-health.html](http://www.aarp.org/health/health-care-reform/info-05-2011/fs222-health.html).
- “Aging in Place: A Toolkit for Local Governments,” by M. Scott Ball, the Atlanta Regional Commission, and the Community Housing Resource Center, offers recommendations to local governments regarding planning and zoning, affordable housing, integration of healthcare and housing, and other issues related to aging in place. [www.aarp.org/content/dam/aarp/livable-communities/plan/planning/aging-in-place-a-toolkit-for-local-governments-aarp.pdf](http://www.aarp.org/content/dam/aarp/livable-communities/plan/planning/aging-in-place-a-toolkit-for-local-governments-aarp.pdf).
- “Compendium of Community Aging Initiatives” (2010), by Andrew Scharlach, lists and provides brief descriptions of more than 100 programs aimed at making communities more accommodating for aging residents. [www.aarp.org/content/dam/aarp/livable-communities/act/planning/Compendium-of-Community-Aging-Initiatives-AARP.pdf](http://www.aarp.org/content/dam/aarp/livable-communities/act/planning/Compendium-of-Community-Aging-Initiatives-AARP.pdf).
- “A Blueprint for Action: Developing a Livable Community for All Ages” (2007), by the MetLife Foundation, offers tools to local leaders and practitioners for building the collaborations needed to create livable communities for people of all ages. [www.livable.org/livability-resources/reports-a-publications/184](http://www.livable.org/livability-resources/reports-a-publications/184).
- “Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors” (2012), by Harriet Komisar et al., identifies key policymaking issues for informing a better integrated understanding of economic and health security and the roles that the Medicare, Medicaid, and Social Security programs play in ensuring the financial security of seniors. [kaiserfamilyfoundation.files.wordpress.com/2013/01/8289.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8289.pdf).
- “Aging in Place: A State Survey of Livability Policies and Practices” (2011), by the National Conference of State Legislatures and the AARP Public Policy Institute, surveys state policies that can help older adults age in place. [www.aarp.org/home-garden/livable-communities/info-11-2011/Aging-In-Place.html](http://www.aarp.org/home-garden/livable-communities/info-11-2011/Aging-In-Place.html).
- “Connecting Residents of Subsidized Housing with Mainstream Supportive Services: Challenges and Recommendations” (2010), by Rebecca Cohen of the Center for Housing Policy, makes policy recommendations to overcome specific obstacles to meeting the service needs of subsidized housing residents. [www.nhc.org/media/files/chp\\_subsidized-housing2011\\_challengesandrecommendation1.pdf](http://www.nhc.org/media/files/chp_subsidized-housing2011_challengesandrecommendation1.pdf).
- “The Maturing of America: Communities Moving Forward for an Aging Population” (2011), by the National Association of Area Agencies on Aging, surveys community programs to meet the needs of older residents, highlights several examples, and makes recommendations for addressing specific challenges. [www.n4a.org/files/MOA\\_FINAL\\_Rpt.pdf](http://www.n4a.org/files/MOA_FINAL_Rpt.pdf).
- “Affordable Senior Housing: A Guide to Conducting Resident Assessments,” by the LeadingAge Center for Applied Research with support from Enterprise Community Partners, is part of a toolkit for property managers of senior housing to assess residents’ health-related needs. [www.leadingage.org/uploadedFiles/Content/About/Center\\_for\\_Applied\\_Research/Expanding\\_Affordable\\_Housing\\_Plus\\_Services/Resident\\_assessment\\_guidebook.pdf](http://www.leadingage.org/uploadedFiles/Content/About/Center_for_Applied_Research/Expanding_Affordable_Housing_Plus_Services/Resident_assessment_guidebook.pdf).
- *Independent for Life: Homes and Neighborhoods for an Aging America* (2012), edited by Henry Cisneros, Margaret Dyer-Chamberlain, and Jane Hickie, describes the challenges and opportunities posed by an aging population and offers strategies for adapting homes and communities to allow older people to successfully age in place. [www.utpress.utexas.edu/index.php/books/cisind](http://www.utpress.utexas.edu/index.php/books/cisind).
- *The New Politics of Old Age Policy* (2010), edited by Robert B. Hudson, contains essays on the challenges to, and political contexts of, various aspects of policies on aging. The volume includes chapters on senior housing, long-term care reform, Medicaid, and Social Security, among other relevant topics. [www.press.jhu.edu/](http://www.press.jhu.edu/)

For additional resources archive, go to [www.huduser.org/portal/periodicals/em/additional\\_resources\\_2013.html](http://www.huduser.org/portal/periodicals/em/additional_resources_2013.html).

### Evidence Matters

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