CHAPTER 15

Housing

It has been a year since Lois sold her home and moved into a federally subsidized senior housing complex. The move was a difficult decision, and the 2 years she waited for an opening were challenging and frustrating. But once settled into her new apartment, she had no regrets. Her modest income of $623 per month had been totally inadequate to meet the expenses of keeping up her home and paying for her heart medication, groceries, and utilities. She rarely had as much as a dime left over at the end of the month. She could not even begin to consider a major roof repair that was sorely needed. She misses her old neighborhood, but she does not miss the worries of taking care of a house and yard. Now that her money goes a little further, she can enjoy some outings with her new friends.

The majority of older individuals perceive their home as one of their most prized possessions. A home is much more than physical shelter. It gives those who dwell in it a sense of security, privacy, comfort, and independence. It also plays a major role in facilitating social interaction with family and friends (Kochera, Straight, & Guterbock, 2005). A home holds for its residents a multitude of memories and a sense of continuity in life. Findings from a recent AARP study suggest that 87% of people age 65 and older want to stay in their homes for as long as possible (Harrell, Lynott, Guzman, & Lampkin, 2014). The quality and type of dwellings in which older adults live depend on many things, such as their income, age, marital status, gender, and race, as well as their health and functional status.

We begin this chapter by describing the theoretical concept of *person–environment fit* as a framework for understanding the relationship between older individuals' place of residence and their physical, psychological, and social needs. We then discuss the various independent and supportive housing arrangements in which older adults reside and policies that support these arrangements. The chapter concludes with a discussion of several emerging issues that are likely to influence the housing options and needs of older adults in the future.

The Person–Environment Fit Model

For older individuals to be satisfied with their environment, an appropriate *fit* needs to exist between their level of competence and the demands of their environment (Lawton, 1980; Lawton & Nahemow, 1973; Wahl & Oswald, 2016). *Competence* refers to the upper limits of an individual's abilities and extends across several areas of functioning, including health, sensory-cognitive abilities, capacity for self-care, ability to perform

instrumental activities, mastery, and social skills (Lawton, 1982). If the environment is too demanding for an older adult's competence, or if the environment puts too few demands on the older adult's competence, there is a poor fit.

Elders enjoy a range of comfort and display adaptive behavior when their physical and social living environments are compatible with their personal abilities and resources. A moderately challenging environment is beneficial because it encourages growth and therefore stretches the person's abilities. Too wide a discrepancy between personal competence and the demands of the environment results in maladaptive behavior and personal stress, and can impede the person's ability to carry out activities of daily living (ADLs). For example, we know that living in their own homes is the preferred housing choice of most older adults. If, however, the home becomes too costly to manage or the older person is physically unable to maintain it, the demands of the environment may be too stressful. Relocation decisions often occur when older adults, or others in their support network, decide that they are no longer competent to remain living in their current housing environment.

When selecting a new housing option, older persons should avoid moving to a residence that requires too little from them or lacks the stimulation necessary to challenge their existence. When older adults find that their skills and abilities are limited by their environment, they often become bored and give up doing many things for themselves. Overstimulation by the environment can cause distress, but understimulation can be just as stressful and can result in greater dependence and feelings of helplessness (Lawton, 1982).

In summary, when one is considering outcomes related to the person–environment fit model, the preferences of the individual and the nature of the environment must be taken into account. The older adult's decision to move often is prompted by a need for greater physical, psychological, or social security (Parmelee & Lawton, 1990). An older person's security needs, however, may be in direct conflict with that person's need for autonomy and independence. To adapt successfully to a new, more structured living environment, older adults need to pursue a level of autonomy appropriate to their personal resources and competencies. We now turn to a discussion of the different types of housing environments that older adults occupy.

Users and Programs: Independent Living Environments

Independent living environments are designed for older adults who are able to manage daily activities, such as housekeeping, cooking, and personal care, with little assistance from others. Widely varying living environments exist that allow older adults to live independently. Each of these is discussed below along with the programs and services that help older adults remain in independent living environments.

Single-Family Dwellings[1]

Most noninstitutionalized, community-dwelling older adults own or rent their dwellings. The majority live in detached, single-family dwellings (80%), whereas the remainder live

[1]Unless otherwise noted, the statistical information is on single-family dwelling characteristics.

in mobile homes (7%), multi-unit buildings (6%), and semidetached houses (6%; see Exhibit 15.1; Joint Center for Housing Studies [JCHS] of Harvard University, 2016). More than two thirds (70%) of older adults who own their homes have no mortgage debt, while 30% are making mortgage payments. Approximately 22% of elders are renters (U.S. Census Bureau, 2016a).

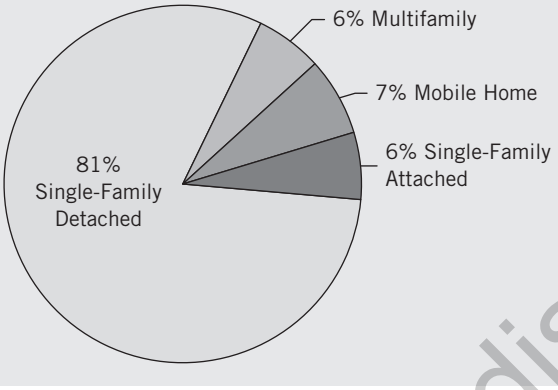
In 2016, approximately 79% of individuals age 65 and older owned their homes (U.S. Census Bureau, 2016a). Personal variables such as age, gender, marital status, and race influence homeownership in later life. About 79% of persons ages 65 to 69 are homeowners, compared with 82% of individuals ages 70 to 74 and 77% of persons age 75 and older. The oldest age-group emerged from the Great Recession with smaller losses to homeownership than any other age-group (JCHS, 2016). In fact, for persons age 75 and older, homeownership rates actually rose overall over the past two decades, despite the intervening recession. Persons ages 50 to 64, in contrast, saw a major reduction in homeownership. Thus, homeownership rates for future generations of older adults are likely be lower than they are today.

Ownership levels are higher for older married-couple families (91.2%) than for older men (64.8%) and older women (67.4%) who live alone (U.S. Census Bureau, 2016a). White elders are more likely to be homeowners than minority elders. Approximately 83% of non-Hispanic White elders are homeowners, compared with 68% of Asian and Native Hawaiian/Pacific Islander elders, 64% of Hispanic elders, and 62% of Black older adults (see Exhibit 15.2; JCHS, 2016). A greater proportion of Black and White elders live alone (44% and 43%), whereas older Hispanic homeowners are least likely to live alone (34%; West, Cole, Goodkind, & He, 2014). Overall, a greater share of households owned by an older Hispanic person have three or more members compared with non-Hispanic households (30% vs. 12%).

Almost three fourths (74%) of elderly homeowners reside in the suburbs; 23% live in central cities, and 26% live in nonmetropolitan areas (B. Lipman, Lubell, & Salomon, 2010). While older renters are almost twice as likely as homeowners to live in a central city (40% vs. 23%), overall, more older renters live in the suburbs (43%) than either a central city (39%) or a nonmetropolitan area (17%). It is common for older adults, particularly homeowners, to have lived in their current place of residence for more than 30 years (AARP Public Policy Institute, 2011). Although only about 6% of dwellings of older persons are considered physically inadequate (e.g., missing siding, broken windows, holes/cracks/crumbling in the foundation, sagging roof, holes in the floor), many housing units may be neither safe nor suitable for older adults due to hazardous bathrooms, steep staircases, and narrow doorways (B. Lipman et al., 2010).

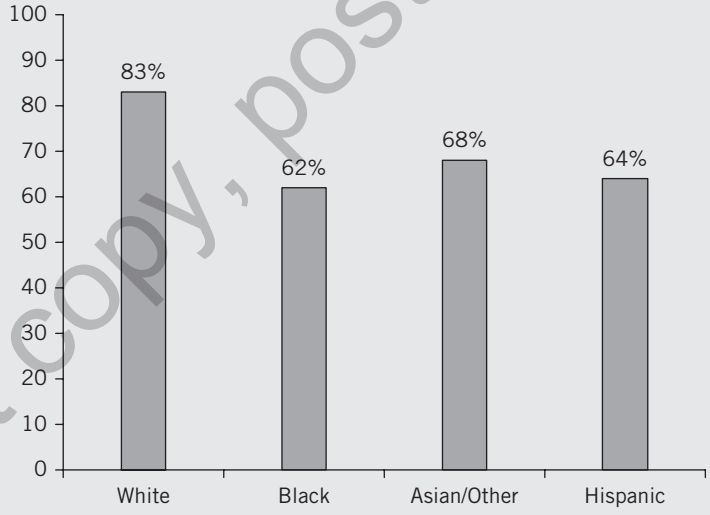
Of the more than 33 million Americans age 65 and older who own their homes, about 6.1 million have a mortgage (Consumer Financial Protection Bureau, 2014). The median amount older homeowners owe on their mortgage is $72,000. Although many older homeowners do not have a mortgage and consequently spend less on housing than do younger and middle-aged adults, approximately one quarter (26.3%) of aged homeowners spend 30% or more of their income on housing (U.S. Census Bureau, 2015b). For older homeowners without a mortgage, their median monthly owner cost is $462 compared with $1,299 for older homeowners with a mortgage. Low-income elders are especially hard hit when it comes to the percentage of their income spent on housing costs (i.e., cost burdened). For example, 77% of older adults with annual incomes of less than $15,000 and more than 54% with incomes of $15,000 to $29,999 spend more

Exhibit 15.1 Types of Dwellings of Older Adults in 2014



Source: JCHS (2016).

Exhibit 15.2 Householders 65 Years of Age or Older Who Are Homeowners, by Race



Source: JCHS (2016).

than 30% of their income on housing-related costs (JCHS, 2014). While 29% of older White households are cost burdened, 39% of older Asian, 43% of older Hispanic, and 46% of older Black households are cost burdened. These older adults clearly represent the predicament of being "house rich" but "cash poor."

The median gross monthly rent paid by older adults is $793 (U.S. Census Bureau, 2015b). A little more than one-half (54.2%) of older renters spend 30% or more of their income on housing. Excluding home equity, the median homeowner age 50 and over has $117,000 in other assets compared with only $6,100 in net wealth accumulated by the median renter in the same age-group (JCHS, 2014).

Housing Programs

As mentioned at the beginning of the chapter, the majority of older adults, such as Lois, want to remain living in their own homes for as long as possible. This may be more difficult for older adults with low and middle incomes and those with houses in need of repair. Most communities offer programs that can provide economic and tangible assistance to make housing costs and repairs more affordable.

Home Equity Conversion Mortgage Programs

Older adults who own their homes can convert part of their home equity into cash while still living in their home through the Federal Housing Administration (FHA) home equity conversion mortgage (HECM) programs. Since the program began in 1988, nearly 1 million loans have been made (Perl, 2017). To be eligible for an HECM, a homeowner must be 62 years of age or older, have a very low outstanding mortgage balance or own the home free and clear, occupy the property as the principle resident, not be delinquent on any federal debt, have financial resources to continue to make timely payment of ongoing property charges (e.g., property taxes, insurance, homeowner association fees), and participate in a consumer information session given by a HUD-approved HECM counselor (U.S. Department of Housing and Urban Development [USDHUD], n.d.-b).

The amount that may be borrowed depends on the age of the youngest borrower or eligible nonborrowing spouse; current interest rate; and lesser of appraised value or the HECM FHA mortgage limit of $636,150 or the sale price. There are no restrictions on how the homeowner uses the income generated through an equity conversion program. Older adults may choose to use the income for home repairs, health care costs, or living expenses, or as a source of discretionary income. Borrowers may choose one of five payment options (USDHUD, n.d.-b):

- *tenure*, which gives the borrower equal monthly payments from the lender for as long as the borrower lives and continues to occupy the home as a principal residence
- *term*, which gives the borrower equal monthly payments for a fixed period selected by the borrower
- *line of credit*, which allows the borrower to make unscheduled withdrawals up to a maximum amount, at times and in amounts of the borrower's choosing until the entire line of credit is used
- *modified tenure*, which combines the tenure option with a line of credit
- *modified term*, which combines the term option with a line of credit

Once borrowers receive a HECM, they are obligated to occupy the home as a principle residence, make timely payments of the property taxes, maintain a home owner's hazard insurance policy, and maintain the property in a condition equal to when they secured the loan (USDHUD, n.d.-b). Borrowers do not need to repay their HECM loan until they move, sell, or die.

The HECM program loans are a very small portion of the mortgage market; about 58,000 HECMs were made in FY 2015 (Perl, 2017). The average age of HECM borrowers is 73 years. Older couples make up 41% of borrowers compared with 37% of older single women and 22% of older single men. HUD's inclusion of the age of nonborrowing spouses in calculating the amount of the loan (starting in 2014) may account for the most recent increase in couple borrowing (Perl, 2017). The primary reason given for pursuing a reverse mortgage is paying off debt.

Although not a home equity program, a *property tax relief* program allows older homeowners to defer property tax payments until they sell their homes or die. There are three types of relief programs: homestead exemptions, property tax credit programs, and property tax deferral programs (Chervin, 2007). *Homestead exemptions* are reductions in the amount of assessed property value subject to taxation for owner-occupied housing. Most homestead exemptions provide the same reduction in the assessed property value for all eligible households. *Property tax credit programs* include homestead credit programs that provide the same reductions in property taxes to all eligible households or "circuitbreaker" programs in which tax credits decrease as income increases. *Property tax deferral programs* allow older and disabled homeowners to defer payment of all or a portion of their property taxes until the sale of their property or death. The deferred taxes become a lien against the value of the home. Eligibility requirements (e.g., age, income, homeowner status—owner or renter) for the property tax relief programs differ by state. Many older homeowners who meet the eligibility criteria of property tax relief programs often are unaware of their existence and do not take advantage of the programs.

Home Repair Programs

Home repairs and maintenance are a considerable expense for many older adults because the majority of older adults have lived in their homes for more than three decades. Although older homeowners are more likely than younger homeowners to have paid off their mortgage, many of these homeowners nevertheless have high housing cost burdens. For example, 4.5% of older persons report housing inadequacies (Harrell & Houser, 2011). Specifically, 0.9% have an inadequate kitchen (e.g., lacking stove, refrigerator, or sink with faucet), 0.5% have inadequate plumbing (e.g., without hot and cold running water, a flush toilet, or bathtub/shower), and 1.2% report overcrowding (e.g., more than two people per bedroom, two or more people in a housing unit with no bedrooms). These inadequacies vary across states, with Alaska ranking first in percentage of 50+ households with inadequate kitchens (3.6%), followed by Oregon (1.9%) and Hawaii (1.6%). Alaska also has the most 50+ households with inadequate plumbing (4.5%), followed by New Mexico (1.6%) and Arizona (1.0%).

Physical housing problems are more frequent among older, frail, poor, and minority seniors. Besides needing specific repairs, many homes do not support frail older adults in conducting daily activities within the home. Older adults who are aging in place

may need to modify their homes' structure to accommodate their physical limitations. Modifications in lighting, accessibility, mobility, and bathing facilities can improve functioning and enhance safety (AARP, 2015).

With the increasing demand for assistance with housing upkeep and repairs, a number of home repair programs have emerged across the country. Home repair programs provide assistance with maintenance or minor repairs. The funding for many of these programs comes from community development block grants or Title III funds from the Older Americans Act (OAA). Programs vary with regard to the type of repairs they subsidize but typically include emergency repairs for plumbing, electricity, heat, and leaking roofs; minor repairs; exterior painting; and the removal of debris.

Two programs that help low-income adults with the costs of heating and cooling their homes are the Department of Energy's Weatherization Assistance Program (WAP) and the Low Income Home Energy Assistance Program (LIHEAP). Under WAP, any household at or below 200% of the poverty level may be eligible for services (U.S. Department of Energy [USDOE], n.d.-b). The DOE provides funds to all of the states, which contract with community action agencies, other nonprofits, and local governments to make repairs that improve the energy efficiency of low-income dwellings. The program provides energy-efficiency services to approximately 35,000 homes every year and has weatherized more than 7 million low-income homes since its inception in 1976 (USDOE, n.d.-a). Through WAP improvements and upgrades, these households save

Best Practice

Los Angeles Housing Department Handyworker Program

The Handyworker Program of the Los Angeles Housing Department provides free minor repairs to low- and moderate-income homeowners who are 62 years of age and older or physically disabled. Emergency repairs that directly affect the occupants' health and safety also are provided to other low- and moderate-income homeowners. Eligible repairs are limited to work that does not require a city building permit or formal inspection. Typical services include the following:

- emergency repairs, such as repair or replacement of broken doors and windows
- accessibility improvements for the physically challenged, such as access ramps and hand railings
- correction of safety hazards, such as repairs to porches, steps, and sidewalks
- home security improvements, such as fences, security doors, and smoke detectors
- habitability improvements, such as replacement of sinks, toilets, and floor tiles
- exterior and interior painting

For more information, contact the Handyworker Program, 213-808-8803 or 866-557-7368, http://hcidla.lacity.org/low-income-sr.

on average $283 or more annually. The average expenditure limit per home is $6,500 (USDOE, n.d.-b). In addition to reducing the utility costs for home owners, the program helps improve health and safety by reducing carbon monoxide emissions and eliminating fire hazards. Funding for the weatherization program in FY 2016 was $215 million (LIHEAP Clearinghouse, n.d.).

LIHEAP provides heating and cooling assistance to low-income families regardless of age either through vendors or to property owners for home heating and cooling costs, energy crisis intervention, or low-cost weatherization. An eligible household's income must not exceed 150% of the poverty level or 60% of the state median income (U.S. Department of Health and Human Services [USDHHS], 2017b). In FY 2014, about 33% of households receiving heating assistance and about 40% of households receiving cooling assistance had at least one member 60 years of age or older (USDHHS, 2014). There is wide variation in states' average household benefit level for various types of fuel assistance. In FY 2014, the national average LIHEAP household benefit for heating costs was $301 and $366 for combined winter and year-round crisis benefits, respectively (USDHHS, 2014). Funding allocated for LIHEAP in FY 2017 was $3.39 billion (LIHEAP Clearinghouse, n.d.).

Home Sharing

When home expense becomes burdensome, home sharing can be a viable solution to managing those expenses. Shared housing is an arrangement in which two or more unrelated individuals share a home or apartment (Kochera et al., 2005). "Tenants" often pay modest rent or provide services to the householder in exchange for room and board. For older adults with extra living space in their homes, this housing option can provide financial assistance, companionship in a familiar and comfortable setting, and help with household chores.

A study conducted by the AARP Foundation Women's Leadership Circle found that more than one third of the 1,200 women age 45 and older surveyed said they would be interested in sharing a house with friends or other women—as long as it included private space (Mahoney, 2007). The biggest incentives for home sharing among the women were financial security and companionship. An earlier AARP study reported that people age 50 and older with a household income under $50,000 were more likely to find the idea very or somewhat appealing than those with a household income of $50,000 or more (Kochera et al., 2005). Older home sharers who are economically secure and active but live alone typically are interested in having someone in their homes at night or someone who will do periodic home maintenance chores (e.g., shoveling snow) but do not expect routine daily assistance or companionship from their "boarder" (Jaffe & Howe, 1988).

There are a growing number of online home-sharing websites, workshops, and meetings for prospective housemates. About 80% of the clients of the online service Let's Share Housing (www.letssharehousing.com/) are over the age of 50, as are 55% of persons enrolled at the central Vermont in-person matching service, Home Share Now (https://homesharenow.org/; Abrahms, 2013). The National Shared Housing Resource Center (http://nationalsharedhousing.org) is a clearinghouse of information for people looking to find a shared housing organization in their community or to help get a program started. Its Match-Up Programs help home providers find a compatible home

seeker to pay rent or possibly provide services in exchange for a reduction in rent; it is not a one-on-one matching program and does not interview clients for home sharing.

Federal Housing Programs

Federal legislation has created a number of housing programs that assist older adults who have limited incomes through Section 8, Section 202, and public housing. In addition, programs under the auspices of the Rural Housing and Community Development Service offer housing assistance for older, low-income individuals living in rural areas.

Section 8

Project-Based Assistance. Under Section 8, rental subsidies are given to property owners who agree to rent to low-income individuals and families. The subsidy covers the difference between the tenants' contribution, an amount that totals 30% of their adjusted income, and fair market rents. From the inception of the Section 8 program, owners have been able to develop properties dedicated for use by elderly households. Approximately 200,455 units, or about one half of project-based Section 8 housing, are dedicated to elderly households (Perl, 2010).

Housing Choice Voucher Program. In contrast to the Section 8 project assistance component, participants in the housing choice voucher program find their own housing, including single-family homes, townhouses, and apartments. They are free to choose any housing that meets the requirements of the program (e.g., rent that is not higher than the fair market value) and are not limited to units located in subsidized housing projects. Tenants are responsible for paying 30% of their income for rent. If the rent is higher than the fair market value, the renters are responsible for the difference (USDHUD, n.d.-c). In 2016, older adults (65+) were heads of households in 24% of tenant-based Section 8 housing (Center on Budget and Policy Priorities, 2017a). The voucher program has enabled more than 1.1 million elderly or disabled individuals to afford to live independently.

Section 202

Section 202 Supportive Housing for the Elderly Program is the only federally funded housing program designed specifically for older persons. It makes low-cost federal loans to nonprofit sponsors for new construction or rehabilitation of existing structures to provide subsidized rental housing for low-income elders 62 years of age and older. Since its inception in 1959, the program has supported the creation of 262,704 residential units designated for elderly households only (Perl, 2010). Beginning in 2002, appropriations have included funding to convert a small number of projects to licensed assisted living facilities. Tenants living in Section 202 units have incomes below 50% of their area's median income. The average age of a Section 202 resident is 79, and nearly 39% of residents are over the age of 80. In 2015, the average annual household income for Section 202 households was $13,238 (Couch, 2017). Most residents are female (71%) and White (61%), and have lived in their current residence for an average of 5.5 years (Haley & Gray, 2008). The majority of Section 202 units are located in central cities (51%) or suburban areas (34%) and usually have on-site service coordinators who assess residents' needs, identify

and link residents to services, and monitor the delivery of services. In FY 2016, Congress appropriated $432.7 million for Section 202, but as in recent years (since FY 2012), no new funding was allocated for construction of new units.

Although there is nothing in the HUD guidelines governing Section 202 (and certain project-based Section 8 housing) assistance programs specifically prohibiting the exclusion of children from these developments, the housing units are typically not equipped to serve families with both elderly residents and young children. To address the growing number of grandparents raising grandchildren, Congress enacted the Living Equitably: Grandparents Aiding Children and Youth (LEGACY) Act in 2003, which provided funding for housing units in the Section 202 program for elderly residents raising grandchildren or other relatives age 19 or younger (Perl, 2010). In FY 2006, Congress appropriated $3.96 million for an Intergenerational Families Demonstration Project. In December 2008, HUD funded two projects: the Roseland Grandfamily Apartments in Chicago, consisting of 10 units, and Fiddler's Annex in Smithville, Tennessee, consisting of nine units (USDHUD, n.d.-a). Both projects opened in 2011; residents receive a range of supportive services tailored to meet the needs of seniors, children, and families as a whole (Generations United, n.d.-a). Roseland Place Grandfamily Apartments, for example, provides residents with access to recreational spaces, shared gardens, a central game/TV room, and an on-campus beauty salon (Mercy Housing, 2011; Trivedi, 2011).

Public Housing

Public housing is the oldest and largest federal housing program assisting individuals and families with low incomes, including older renters. In 1956, Congress for the first time gave preference to seniors in public housing (Milbank Memorial Fund, 2006). Throughout the 1960s and 1970s, a large number of developments were built specifically for low-income seniors. Approximately 76,000 public housing units are designated exclusively for older residents (Perl, 2010). With very few exceptions, these units are traditional apartments. In 2016, older adults (age 62+) were heads of households in 32% of public housing units (Center on Budget and Policy Priorities, 2017b).

Local public housing authorities usually operate these housing units, and renters pay rent equal to no more than 30% of their adjusted monthly income. Older residents of public housing are older, poorer, and perhaps frailer than residents of most elderly households. One third (32%) of public housing residents are White, 45% are Black, and 21% are Hispanic (National Low Income Housing Coalition, 2012). About 86% of residents in public housing have annual incomes under $20,000. Public housing tenants tend to be clustered in census tracts with high poverty rates, with Black and Hispanic residents of public housing the most likely to live in census tracts with poverty rates over 40%. Although current age-specific data are not publicly available, elderly households are likely to mirror characteristics of public housing households overall.

Many public housing communities employ on-site service coordinators who help elderly residents obtain supportive services that allow them to continue to live in place, independently, without having to move to more expensive assisted care environments (McNickle, 2007; USDHUD, n.d.-d). Service coordinators work with community service providers to tailor services to the needs of eligible residents, establish a system to monitor and evaluate service delivery and outcomes, and coordinate with other independent living programs to meet the needs of their elderly residents.

For Your Files

B'nai B'rith

B'nai B'rith is the largest Jewish sponsor of nonsectarian, federally subsidized housing for older adults in the United States. B'nai B'rith, through its Senior Citizens Housing Committee, has been involved in a cooperative partnership with HUD to make available rental apartments for low-income older adults. It has a network of 42 apartment buildings in 26 communities across the United States, which encompasses more than 4,000 apartment units serving more than 8,000 persons. Each project has a volunteer board of directors that makes sure each apartment building is responsive to its residents. Professional staff members offer support and assistance to individual apartment building boards of directors. For more information, contact B'nai B'rith at 2020 K Street NW, 7th Floor, Washington, DC 20006, 202-857-6600 or 888-388-4224, www.bnaibrith.org.

Rural Programs

Two housing programs are available to rural elders under the Rural Housing and Community Development Service program. Section 515 offers low-interest construction loans for rental and congregate housing for low-income individuals. Since it began operating in 1963, Section 515 has provided 533,473 affordable rental homes for the lowest income rural residents (Housing Assistance Council, 2011). Section 515 financed more than 38,000 units at its peak in 1979, but produced only 2,800 units in 1995, 783 in 2005, and 763 in 2011 (Housing Assistance Council, 2017). Since then, financing for new construction has stopped. The vast majority of funding now is used for repair and rehabilitation of the existing Section 515 units (National Development Council, 2017). About 40% of Section 515 tenants are older adults (U.S. Department of Agriculture, Rural Development Program, 2011). The Section 504 Rural Repair and Rehabilitation Loan and Grant Program provides loans up to $20,000 and grants up to $7,500 to low-income rural residents 62 years of age and older to repair new or existing single-family housing. This program provides funds for removing electrical and fire hazards, replacing roofing, installing or improving water and wastewater disposal systems, and installing insulation and heating and cooling systems (Housing Assistance Council, 2014).

Naturally Occurring and Planned Retirement Communities

Although the majority of older adults live in age-integrated communities, almost one third of all older adults live in a naturally occurring retirement community (NORC) in which, by most definitions, at least half of the residents are 60 years of age or older (Ormond, Black, Tilly, & Thomas, 2004). NORCs emerge through long periods as people living in the same location age in place. NORCs evolve in three ways: aged-left-behind, aging in place, and in-migration (Hunt, 1998). The first two types of NORCs are populated primarily by long-term residents—the first by residents who stayed in a community characterized by out-migration, the second by older residents who gradually became the dominant population in a stable community. The third type is distinguished

by the proportion of older residents who are new to the community. Residents aging in place in these communities may reside in an apartment type of building (i.e., vertical NORCs) or single-dwelling homes in a specific neighborhood (i.e., horizontal NORCs; Ivery & Akstein-Kahan, 2010).

Launched in 2002 with funds from Title IV of the OAA, the NORC Supportive Services Program (NORC-SSP) provides NORC building residents with a range of coordinated health and social services on site or in proximity to it. This service delivery framework is designed to assist older adults to age in place with independence, dignity, security, and quality of life (Bedney, Goldberg, & Josephson, 2010; Ivery & Akstein-Kahan, 2010). In addition, NORC-SSPs provide older adults with the opportunity to participate in the development and operation of NORC programs. Between 2002 and 2010, Congress initiated 50 NORC-SSP demonstration projects in 26 states. Findings from a 2006 survey of NORC-SSP residents from 24 communities around the country suggested that the program is an effective way of increasing socialization and reducing social isolation of residents, linking older adults with services that can help them age in place, and promoting their health and well-being (Bedney et al., 2010). Today, approximately 18 NORC-SSP demonstration projects remain in operation, supported largely by philanthropy (Vladeck & Altman, 2015). The development and sustainability of future NORC-SSP programs will require highly skilled leadership to engage and maintain a mutually productive relationship with a community and its residents, form and maintain the necessary cross-sector partnerships and collaborations, leverage resources, promote multidisciplinary teamwork, and collect and use appropriate data to inform and measure what a program does (Vladeck, & Altman, 2015, p. 21). For additional information about developing NORC programs, download the NORC Blueprint at www.norcblueprint.org.

The Senior Village Model represents an emerging consumer-driven housing and support model. The original Senior Village, the Beacon Hill Village in Boston, started in 2001 and was driven by a philosophy of interdependence and a shared sense of community (McDonough & Davitt, 2011). The "it takes a village" approach aims to enhance the independence and well-being of community-dwelling seniors through a combination of social activities, volunteer opportunities, service referral, and direct assistance (Scharlach, Graham, & Lehning, 2012). Senior Villages are not residential developments, but virtual constructs superimposed over a fairly defined geographic area (e.g., neighborhoods). There are currently more than 200 Villages and more than 150 in development in 45 states and the District of Columbia (Village to Village Network, 2018). Nationally, Villages are generally found in affluent neighborhoods with a mix of housing types (Greenfield, Scharlach, Lehning, Davitt, & Graham, 2013) and tend to attract members who are White, economically secure, and with relatively low levels of disability (Greenfield et al., 2013). A recent study found that about three fourths of the 282 respondents reported that the Village increased their ability to age in place (C. L. Graham, Scharlach, & Price, 2014). Positive impacts were associated with level of Village involvement and were less likely found among members who had worse self-reported health.

Age-restricted communities, such as Sun City in Arizona, provide housing for about 3 million persons age 55 or older, with owners and renters about evenly split (JCHS, 2014). Such communities are more common in the South and West (MetLife Mature Market Institute, 2011a). Homeowners typically choose age-restricted communities to live in because such communities are easier living, quieter neighborhoods and maintenance costs

are included in fees (National Association of Home Builders Research Center, 2002). As for community attributes, the community clubhouse, proximity to shopping, and planned social activities are the most common reasons older adults gave for moving to a planned age-restricted community. It is easy to see that most of these residences support an active lifestyle. For example, the 18,000 residents (average age of new resident is 66) of Laguna Woods Village (www.lagunawoodsvillage.com) in Orange County, California, enjoy special-interest activities including fitness, swimming, golf, tennis, arts and crafts, and two computer-learning centers, plus the opportunity to participate in the Saddleback College Emeritus class program. Facilities include seven clubhouses, five swimming pools, a performing arts center seating 814, and the community's "living" amenity, the equestrian center.

Senior Cohousing and Other Intentional Communities

Cohousing, a form of residential development designed to promote the practice of caring for neighbors as they age while retaining individual privacy, is emerging as an appealing living arrangement for older adults (Wardrip, 2010a). Although the majority of the 115 cohousing communities in the United States are multigenerational, there are at least three existing communities (and several more in the planning stages) specifically for persons age 50 and older: ElderSpirit Community in Abington, Virginia (www.elderspirit.net); Glacier Circle in Davis, California (www.calcoho.org/glaciercircle); and Silver Sage Village in Boulder, Colorado (www.silversagevillage.com). Each of these communities incorporates universal design elements and accessible common areas. Residents define their collective approach to aging in community, including the limits of co-care that they are willing to provide to one another. Residents, a high proportion of whom are never married, divorced, or childless, have identified mutual support as a driving reason to move into cohousing and have emphasized the centrality of community "fictive kin" support in their lives (A. P. Glass, 2009). Interviews with 43 residents of a cohousing community designed for moderate- to low-income residents provided a number of suggestions for the development of elder intentional communities, including bringing prospective residents together regularly while the buildings are under construction to begin to build a sense of community and to discuss expectations about the community; expect to spend about 2 years on establishing policies, procedures, and covenants for operation, particularly if most residents do not have prior cohousing experience; and make frank and open discussion of aging part of everyday life and provide events that promote such discussion (A. P. Glass, 2013).

Retirement and long-term care communities for lesbian, gay, bisexual, and transgender (LGBT) older adults are burgeoning as LGBTQ seniors and advocates have voiced concern about current housing and health care options (Adelman, Gurevitch, de Vries, & Blando, 2006; Stein, Beckerman, & Sherman, 2010). Projects such as Services and Advocacy for Gay, Lesbian and Transgender Elders (SAGE; www.sageusa.org/) are helping service professionals and LGBTQ seniors realize the possibilities for more inclusive housing options in late life. Researchers also are starting to pay greater attention to housing needs and concerns of LGBTQ older adults (e.g., Donaldson & Vacha-Haase, 2016; Furlotte, Gladstone, Cosby, & Fitzgerald, 2016; Sullivan, 2014; J. T. White & Gendron, 2016). Their findings contribute valuable new knowledge about the housing

needs, concerns, and expectations of this understudied group of elders as well as provide evidence-based information for practitioners, service providers, and policy makers.

One of the earliest LGBTQ-friendly retirement community efforts was Openhouse (http://openhouse-sf.org), established in San Francisco in 1998 to provide housing and offer a full range of care for residents of all income levels and operate as a community hub offering a variety of LGBTQ-sensitive services, programs, and events to both residents and nonresidents (Adelman et al., 2006). Although actual housing units specifically for LGBTQ seniors were not available through Openhouse until 2008, this organization has educated LGBTQ seniors about their rights and the LGBTQ-friendly policies of existing housing options.

Best Practice

Public–Private Partnerships

Some elderly residents of public and federally subsidized multifamily housing receive supportive services through partnerships between property owners and local organizations and through programs provided by USDHHS. For example, property owners can establish relationships with local nonprofit organizations, including churches, to ensure that residents have access to the services they need. At their discretion, property owners may establish relationships that give older adults access to meals, transportation, and housekeeping and personal care services. Examples of such partnerships include the following:

- In Greensboro, North Carolina, Dolan Manor, a Section 202 housing development, has established a relationship with a volunteer group from a local church. The volunteer group provides a variety of services for the residents, such as transportation.
- In Plain City, Ohio, residents of Pleasant Valley Garden, a Section 515 property, receive meals five times a week at the community's senior center (a $2.50 donation is suggested). A local hospital donates a large portion of the food, and volunteers, including residents, serve the meals. Any funds collected from the lunch go directly back into the senior center food program. The United Way, several other local businesses and organizations, private donors, and some funds from neighboring counties provide additional support for both the food program and other senior center activities.
- In Philadelphia, Pennsylvania, with the support of HUD, a public–private partnership between the Pennsylvania Housing Finance Agency, dmhFund, and Pennrose Properties formed to develop LGBT-friendly housing. The partnership between government and private entities has laid the groundwork for building a $19 million, 56-bedroom housing establishment for LGBT seniors 62 and older who earn less than 60% of the Philadelphia median income.

Sources: USDHUD (2012); U.S. Government Accountability Office (2005).

Single-Room Occupancy Hotels

Single-room occupancy hotels (SROs) are "cheap hotels and rooming houses located in areas adjacent to the downtown business districts" (Erickson & Eckert, 1977, p. 440). They can be remodeled hotels, tenements, school buildings, hotels that have always served as SROs, or newer buildings built specifically as SROs. Typically, SROs provide inner-city residents with a private room and a shared kitchen, bath, and common area. Some SROs have been built as micro-efficiency units that include a small kitchenette and a bathroom with a shower (Regnier & Culver, 1994). Services provided to tenants range from nothing to highly managed care. Sometimes, SROs offer limited security, light housekeeping, or an errand service (Rollinson, 1991a). Although perceived to be at the bottom rung of the housing ladder, SROs provide emergency, transitional, and permanent housing for single low-income persons of all ages (Regnier & Culver, 1994).

Most research on older adults living in SROs was published before the mid-1990s. In studies of SROs located in Chicago and New York, the percentage of tenants who were older adults ranged from 15% to 33%. Most of these individuals indicated not only that they were lifelong residents of the city but also that many had lived in the same neighborhood during their childhood (Crystal & Beck, 1992; Rollinson, 1991b). More recent unpublished studies of SRO residents conducted for the San Francisco Human Services Agency found older adults in SROs to be exceptionally poor and have none of the rent protections of seniors in public housing (T. Carter, 2014). Approximately 58% of residents had lived in their SRO from 4 to 21 or more years. Only half of the persons interviewed said their hotel had a consistently working elevator, and less than half reported having grab bars in their bathrooms.

In contrast to the image of the SRO tenant as primarily male and alcoholic, older adults who live in SROs represent a diverse group with regard to gender, age, health status, marital status, race, and education (T. Carter, 2014; Crystal & Beck, 1992; Rollinson, 1990). Approximately 40% of older tenants are women. The age and health profile of tenants creates a picture of an older adult, usually in his or her 70s, coping with chronic conditions such as arthritis and other musculoskeletal problems, diabetes, heart conditions, and sensory losses. Few older SRO residents reported a past or current drinking problem. Almost one half of older SRO tenants reported never being married; most others were widowed, divorced, or separated. Approximately one third of the tenants had less than a ninth-grade education, whereas almost one fourth reported that they had attended or graduated from college. Researchers also report a diverse picture with regard to the race of tenants, with 54% to 97% being White (Bild & Havingurst, 1976; Community Emergency Shelter Organizations, cited in Rollinson, 1991b; Crystal & Beck, 1992). Residents live on small incomes from Supplemental Security Income (SSI) and Social Security. The majority of older tenants reported average incomes falling below current poverty levels, with their housing costs (i.e., rent and utilities) taking up as much as half of their monthly income. For example, monthly rents at the Ellis Hotel in Los Angeles range from $180 for General Relief recipients to $240 for Social Security recipients (LA4Seniors.com, n.d.). Elderly SRO residents in San Francisco used about 60% of their $991 monthly SSI check to pay rent, which averaged $589 (T. Carter, 2014).

Researchers and service providers characterize residents of SROs as fiercely independent individuals who are protective of their autonomy and who receive little assistance from relatives, friends, or neighbors (Rollinson, 1990). Rollinson (1990) quotes

one resident, confined to a wheelchair, as saying, "Some people say, 'Can I help you do this and help you do that,' and being bullheaded as hell I tell them no, except to go to the [grocery] store" (p. 201).

Challenges for Independent Living Programs

As discussed at the outset of the chapter, the majority of older adults reside in independent living settings and desire to do so for as long as possible. Many issues need to be addressed, however, to promote independent living in the community.

Removing Barriers to Shared Housing

Several barriers can impede the use of shared housing in later life (Mantell & Gildea, 1989). The most frequently cited barrier is a lack of financial support for programs that help match older individuals with prospective housemates. Limited federal, state, or local support is available for these programs, and the clients served are often unable to pay the actual cost of providing the service. Second, restrictive zoning regulations and building and fire codes prohibit shared housing in many residential neighborhoods (Liebig, Koenig, & Pynoos, 2006). A third barrier is older adults' fear that their income from SSI, food stamps, or fuel subsidies will be reduced if regulatory agencies base decisions on the income of the household. In addition, older adults may be hesitant to share their homes with a stranger. Such attitudes, no doubt, are tied to deep-rooted values of privacy and independence.

Serving Older Adults Living in Public Housing

Several challenges have emerged for older adults living in public housing. While public housing units are adequate for the majority of low-income older residents, the units do not provide the flexibility to allow residents to age in place, nor do they necessarily provide the range of housing options needed to serve the increasing share of frail seniors. In addition, a significant portion of public housing for older adults is rapidly becoming physically and functionally obsolete. Most developments are simply not equipped to meet the residential and supportive service needs of their increasingly frail and diverse residents (Milbank Memorial Fund, 2006). Furthermore, there are lengthy waiting lists to get into public housing. In some cities, 28 older persons apply for every vacancy that occurs in newer units. The lengthy waiting lists are due in part to the lack of available units and a low turnover rate. Yet, since FY 2012, Congress has not appropriated any money for new construction. As the low turnover rate suggests, many older tenants who move into public housing stay there until they are no longer able to live independently, creating a tremendous need for supportive services to help them age in place. About one third of Section 202 properties have a service coordinator available to assess residents' needs, identify and link residents to services, and monitor the delivery of services (Waldrum, 2015). In addition, in 2004, HUD completed conversion of seven existing Section 202

housing units into assisted living facilities. This was one of the first attempts to develop an affordable continuum of care within public housing complexes for low-income seniors.

Promoting Communities for Older Adults

The future of planned retirement communities is uncertain because many of the original residents are aging in place. In addition, some older individuals who move to a planned community find that they miss interacting with children and younger adults, who typically live in traditional community neighborhoods.

Because NORCs typically emerge within traditional residential environments, health and other supportive services are not usually available in or close to the immediate neighborhood. Residents therefore must be able to seek out and obtain these services on their own. NORCs that develop within structured environments, such as an apartment complex, are likely to have some form of building management and may also have resident councils or recreation committees. How successful NORC supportive services programs are depends on how successful service providers are in establishing strong relationships with the NORC organizational structure and its residents (Bedney et al., 2010; Ormond et al., 2004).

Will cohousing options for the older adult be the wave of the future for aging baby boomers? Current developments and neighborhoods have had initial success, but their long-term growth and viability is yet to be determined. It takes a significant amount of time and work to establish such communities, and the downturn of the real estate market makes the process, particularly financing, a difficult challenge. On the resident side, not everyone is suited to consensus decision making or the responsibilities of community life. As residents of cohousing developments "age in place," members will face choices about adapting the buildings and units for safety and security, making accommodations for their oldest residents, and caring long-term for members in the community.

At the 2015 White House Conference on Aging (WHCoA), private sector leaders announced their support for age-friendly communities. The Dementia Friendly America Initiative, led by Collective Action Lab, in partnership with USAgainstAlzheimer's, the National Association of Area Agencies on Aging, and Blue Cross Blue Shield of Minnesota announced plans to support dementia-friendly communities across the country (WHCoA, 2015). Input to the WHCoA from the public collectively noted that the dimensions of age-friendly communities must include not only affordable, accessible housing and preventive health services, but also access to outdoor recreational environments, volunteer-based movements to age in place, accessible transportation, ability to enjoy good nutrition, outlets for physical activity, cognitive and behavioral health services, and participation in the arts to promote healthy aging and avoid isolation. There also was strong sentiment that inclusiveness must extend to people of diverse backgrounds, including people of color, LGBT individuals, and people with physical, intellectual, and cognitive disabilities (WHCoA, 2015).

Enhancing SROs

Although SROs offer the most vulnerable persons in society a place to live, they provide little in the way of comfort, security, or support. They often are in deteriorating condition

and poorly maintained. Faced with no other viable options for affordable or senior housing, however, many SRO residents, particularly those in the most economically and socially vulnerable groups of elders, are aging in place and in need of services such as case management, health care, and food access (D. Kelly, 2009; National Resource Center on LGBT Aging, 2011).

Many SROs in large cities such as New York, San Francisco, and Los Angeles were built before or at the turn of the 20th century (Ovrebo, Minkler, & Liljestrand, 1991). The rooms are sparse and small; most cannot easily accommodate wheelchairs. Kitchenettes often consist of a nonworking stove (Rollinson, 1990). Elevators frequently break down, leaving frail residents stranded in their rooms. Lack of adequate heating in the winter and extreme heat in the summer, steep stairs, unsteady banisters, torn tiles, holes in the wall, bedbug-infested mattresses, mold covering bathtubs, drug paraphernalia litter, and rodents are problems reported by residents (D. Kelly, 2009; Knight & Lee, 2011).

Urban renewal has eliminated many SROs (Harahan, Sanders, & Stone, 2006). The media has captured some particularly prolonged conflicts between property owners or developers and SRO tenants in New York City, where battles have raged regarding whether conversions of SROs to tourist hotels have followed legal guidelines (Kamping-Carder, 2011; Segan, 2006). Some SRO projects have moved in the direction of providing

Best Practice
Communities for a Lifetime

Communities for a Lifetime is a statewide initiative started by former Florida Governor Jeb Bush to assist Florida cities, towns, and counties in planning and implementing improvements benefiting the lives of all residents, from youth to seniors. This initiative recognizes the diverse needs of residents and the unique contributions individuals can make to their communities. Participating communities use existing resources and state technical assistance to make crucial civic improvements in such areas as housing, health care, transportation, accessibility, business partnerships, community education, efficient use of natural resources, and volunteer opportunities to the betterment of their communities. A Community for a Lifetime values individuals of all ages and engages communities in a process of continuous self-assessment and improvement. Through this process, communities enhance opportunities for people to age in place, or continue living in their own communities for a lifetime, while also benefiting people of all ages. Once a community commits to creating a Community for a Lifetime, they assemble a team of community partners to gather information about the opportunities, programs, and services that are available to older adults. The information is used by community planners to develop work plan strategies for incorporating universal design for housing accessibility, health care, transportation, and efficient use of natural resources. More than 100 Florida cities, towns, and counties had committed themselves to creating a better place for older adults to live, providing all residents with the opportunity to achieve their full potential and contribute to the betterment of their communities. For more information, visit www.mnlifetimecommunities.org/.

better supports for older residents rather than pushing them out. For example, Project Hotel Alert in Los Angeles received funds from the city aging department to offer older SRO residents a wide range of services including case management, information and referral, transportation, meals, and medical screening; one SRO was even renovated with wheelchair-accessible bathrooms through this initiative (Harahan et al., 2006).

Although SROs are fraught with serious problems, they provide housing to a group of older persons who are at risk of being homeless. However, the SRO as a housing option for low-income older persons is diminishing. Since the 1970s, the number of SRO units has rapidly declined. An estimated 1.1 million SRO units were eliminated from 1970 to 1980 (Hooper & Hamberg, 1986). The major forces behind the loss of SROs include downtown revitalization, gentrification, and lack of funding to rehabilitate deteriorating buildings (Ovrebo et al., 1991). This loss of housing represents a serious problem for older SRO residents, many of whom reported that they did not know what they would do if they had to move.

Supportive Living Environments

Supportive living environments are designed to help older adults who are self-sufficient and are capable of self-care to some extent, but who need some assistance with ADLs. Generally, supportive environments provide older adults with varying degrees of assistance and oversight.

Accessory Dwelling Units

Accessory dwelling units (ADUs) are residential units that provide independent living facilities for one or more persons, with designated areas for cooking and sanitation, plus space for living, sleeping, and eating (Antoninetti, 2008; Liebig et al., 2006). Between 65,000 and 300,000 units are created legally each year (Cobb & Dvorak, 2000); the number of annually built illegal ADUs (e.g., home additions or garage conversions completed without permits) is estimated at between 60,000 and 300,000 units nationwide. Depending on their location relative to the primary dwelling unit, ADUs are categorized as interior units, attached units, or detached units (USDHUD, 2008). Regardless of type, ADUs contribute to a community's housing supply and provide an affordable housing option for many low- and middle-income older adults.

Elder Cottage Housing Opportunity (ECHO) housing units (also known as *granny flats* or *garden suites*) are small, self-contained, movable housing units located next to the home of a family member. The units also may fit into the space of an attached garage or be connected directly to the main house. They have their own electrical system, temperature controls, and plumbing. Meters can be attached to the unit to keep utility costs separate from the main house. Configurations of the units vary; most have a living room, kitchen, bedroom, and bath. ECHO senior housing units can cost far less to purchase or lease than traditional homes—companies in California and Pennsylvania offer 500-square-foot one-bedroom units, completely installed, for around $25,000 (Senior Living, 2017). In other areas, ECHO senior housing may cost more, but leasing a unit could be an option. Once no longer needed, the units are removed.

To create an accessory apartment, families remodel an existing room or basement into a living area in which a frail older adult can live. An accessory cottage, also known as *guest cottage* or *carriage house*, is a permanent separate structure placed on the same parcel or lot as the single-family dwelling. Garage or barn apartments are similar to accessory cottages because they are not part of the primary dwelling; the latter is more popular in rural areas (Liebig et al., 2006). As with ECHO housing, accessory apartments and cottages provide the same benefits of privacy and support, although the construction is more permanent.

Both ECHO housing and accessory apartments/cottages allow older adults to live with or near their families. They offer families a way to assist older family members yet allow privacy and independent living. Other benefits include lower living costs, increased intergenerational interaction, a possible delay of institutionalization, and enhanced quality of life. For example, in comparison with older adults on a waiting list for a cottage, residents of elder cottages reported significantly greater satisfaction with their housing, increased independence, more telephone contacts with friends and family, improved relationships with family members living in the main house, and less formal service use (Altus, Xaverius, Mathews, & Kosloski, 2002). However, zoning requirements, policy barriers, and low consumer acceptance have severely limited the growth of ADUs in the United States (Coppage, 2017; Koebel, Beamish, & Danielson, 2003; Wardrip, 2010b).

Congregate Housing

Although public housing often is referred to as *congregate housing*, many congregate facilities are privately owned. Most congregate housing facilities have separate apartments for each resident plus common, shared areas for meals and recreation, including "congregate dining, social lounges, laundry facilities, recreation spaces, and a secure barrier free environment" (Heumann, 1990, p. 46; Monk & Kaye, 1991). These facilities provide services in a residential setting for persons who can no longer independently manage the tasks of everyday living. The typical on-site staff includes a building manager, janitorial services, and a social/activity organizer. Medical personnel are not usually on site in a congregate facility.

Residents in congregate housing receive at least one major group meal per day and have the option of receiving assistance with additional meals, housekeeping, personal care, transportation, and other support services if needed. Residents typically have some limitation that precludes independent living but that does not require continuous medical or nursing care or full-time personal care.

Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs) provide a full range of housing options for retired adults, from independent living through nursing home care. There are more than 1,950 CCRCs in all 50 states and the District of Columbia with more than 745,000 residents (CCRCs, n.d.; U.S. Senate Special Committee on Aging, 2010). Pennsylvania, Ohio, California, Illinois, Florida, Texas, Kansas, Indiana, Iowa, and North Carolina have the largest number of CCRCs. Eighty-two percent of CCRCs are nonprofit, and approximately one half of are affiliated with faith-based organizations. The majority

of CCRCs are part of a multisite system, with the typical CCRC having fewer than 300 units (Zarem, 2010).

CCRCs offer incoming residents a contract that remains in effect for the balance of their lifetime. There are three basic types of CCRC agreements (Zarem, 2010).

A *life-care*, *extensive*, or *all-inclusive contract* includes shelter, residential services, and amenities, as well as long-term nursing care for little or no substantial increase in monthly payments, except for normal operating costs and inflation. They provide for the prepayment of medical expenses, similar to an insurance arrangement. About 54% of CCRCs offer extensive/all-inclusive contracts (L. A. Bowers, 2017).

A *modified contract* also includes shelter, residential services, and amenities, but offers only a specified amount of long-term nursing care for little or no substantial increase in monthly payments, except for normal operating costs and inflation adjustments. After using the specified amount of nursing care, residents pay either partial or full per-diem rates for the care they require. About 35% of CCRCs offer modified agreements (L. A. Bowers, 2017).

A *fee-for-service contract* includes shelter, residential services, amenities, and emergency and infirmary nursing care, but does not include any discounted health care or assisted living services. Residents receive priority or guaranteed admission for these services, as needed, but must pay full per-diem rates. About 53% of CCRCs offer fee-for-service agreements (L. A. Bowers, 2017).

Basic continuing care agreements typically require a lump-sum entrance fee, paid on moving into the community, and monthly payments thereafter. Still other CCRCs have periodic fee-only agreements where there is no entry fee and the costs of the living unit, service, and care are covered solely by a monthly fee. Rental CCRC contracts, like the fee-for-service, entrance-fee contract, include no coverage for the cost of assisted living or nursing services, but offer the resident the lowest level of upfront expense (Zarem, 2010). Least common are CCRCs with equity agreements that involve the actual purchase of real estate or membership; service and health care package transactions are generally separate from the purchase transaction.

Entry fees and monthly fees vary greatly from one CCRC to another. Entrance fees can range from about $20,000 to more than $500,000 (AARP, n.d.); nationally, the average CCRC entrance fee in 2010 was $248,000. The majority of CCRCs offer some type of entrance-fee refund. Refundable entrance-fee contracts may include a declining-scale feature where the refund declines over time, a partial refund, or a full refund. Many CCRCs offer contracts that refund a specific percentage of the entrance fee (e.g., 50%, 75%, 90%, 100%) regardless of the length of residency (Zarem, 2010).

As one might expect from the high entry fees, which make CCRCs the most expensive of all long-term care options, CCRCs typically attract an affluent older population. In addition to required entrance fees, residents pay monthly charges that may range from $3,000 to $5,000 (AARP, n.d.). The typical CCRC resident is a White, widowed woman in her mid-80s (Zarem, 2010). They tend to have higher incomes and educational attainments than the general population of older adults. Krout, Moen, Holmes, Oggins, and Bowen (2002) found that a decline in the health of one's spouse or in one's own health

and freedom from the burden of home maintenance were motivating factors for those who recently moved to a nonprofit CCRC designed for people older than age 65 in good physical and mental health. Enticing features of the CCRC included the quality of the management of the facility; the size, design, and choice of units; climate; and location near cultural activities.

Attitudes toward CCRCs have changed since the emergence of this type of retirement housing in the 1960s. Current and future generations of older adults are looking for retirement communities where they can enjoy an active life, rather than simply shopping for quality health care they hope never to need (High, 2000). CCRCs have responded by adding new housing, health care, and amenities options to their current structures. Examples include fitness centers, casual dining programs, business centers, computer labs, putting greens, expanded libraries, and indoor pool/fitness complexes.

Assisted Living

Assisted living has emerged as a popular choice for people who need supportive and health-related services and help with unscheduled ADLs. According to a 2013 study, there are 30,200 assisted living facilities accommodating about 1 million residents in the United States (National Center for Assisted Living, 2018a). Although definitions of assisted living vary across states, the term is generally defined as a residential setting that provides or coordinates personal care services, 24-hour supervision, scheduled and unscheduled assistance, social activities, and some health-related services. These settings may include personal care boarding homes with additional services, residential care units owned by and adjacent to nursing homes, congregate housing settings that have added services, purpose-built assisted living programs, or the middle level of CCRCs. Ownership of these facilities may be either nonprofit or for-profit (Wright, 2004).

The average assisted living community has 33 units (National Center for Assisted Living, 2018a). Whereas studios used to be the most common type of assisted living apartment, one-bedroom units are now more preferable as they allow residents to keep more of their furniture and personal belongings. Most facilities offer private occupancy units with at least full bathrooms, kitchenettes with refrigerators and cooking capacity, and lockable doors; three meals a day in a group dining room; general housekeeping and maintenance services; personal care according to individual needs; on-site delivery or coordination of nursing, health, and social services; and supervision and oversight for persons with cognitive limitations. Facilities use fewer medical staff than nonmedical staff, and the majority of facilities contract services from a variety of consultants, ranging from beauticians to physicians (Wright, 2004).

In 2017, the median private-pay annual rate for a private, one-bed room with a private bath in an assisted living facility was $45,000, with the median monthly rent of $3,750 (Genworth Financial, 2017). Most facilities charge higher rates for added services. Most of the rates, even at the high end, are substantially less than nursing home care for private-paying residents. Insurance companies are increasingly allowing holders of long-term care policies to use their benefits for assisted living if the services are cost-effective. Public payment for assisted living includes supplemental payments to the facility for services for SSI clients; reimbursement by Medicaid, Medicaid waiver, or state long-term care programs; or some combination of these sources.

According to the National Center for Assisted Living (2018b), the typical assisted living resident is a woman over the age of 75 who is mobile but needs assistance with two activities of daily living such as bathing (62%), dressing (47%), or toileting (39%). About 87% of residents also need help with meal preparation, and 81% need help managing their medications. Residents come to assisted living facilities from a variety of settings, including a private home or apartment (70%), a retirement or independent living community (9%), a nursing facility (9%), a family residence (such as living with adult children; 7%), or another assisted living residence or group home (5%; National Center for Assisted Living, 2012). Most facilities admit and retain residents with a variety of disabling conditions and physical health care needs, but few residents typically need moderate or heavy care. The average length of stay of residency in an assisted living facility is about 28 months. Sixty percent of residents will move into a nursing care facility (National Center for Assisted Living, 2018b), 33% will pass away, and the remainder will move home or to another location (National Center for Assisted Living, 2012).

Personal Care Boarding Homes

Board-and-care homes are "non-medical community-based living arrangements that provide shelter (room), board (food), and 24-hour supervision or protective oversight and personal care services to residents" (Hawes, Wildfire, & Lux, 1993, p. 3). The names used to identify board-and-care homes, and the nature of the homes, vary considerably. Small homes may provide for as few as two residents, whereas some institutions may designate all or a large percentage of their beds for board-and-care residents. All states license board-and-care homes, although licensing requirements differ. The variability of the names used to classify board-and-care homes makes it difficult to get an exact count of the number of these facilities nationwide. Unlicensed homes include facilities excluded from mandatory licensure because of size or service criteria established by the state in which they operate as well as homes that meet a state's criteria for obtaining an operating license but avoid securing one.

We know little about the characteristics of board-and-care residents except that persons seeking this type of housing alternative are likely to need some supervision and personal care. Most residents are physically or cognitively frail and at risk for further health and functional declines (Hopp, 1999; L. A. Morgan, Gruber-Baldini, & Magaziner, 2001; M. E. Quinn, Hohnson, Andress, McGinnis, & Ramesh, 1999). Compared with larger facilities, smaller board-and-care homes (five to six residents) have a higher proportion of Black residents, residents with lower incomes and educational levels, and residents with higher physical dependency and cognitive impairments (Carder, Morgan, & Eckert, 2006).

The cost of living in a board-and-care residence is modest compared with other assisted living or nursing home options, but can vary widely depending on its location, the size of living space, the amount of privacy, and the amenities provided. Price can range from several hundred dollars a month to several thousand (Katz, 2009). Some residents rely on assistance from federal and state programs to pay at least part of the cost of living in a board-and-care home. For example, the monthly check of an SSI recipient may go toward the payment of the home's charges. Most states also provide some form of additional payment to supplement an older person's SSI payment. In some states, payment for board-and-care homes comes from Medicaid waiver program funds, block grants, or county funds.

Across the Globe

Old-Age Homes

In India, old-age homes are available for older adults who are unable to stay with their families or who are poor and have very few resources. These homes are either government supported or funded by human service organizations and strive to create a family-like atmosphere for the residents. Although the quality and range of services available through the more than 1,000 government-run homes vary considerably, they may provide free accommodations, special medical facilities, mobile health care systems, nursing care, well-balanced meals, access to communication services, and yoga classes. HelpAge India assists the government in addressing the increasing need for age-friendly housing for poor older adults who have no family support by building integrated housing and care facilities. This organization is working to transform old-age homes into "composite shelters which go beyond providing simply a roof and meeting the basic needs of the elderly," envisioning residential complexes for elders offering a broader range of services and comfort.

Source: HelpAge (2017).

Foster Care

Adult foster care (AFC) "serves people who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in the community and who need and desire the support and security of family living" (U.S. Department of Health, Education, and Welfare, 1964, p. 2). Foster care includes support services, supervision, and personal care provided by a private host family or an individual who takes in a small number of older adults and encourages them to participate in the lives of the family and in the community (Sherman & Newman, 1988). Foster care homes operate under a social care model in contrast to the medical model of nursing homes. Individuals needing only supervision and assistance, but not continuous medical attention, can benefit from foster care. Elders generally go into foster care because they do not have family who can take care of them or because their family is unable or unwilling to provide daily care.

Research on foster care for older adults is scant. The landmark study by Sherman and Newman (1988) provided an extensive examination of three populations of foster care residents: residents with mental illness, residents with intellectual disabilities, and frail elders. The elder residents in foster care are likely to have one of three histories: They may have been in foster care for many years, they may have been residents of institutions (e.g., a psychiatric hospital) for many years and only recently been placed in foster care, or they may recently have been placed with a foster family from the community. Many elders in foster care remain with their foster family until their death. Others leave AFC for a more specialized care center, such as a nursing home, psychiatric hospital, or residence for persons with intellectual disabilities. In Carder et al.'s (2006) comparison of small care facilities for older adults, they describe Oregon's adult foster care program, which began in the early 1980s. The program requires that facilities provide residents

with three meals daily, assistance with personal care, assessment, and care planning. Oregon uses the Medicaid 1915(c) waiver to help finance adult foster care and requires training of both managers and staff, including successful completion of a competency examination. Surveys of residents and family members suggest the family-like, home-style setting and the interpersonal relationship between the resident and the provider heavily influenced ratings of satisfaction and quality of care.

In 2008, the AARP Public Policy Institute conducted a national survey of state AFC regulations or standards, focused on homes that provided care to older adults and adults with physical disabilities (Mollica et al., 2009). States reported that 18,901 licensed and certified facilities were operating, with a capacity to serve 64,189 residents. AFC falls into three categories: (1) single-home, owner-occupied "mom and pop" residences—a person or household has become an AFC provider for a small number of residents; (2) corporate chains—a company, for-profit or nonprofit, owns or rents the property and is responsible for all business operations, and services are delivered by staff who live on site; and (3) agency-sponsored homes—the home owner/operator is in residence but relies on an agency for referrals, training, oversight, and some business functions. Family-owned and -operated homes are the dominant provider type. AFC homes provide a range of services, including social activities, assistance with personal care and money management, transportation, housekeeping services, and oversight of or help with medications. States tend to require that providers have sufficient staff available to provide 24-hour supervision and to meet the needs of residents.

A qualitative study of the experiences of 26 adult foster care providers in North Carolina found that providers were completely committed to their work, which often included widely diversified responsibilities such as hands-on care work, resident and staff recruitment, resident intake, staff training, financial and resident paperwork, and physical maintenance of the facility (Munly, 2015). Providers expressed an enthusiasm for making their homes thrive and related great satisfaction in the activities, progress, and well-being of their residents. They viewed their residents as individuals deserving of empathy, family, opportunity for choice, and a good quality of life. The providers integrated residents into their AFC homes and surrounding communities by including residents in the family-like environments of the facilities, including their own biological family's activities. The providers' success with running their businesses allowed the family-like quality of their AFC home to be viable and sustainable.

In 1999, the Department of Veterans Affairs (VA) began implementing a Medical Foster Home (MFH) program designed for veterans with disabling chronic disease or terminal illness who need assistance and supervision, and who are no longer able to live safely at home because of functional, cognitive, or psychiatric impairments and have no caregiver able to meet their needs. Foster care providers take dependent veterans into their private homes and serve as MFH caregivers, providing daily supervision and personal assistance. The VA's home-based primary care staff members provide comprehensive medical care, management, and caregiver education support for the providers. Placements are coordinated through the VA, which also inspects and approves the homes and offers supplemental training for caregivers. Veterans are responsible for paying the cost of Medical Foster Home room and board. Typical rates range from $1,500 to $3,000 per month. About one half of VA medical centers have MFH programs; the long-term goal is for each VA medical center to have an MFH program (VeteranAid.org, 2015).

Best Practice

Mary Sandoe House

The Mary Sandoe House assisted living project in Boulder, Colorado, has been operational since 1988. Its multiple sponsors include the City of Boulder Housing Authority, the Boulder County Community Action Program, the Boulder Gray Panthers Service Project, and an interfaith housing group. Funding for the project was leveraged through the Community Development Block Grant program, Colorado Housing and Finance Authority low-interest loans, and local fundraising. Juniper Partners provides day-to-day oversight of management and conducts board development training and technical assistance.

A small project built in an existing neighborhood, Mary Sandoe House accommodates elders in 24 private bedrooms adjacent to shared living and dining areas. Many of the residents have mobility limitations because of a stroke or arthritis, and some suffer from mild dementia. A unique aspect of Mary Sandoe House is that for private pay residents, all services are included in a flat fee of $4,000 a month. Support services include some bathing assistance, supervision of medications, personal laundry, social activities, and arrangements for special transit. Rooms are also available for Medicaid-eligible residents.

Two words sum up the underlying philosophy that influenced the design of the house and continues to influence its day-to-day management: good neighbor. Residents of Mary Sandoe House are part of the community. Neighbors attend outdoor barbecues, and neighbor children are encouraged to visit the residents. Typical residential activities, such as tending a garden, picking up the mail, and socializing on the patio, are part of the daily routine of the residents. Persons associated with Mary Sandoe House believe it has been successful, in part because many sectors of the community—public and private—were committed to the concept of a small residential program that could blend in with the day-to-day activities of an existing neighborhood.

For more information, contact Mary Sandoe House, 1244 Gillaspie Drive, Boulder, CO 80305, 303-494-7317, www.themarysandoehouse.com.

Long-Term Care Facilities

At the most dependent end of the housing continuum are long-term care facilities, known more commonly as nursing homes. In 2014, 2.6% of Americans 65 years of age and older were nursing home residents. By contrast, 9.5% of individuals 85 and older resided in a nursing home in the same year (Centers for Medicare and Medicaid Services [CMS], 2015b). Although the population of nursing home residents continues to become more ethnically diverse and the proportion of male nursing home residents is rising, the typical nursing home resident is still female, non-Hispanic White, not married, over the age of 75, and in need of assistance with several activities of daily living because of severe physical or cognitive limitations (CMS, 2015b). In 2017, the median annual cost for a private room was $97,455 and $85,775 for a semiprivate room in a nursing home, with the median monthly cost of $8,121 and $7,148, respectively (Genworth Financial, 2017). Given the unique role of nursing homes in the continuum of care, and the broad range of issues to consider, we discuss them separately in Chapter 19.

Challenges for Supportive Living Environments

Supportive living environments make it possible for many frail elders to continue living in the community. A wide range of supportive living options, including long-term care facilities, is needed to address the physical, psychological, and social needs of older adults. Exhibit 15.3 displays a summary of the different housing options discussed in this chapter and the level of assistance appropriate in each option. We now turn to

Exhibit 15.3 Spectrum of Housing Options

Housing Option	Little or No Assistance	Moderate Assistance	Cannot Perform Without Assistance
Single-family dwelling			
Public housing			
Naturally occurring retirement communities			
House sharing			
Home with			
Home repair			
Home equity conversion			
Low-income energy assistance			
Congregate housing			
ECHO housing accessory apartments			
Home with			
Delivered meals			
Homemaker			
Home health aide			
Telephone reassurance			
Visiting programs			
Home with adult day services			
Assisted living/personal care			
Boarding homes			
Foster care			
Long-term care facilities			
Continuing care retirement communities			

Source: Adapted from AARP (1985).

the concerns that will need to be addressed in the future regarding supportive living arrangements for older adults.

Removing Barriers

Although ADUs promise many benefits, there are several barriers facing elders and their families interested in this housing option. In some jurisdictions, zoning laws prohibit the addition of such units, and neighbors often are concerned about ADUs becoming permanent rentals, thereby changing the neighborhoods from single-family to multifamily dwellings and negatively impacting property values, parking, and community services (Cobb & Dvorak, 2000; Liebig et al., 2006). In addition, few manufacturers of ECHO housing exist, limiting the purchasing opportunities for families who are looking for solutions for immediate care needs. A viable alternative may be a mobile version of an ADU used in Canada, Homecare Suite, which can quickly be installed in a garage space (Chapman & Howe, 2001).

Enhancing Services

Almost all the research shows cost savings with congregate housing compared with long-term care facilities. Congregate housing, however, relies on the availability of community-provided services to assist residents in meeting their care needs. Where such services are not readily available, staff at the congregate facility must carefully monitor residents and coordinate their care to appropriately support the residents' independence. Although older adults may prefer to "age in place" with assistance from community programs, the successful linking of housing with services requires a competent, stable, and committed workforce, the absence of which currently plagues the long-term care system (R. Stone, 2006).

Protecting Residents

In the mid-1980s, reform advocates called for increased regulation among CCRCs to protect elderly consumers (Saunders, 1997). In an effort to prevent strong government involvement in the industry and maintain security for older adults without the negative side effects of regulation, CCRCs formed their own regulating agency, the Continuing Care Accreditation Commission (CCAC). Acquired by the Commission on Accreditation of Rehabilitation Facilities (CARF) in 2003, CARF-CCAC has adopted basic standards that cover critical areas such as the organization's governance structure, financial status, and quality of services provided to residents. To qualify for accreditation, CCRCs must perform self-evaluations that focus on these aspects of operation as well as undergo inspections from CARF-CCAC; CCRCs go through recertification every 5 years. CARF-CCAC accredits approximately 15% of the CCRC market (S. Matthiesen, personal communication, December 15, 2011).

In the past, the financial stability of the CCRC industry was a serious concern, resulting from a number of bankruptcies among various CCRCs. Today, fears are alleviated somewhat as the industry has gained more experience in management and as regulation has taken hold in many states (Saunders, 1997). However, concern over possible bankruptcy, particularly during economic turndowns, still exists (U.S. Senate Special

Committee on Aging, 2010). Opinions on exactly how much of a threat financial failure is vary among those monitoring the industry.

Although there are federal laws that impact assisted living, oversight of assisted living occurs primarily at the state level. The varying laws and regulations affecting these settings have created a diverse and fluid operating environment for providers and a mix of terminology, settings, and available services for consumers (National Center for Assisted Living, 2006). States vary significantly in their licensing requirements, quality standards, and monitoring and enforcement activities to help ensure quality care of residents (L. A. Morgan et al., 2011).

States face a variety of issues in deciding whether and how to regulate board-and-care settings, including resources, affordability, local culture, quality standards, and consumer demand (Carder et al., 2006). Some states require a license for every residential setting that houses people who need personal care or supervision; most states require licensure only if the home actually provides such services or advertises that it provides care and supervision. Licensure requirements also may depend on the size of the facility and the number of persons receiving care. The content of the licensure standards also varies from state to state, as do minimum staffing levels and training requirements. Needless to say, evaluating the quality of board-and-care homes is an ongoing challenge.

Enhancing Opportunities for Foster Care Residents

Adult foster care will be most successful if older adults understand how the setting and services operate and if they are good matches with the provider (Mollica et al., 2009). More consumer education is needed to inform older adults about the potential of foster care as a viable housing option. In addition, there is a need for more research to characterize older adult foster care residents and assess the benefits and challenges of living in this type of housing environment.

Developing Housing Options for Marginalized Older Adults

The issues and needs of the aging LGBTQ population is gaining attention in the gerontology research (Herdt & de Vries, 2004). Housing and supportive services is a critical issue, as older LGBTs often find that they must conceal their sexual identity when they begin to require supportive services (Brotman, Ryan, & Cormier, 2003). De Vries (2006) describes several housing communities designed to openly address the needs of this growing population of elders. For example, Rainbow Vision, located in Santa Fe, New Mexico (www.rainbowvisionsantafe.com/), is said to be the first retirement and care community developed specifically for LGBTQ older adults. It offers a range of options from condominiums for purchase to independent living in leased residences to assisted living with access to health care and supportive services.

Expanding Housing Options for Older Adults

In closing, although older adults have a myriad of options regarding their living arrangements, problems in housing availability and affordability continue to exist. As baby

boomers age, the tension between the issues of person–environment fit will become apparent for many more older adults, and a variety of housing options and programs will continue to be in demand. At the 2015 White House Conference on Aging, the U.S. Department of Housing and Urban Development announced the release of a guide to help older homeowners, families, and caregivers make changes to their homes so that older adults can remain safe and independent in housing they can afford. In addition, the U.S. Department of Housing and Urban Development confirmed that its Equal Access rule applies to all HUD-assisted and HUD-insured multifamily housing, including Section 202 Supportive Housing for the Elderly, and that such housing be made available without regard to actual or perceived sexual orientation, gender identity, or marital status.

Case Study

Finding a New Home

Ellen, an active 77-year-old widow, had resided in a triplex rental for 8 years. Ellen was happy with her living arrangement and said that she planned to "live here the rest of my life." An outgoing person, she became well acquainted with her neighbors and enjoyed the convenient location of her home. She spent many hours out of doors tending her roses and helping with other yard duties voluntarily. Because she had established herself as an excellent renter, the owner considered Ellen's fixed income of $1,000 per month and in 8 years had increased her rent by only $75, bringing it to $350 per month. She could cover her living expenses and enjoy recreational activities at a local senior center.

In 1994, the owner notified Ellen that he had turned over his property to his daughter and that she would raise the rent to $700 per month. Ellen reported that "the rent increase devastated" her and that for days she "cried at the drop of a hat" because she had no idea what she was going to do. Ellen did not want to depend on her two children, who lived nearby. She wanted to be independent. If she found another rental, the same thing could happen to her again. Where would she find affordable rent now that this midsized community was growing rapidly and rentals were in great demand?

Ultimately, a friend advised her to contact the manager of a small mobile home park in a nearby community of 7,500. Ellen knew nothing about mobile homes and was skeptical but open-minded. She had heard that the manager was "very strict" about whom he accepted into the park. Initially, the manager told her that nothing was available. As the conversation progressed, Ellen won him over with her pleasing personality. He offered that she could look at one unit that was available. Ellen was more than impressed with the well-kept home that was for sale by an older couple.

Her next problem was financial. Her banker advised her to use a certificate of deposit of $35,000, her entire savings, for collateral. This would more than cover the full cost of the mobile home at $28,000 and generate enough interest to pay the interest of the loan. The lot fee was $175 per month and included water and trash rates. Ellen pays on the principal each month in an amount that varies depending on her monthly finances. Ellen has settled into her two-bedroom mobile home with an attached garage and "more storage space" than she has "ever had." Her children like her new home and visit often. Ellen's grandson says, "Grandma, you do not live in a mobile home, you live in a home." Ellen tells her

friends, "I love it. I have never been happier in my life. Please, God, don't do anything to my little house."

Case Study Questions

1. Citing research, explain Ellen's emotional reaction to having to move from her apartment home of many years.
2. What factors does Ellen have working in her favor in this situation? What circumstances could be working against her?
3. Ellen has advanced arthritis in her hips and knees. What bearing does this condition have on her future housing choices?
4. On the basis of the person–environment fit model, what housing options would be appropriate for Ellen? Why?
5. Where might Ellen go to find out more about housing options in her community?

LEARNING ACTIVITIES

1. Investigate the housing opportunities available for older adults in your community. What types of services, if any, are offered? Do the residents reflect what you have learned about senior housing in this chapter?
2. Interview someone from the public housing authority. What does the person see as the primary challenges for providing housing for older adults? What policy changes are needed to address these challenges?
3. Conduct a review of recent housing legislation (federal, state, and local) that deals with housing for older adults. What is the focus of legislation or policy? What are its strengths and weaknesses?
4. Interview older residents who reside in a public or residential housing facility. What do they like about the facility? What are their primary concerns? What do they like about living in an age-specific environment? What don't they like about it? What do you perceive to be the advantages and disadvantages for residents living there? Would you encourage a family member to live in age-specific housing? Would you consider it as an alternative for yourself?

FOR MORE INFORMATION

International Resources

1. **World Health Organization Global Network of Age-Friendly Cities:** www.who.int/ageing/age_friendly_cities_network/en/index.html

   This online network is designed to support a common global understanding of "age-friendly" city. The goals of the network are to provide technical support and training, link cities to the WHO and each other, facilitate the exchange of information and best practices, and ensure that interventions taken to improve the lives of older people are appropriate, sustainable, and cost-effective.

2. ***Changing Housing Schemes for an Ageing Society: Emerging Issues and Design Solutions*** (Biocca & Morini, 2011):

www.cnr.it/istituti/Allegato_101439.pdf?LO=01000000d9c8b7a6090000000c000000dcb50000da809c530000000001000000000000000000000000000000000000000000000000000000000000000000000000000000000000000&type=application/pdf

This paper, from the 23rd European Network for Housing Research Conference in Toulouse, France, examines relevant trends and future consideration in the European Union regarding housing for aging populations.

3. ***Lifetime Homes, Lifetime Neighborhoods: A National Strategy for an Ageing Society:*** www.cpa.org.uk/cpa/lifetimehomes.pdf

   The United Kingdom was the first country in the world to set out a national strategy to address comprehensively the unique housing needs of an aging society. This report outlines the country's plans "for making sure that there is enough appropriate housing available in the future to relieve the forecasted unsustainable pressures on homes, health and social care services."

4. **Guide to Seniors Housing in Canada:** www.aplaceformom.com/canada/canada-seniors-housing-guide

   Our friends up north have put together a great page that explains all the types of living accommodations available to older adults. Take a look at the different housing options available for older adults in Canada.

National Resources

1. **National Resource Center on Supportive Housing and Home Modification, Andrus Gerontology Center,** 3715 McClintock Avenue, University of Southern California, Los Angeles, CA 90089-0191, 213-740-5156, www.homemods.org/directory/nrcshhm/index.htm, homemods@usc.edu

   The purpose of the Center is to promote supportive housing that encourages healthy, independent living. The Center conducts applied research, evaluation and policy analysis, training and education, policy updates, and national teleconferences. It also provides reports, guidebooks, newsletters, and fact sheets to make available objective information about housing.

2. **The Cohousing Association of the United States (Coho/US),** 4710 16th Street, Boulder, CO 80304, www.cohousing.org/aging

   In 2017, Coho/US created the Aging in Cohousing initiative to support the creation of age-friendly cohousing communities in the United States, both multigenerational and senior only. Its goal is to empower cohousing communities to create physical and social environments that allow people to flourish as they get older.

3. **Argentum,** 1650 King Street, Suite 602, Alexandria, VA 22314-2747, 703-894-1805, www.argentum.org/

   This is the largest national association exclusively dedicated to professionally operated assisted living communities for seniors. Argentum's member-driven programs promote business and operational excellence through national conferences, research, publications, and executive networks. Argentum works to influence public policy by advocating for informed choice, quality care, and accessibility for all Americans seeking assistance with long-term care. It produces numerous publications and reports on the business of assisted living, including its flagship magazine, *Senior Living Executive*.

4. **LeadingAge,** 2519 Connecticut Avenue NW, Washington, DC 20008, 202-783-2242, www.leadingage.org/

   This national association (formerly the American Association of Homes and Services for the Aging) represents 6,000 nonprofit nursing homes, continuing care retirement communities, assisted living residences, senior

housing facilities, and community service organizations for older adults. This group also sponsors the Continuing Care Accreditation Commission, which accredits continuing care retirement communities. Free information on long-term care and housing for older adults is available on its website, along with links that explore different housing options.

5. ***Journal of Housing for the Elderly***, Taylor & Francis, www.tandfonline.com/loi/wjhe20

   This journal covers the latest efforts of housing researchers and policy experts—from research on energy conservation and privacy needs to policy implications of home equity conversion. It also examines management issues, housing-related service delivery innovations, case histories of successful housing alternatives, and financing strategies.

Web Resources

1. **U.S. Department of Housing and Urban Development (HUD):** www.hud.gov

   This is the place to start to look for information about housing policies or programs. Visitors can search HUD's database and gain access to housing reports, program information, and a variety of housing data. The site also has consumer information about housing.

2. **SeniorHousingNet:** www.seniorhousingnet.com/

   SeniorHousingNet provides senior living listings and resources. On its website you can find a range of community options from active living apartments to nursing homes. Search for senior living and senior care by simply typing in a location and selecting the types of care of interest to access community descriptions, photos and floor plans, and information about pricing, amenities, and features.

3. **Mature Market Resource Center:** www.seniorprograms.com

   The Mature Market Resource Center has two web-based organizations. First, the Association of Marketing and Sales Executives in Senior Housing is a web-based national membership organization dedicated exclusively to the needs of marketing, sales, and communications executives in senior housing. Second, the National Association of Senior Health Professionals is a web-based membership organization specifically designed to address the unique needs and special interests of professionals in the rapidly growing field of senior health.

4. **Center for Excellence in Assisted Living (CEAL):** www.theceal.org/

   CEAL's website provides information about assisted living including research findings and outcomes, best practices, consumer materials, training and education materials, and links to other relevant websites.

5. **Consumer Consortium on Assisted Living (CCAL):** www.ccal.org

   CCAL is the only national consumer education and advocacy organization focused on the needs, rights, and protection of assisted living consumers and their caregivers. CCAL educates consumers, trains professionals, and advocates for assisted living issues.

6. **Center for Housing Policy:** www.nhc.org/

   The Center for Housing Policy is the research affiliate of the National Housing Conference (NHC), an organization dedicated to ensuring that all Americans have access to safe, decent, and affordable housing. In partnership with NHC and its members, the Center combines research with practical expertise to broaden understanding of the nation's housing challenges and to examine the impact of policies and programs developed to address these needs.