# Healthy Aging Begins at Home

*May 2016*

BIPARTISAN POLICY CENTER

## SENIOR HEALTH AND HOUSING TASK FORCE

The Bipartisan Policy Center formed the Senior Health and Housing Task Force to underscore the synergies between health care and housing in fostering improved health outcomes, cost savings, and enhanced quality of life for America's aging population.


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# *Letter from the Task Force*

America stands on the cusp of a major expansion of its senior population, a circumstance that will impose unprecedented strains on the nation's fiscal health as well as its health care and housing systems. Despite the high stakes, public policy has failed to keep pace, underestimating the profound nature of the demographic transformation now underway. As a result, the United States is dramatically unprepared for the challenges that lie just ahead.

By 2030, 74 million Americans, representing more than 20 percent of the overall population, will be 65 years of age or more. Those 85 and above constitute the nation's fastest-growing demographic group. Unfortunately, absent a comprehensive and sustained national response, the well-being and safety of millions of older Americans will be jeopardized by the following realities:

- The current supply of housing that is affordable to the nation's lowest-income seniors is woefully inadequate. As more low-income Americans enter the senior ranks, this supply shortage — *currently measured in millions of units* — will become even more acute.

- The overwhelming majority of seniors say they wish to "age in place" in their own homes and communities. Yet most homes and communities lack the structural features and support services that can make living there independently a safe, realistic option.

- About 70 percent of adults over 65 will eventually require help with bathing, food preparation, dressing, and medication management—assistance that is referred to as "long-term services and supports," or LTSS. Medicare does not cover LTSS, though the costs of this care can consume a large portion of a household's budget. In addition, only a small minority of Americans has long-term care insurance covering these expenses.

- Personal savings are a critical source of retirement funding, but for millions of seniors these savings will fall far short of what is necessary to pay for housing, modifications to make homes safer, LTSS, health care, and other retirement needs.

The Bipartisan Policy Center established the Senior Health and Housing Task Force to draw public attention to these very serious concerns and to offer some solutions. A key premise of this report is that a greater integration of America's health care and housing systems will be absolutely essential to help manage chronic disease, improve health outcomes for seniors, and enable millions of Americans to age successfully in their own homes and communities. A growing body of evidence is also showing that more tightly linking health care with the home can reduce the costs borne by the health care system.

We offer this report with humility and gratitude. We are heartened by the thousands of health care and housing providers across the country who each day enhance the lives of America's oldest citizens. Their work is an inspiration to us.

Over the past year, we have been witness to many success stories: housing providers who made integrating supportive services with the home a central focus of their mission. Health care providers who understood the importance of the home as a site for care and service delivery. Local communities who deployed the power of technology to help seniors remain connected to their neighbors and friends. It is time to scale up these efforts so they become truly national in scope.

Without such a national commitment, one that involves not just the government but the private sector and philanthropic community as well, far too many Americans will likely find their retirement years to be ones of increasing stress and instability. It is our hope that this report, modest in its scope but large in its ambitions, will help provide the spark for this effort.

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# *Executive Summary and Recommendations*

In its 2013 report, *Housing America's Future: New Directions for National Policy*, the Bipartisan Policy Center Housing Commission identified meeting the needs of the rapidly increasing number of older Americans as a "new frontier in housing." The work of the Senior Health and Housing Task Force grows out of the Housing Commission's examination of this issue. The Task Force has also benefited from the insights of other BPC projects: the Long-Term Care Financing Initiative, the Prevention Initiative, the Health Innovation Initiative, and the Commission on Retirement Security and Personal Savings.[1]

Over the next 15 years, the explosive growth of the nation's senior population will present unprecedented challenges. Unfortunately, millions of Americans will find they lack enough savings to fund their retirements. Some will struggle to afford their housing, while others will find their housing is ill-suited for living independently. Many will eventually need help with the "activities of daily living," like eating, bathing, and dressing, assistance that can be both costly and taxing on other family members. Most older Americans will suffer from at least one chronic condition.

A successful response will require a much higher level of focus and preparation than exists today in the United States. Experimentation and innovation, as well as a willingness to move beyond established conventions, are essential elements of this process. An ability to see important connections that span across the seemingly disparate disciplines of housing, architecture, health care, information technology, telecommunications, transportation, urban planning, and financial services is critical. Communities across the country

must make meeting the needs of their older residents a priority consideration as they plan for the future. This work must proceed apace with the urgency it deserves.

This report examines four specific aspects of the challenge before us:

- The need for a much greater supply of homes affordable to our nation's lowest-income seniors.
- The importance of transforming homes and communities so that seniors can age with options, a desire shared by the overwhelming majority of older adults.
- The imperative to better integrate health care and supportive services with housing, recognizing that this integration has the potential to improve health outcomes for seniors and reduce the costs borne by the health care system.
- The need to deploy technologies on a far wider scale to help all Americans age successfully.

The recommendations outlined below are a call to action by a variety of actors — the Congress, members of the administration, public officials serving in state and local governments, the private sector, and leaders in the nonprofit and philanthropic communities.

The Task Force recognizes that several of its recommendations propose additional public spending. Nevertheless, the Task Force believes this additional spending is a necessary and worthwhile investment in the health and well-being of America's seniors. Other Task Force recommendations offer the potential to generate savings in health care costs. Achieving the full benefits of the recommendations, including a long-term reduction in federal and state health care expenditures, remains a priority of the Task Force.

## *Health Begins at Home: The Overriding Need for More Affordable Supply*

Monthly mortgage payments — along with property taxes, utility payments, and the cost of home maintenance and upkeep — can be major strains on the budgets of senior households. In fact, for many seniors, housing-related costs constitute their biggest household expenditures.

A major factor contributing to high housing costs is the scarcity of affordable and available rental homes. This supply-demand imbalance most negatively impacts lower-income households, many of whom are older adults living on fixed incomes. In 2013, there were 11.2 million "extremely low-income" renter households competing for only 4.3 million affordable and available rental homes, resulting in a total shortfall of 6.9 million homes. Of the 11.2 million households in this competition, 2.6 million were elderly households with no children. Unfortunately, the current shortage of affordable rental homes will intensify in the years ahead as the low-income senior population grows and more seniors transition from homeownership to rental housing.

The following recommendations aim to provide the foundation for a comprehensive national effort to increase the supply of affordable homes for our nation's oldest citizens. Such an effort must begin with making the prevention and ending of senior homelessness a major national priority. Greater federal investment in the Low-Income Housing Tax Credit will also be necessary, as will the establishment of a new senior-supportive housing program. Federal regulatory policies must work to encourage, not stymie, the production and preservation of new affordable homes. A much broader engagement of the private and nonprofit sectors will also be necessary. And states and communities across the country must be committed to adopting land-use policies that promote a range of affordable housing options for their seniors.

## Recommendations

1. Preventing and ending homelessness among older adults should become a major national priority. The U.S. Interagency Council on Homelessness should explicitly adopt a goal to prevent and end homelessness among older adults.

2. Congress and the administration should work together to fund federal rental-assistance programs at adequate levels, particularly since these programs will serve increasingly larger numbers of low-income seniors.

3. Congress and the administration should support continued funding at adequate levels for rental assistance and for service coordination under the Section 202 Supportive Housing for the Elderly program.

4. Congress and the administration should create and fund a new program for senior-supportive housing that uses project-based rental assistance and Low-Income Housing Tax Credits to support new construction and attract funding for services from health care programs.

5. Congress should support the preservation of existing Section 202 units by making them eligible for the Rental Assistance Demonstration program.

6. Congress and the administration should identify ways to more effectively support the service coordination needs of senior housing providers, particularly mission-oriented nonprofits.

7. Congress and the administration should substantially increase federal support for the Low-Income Housing Tax Credit (LIHTC) program to help finance the production and preservation of additional units of affordable rental housing, including affordable homes for low-income seniors.

8. The states should use their National Housing Trust Fund allocations and the U.S. Treasury Department should use the Capital Magnet Fund to support the production and preservation of affordable housing for the nation's lowest-income seniors.

9. States and local communities should consider adopting permissive land-use policies that allow for and encourage alternative housing structures for seniors, such as accessory dwelling units, micro-units, and congregate/group homes. States and local communities should also undertake a comprehensive examination of their existing policies to ensure they promote a range of affordable housing options for their seniors.

10. The Office of Management and Budget should convene an interagency task force that assesses the impact of federal laws and regulations on the production and preservation of new affordable housing, particularly for seniors, and identify ways these laws and regulations can be modified to reduce costs and increase production.

## *Aging with Options: Transforming Our Homes and Communities*

According to a 2014 AARP survey, 88 percent of senior households strongly or somewhat agree that they would like to stay in their current residences as long as possible, while 89 percent strongly or somewhat agree they would like to remain in their community as long as possible.[2] If these preferences continue to hold, there will likely be a growing mismatch between the desire of seniors to age in place in their own homes or communities and their ability to do so.

A big hurdle will be household finances: Over the next 20 years, nearly 40 percent of individuals over the age of 62 are projected to have financial assets of $25,000 or less; 20 percent of those over 62 will have $5,000 or less. For many, this level of savings will be woefully inadequate to cover the expenses of daily living, never mind finance long-term services and supports or the modifications necessary to make living independently at home safe and secure.

In light of these difficult conditions, new solutions will be necessary — solutions that expand the range of housing options and that accommodate a variety of needs and preferences as individuals age. The following recommendations offer ideas that can help seniors age with options in their existing homes and communities and ensure the

needs of seniors are prioritized in community decision making. These recommendations call for better planning and improved data on the needs of existing and future senior households, as well as the availability of housing options to meet those needs. Increased coordination across government agencies will be necessary. So, too, will be greater transparency about existing government programs that can benefit senior households and help spur greater private investment.

### Recommendations

1. Congress should authorize a new Modification Assistance Initiative (MAI) that would work on an interagency basis to coordinate federal resources available for home modifications to support aging with options.
2. The U.S. Department of Housing and Urban Development (HUD) should maintain protections and counseling services for the Home Equity Conversion Mortgage insured loan program and consider new products that assist borrowers in safely accessing home equity.
3. Congress should modernize the U.S. Department of Agriculture's (USDA) Section 504 housing repair program.
4. States and municipalities should establish and expand programs to assist low-income seniors with home modifications through property tax credits, grants, or forgivable loans.
5. States should protect and expand property tax circuit breaker programs and other forms of property tax relief that are targeted to assist low- and moderate-income senior taxpayers.
6. Congress should reauthorize and fund the Community Innovations for Aging in Place (CIAIP) initiative to assess community living models for possible replication in low- to moderate-income communities.
7. HUD should update its Consolidated Plan to require states and local jurisdictions to more explicitly assess the housing needs of seniors and the availability of age-friendly housing and community services.
8. The federal agencies involved in the Interagency Transportation Coordinating Council on Access and Mobility should develop a one-call/one-click platform for door-to-door transportation services for older adults.
9. HUD, in partnership with the American Planning Association, should develop a model senior zoning ordinance that local jurisdictions across the United States could adopt.
10. A wide range of professionals and organizations in the health care and housing fields should establish a work group to develop a suitability-rating scale for age-friendly housing and communities.

## *Integrating Health Care and Supportive Services with Housing*

One of the most important public health findings over the last two decades has been that there are a number of factors, beyond medical care, that influence health status and contribute to premature mortality. Of these factors, social circumstances and the physical environment (particularly the home, whether a single-family home or an apartment) impact an individual's health. Housing takes on even greater importance for older Americans, since they spend a significant portion of their days in this setting. The home is also increasingly being seen as a potential site of care for seniors to receive health and wellness services and as an essential tool in chronic care management.

By virtue of the rapid expansion of the senior population, more and more Americans will be living with multiple chronic conditions and experiencing limitations in activities of daily living. Models and interventions that deliver health care and other services to seniors with these conditions in their own homes have the potential to improve health outcomes and reduce health care utilization and costs. In addition, a greater focus on preventing falls has a

tremendous upside: Approximately one in three older adults fall annually, resulting in about 2.5 million emergency-department visits, 700,000 hospitalizations, and approximately $34 billion in health care costs. Falls are the leading cause of injury-related deaths in older adults, and most falls occur in the home setting.

Today, there are several important policy opportunities to help accelerate the integration between health care and housing. Each involves key actors in the nation's health care system: public and private insurers, health care professionals, and hospitals. The following recommendations are designed to help capture these opportunities.

### Recommendations

1. The Centers for Medicare and Medicaid Services (CMS) should launch an initiative that coordinates health care and long-term services and supports (LTSS) for Medicare beneficiaries living in publicly assisted housing to test the potential of improving health outcomes of a vulnerable population and reducing health care costs.
2. Congress should consider expanding the Independence at Home Demonstration program into a permanent, nationwide program to maintain optimal health status and to reduce health care costs of frail, medically complex Medicare beneficiaries.
3. The administration should ensure Medicare and other federal programs and policies support substantially reducing the number of older adult falls and their associated financial impacts.
4. CMS should incorporate housing-related questions in health risk assessments used by Medicare providers and Medicare Advantage plans.
5. Congress and the administration should work together to extend the Money Follows the Person Program to support state efforts to rebalance their Medicaid long-term care systems.
6. Medicaid should collect data on state coverage of housing-related activities and services and, where possible, track its impact on beneficiary health outcomes and health costs.
7. Hospitals should incorporate questions about housing as part of their discharge planning to prevent hospital readmissions, and nonprofit hospitals, specifically, should include housing in their triennial IRS-required community health needs assessment.

## *The Power of Technology to Support Successful Aging*

Older adults and their caregivers can benefit considerably from the use of existing and emerging health care technologies, including "telehealth" and remote patient monitoring services, easy access to information contained in their electronic health records, and tools that assist with medication management. Other technologies may help older adults age in place. They include fall monitoring systems, home-based activity monitoring to address cognitive impairments, speech-equipped or visually oriented "smart devices" to support sensory impairments, and social-networking applications to help with loneliness and depression.

Despite growing interest in these technologies, a number of barriers continue to stand in the way of higher levels of adoption. These barriers include high costs for innovators and consumers, lack of reimbursement, interstate licensing requirements, limited Internet access (particularly in rural areas and among low-income Americans), and continued concerns about the privacy and security of sensitive health information. There are also other barriers that prevent effective use of technologies by older adults, including: paying for devices on a fixed income, forgetting or losing the technology, low ease of use, physical challenges, skepticism about benefits, and difficulty learning to use new technologies.

In the coming years, the federal government, state governments, and the private sector must ramp up their efforts to remove the barriers that prevent widespread adoption of increasingly important health technologies. The following recommendations are designed to help further this objective.

## Recommendations

1. CMS and the states should encourage greater reimbursement of telehealth and other technologies that have the potential to improve health outcomes and reduce costs.

2. Congress, the administration, and the states should work together to make broadband (with sufficient speed to use online education and training programs) available to as many HUD, U.S. Department of Agriculture, and LIHTC properties where low-income seniors reside, including in rural communities, as possible.

3. Relevant federal agencies should work with the scientific research community and the private sector to demonstrate the benefits of home Internet access for very low-income seniors and the effectiveness of health technologies.

# *Task Force Priority Recommendations*

The Task Force has identified the following recommendations as its highest priorities in light of their great potential to improve the lives of America's seniors and their positive prospects for implementation:

**Preventing and ending homelessness among older adults should become a major national priority. The U.S. Interagency Council on Homelessness should explicitly adopt a goal to prevent and end homelessness among older adults**. According to the Homelessness Research Institute, the number of homeless seniors will rise from 44,000 in 2010 to nearly 59,000 in 2020 if shelter and poverty rates remain constant. The United States should not accept a situation in which so many of its older citizens live on the streets without adequate shelter and appropriate care.

**Congress and the administration should substantially increase federal support for the LIHTC program to help finance the production and preservation of additional units of affordable rental housing, including affordable homes for low-income seniors.** The LIHTC is the nation's most effective "supply-side" affordable housing program that leverages private capital to help finance the preservation and new construction of affordable rental homes. Many states provide preferences and set-asides in their annual LIHTC qualified allocation plans for projects that serve older adults.

**Congress and the administration should support continued funding at adequate levels for rental assistance and for service coordination under the Section 202 Supportive Housing for the Elderly program and also create and fund a new program for senior-supportive housing.** HUD's Section 202 program is the only federal rental assistance program designed explicitly to serve seniors, yet there has been no funding for new construction under the program since fiscal year 2011. The Task Force proposes a new program for senior-supportive housing that uses project-based rental assistance and the LIHTC to support new construction and attract funding from health care programs.

**Congress should authorize a new Modification Assistance Initiative (MAI) that would work on an interagency basis to coordinate federal resources available for home modifications to support aging with options.** Numerous programs within the federal government provide resources and expertise for home assessments and modifications, yet there is little coordination among these programs and public awareness of them is limited. The MAI, administered by the Administration for Community Living within the U.S. Department of Health and Human Services, would aim to rectify these shortcomings.

**States and municipalities should establish and expand programs to assist low-income seniors with home modifications through property tax credits, grants, or forgivable loans, and states should also protect and expand property tax circuit-breaker programs and other forms of property tax relief that are targeted to assist low- and moderate-income senior taxpayers.** Currently, 80 percent of home modifications and retrofits for aging are paid out of pocket by residents. States and municipalities can help relieve some of this burden by making funding available to both individuals (homeowners and landlords) and contractors for expenses incurred acquiring or modifying a property for accessible use.

**CMS should launch an initiative that coordinates health care and LTSS for Medicare beneficiaries living in publicly assisted housing to test the potential of improving health outcomes of a vulnerable population and reducing health care costs.** Approximately 1.3 million older adult renters live in publicly-assisted housing, the vast majority of whom are dually eligible for the Medicare and Medicaid programs. Health care providers, in partnership with housing entities, should implement evidence-

based care models and programs to improve outcomes and reduce costs for these beneficiaries. This proposal would address the "wrong-pocket problem" by ensuring the health care system bears the cost of implementing a program from which it can potentially benefit.

**The administration should ensure Medicare and other federal programs and policies support substantially reducing the number of older adult falls and their associated financial impacts.** Approximately one in three older adults falls annually, resulting in about $34 billion in health care costs. Falls are the leading cause of injury-related deaths for older adults, and most falls occur in the home setting.

**CMS and the states should encourage greater reimbursement of telehealth and other technologies that have the potential to improve health outcomes and reduce costs.** In 2014, reimbursements for telehealth accounted for less than $14 million out of the more than $600 billion spent through the Medicare program.

# Chapter 1. Introduction: Bridging the Health-Housing Divide: A National Imperative

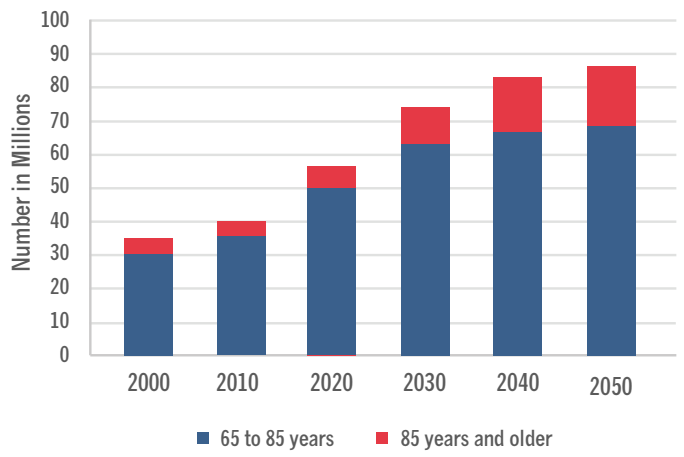
The United States is in the midst of a profound demographic transformation the likes of which we have never seen before. The nation is collectively growing older. Millions of Americans are also living further into their senior years without suffering from a debilitating disease, enjoying what experts call a "longevity dividend," the propitious result of better nutrition, technological advancements, and safety improvements.

Each day, approximately 10,000 baby boomers, the 78 million Americans born between 1946 and 1964, turn age 65.[3] By 2030, the number of older adults in the United States is projected to exceed 74 million, nearly doubling the senior population in a mere 20 years (see: Figure 1-1).[4] Seniors are also expected to constitute an increasingly larger share of the overall U.S. population, accounting for more than one in five Americans by 2030.[5] By contrast, fewer than one in ten Americans were seniors not too ago, in 1970. In addition, individuals over the age of 85 constitute the fastest-growing age group in the United States.[6]

*Each day, approximately 10,000 baby boomers, the 78 million Americans born between 1946 and 1964, turn age 65.*

Further, the aging population is not evenly distributed across the country. In certain regions, the population of older adults is increasing at a faster rate than in others. For example, the Central Midwest, West, and many Southern states have a larger share of counties where the 65-and-over population is at least 20 percent of the overall population.[7] About 15 percent of residents

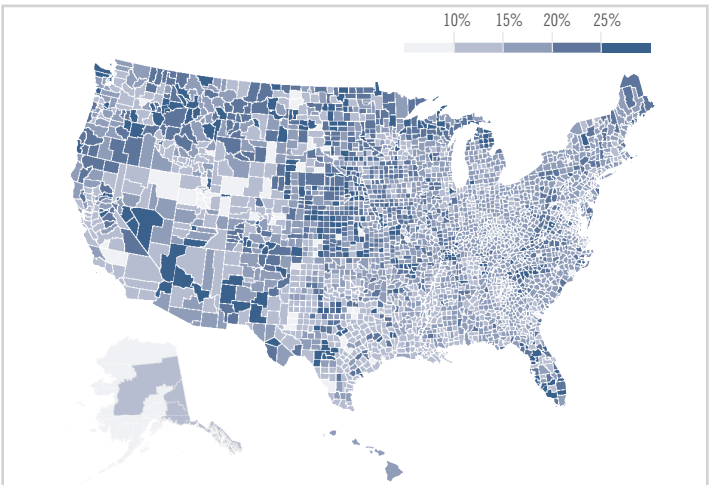
**Figure 1-1. Population Projections by Age Group**




Source: U.S. Census Bureau.

**Figure 1-2. Counties with the Largest/Smallest Share of Seniors**

*Percent of County Population Ages 65+*




Source: Pew Research Center tabulation of U.S. Census Bureau 2014 Population Estimates.

in nonmetropolitan regions are 65 or older, compared with 12 percent in urban areas.[8] Among those over 65, poverty rates run higher outside metropolitan counties. Approximately 9 percent of metropolitan residents aged 65 or older are below the poverty level, compared with 13 percent of nonmetropolitan senior residents.[9]

The aging of America will present tremendous challenges that will affect virtually every sector of society; it will place added pressure on already strained household and public budgets. But with these challenges also comes a great opportunity: *the chance to enhance the quality of life for all Americans, regardless of age, who stand to benefit from a healthier and more engaged senior population.*

The first order of business is seeking a greater integration of the health care and housing systems, an essential step if the nation is to ensure that limited federal dollars are wisely spent and seniors are effectively served. Rather than operating in isolation, those working in the housing and health care fields must move out of their separate silos and find ways to foster greater collaboration. This collaborative approach must become the rule rather than the exception it is today. After all, housing is widely recognized as a leading determinant of physical and mental well-being, while the home can serve as a vital platform for the delivery of health care and other critical services. Seniors spend a significant amount of time in the home setting, and health is an issue foremost on their minds.

The fiscal impact that growing numbers of older Americans will have on Social Security and our major federal health care programs, Medicare and Medicaid, is well known. With so many baby boomers entering retirement, spending for Social Security is projected to increase relative to the size of the economy — from 4.9 percent of GDP in 2015 to 6.2 percent of GDP in 2040.[11] On average, Medicare enrollment is expected to rise by 1.6 million annually, leading to a total of nearly 81 million beneficiaries by 2030.[12] The Congressional Budget Office projects federal outlays for Medicaid will rise from $350 billion in 2015 to $642 billion in 2026.[13]

Far less appreciated than these trends is the alarming scarcity of housing that is safe, affordable, and physically suitable for older adults, particularly those with the least financial resources. Absent a comprehensive and sustained effort to increase the supply of these homes, the situation will likely worsen as the senior population expands. Millions of older adults understand all too well that their health and well-being depend as much on their housing as they do on their health insurance and monthly Social Security check.

The upside of a more integrated approach to senior health and housing is significant: *by more tightly linking the two, the United States has the potential to improve health outcomes for older adults, reduce costs borne by the health care system, and*

***The home can serve as a vital platform for the delivery of health care and other critical services.***

*enable millions of Americans to "age in place" in their own homes and communities.*

Important work is currently underway proving the validity of this proposition. Stewards of Affordable Housing for the Future, a network of 11 nonprofit organizations that support and provide affordable rental housing for low-income older adults, and its members have pioneered how housing providers can work effectively with the health care system, including with accountable care organizations and managed care entities. Vermont's Senior Services at Home program, run by housing provider Cathedral Square, is demonstrating how housing — when combined with supportive services for seniors — can slow the rate of growth of Medicare spending.[14] And CAPABLE, short for "Community Aging in Place, Advancing Better Living for Elders," is a federally funded trial at John Hopkins University that brings together a nurse, occupational therapist, and handyman for tailored home interventions. The CAPABLE model is already showing it can make a positive difference in the health of at-risk seniors, helping them avoid hospitalization and nursing home stays, with the potential to save taxpayers millions of dollars.[15]

Contributing to the growing evidence base is a recent study by the Center for Outcomes Research and Education, which found that Medicaid-covered residents who moved into one of 145 different affordable housing properties in Portland, Oregon, used more primary care, had fewer emergency department visits, and accumulated lower medical expenditures. According to the study, the availability of integrated health services to housing residents was a key driver behind lower costs and fewer emergency department visits.[16]

The challenge America faces today is one of scale. The United States needs to dramatically "up its game," building upon the strong foundation that has already been laid. Bridging the senior health-housing divide must not remain the province of just a few enlightened health care and housing providers. Instead, it is a national imperative that must draw broadly upon the resources and intellectual capital of all sectors of society — the private sector, government at all levels, and the philanthropic and nonprofit communities. In the years ahead, fulfilling this imperative will grow even more important as millions of seniors seek and demand choices in how and where they age.

## *Aging with Options*

As noted by the Bipartisan Policy Center Housing Commission, a substantial majority of seniors have a desire to "age in place," defined as the "ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level."[17] As they age, many seniors understandably hope to remain close to family and friends and to maintain the social connections that have enriched their lives. Unfortunately, this desire runs into a harsh reality: many homes and communities lack the structural features and support services to make living there independently a safe and viable option. In fact, one study estimates that just 3.8 percent of housing units in the United States are suitable for individuals with moderate mobility difficulties.[18]

With rising numbers of seniors, ensuring that more of the nation's homes are suitable for living independently must become a major national priority. Five "universal design" elements can help make homes safer for seniors: no-step entries; single-floor living, eliminating the need to use stairs; switches and outlets accessible at any height; extra-wide hallways and doors to accommodate walkers and wheelchairs; and lever-style door and faucet handles. However, according to Harvard's Joint Center for Housing Studies, only 57 percent of existing homes have more than one of these features.[19] The percentage of homes with these universal design features also varies by geographic region, with homes in the Northeast least likely to include them (see: Figure 1-3).

At the federal level, there are numerous programs that can help

**Figure 1-3. Geographic Differences in Accessible Housing**

| | SHARE OF UNITS WITH ACCESSIBILITY FEATURE (PERCENT) | | | | |
|---|---|---|---|---|---|
| | NO-STEP ENTRY | SINGLE-FLOOR LIVING | EXTRA-WIDE HALLWAYS & DOORS | ACCESSIBLE ELECTRICAL CONTROLS | LEVER-STYLE HANDLES ON DOORS & FAUCETS |
| REGION | | | | | |
| NORTHEAST | 31.2 | 56.8 | 7.3 | 37 | 6.5 |
| MIDWEST | 32.4 | 72.5 | 8.2 | 49.2 | 8.6 |
| SOUTH | 48.5 | 84 | 7.8 | 41.8 | 6.9 |
| WEST | 49.5 | 80.9 | 8.3 | 48.7 | 12 |
| METRO AREA STATUS | | | | | |
| CENTRAL CITY | 39 | 74 | 6.6 | 40.5 | 7.1 |
| SUBURB | 46.2 | 72 | 8.1 | 45.8 | 9.7 |
| NON-METRO | 37.4 | 86.3 | 9.1 | 45 | 7.1 |
| **TOTAL** | **42.1** | **76.1** | **7.9** | **44.1** | **8.3** |

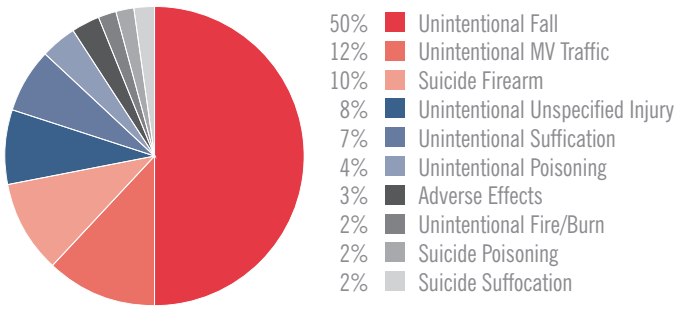
Note: Single-floor living units have both a bedroom and a bath on the entry level. Source: Adapted from Harvard Joint Center for Housing Studies, Housing America's Older Adults: Meeting the Needs of an Aging Population. JCHS tabulations of US Department of Housing and Urban Development, 2011 American Housing Survey.

older adults age in place by supporting home retrofits and other modifications, but there is little coordination among agencies to maximize the effectiveness and reach of these programs. Some states and cities offer loans, grants, and tax benefits to help seniors with their home modifications. These efforts should be encouraged and more widely adopted. As explained later in this report, new sensor-based technologies also hold great promise in enabling seniors to live independently.

Making homes safer for seniors can pay substantial dividends: falls are the leading cause of injury-related deaths for those 65 and older (see: Figure 1-4) and result in annual medical costs of $34 billion. Most falls occur in and around the home and are preventable.

Communities, too, must aim to adopt age-friendly strategies that optimize the ability of seniors to participate fully in civic life. That means accessible transportation systems, streets that are well

**Figure 1-4. Ten Leading Causes of Injury Deaths, Age 65+, United States, 2014**




Source: Centers for Disease Control and Prevention.

*Just 3.8 percent of housing units in the United States are suitable for individuals with moderate mobility difficulties.*

maintained and well lit, an abundance of affordable housing that is close to retail stores, services, and opportunities for social activities. In addition, access to healthy food markets and public parks and recreation facilities are important for healthy aging. A number of these community elements are measured as part of the AARP Livability Index.[20] The Index is a tool for communities seeking to understand how they might improve upon certain quality-of-life indicators as well as how they compare with other neighborhoods across the country.

While taking these steps will be critical, we must also recognize that aging in place is neither a realistic option for every senior nor is it possible or cost-effective to modify every home to enable living independently. In addition, it may be the case that living alone, socially isolated, in a single-family home is not the most appropriate or healthiest living situation, particularly for a frail senior. America needs a broader perspective: the aspiration should be to help seniors not just to age in place but to age with options.

What does this mean? For a moderate-income senior couple, aging with options may mean the opportunity to move out of their single-family home while still healthy and independent and into a multifamily apartment building within their neighborhood, one that is conveniently located near a recreational center, shops, and medical offices and that boasts universal design features. For a lower-income senior with some disabling conditions, aging with options may mean having access to affordable housing with supportive services and not being forced to enter a nursing home or other institution simply because the demand for affordable housing far exceeds the available supply in one's community.

## Some Hard Truths

The 74 million Americans who will be 65 or older in 2030 will be an incredibly heterogeneous group. They will be more racially and ethnically diverse than at any time in the nation's history. As is the case today, they will have very different professional backgrounds and family situations and suffer from a range of health conditions. Financial insecurity will be a concern for millions, while others will have sufficient funds to comfortably finance their retirements. In addition, the physical and financial needs of a senior at 65 can be very different when that same individual reaches the age of 75 or 85.

Providing such a diverse group of seniors with more housing options as they age is admittedly a very ambitious goal, one that will be complicated by a number of hard truths. These truths represent major challenges, but at the same time, the challenges also present important opportunities.

*The aspiration should be to help seniors not just to age in place but to age with options.*

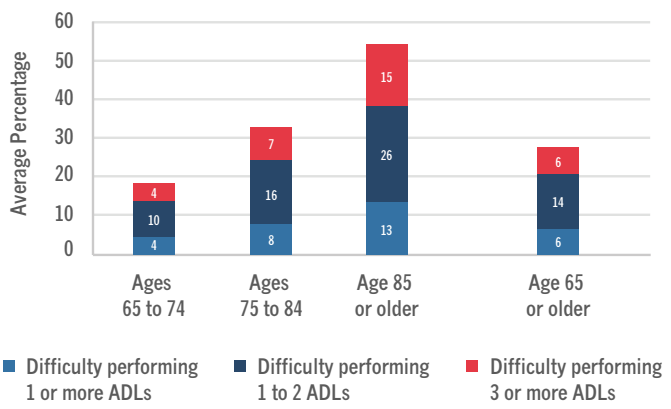
### 1. The growing population of older adults will create a proportionally higher demand for expensive long term services and supports (LTSS).

LTSS refers to a range of clinical health and social services that assist individuals with activities of daily living such as bathing, dressing, cleaning, and taking medications. About 70 percent of adults over 65 will need LTSS at some point in their lifetimes, with

## The Senior Population Will Grow Increasingly Diverse

Over the next four decades, the United States will become more racially and ethnically diverse. The U.S. Census Bureau estimates that minorities will constitute 39.1 percent of the population aged 65 and above by 2050, nearly a doubling of the 20.7 percent share that was recorded in 2012.[21] A big part of this diversity story will be the explosive growth in the number of Hispanic seniors. The U.S. Census Bureau projects that the number of Hispanics aged 65 and over will grow from 3.1 million in 2012 to 15.4 million in 2050, an increase of about 500 percent. In 2050, Hispanics will constitute 18.4 percent of the 65-plus population, up from 7.3 percent in 2012.[22] As they age, older Hispanics as well as Asian-Americans are more likely than members of other ethnic and racial groups to live with relatives.[22]

**Figure 1-5. Functional Limitation Among Seniors Living in the Community, 2000 - 2010 (ADLs and IADLs)**




Note: Activities of Daily Living (ADLs) include bathing, dressing, eating, walking, transferring out of bed or a chair, and using the toilet. Instrumental Activities of Daily Living (IADLs) include preparing meals, shopping, using the telephone, managing money, and taking medications. Source: Congressional Budget Office.

this need intensifying by the time an individual reaches the age of 85 (see: Figure 1-5). LTSS can be provided in nursing homes or other institutional settings, and importantly, through home- and community-based services.

With rising numbers of older adults, spending on LTSS is expected to increase from 1.3 percent of GDP in 2010 to 3 percent of GDP in 2050.[24] Today, these costs are financed in a variety of ways. Individuals and their families pay for about 53 percent of their total LTSS expenditures out of pocket. The states and the federal government pay for about 34 percent of total LTSS expenditures through the Medicaid program. Other public programs, such as benefits available to veterans, cover about 10 percent of total LTSS expenditures, while private long-term care insurance accounts for less than 3 percent. A significant number of individuals receive unpaid LTSS from caregivers who are family members or friends. This unpaid care has an estimated annual value of $470 billion.[25]

While many people who engage in caregiving consider it rewarding, caregiving can also take a toll on the physical and mental health of the caregiver and result in missed time at work.

Under Medicaid, states must provide nursing home care and other in-patient facility care to eligible individuals who need LTSS; however, coverage for services received at home or in the community varies significantly by state. Medicare largely does not cover these services today, making the provision of LTSS for a loved one a significant expense for many moderate-income families who are not eligible for Medicaid. Some of these families gradually "spend down" their personal or retirement savings and eventually qualify for LTSS under Medicaid, thereby increasing pressure on state and federal budgets.

In 2014, the average annual cost for community-based adult day care averaged $16,900 per year,[26] while the annual cost for a home health aide was approximately $45,800.[27] Nursing facility care averaged approximately $87,600 annually.[28] With demand for LTSS expected to double over the next 35 years, current financing options are fiscally unsustainable, a fact recognized by the BPC

Long-Term Care Initiative.[29] The initiative recently released a set of recommendations[30] to improve the financing of LTSS, including proposals to enhance the affordability of private long-term care insurance and to modernize Medicaid. Understanding the role of housing and its potential as a delivery platform for LTSS will become increasingly important as a way to bring down costs and improve health outcomes.

### *2. Nearly all seniors in the United States have a chronic condition — the care of which is a significant driver of future health care spending.*

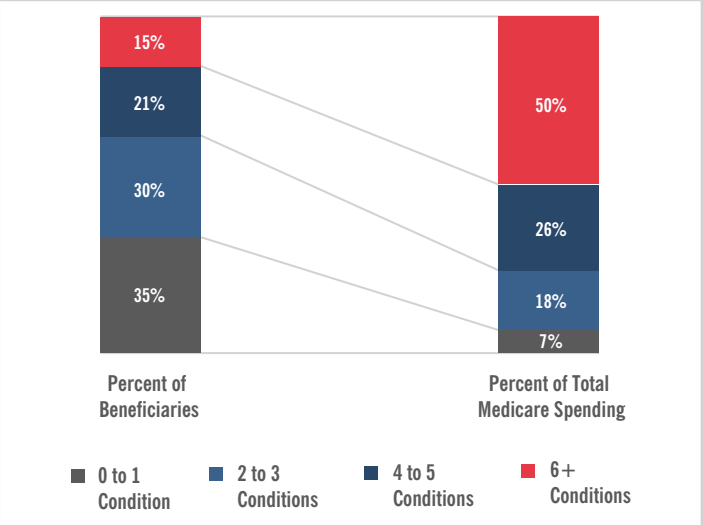
Chronic diseases are conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living.[31] Examples of chronic conditions include arthritis, asthma, chronic respiratory conditions, diabetes, and heart disease. In addition to comprising physical medical conditions, chronic conditions also include ailments such as substance abuse and addiction disorders, mental illnesses, dementia, and other cognitive impairment disorders.[32] A recent analysis of just ten common chronic conditions revealed that 86 percent of seniors had a chronic condition.[33] Additional estimates of a broader array of chronic conditions demonstrate prevalence rates above 90 percent among seniors. Importantly, more than 80 percent of seniors have multiple (two or more) chronic conditions,[34] leading to a higher frequency of mortality, poor functional status, hospitalizations and readmissions, and adverse drug events.

Seniors with chronic conditions also account for an overwhelming share of federal health care spending and will continue to do so for the foreseeable future. It is estimated that 99 percent of Medicare spending is for seniors with chronic conditions, and 93 percent of Medicare spending is for seniors with multiple chronic conditions (see: Figure 1-6).[35]

Looking ahead, care coordination for seniors with chronic conditions will be critical to improve health outcomes and reduce health care costs for this population. Several new delivery and payment models, including accountable care organizations and bundled payments, are currently being tested to help shift the health care system away from fee-for-service medicine — with its focus on the volume of services performed — to a model based on the actual value of these services.

***80 percent of seniors have multiple (two or more) chronic conditions.***

**Figure 1-6. Distribution of Medicare Fee-for-Service Beneficiaries and Spending by Number of Chronic Conditions, 2014**




Source: Centers for Medicare and Medicaid Services.

As this transformation of the health care system continues, health care entities will be increasingly accountable for health outcomes and will need to embrace a "population health" approach that takes into account a broader view of health and the factors that influence health. This approach will require more than just care coordination; rather, it will also require self-management and care in the home setting. Medication adherence, the prevention of falls, and proper nutrition are important aspects of the care regimen that occur at home and are essential to ensuring optimal health for seniors

***With demand for LTSS expected to double over the next 35 years, current financing options are fiscally unsustainable.***

with chronic conditions. In addition, evidence-based programs in the community that assist seniors with falls prevention, physical activity promotion, and chronic disease self-management need to be integrated with new payment and delivery models.

To achieve these benefits, it will be necessary to successfully link the existing care delivery system with community-based assets and other nontraditional stakeholders. Most health care providers have historically operated with limited connection to community-based health and social-service organizations, although this is beginning to change given the systemic collaboration necessary to improve population health, including for seniors.

### 3. The personal savings of millions of seniors are and will be inadequate.

In the coming decades, the personal savings of older adults will continue to be a critical source of funds to support aging in place, health care, LTSS, and other needs. But for millions of seniors these savings will fall woefully short.

The lack of significant personal savings for retirement is remarkable: 29 percent of households aged 55 and older have neither assets in a retirement account nor a defined benefit pension.[36] And even among households aged 55 to 64 with retirement savings, the median total account balance is only about $104,000, which in most cases is insufficient, by itself, to support a retirement that could last 20 or 30 years (or longer), let alone pay for home modifications or other LTSS needs associated with aging.[37]

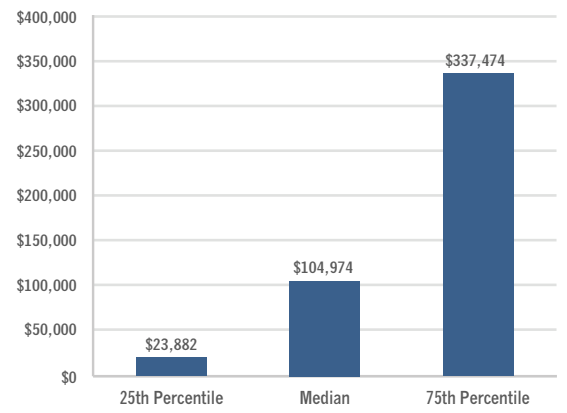
The Urban Institute developed projections for the BPC Commission on Retirement Security and Personal Savings that paint a troubling picture of retirement security, especially for those in the bottom half of the distribution of retirement assets. Median per capita retirement assets among younger retirement-age individuals (age 62 to 69) was around $32,000 in 2015, while those in the 25th percentile lack any retirement assets. Meanwhile, individuals in the 75th percentile of retirement assets have around $130,000 in retirement savings, which is likely still insufficient to finance a decades-long retirement on its own.[38]

But looking at retirement assets[39] alone paints an incomplete picture of financial security, as many individuals have savings outside of retirement accounts. And while the Urban Institute's projections of financial assets — which include bank account balances, stocks and bonds — paint a somewhat brighter picture of older Americans' finances, overall savings levels remain largely insufficient to finance a long retirement. According to the Urban Institute's projections, median total assets per capita, sum of retirement accounts and financial assets, for 62- to 69-year-olds was around $105,000 in 2015, compared with $338,000 at the 75th percentile and just $24,000 at the 25th percentile (see: Figure 1-7).[40]

Of course, the stored equity in a home is another important source of personal retirement savings for homeowners. And, for many low- to middle-income owner-occupied households, home equity actually exceeds the amount of savings held in retirement accounts (see: Chapter 3). This trend is projected to continue into the future.[41] It is important to note that the average amount of per

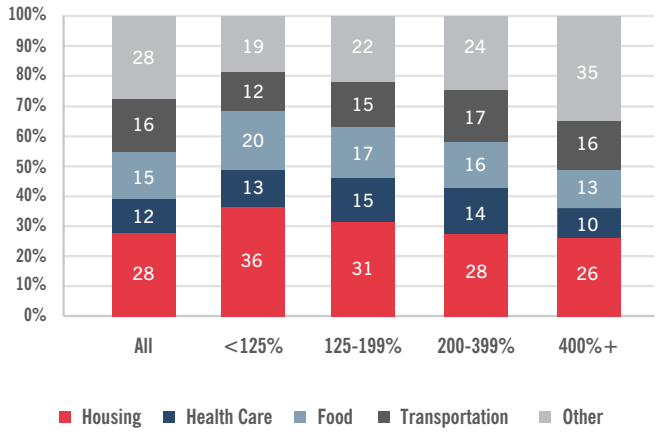
***Seniors with chronic conditions also account for an overwhelming share of federal health care spending.***

**Figure 1-7. Per Capita Retirement and Financial Assets (Not Including Home Equity) in 2015, Ages 62-69 (in 2015 Dollars)**




Source: The Urban Institute, DYNASIM3.

**Figure 1-8. Distribution of Senior Household Spending by Income Relative to Federal Poverty Level, 2013**




Source: The Urban Institute.

capita home equity among homeowners age 62 and older hovers around $136,000. In black and Hispanic households, however, the average amount of home equity in 2015 was well under half the national average at $59,000 and $65,000 respectively.[42] This is savings not available to renter households.

## *Affordable Housing is the Glue that Holds Everything Together*

One thing is clear: all bets are off in bridging the health-housing divide if seniors lack access to affordable housing. Affordable housing is the glue that holds everything together: without access to such housing and the stability it provides, it becomes increasingly difficult, if not impossible, to introduce a system of home- and community-based supports that can enable successful aging. Unfortunately, even for those seniors who own their homes outright, housing-related costs often constitute their biggest household expenditures (see: Figure 1-8).

With the over-65 population poised to grow dramatically in the coming years, increasing the supply of affordable homes suitable for seniors — as well more tightly connecting the delivery of supportive services with housing — must be an urgent focus of national policy.

# Chapter 2. Health Begins at Home: The Overriding Need for More Affordable Supply

*"I pay $650 per month in rent for my apartment. That's more than half my monthly Social Security check. But the building managers tell me they could be getting $850 per month for my apartment. I can't afford that. I've moved 11 times in my life. I'm going to be 72, I don't want to move again."*

—Patricia Wilson, 71

## Introduction

According to the Harvard Joint Center for Housing Studies, 6.5 million senior households will have incomes under $15,000 in 2024, an increase of 1.8 million households, or 37 percent, from 2014.[43] Low incomes naturally affect the affordability of housing: the lower a household's income, the fewer resources available to cover housing costs. The affordability of housing is a growing concern not only for older adults who rent their homes but also for senior homeowners. More and more senior homeowners are carrying mortgage debt into their retirement years.[44] Monthly mortgage payments, along with property taxes, utility payments, and the cost of home maintenance and upkeep, can be a major strain on the budgets of senior homeowners.

## Terms and Definitions for Affordable Housing and Household Income

The federal standard for affordable housing is that a household should pay no more than 30 percent of its income on rents and utilities. "Rent burden" is a term used to indicate the extent to which a household spends a disproportionate share of its income on rental costs

If expenditures on housing (rent and utilities) account for:

- Between 30 and 50 percent of income, a household has a "moderate" rent burden.
- Above one-half of household income, a household has a "severe" rent burden.

"Low income" is a term used to indicate a household's income level relative to other households in the same metropolitan area.

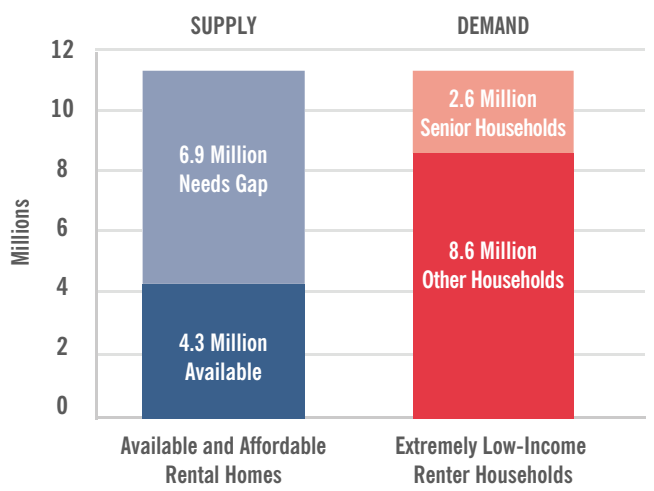
If a household has an income:

- Above 50 percent, up to and including 80 percent of the area median income (AMI), it is a "low-income" household.
- Above 30 percent, up to and including 50 percent of the AMI, it is a "very low-income" household.
- At or below 30 percent of the AMI, households are considered "extremely low-income."

Another major factor contributing to high housing costs is the scarcity of affordable and available rental homes. This supply-demand imbalance most negatively impacts lower-income households, many of whom are older adults living on fixed incomes. To understand the severity of the problem, consider this fact: In 2013, there were 11.2 million "extremely low-income" renter households competing for only 4.3 million affordable and available rental homes, resulting in a total shortfall of *6.9 million* homes.[45] Of the 11.2 million extremely low-income households competing for this limited supply, 2.6 million were senior households with no children (see: Figure 2.1).[46]

***6.5 million senior households will have incomes under $15,000 in 2024.***

**Figure 2-1. Supply-Demand Imbalance in Available and Affordable Rental Homes**




Source: Adapted from U.S. Department of Housing and Urban Development data.

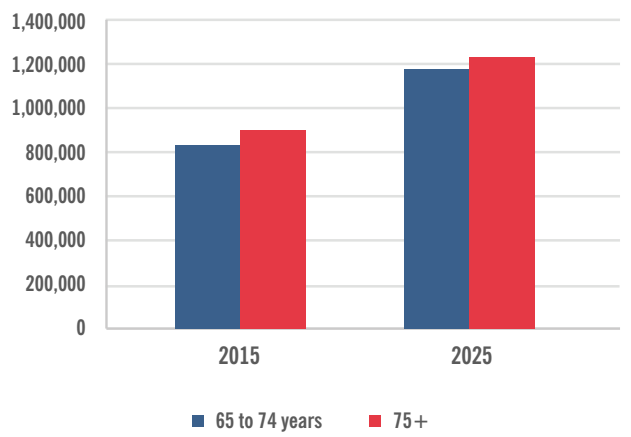
The acute shortage of affordable rental homes has contributed to soaring rents in many communities. According to one recent estimate, 1.8 million senior households now suffer "severe" rent burdens, paying in excess of 50 percent of their incomes just for housing.[47] Those affected by these rent burdens reside not just in the major cities along America's two coasts but also in communities like Louisville, Kentucky; New Orleans, Louisiana; and Hartford, Connecticut. Many of these senior households rely exclusively on

## *1.8 million senior households now suffer "severe" rent burdens.*

Social Security for their income. With so much of their income devoted to covering housing costs, some are forced to cut back on medical care, nutritious food, and other essentials.

Absent a comprehensive and sustained effort to increase the supply of affordable homes for America's seniors, this already unacceptable situation will only worsen. Why? Over the next 15 years, the United States can expect to see both a growth in the low-income senior population and millions of seniors transitioning to rental housing. In fact, according to projections by the Urban Institute, the number of senior renter households will more than double from 2010 to 2030 — from 5.8 million to 12.2 million.[48] This new demand will combine with the demand created as a result of new household formation by millions of young adults to exert tremendous pressure on the existing supply of rental homes. In the absence of new supply, rents will likely increase and the housing cost burdens borne by seniors will grow. Confirming this trend, the Harvard Joint Center for Housing Studies projects that, over the next ten years, the number of households aged 65 to 74 and 75 and older with "severe" rent burdens will rise by 42 percent and 39 percent, respectively (see: Figure 2-2).[49]

**Figure 2-2. Projected Growth in Number of Seniors with Severe Rent Burdens**




Source: Harvard Joint Center for Housing Studies.

On top of these housing affordability concerns is the question of suitability. As explained in greater detail in Chapter 3, most of the nation's homes — both rental and owned — lack the basic features that can allow safe, independent living by America's seniors, particularly those with disabling conditions.

Increasing the supply of affordable and suitable homes to meet demand from a rapidly expanding senior population may seem like an insurmountable challenge. But we cannot let the sheer magnitude of the problem overwhelm us and delay action. America needs to get started immediately. The Task Force believes the following principles should guide a national approach to the issue:

- Limited federal resources should be targeted to help the most vulnerable, lowest-income seniors.
- Increasing the supply of affordable housing for seniors through preservation and new construction will require much greater investment by the private sector as well as more effective partnerships with state and local governments and the nonprofit community.
- Better integration of health and LTSS with housing can lead to improved health outcomes for seniors, delay or eliminate the need for more expensive assisted living or licensed nursing care, and potentially reduce per capita medical costs.
- Technology should be integrated where possible to facilitate independence and dignity and, potentially, to reduce costs.

## *The number of senior renter households will more than double from 2010 to 2030 — from 5.8 million to 12.2 million.*

- Regulatory and land-use policies should actively promote, not hinder, the development of new affordable housing for seniors, including housing with supportive services.
- Policies and programs should enable seniors to remain in the communities they know and where they have critical social, religious, and health ties.

## *Senior Homelessness*

Any discussion of increasing the supply of affordable and suitable homes for our nation's seniors must first begin with a focus on those who are among the most vulnerable citizens in society: those seniors without a home or at risk of becoming homeless.

Over the past decade, the United States has made considerable progress in reducing the incidence of homelessness. In 2015, there were 82,550 fewer people homeless on a single night than in 2007, a 13 percent decline. Notably, a reduction in the unsheltered population has accounted for the entirety of this decline, while in 2015 the number of people in shelter programs returned to 2007 levels.[50]

Goal setting has been an important element of the federal government's strategy to prevent and end homelessness. Current goals include preventing and ending homelessness among veterans by 2015 and ending chronic homelessness by 2017.[51] Both categories of homelessness have experienced significant declines since 2010, with veterans' homelessness declining by 36 percent and chronic homelessness dropping by 31 percent.[52] The federal government has also set goals to "prevent and end homelessness for families, youth, and children by 2020" and to "set a path to ending all types of homelessness."

Homelessness has traditionally been viewed as a problem affecting younger adults more severely than older adults. Yet, with the dramatic increase in the number of seniors, many of whom will be economically vulnerable, it is, unfortunately, expected that older adults will assume a larger share of the nation's homeless population. The Homelessness Research Institute of the National Alliance to End Homelessness has estimated that, assuming shelter and poverty rates remain constant, the number of homeless older adults will rise from approximately 44,000 in 2010 to nearly 59,000 in 2020, an increase of 33 percent. According to the Homelessness Research Institute, the older adult homeless population will likely rise to nearly 95,000 by 2050 (see: Figure 2-3).[53] A growing body of evidence substantiates this projection.[54]

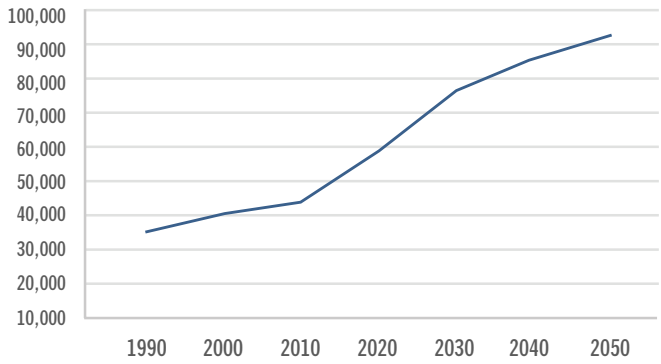
***The number of homeless older adults is projected to rise from approximately 44,000 in 2010 to nearly 59,000 in 2020.***

As is the case today, some chronically homeless adults will be unable to break the cycle of homelessness and will continue to age into their senior years without stable housing. Others will experience homelessness for the first time as an older adult. The scarcity of affordable housing for those on fixed incomes, long waiting lists for subsidized housing, alcohol abuse, and the onset of Alzheimer's disease, dementia, and other common geriatric conditions are some of the key factors contributing to homelessness among older adults.[55]

Reengaging homeless people with mainstream society (including finding employment and job-training opportunities) is a key element of national, state, and local strategies to end homelessness. Because many seniors are unable to return to the workforce, that reengagement is equally important but may take a somewhat different form.

Moreover, like many younger homeless individuals, the older adult homeless are high utilizers of emergency medical and other health care services. Studies have demonstrated that allowing a person to remain chronically homeless can cost the taxpayers as much as $50,000 annually.[56] A "housing first" approach that connects older adults experiencing homelessness to affordable, stable housing

**Figure 2-3. Projected Increase of Senior Homelessness**




Source: Homelessness Research Institute.

with supportive services has been shown to lower public costs and generate longer-term savings.[57] This approach is likely to grow in importance as the senior ranks swell.

In the years ahead, a much greater awareness of the problem of senior homelessness as well as a better understanding of its causes will be critical. We will need to identify effective interventions and deploy them on a far greater scale.

What America can do today, however, is set a clear goal: as one of the world's richest nations, the United States should not accept a situation in which so many of its older citizens live on the streets without adequate shelter and appropriate care. Eradicating homelessness among older Americans must become a national priority that harnesses the resources and focused commitment of the private, nonprofit, and government sectors. To this end, the U.S. Interagency Council on Homelessness should add the specific goal of preventing and ending homelessness among older adults to its list of objectives. Setting similar goals for veterans and the chronically homeless has proved to be highly effective in raising awareness and marshaling resources. It is time to do the same for the nation's seniors.

Management consultant Peter Drucker once observed, "You can't manage what you can't measure." In other words, to be successful, one must track and quantify progress toward a goal over time. The

***As one of the world's richest nations, the United States should not accept a situation in which so many of its older citizens live on the streets without adequate shelter and appropriate care.***

U.S. Department of Housing and Urban Development's (HUD) annual Point-in-Time estimates, which offer a snapshot of homelessness (both sheltered and unsheltered) on a single night in late January of each year, are an extremely valuable assessment tool but they currently track homelessness only among three age groups — those under 18, those 18 to 24, and those over 24.[58] To help better understand and track homelessness among older adults, the Point-in-Time estimates should take a more granular approach and monitor homelessness among individuals who are aged 50 and above and 65 and above.

**Recommendation #1.** Preventing and ending homelessness among older adults should become a major national priority. The U.S. Interagency Council on Homelessness should explicitly adopt a goal to prevent and end homelessness among older adults.

## *Federal Rental-Assistance Programs*

Federal rental-assistance programs are a critical source of help for low-income seniors. Of the approximately 5.1 million households served by HUD programs,[59] 34 percent are headed by an "elderly person" (defined as someone 62 years of age or older) (see: Figure 2-4). Seniors head 23 percent of the households served by the Housing Choice Voucher program, and they head even greater shares of households in public housing (32 percent) and the project-based Section 8 program (48

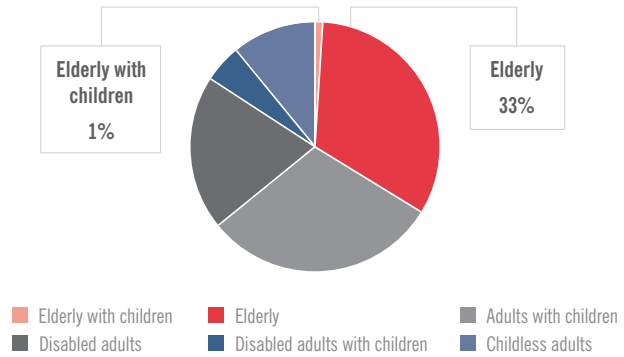
percent).[60] In addition, more than 60 percent of the renters assisted by the U.S. Department of Agriculture's (USDA) housing programs — many of whom live in rural communities — are seniors or people with disabilities.[61] USDA's Section 515 program, which provides long-term, low-interest loans to support the construction and rehabilitation of multifamily housing, is a particularly important source of funding for housing that serves low- and moderate-income seniors in rural communities.

Reflecting the graying of the general population, the age of those households utilizing federal rental assistance has steadily risen over the past decade. According to HUD, the share of HUD-assisted households headed by someone 50 years of age or older has increased from 45 percent in 2004 to 55 percent in 2014.[63] As these residents continue to age in place, the share of households headed by seniors will increase dramatically.

Today, with federal resources stretched so thin, fewer than one in four households eligible for federal rental assistance actually receives it.[64] The result is a system in which housing subsidies are allocated by lottery or through ever-growing waiting lists. In response to this situation, the BPC Housing Commission recommended a transition over time to a system in which the country's most vulnerable households, those with extremely low incomes (at or below 30 percent of the area median), are assured access to federal housing assistance if they need it.[65]

With the nation's debt burden soaring, the Task Force recognizes that budgetary pressures are likely to continue to weigh heavily on HUD, USDA, and the other agencies of the federal government. Policymakers will be forced to set priorities and make difficult budget choices. But as policymakers engage in this important exercise, they should understand that federal rental-assistance programs represent vital lifelines for hundreds of thousands of the nation's seniors. With the senior population poised to expand dramatically over the next 15 years, demand for this help will intensify, not lessen. According to one estimate, the number of older households (aged 60 and above) eligible for federal rental assistance will likely increase by 1.3 million between 2011 and 2020, and another 1.3 million between 2020 and 2030.[66]

**Figure 2-4. Populations Served by Federal Rental Housing Programs[62]**




Source: Center on Budget and Policy Priorities tabulation of 2014 HUD data.

At a time of scarcity, it is also incumbent that the nation's rental-assistance programs achieve a higher level of performance to ensure that limited funds are used as effectively as possible. These programs must more fully realize the potential of rental assistance to substantially improve the life opportunities of assisted households — for example, by helping older adults to lead independent lives and assuring that work-capable households make progress toward economic self-sufficiency. Requests for additional program funds should be accompanied by well-conceived plans to achieve these and other important reform objectives.[67]

**Recommendation #2.** Congress and the administration should work together to fund federal rental-assistance programs at adequate levels, particularly since these programs will serve increasingly larger numbers of low-income seniors.

HUD's Section 202 Supportive Housing for the Elderly program is the only federal rental-assistance programs designed explicitly to

serve seniors. Since its creation in 1959, the Section 202 program, in partnership with the nation's leading nonprofit housing providers, has helped create nearly 400,000 affordable rental homes for older Americans in developments throughout the United States. Many of the seniors served by the program are at risk of institutionalization but benefit from the supportive services available to them at the project sites. These properties have responded to a critical need that the market was not adequately serving, and the nonprofit sponsors of the properties have enhanced the lives of literally hundreds of thousands of lower-income seniors and their families. Not surprisingly, there are often long waiting lists to get into many Section 202 properties.[68]

Since 1990, the Section 202 program has authorized (a) interest-free *capital advances* for new construction (these capital advances do not have to be repaid as long as the project serves very low-income seniors for 40 years); (b) *rental assistance* through what are known as Project Rental Assistance Contracts (PRACs), which cover the difference between the HUD-approved operating cost for the project and the tenants' contributions toward rent; and (c) funding for s*ervice coordinators* at Section 202 properties.[69]

Due to federal budgetary pressures, since fiscal year 2011, there has been no funding in the form of capital advances for construction under Section 202 or rental assistance for new units. In fiscal year 2016, funding for Section 202 amounted to $433 million ($356 million for PRAC renewals and $77 million for service-coordinator grants), a 3 percent increase over fiscal year 2015 levels to accommodate increased operating costs. Looking ahead, Congress must continue to provide funding for rental assistance and service coordination at adequate levels for existing Section 202 housing, but alternative approaches to finance the construction of new affordable senior homes that incentivize private sector and state involvement are clearly also necessary.

**Recommendation #3.** Congress and the administration should support continued funding at adequate levels for rental assistance (PRACs for post-1990 properties and Section 8 and other forms of rental assistance for older properties) and for service coordination under the Section 202 Supportive Housing for the Elderly program.

One promising alternative approach is reflected in recent reforms to another HUD program that is closely related to Section 202 — the Section 811 Supportive Housing for Persons with Disabilities program. Like Section 202, the Section 811 program has linked affordable housing with services aimed at allowing residents to live independently. It, too, traditionally supported properties sponsored by nonprofit developers by providing interest-free capital advances and operating subsidies to these developers. As is the case with Section 202, the last appropriation for capital advances under Section 811 occurred more than five years ago, effectively eliminating the program as a viable source of funds for new construction.

In response to these circumstances, the bipartisan Frank Melville Supportive Housing Investment Act of 2010 authorized a new Section 811 Project Rental Assistance initiative in lieu of capital advances. Under this initiative, state housing agencies can competitively apply to HUD for Project Rental Assistance that can then be leveraged to help finance new or existing Section 811 affordable housing developments. These developments are typically also supported by

### The Section 202 Program Serves Some of The Nation's Most Vulnerable Seniors

To be eligible for Section 202 housing, a household's income must be at or below 50 percent of the area median at the time of initial occupancy. Most residents fall far below that threshold. The average annual household income for Section 202 households is between $12,300 and $12,600.[70] What's more, 38 percent of existing Section 202 tenants are considered frail or near frail, requiring assistance with basic activities of daily living.[71]

Low-Income Housing Tax Credits (LIHTC), funds provided through the HOME Investment Partnerships program (HOME), and financing from other sources. As a condition to applying, state housing agencies must enter into partnerships with state health and human services and Medicaid agencies to develop policies for referrals, tenant selection, and service delivery to ensure they are targeting a population most in need of deeply affordable supportive housing.

Initial results of the Section 811 reforms are encouraging: the number of new Section 811 units produced annually is expected to increase from approximately 1,000 to more than 4,000.[72]

Not every aspect of the reformed Section 811 program has application to affordable senior housing. For example, the general policy goal of the Section 811 program is to disperse persons with disabilities in apartment buildings that serve the general population, while Section 202 properties typically serve only seniors. However, the general approach is worth considering. In lieu of interest-free capital advances for new construction, a replacement for the Section 202 program could:

- Offer project-based rental assistance through state housing agencies to provide permanent supportive housing focused on seniors who are dually eligible for Medicaid and Medicare and have challenges with activities of daily living and so can benefit from on-site services.
- Provide this rental assistance for state housing agencies to award to qualifying sponsors in tandem with LIHTC, HOME and Community Development Block Grant funds, bond financing, and other federal, state, and local financing sources to support the construction of new projects.
- As a condition of participating, require state housing agencies to: (1) develop policies for resident eligibility to ensure they are targeting a population most in need of deeply affordable supportive housing; and (2) enter into partnerships with state health and human services agencies, who will provide funding to housing sponsors for their use in providing or arranging for service delivery designed to lead to agreed-upon outcomes for residents.

The combination of rental and service operating revenue, LIHTC, and other program funds would allow mission-driven nonprofits and other qualifying developers to raise private capital for construction, obviating the need for capital grants of the type provided in the Section 202 PRAC program.

This approach would also help ensure that a broader set of actors has "skin in the game" — not just the federal government and mission-oriented nonprofits but state governments and private developers and investors. By requiring states to commit to funding health care and related services, the approach would also promote the more integrated delivery of housing, health care, and other services.

The Task Force recommends building in a multiyear evaluation to assess the impact of the new senior-supportive housing program on (a) the health outcomes of the dual population served by the program and (b) per capita health care costs. If the evaluation fails to show improved health outcomes and/or reduced costs, the program could be appropriately adjusted.

**Recommendation #4.** Congress and the administration should create and fund a new program for senior-supportive housing that uses project-based rental assistance and the LIHTC to support new construction and to attract funding for services from health care programs.

Any effective strategy to increase the supply of affordable senior housing must begin with the preservation of the existing affordable housing stock. HUD's Rental Assistance Demonstration (RAD) program offers a promising model to achieve this preservation goal.

RAD was created to help preserve and modernize the existing stock of public housing by giving public housing authorities the ability to use existing rental subsidies to leverage private sources of capital

for this purpose. In RAD, public housing units move to a Section 8 platform with a long-term contract that, by law, the owner must renew if appropriations are available. Public housing authorities, or the sponsors and developers they select, then use this steady stream of funding to tap the capital markets for funds to make improvements in their housing stock.

Allowing nonprofit owners of Section 202 PRAC properties to participate in the RAD program would enable them to tap the capital markets for preservation financing. This approach should also make it easier for small organizations that lack the capacity to undertake major property recapitalizations to transfer these properties to other higher-capacity nonprofit owners who have larger portfolios and who can take advantage of greater operating efficiencies. Making PRAC properties eligible for RAD has the potential to preserve at least a portion of the 124,000 units in the PRAC portfolio that are at risk of loss or deterioration. Additional financial tools will be needed to preserve the entire stock of aging properties — both Section 202 properties and those financed under other programs — that serve low-income seniors.

**Recommendation #5.** Congress should support the preservation of existing Section 202 units (PRAC properties) by making them eligible for the RAD program.

Service coordinators play a critical role in transforming affordable senior housing into a platform for the delivery of supportive services that enable older adults to live independently in communities of other seniors. These services can include connecting seniors to meals-on-wheels, transportation, home health aides, financial counseling, group health initiatives such as falls prevention, and preventative health screening. Service coordinators may also perform activities such as resident health assessments, case management, acting as an advocate or coach, coordinating group programs, or training housing management staff. Service coordination may help many older adults, especially those who are frail or otherwise at risk, reduce their hospital emergency-room visits and avoid permanent placement in more costly nursing homes and other institutional settings.

HUD is currently contributing to the evidence base for the proposition that supportive services and service coordination are essential to senior health through a $15 million Housing with Services Demonstration for low-income seniors in its assisted properties.[73] The Task Force applauds HUD for undertaking this effort. As will be discussed in Chapter 4, health care providers have the ability to build on these efforts to help further scale health and wellness services for low-income seniors residing in congregate settings.

While HUD provides funding for the "service coordination" function to some Section 202 properties, many housing providers without HUD funding have struggled to fund service coordinators. In some instances, these providers, many of whom are mission-oriented nonprofits, have been able to assemble public and private resources on an ad hoc basis to defray the costs of service coordinators, but funding sources are often unstable and the level of support inadequate. As the lower-income senior population grows, it is critical for the federal government to continue its investment in service coordination and commit itself to a better understanding of the most effective service coordination models.

**Recommendation #6.** Congress and the administration should identify ways to more effectively support the service coordination needs of senior housing providers, particularly mission-oriented nonprofits.

## *New Construction and Preservation of Affordable Rental Housing*

The LIHTC is the nation's most effective policy tool supporting the

## How the LIHTC Works

The LIHTC is a capped federal incentive that is allocated to private developers, including nonprofits, through state housing finance agencies that receive an annual per capita allocation of credits indexed to inflation. Developers compete for credit awards through applications that are scored based on how closely the proposed development would meet the affordable housing priorities of the state as laid out in an annual qualified allocation plan. The properties must be rented to tenants with incomes at or below 60 percent of the area median income at rents that are capped for a period of at least 30 years. In practice, the program typically serves households below this income threshold.

new construction and preservation of affordable rental housing. Since the program's creation in the Tax Reform Act of 1986, the LIHTC has leveraged approximately $100 billion in private capital, helping to finance the construction and preservation of almost 2.8 million affordable rental homes for low-income families. About 90,000 to 95,000 units are built or preserved annually due to the LIHTC and the private investment it has brought to the table.[74]

The LIHTC is an important source of financing for rental homes affordable to the nation's lowest-income seniors. According to HUD, nearly 33 percent of reported LIHTC households have a senior member (62+), and more than one-fourth (28.6 percent) have a head of household who is at least 62 years old.[75] The "qualified allocation plans" of some states provide set-asides and other preferences for senior housing projects. In fact, the LIHTC program supports approximately 40,000 senior-restricted affordable units annually.[76]

With the need for affordable rental housing so great today — a need that affects not just seniors but individuals of all ages — the Task Force joins the call of other organizations in urging a significant expansion of federal support for the LIHTC. For example, the BPC Housing Commission recommended a 50 percent increase in funding for the LIHTC along with additional resources for LIHTC "gap" financing. Others have gone further, calling for the gradual doubling of the annual LIHTC allocation with sufficient funds for gap financing to support this expansion.[77] Investor interest in the LIHTC is currently very strong, far exceeding available authority. The United States must seize this opportunity to leverage even greater private investment in the production of new affordable housing, particularly for the nation's lowest-income seniors whose ranks will swell in the coming years.

The Task Force strongly encourages the states to provide robust preferences and set-asides in their annual LIHTC qualified allocation plans for projects that serve older adults and to adopt scoring systems that appropriately reflect the critical importance of these projects.

In addition, the states should use their qualified allocation plans as a tool to encourage applications for LIHTC projects that are designed to be close to transit and essential services and that include accessibility features enabling living independently and the better integration of health care and other services with housing.[78] To the extent feasible, LIHTC-supported properties should:

- Use space efficiently to ensure the greatest possible number of seniors are served.
- Include common areas that can serve as a platform for the delivery of health care, wellness, and other services for residents as well as potentially for the broader community.
- Include universal design features such as no-step entries; single-floor living that eliminates the need to use stairs; switches and outlets accessible at any height; extra-wide hallways and doors to accommodate walkers and wheelchairs; and lever-style door and faucet handles in new construction and, where feasible, in rehabilitation.
- Maintain onsite service coordinators in significant measure to address the social determinants of health and serve as a bridge to service providers.

## The 2016 Qualified Allocation Plan of the Commonwealth of Pennsylvania

The Commonwealth of Pennsylvania is an example of a state promoting the development of new senior housing through its LIHTC qualified allocation plan. In its most recent qualified allocation plan, Pennsylvania provided a preference for senior housing projects, reserving credits for a minimum of two senior-occupancy developments targeting persons 62 years of age and above in both an urban and suburban/rural "pool."[79] To be eligible
for the preference, an applicant must demonstrate that services will be provided to residents in the proposed project that will enable them to continue to live independently.

The Pennsylvania qualified allocation plan also requires that projects seeking credits conform to minimum "visitability" requirements. These requirements include:

- The building and units must have at least one zero-step entrance with a 36-inch-wide door.
- All doorways and passages on the entry-level floor should have a width of 36 inches.
- There should be clear pathways to bathrooms and powder rooms, and these rooms should include a minimum 24-inch grab-bar beside the toilet on a reinforced wall, which can also serve as a towel bar.
- There should be clear pathways to living rooms and dining areas.
- Promote healthy living through good lighting, opportunities for walking, and no-smoking policies.

**Recommendation #7.** Congress and the administration should substantially increase federal support for the LIHTC program to help finance the production and preservation of additional units of affordable rental housing, including affordable homes for low-income seniors.

## *Additional Opportunities for Affordable Housing Production and Preservation*

The Housing and Economic Recovery Act of 2008 created the National Housing Trust Fund (NHTF) and the Capital Magnet Fund (CMF) to help support new affordable housing production. The NHTF is administered by HUD, which has developed a formula by which money will be distributed to the states. The CMF, an account within the Community Development Financial Institutions Fund overseen by the U.S. Treasury Department, funds a competitive grant program for community development financial institutions and nonprofit housing agencies.

The Housing and Economic Recovery Act required Fannie Mae and Freddie Mac to set aside 4.2 basis points of their business volume each year for the NHTF and the CMF, with the NHTF receiving 65 percent of these funds and the CMF 35 percent. While this requirement was temporarily suspended when Fannie and Freddie were placed under government conservatorship in September 2008, the suspension was lifted in December 2014. HUD announced nearly $174 million in total funding for the NHTF in 2016, which may rise in future years.[80] By law, most of the NHTF funds must be used to serve very low-income persons, of whom seniors are a significant share.

The NHTF and CMF can become vital sources of funding for the production and preservation of homes affordable to our nation's lowest-income seniors and help stimulate innovative strategies

by housing providers. In the coming years, both funds should be deployed and maximized for this purpose. Both HUD and the U.S. Treasury Department should regularly assess the regulations governing the NHTF and the CMF to ensure they further this goal in the most effective, efficient, and creative manner possible.

**Recommendation #8.** The states should use their National Housing Trust Fund allocations and the U.S. Treasury Department should use the Capital Magnet Fund to support the production and preservation of affordable housing for the nation's lowest-income seniors.

## *Reducing Regulatory Barriers*

Alternative housing structures, such as accessory dwelling units (ADUs), micro-units, and congregate or group homes, typically are a less expensive form of housing than a new single-family home on a separate lot. In communities throughout the United States, they are an important source of affordable housing for low- and moderate-income older adults. In the coming years, these housing structures and arrangements can play an even greater role in meeting the affordable housing needs of seniors as the demand for affordable homes increases.

ADUs, in particular, can help seniors of all income levels realize their aspiration to age in their communities when these structures are located on the property of a grown child or close relative. When an ADU is located on a senior's own property and then rented, it can provide a new stream of income that can help finance the senior's retirement or serve as an offset to property taxes. ADUs also represent a potential source of housing for a caregiver to a senior.

Despite these benefits, concerns are sometimes raised that the proliferation of ADUs and other alternate housing structures will change the character of a neighborhood, increase traffic flow, make parking more difficult, and impose even greater burdens on public services. In response, some communities impose zoning-code overlays, ordinances that create extra requirements beyond simple land-use specifications, before an ADU can be approved. Complying with these overlays, which range from minimum lot sizes for homes that seek to add an ADU, limits on how much of the lot can be covered with structures, and regulations governing the ADU's relationship to the primary unit on the lot, can be time-consuming and costly.[81] Rigid parking requirements, as well as high permit and impact fees, can also act as barriers to building a new ADU or legalizing an existing one.

Some communities, however, have found that promoting ADUs as a vital source of affordable housing has not compromised their integrity or livability. Santa Cruz, California, is one such city.

Given its proximity to San Francisco, excellent climate, and local

### Types of Alternative Housing Structures

A 2008 HUD report separates ADUs into three categories: interior, attached, and detached.[82] Interior ADUs are located within the primary dwelling and are typically built through conversion of existing space, such as an attic or basement. Attached ADUs are living spaces that are added on to the primary dwelling. The additional unit can be located to the side or rear of the primary structure, but can also be constructed on top of an attached garage. Detached ADUs are structurally separate from the primary dwelling.They are often a backyard cottage or an apartment above a detached garage.

Micro-units are homes that that "contain their own bathroom and a kitchen or kitchenette, but are significantly smaller than the standard studio in a given city," generally including less than 400 square feet of living space.

In a congregate or group home, "each individual or family has a private bedroom or living quarters but shares with other residents a common dining room, recreational room, or other facilities." These individual units can be rented or owned.

university, Santa Cruz boasts some of the highest housing prices in the country, creating a situation where affordable homes are very scarce. In response to this problem, the city decided to promote ADUs for lower-income residents—typically those aged 18 to 25 or over 65. This program sprung out of the need to regulate the growing number of illegal ADUs being built in the early 2000s as real-estate prices soared; today, the program is unique because it does not just allow ADUs to be built, but incentivizes them. For example, development fees are waived for ADUs made available for low- and very low-income households. The city also provides resources on floor plans and suggestions for development that would not sacrifice aesthetics. In addition, it has also partnered with a local credit union to provide mortgages for ADU development. Critical to the success of the ADU program in Santa Cruz were zoning code reforms that eased parking requirements.[83]

Communities as diverse as Fauquier County, Virginia; Lawrence, Kansas; Lexington, Massachusetts; and Portland, Oregon have also taken major steps to include ADUs in the range of affordable housing choices available to their residents. In their land-use regulations, these jurisdictions make clear that ADUs are fully permissible under certain circumstances, either by right (without the need for extensive reviews) or special permit. Lawrence, Kansas, specifically acknowledges that ADUs provide an important means for seniors and others to "remain in their homes and neighborhoods, and obtain extra income, security, companionship and services."[84] In addition, the AARP and American Planning Association have a drafted a model state act and local ordinance to encourage the wider availability of ADUs.[85]

More generally, local communities throughout the country should comprehensively examine their land-use policies to ensure they do not unnecessarily impede the development of affordable housing. After all, a rule or requirement that may have made sense a decade or more ago may no longer do so today. Minimum lot requirements that restrict housing density, maximum floor-area ratios, unnecessarily onerous parking requirements, impact fees that are unrelated to the size of a home or the use of a service, excessive red tape, and lengthy permitting processes can increase the cost of housing by as much as 25 percent, if not more.[86] These higher costs often impact lower-income households the hardest since these households typically dedicate a higher portion of their income to housing.[87]

After completing this review, local communities should scrap or appropriately alter those land-use policies deemed unnecessary or excessive.

A more proactive approach is also necessary: in light of the dramatic increase in the senior population and the increased demand for affordable housing that will ensue, every community should ensure its land-use policies actively foster a range of affordable housing options for its senior residents. This housing should be accessible to transportation, health care, retail, and other important services (see: Chapter 3). Recognizing that land availability and cost are major deterrents to developing new affordable housing, communities should also review their own land assets and work with their anchor institutions, such as hospitals and universities, to identify parcels that could be developed into affordable housing for seniors. HUD and the USDA should support the partial release of liens on existing senior housing when there is sufficient land for sponsors to increase density

**Recommendation #9.** States and local communities should consider adopting permissive land-use policies that allow for and encourage alternative housing structures for seniors, such as ADUs, micro-units, and congregate/group homes, and they should undertake a comprehensive examination of their existing policies to ensure they promote a range of affordable housing options for their seniors.

The federal government must also do its part. As a source of case studies, best practices, and the latest research, HUD's Regulatory Barriers Clearinghouse is a valuable tool for local communities seeking to develop more effective affordable housing strategies.[88] HUD should ensure that information about successful local strategies to expand the range of affordable housing options for seniors,

including through the use of the latest technologies (see: Chapter 5), is disseminated as broadly as possible.

While much of the discussion concerning regulatory barriers to affordable housing focuses on state and local requirements, federal regulations can also have an appreciable impact on the cost of housing. Federal regulations, most notably those issued by agencies like HUD, the Environmental Protection Agency, the Occupational Health and Safety Administration, and the Department of Energy (DOE), can alter the supply of land and the cost of land development. Federal regulations can also impact the ongoing cost of housing by affecting the price of utilities and replacement parts needed for home upkeep. In addition, regulations governing the purchase and financing of a home can impact affordability.[89]

In 1991, the Advisory Commission on Regulatory Barriers to Affordable Housing (also known as the "Kemp Commission") recommended that an assessment of the impacts of new federal regulations on the affordability of housing be made part of the standard federal rulemaking process.[90] Nine years later, the bipartisan Millennial Housing Commission offered a similar recommendation.[91] Although a housing impact assessment is not part of the "regulatory impact analysis" now required for new federal rules, more modest but important efforts have been undertaken: during President George W. Bush's administration, HUD launched Operation Regnet, a department-wide effort in which all offices within HUD were directed to review their existing rules, major handbooks, notices of funding availability, and other notices to determine whether they constituted barriers to housing affordability. This review resulted in the elimination of some policies that were deemed unnecessary.[92]

In light of the strong and intensifying demand for affordable housing, it is time for the federal government to comprehensively review the panoply of federal laws and regulations to ensure they are not acting as barriers to the production and preservation of affordable housing. This task is not easy: distinguishing between unnecessary regulations that should be revised or eliminated and useful regulations that should be preserved requires making difficult value judgments and weighing competing considerations. But making these assessments can be essential to reducing costs and helping generate new affordable housing supply.

**Recommendation #10.** The Office of Management and Budget should convene an interagency task force that assesses the impact of federal laws and regulations on the production and preservation of new affordable housing, particularly for seniors, and should identify ways these laws and regulations can be modified to reduce costs and increase production.

## *Task Force Takeaway*

It is shameful that so many of our nation's lowest-income seniors lack access to affordable housing. The current shortage of affordable rental homes, measured in the millions, will only intensify in the years ahead as the low-income senior population grows and more seniors transition from homeownership to rental housing. What is needed is a comprehensive and sustained national effort to increase affordable supply. Such an effort will require greater investment by the federal government, much broader engagement of the private and nonprofit sectors, and a commitment by states and communities across the country to increase the range of affordable housing options for their senior residents.

# Chapter 3. Aging with Options: Transforming Our Homes and Communities

*"I had gotten to the point that I couldn't get into my bathtub. If I got in, I couldn't get out. And, I didn't have a shower. I just happened to mention this challenge in a conversation with my local area agency on aging care manager. She got back to me in less than a week, and told me that the Philadelphia Corporation for Aging would be able to help me. In less than three months my bathroom was completely gutted – the bathtub removed and an accessible shower put in. I got a beautiful new bathroom that I can access with peace of mind. I can't say enough about how much this program helped me."*

—Laura Washington, 69

According to a 2014 AARP survey, 88 percent of senior households strongly or somewhat agree that they would like to stay in their current residences as long as possible, while 89 percent strongly or somewhat strongly agree they would like to remain in their communities.[93] If these preferences continue to hold, there will likely be a growing mismatch between the desire of seniors to age in place and their ability to do so.

A big hurdle will be household finances: Over the next 20 years, nearly 40 percent of individuals over the age of 62 are projected to have financial assets of $25,000 or less; 20 percent of those over 62 will have $5,000 or less. For many, this level of savings will be

woefully inadequate to cover the expenses of daily living, never mind finance LTSS or the modifications necessary to make living independently at home safe and secure. Just securing access to an affordable home will be a major challenge for millions of lower-income seniors. Assisted living and other housing options will be prohibitively expensive for many (see: Figure 3-1).

***Over the next 20 years, nearly 40 percent of individuals over the age of 62 are projected to have financial assets of $25,000 or less.***

**Figure 3-1. Types of Senior Living**

| TYPE | DESCRIPTION | NATIONAL MEDIAN COST | NATIONAL MEDIAN ANNUAL COST |
|---|---|---|---|
| INDEPENDENT LIVING COMMUNITIES | Residents generally independent and self-sufficient | $2,000 - 5,000 per month | $24,000 - 60,000 |
| ASSISTED LIVING FACILITY | Residents live in private apartments; staffed for assistance with some daily tasks and activities/ entertainment | $3,600 per month | $43,200 |
| MEMORY CARE | Secured area of assisted living or skilled nursing facility | $3,500 - 6,600 per month | $42,000 - 79,200 |
| RESIDENTIAL CARE HOMES | Private residential homes adapted to accommodate limited number of residents; 24-hour supervision and assistance | $2,200 - 3,400 per month | $26,400 - 40,800 |
| NURSING HOME CARE | 24-hour monitoring and medical assistance (semi-private and private) | $220 - 250 per day | $80,300 - 91,250 |
| HOME HEALTH AIDE SERVICES | Range from weekly visits to 24-hour care | $20 per hour | $41,600 |
| ADULT DAY HEALTH CARE | Half-day or full-day care at center with transportation option | $69 per day | $17,940 |
| RESPITE CARE | Short-term stay or temporary in home care, typically less than a month | $75 - 200 per day | $19,500 - 52,000 |

Sources: A Place for Mom, Guide to Senior Housing and Senior Care 2016. Available at: http://web28.streamhoster.com/apfmdev/apfm _ ebook _ guide-to-senior-housing _ final.pdf.
Genworth, 2015 Cost of Care Survey. Available at: https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568 _ 040115 _ gnw.pdf.

For some households, aging with options may mean the opportunity to move from a single-family home into a multifamily apartment building within the same neighborhood. For others, aging with options may mean having access to affordable housing with supportive services and not having to enter a nursing home or other institution simply because affordable housing is not available in one's community.

In light of these difficult conditions, new solutions that expand the range of housing options and accommodate a variety of needs and preferences as individuals' age will be necessary. Government action will also be necessary, both as a driver of public policy and as a force multiplier. But aging with options should also be viewed as an opportunity for the private sector to deploy new products and services to meet the needs of a growing market of consumers. New technologies hold great promise to make America's homes and communities safer and more accessible places.

The following recommendations offer ideas that can help seniors age with options in their existing homes and communities. These recommendations call for better planning and improved data on the needs of existing and future senior households, as well as the availability of housing options to meet those needs. Increased coordination across government agencies and greater transparency about existing programs would benefit senior households and help spur private investment.

## *Transforming Our Homes*

Today, numerous programs within HUD, the U.S. Department of Veterans Affairs (VA), the U.S. Department of health and Human Services (HHS), USDA, DOE, and other federal departments provide resources and expertise for home assessments and modifications, including in some cases, apartments that serve low-income people (see: Figure 3-2). Unfortunately, there is little coordination among these programs and public awareness is limited.

**Figure 3-2. Select Federal Programs Supporting Home Modifications**

| DEPARTMENT | AGENCY/OFFICE | PROGRAMS |
|---|---|---|
| AGRICULTURE | Rural Development | Section 504 Home Repair Program; Section 502 Direct Loan Program |
| ENERGY | Energy Efficiency and Renewable Energy | Weatherization Assistance Program |
| HEALTH AND HEALTH SERVICES | Administration for Community Living; Centers for Medicare and Medicaid Services | Title III of the Older Americans Act; Medicaid 1915(c) HCBS waivers |
| HOUSING AND URBAN DEVELOPMENT | Community Planning and Development | Community Development Block Grant; HOME Investment Partnership Program; Housing Trust Fund |
| VETERANS AFFAIRS | Veterans Health Administration | Home Improvements and Structural Alteration, or "HISA," grants |

To support greater coordination and awareness, the Task Force recommends the federal government establish a new Modification Assistance Initiative (MAI) that would be administered by the HHS Administration for Community Living (ACL). Under MAI, the ACL would coordinate existing federal efforts, as well as publish an annual inventory of programs that support home assessments and modifications for homeowners and landlords that rent to seniors. This inventory would include a demographic analysis of households served and approximate dollars invested for senior households by program. The MAI would serve as a resource center to inform the Aging Network — a national network of federal, state, and local agencies that provide services to enable older adults to live independently in their homes and community — about resources available for home assessments and modifications. The inventory would also help identify and address duplication and gaps in populations supported. Further, the effort would aim to create a national partnership with private-sector entities offering modification services.

The ACL should call on the Aging Network to identify and publish standardized information on state and local resources available for home assessments and modifications. This effort would help to encourage states and local governments to better coordinate their own existing home-modification programs. Each Area Agency on Aging in the Aging Network should be responsible for providing information to its senior-household clients on resources available for home modifications, as well as for developing and providing a resource guide on how low-cost modifications might be helpful to facilitate aging with options. AARP's Home Fit Guide could be a model.[94]

The mission of the ACL is to enable Americans — particularly people with disabilities and older adults — to live at home with the supports they need.[95] Through its support of the National Eldercare Institute in the 1990s, the ACL has historically been responsible for providing information on best practices and resources relating to home modifications.[96] This effort included publishing a home modification resource guide, producing a fact sheet on home modifications and repairs, and hosting national teleconferences on home modifications and repairs for aging in place. These resources should now be updated for a new generation of seniors.

The home modifications necessary to support aging with options range from very low-cost solutions, like removing hazards, to higher-cost adaptations, such as adding ramps and widening doorways — those costs can run beyond $5,000 (see: Figure 3-3). Modifications can be targeted to address particular physical ailments, prevent adverse events such as falls, or address particular environmental conditions such as extreme heat waves when seniors are at highest risk.

***Only 1 percent of houses today have the five features necessary for universal design. Yet, 38 percent of households 65 and older have at least one person living with a disability.***

Only 1 percent of houses today have the five features necessary for universal design.[97] Yet, 38 percent of households 65 and older have at least one person living with a disability. This rate increases to more than 44 percent among very low-income older households. Individuals with disabilities increasingly live alone as they age, from 22 percent between the ages of 50 to 64 to 35 percent of individuals who are 80 and over.[98] More effectively coordinating federal resources for home modifications should help make resources more readily available, improve opportunities for leveraging private funds, and ultimately make many of the nation's homes safer for independent living by older adults.

**Recommendation #1.** Congress should authorize a new Modification Assistance Initiative (MAI) that would work on an interagency basis to coordinate federal resources available for home modifications to support aging with options.

**Figure 3-3. Home Modifications Options**

| LOW COST SOLUTIONS | AVERAGE COST |
|---|---|
| Removing hazards, such as clutter, throw rugs, moving furnishings and modifying where activities occur (e.g., sleep on first floor instead of second) | $0 |
| **ADDING FEATURES** | |
| Adding nonslip strips to floors and smooth surfaces | $100-500 |
| Installing home emergency-response units | $30-100/month |
| Improving lighting | $50-100/unit |
| Providing telephones with large numbers and letters | $25-100 |
| Installing grab bars and lever door handles | $250-1500 |
| **MORE COMPLEX** | |
| Installing ramps. | $400 - 4,000 |
| Installing chairlifts or stair glides. | $2,500 - 6,000 |
| Widening doorways. | $500 - 1,000 |
| Lowering countertops. | $1,650 - 4,000 |
| Building roll-in showers. | $700 - 1,000 |
| Remodeling bathrooms. | $20,00 - 25,000 |
| Improving wiring to eliminate extension cord. | $8,000 - 15,000 |
| Upgrading home cooling and climate-control systems. | $3,500 - 4,000 |

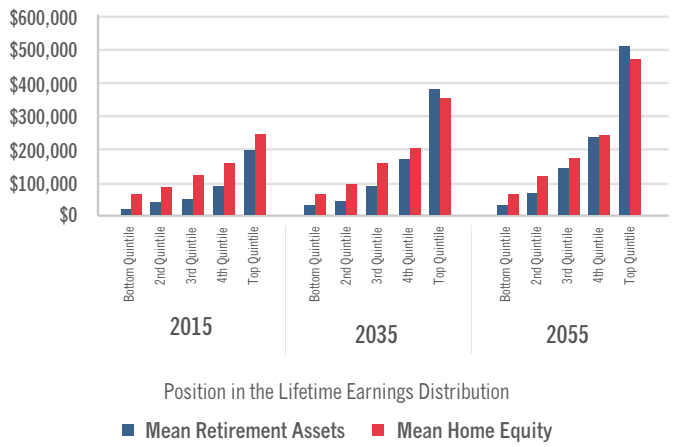
Sources: AARP, Angie's List, Arrow Lift, Home Advisor, Home Wyse, This Old House, and Medical Alert Systems.[99]

Home equity, for seniors who own their home, offers a potential source of capital for home modifications. The homeownership rate among individuals age 62 and over is projected to dip slightly over the next 50 years. However, a large majority of seniors, nearly 75 percent, are expected to own a home well into the future.

This projected rate of homeownership among seniors offers a sustained opportunity to consider home equity as a source to cover necessary expenditures, including home modifications and LTSS. In fact, home equity is projected to exceed retirement savings for lower- and middle-income earners well into the future (see: Figure 3-4).

Home equity is the difference between the value of one's home and the outstanding debt remaining to be paid on loans or mortgages held on the property. Stored equity can be accessed through financial instruments such as reverse mortgages. A reverse mortgage allows borrowers to gain access to the equity and convert it for other purposes. Reverse mortgages, as with any other mortgage product, must be repaid. However, unlike with traditional mortgages, reverse-mortgage borrowers do not make monthly payments, though payments into escrow accounts for property taxes and homeowners insurance may be required. The loan is only repaid when the borrower or their estate sells the property. When drawing on equity, a borrower reduces the capital stored in his or her home; when that property is sold, the borrower may see a lower return than if the equity had not been accessed.

**Figure 3-4. Projected Per Capita Retirement Savings and Home Equity Among Homeowners Age 62+ (in 2015 Dollars)**




Source: The Urban Institute, DYNASIM3.

Concerns have been raised about the complexity of reserve-mortgage products. These concerns can be mitigated with access to low-cost and effective mortgage counseling to ensure potential borrowers are clearly aware of the risks and benefits associated with the products.

In addition, efforts should be made to promote the development of alternative, low-cost products to access home equity with appropriate borrower protections. These products should be developed in a way that ensures the effective use and orderly draw-down of home equity. The BPC Commission on Retirement Security and Personal Savings calls for

establishing a low-dollar reverse-mortgage pool for retired homeowners. This structure could help to reduce fees on mortgages and make the market more accessible. The current Federal Housing Administration reverse-mortgage program, known as the Home Equity Conversion Mortgage, allows qualifying homeowners to withdraw a maximum loan amount that varies based on the interest-rate environment and the age of the borrower.[100] A low-dollar reverse-mortgage pool would allow retirees to tap into smaller amounts of their home equity, which could mean lower risk for lenders, borrowers, and taxpayers, and it could have the added benefit of reduced fees and interest rates.

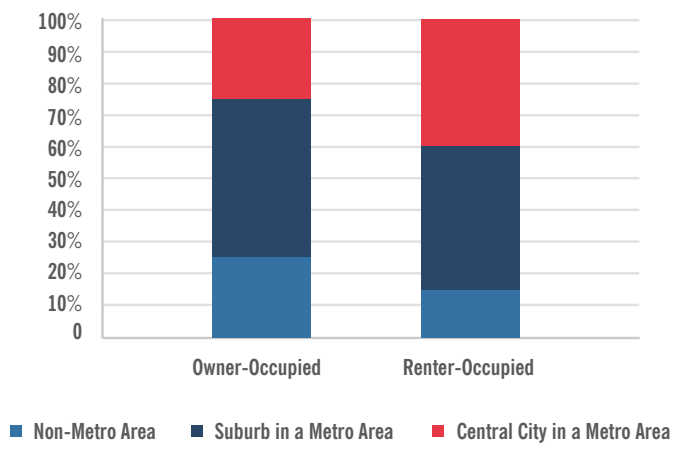
**Recommendation #2.** HUD should maintain protections and counseling services for the Home Equity Conversion Mortgage insured loan program and consider new products that assist borrowers in safely accessing home equity.

A disproportionate and increasing share of seniors live in rural communities across America. About 15 percent of residents in nonmetropolitan regions are 65 or older, compared with 12 percent in urban areas.[101] These differences among communities are expected to hold, and have the potential to grow more drastic, as younger households seek educational and job opportunities outside of the rural communities and retirees move to rural retirement destinations. In 2013, for the first time, two states — Maine and West Virginia — recorded more deaths than births.[102]

Among those over 65, poverty rates run higher outside metropolitan counties. Approximately 9 percent of metropolitan residents aged 65 or older are below the poverty level, compared with 13 percent of nonmetropolitan senior residents.[103] Further, mortality rates among seniors also offer a contrast of life in rural communities compared with urban, where according to a study conducted by Dr. Leah Goeres at Oregon State University, rural seniors who took prescription drugs survived 3.5 years longer on average compared with 7.1 years for urban dwellers.[104]

USDA's Section 504 home repair program makes valuable resources available to low-income seniors living in rural areas for single-family home modifications. The program has become somewhat outdated for today's marketplace. USDA currently caps available resources at a $7,500 grant limit and a $20,000 loan limit. Congress should provide flexibility to transfer funds between the loan and grant portions of the program, as was done for the USDA Farm Labor Housing program. Further, the loan program suffers from lack of applications, in part because homeowners who borrow more than $7,500 in the current loan program have a lien placed against their property. The loan program should be updated to increase the $7,500 borrowing threshold requiring a lien.

**Figure 3-5. Location of Households 65+, 2009[105]**




Source: Center for Housing Policy tabulation of 2009 American Housing Survey data.

Further, there are opportunities to streamline the application process for the Section 504 program. It currently takes the same amount of time and paperwork to make a $15,000 Section 504 loan as it does to underwrite a $150,000 Section 502 mortgage loan. USDA must work to automate the process, making it less onerous for senior residents in need of necessary resources for home modification.

**Recommendation #3.** Congress should call on USDA to modernize the Section 504 home repair program.

Currently, 80 percent of home modifications and retrofits for aging are paid out of pocket by residents.[106] States and municipalities can help relieve some of this burden by making funding available to both individuals (homeowners and landlords) and contractors for expenses incurred acquiring or modifying a property for accessible use. The funding offered either through tax credit, grant, or forgivable loan should be modeled on other local jurisdictions that have implemented these types of programs (see: Figure 3-6). Claims could be offered in an amount not to exceed $5,000 per home, and the overall program could be limited to an annual amount that is feasible for the authorizing jurisdiction. A more widespread deployment of these financial incentives by state and local governments would help increase the supply of accessible housing available to the nation's aging population.

**Recommendation #4.** States and municipalities should establish and expand programs to assist low-income seniors with home modification through property tax credits, grants, or forgivable loans.

Property tax relief is a particularly important way to help senior homeowners age with options in their own homes and communities. Because property taxes are based on home values, not income, they are not connected to a homeowner's ability to pay. Property taxes can hit older seniors particularly hard since incomes decline dramatically following retirement.

States provide property tax relief through a number of different mechanisms, including homestead exemptions that reduce the appraised value of a senior's home and the deferral of property tax payments until after a home is sold or the owner passes away.[107] In some states, these tax benefits are not means-tested and are open to everyone regardless of income level.

Property tax "circuit breakers" are another mechanism by which to provide tax relief to lower- and moderate-income households. Under these programs, taxpayers receive a credit if their income is below a defined level and their property taxes exceed a specified percentage of their incomes.

Currently, 33 states and the District of Columbia offer property tax circuit-breaker programs in some form.[108] Many states extend eligibility only to the very poorest homeowners, every state limits the dollar amount that can be claimed, and some states index the credit to inflation. Some states have experimented with extending eligibility for the circuit breaker to renters based on the view that owners of rental properties pass through some of their property tax liability to tenants in the form of higher rents.[109]

With the senior population poised to increase, property tax circuit-breaker programs have great potential value in helping seniors afford their housing and remain in their communities. Yet the cost of these programs is likely to increase in the coming years, putting additional pressure on state budgets. Protecting and expanding property tax relief programs that target their assistance to low- and moderate-income senior households should be a priority of state policy.

**Recommendation #5.** States should protect and expand property tax circuit-breaker programs and other forms of property tax relief that are targeted to assist low- and moderate-income senior taxpayers.

## *Transforming Our Communities*

The role of communities in supporting aging with options is critical to ensure optimal health and well-being. There are a number of opportunities for federal agencies to help support older adults access

**Figure 3-6. Case Studies of State and Local Accessible Housing Tax-Credit Programs**

| PROGRAM NAME | REQUIREMENTS | TERM |
|---|---|---|
| **Virginia Livable Homes Tax Credit** at the Virginia Department of Housing and Community Development[110] | *Eligibility: individuals and contractors*<br>• New units include three visitability or accessibility standards<br>• Modifications include one visitability or accessibility feature | • $5,000 purchase/construction new accessible unit<br>• 50% of cost of modifying existing units (cap $5,000)<br>• Program FY allocation $1 million |
| **Allegheny County Residential Visitability Design Tax Credit** at the Allegheny County, PA, Office of Property Assessments[111] | Create "visitable floor" with all features:<br>• at least one no-step entrance<br>• firm, stable, slip-resistant, and reasonable sloping path to enter<br>• entrance door opening at least 32" and lever door handles<br>• hallways at least 36" wide and inside doors at least 32" wide<br>• bathrooms with lever handles and reinforced walls for grab bars<br>• accessible light switches | • $2,500 over 5 years to cover increases in property taxes as a result of construction/ renovation<br>• Participating municipalities offer additional $2,500 credit toward municipal property taxes |
| **Georgia Disabled Person Home Purchase or Retrofit Tax Credit**[112] | Qualified visitability standards include:<br>• no-step entrance<br>• inside doors at least 32" wide<br>• reinforced bathroom walls to facilitate installation of grab bars<br>• accessible light switches/outlets | • Lesser of $500 or taxpayer income tax liability for purchase of new accessible home<br>• $125 for cost of modifications, claimed by taxpayer |
| **District of Columbia Safe at Home Program**[113] | *Eligibility: seniors age 60 and older, and persons living with a disability age 18-59*<br>Home accessibility adaptations to reduce the risk of falls and reduce barriers that limit mobility, such as:<br>• Bed transfer handles<br>• Furniture risers<br>• Handrails<br>• Lamps<br>• Shower seats<br>• Stair lifts | • Grants up to $10,000 to cover an in-home assessment from an occupational therapist to identify problematic areas and develop a list of modifications, equipment, and labor costs |
| Proposed: **Ohio Livable Homes Tax Credit**[114] | *Eligibility: individuals and contractors* | • $5,000 income credit cap for purchase/build accessible home or modify existing property to be accessible |
| **Canada Healthy Homes Renovation Tax Credit**[115] | Remodeling expenses for homeowners, renters, and those who share homes with older relatives | • Up to $1,500 per year |

vital services in their communities, as well as opportunities for local organizations to come together with the private sector and social-service providers to ensure the needs of seniors are prioritized in community decision making.

One promising idea is the "Village" concept, which helps to connect individuals in a neighborhood to a coordinated system of local service providers. While there can be dues associated with accessing these networks, the idea may help seniors stay in their communities and age with options. These efforts have been most effective in jurisdictions such as Washington, D.C., where the city's Office of Aging has recognized the value of partnering with the numerous Villages set up across the city, helping to fill in gaps in available services for seniors. The federal Commission on Long-Term Care, which issued a report to Congress in 2013, included a service delivery idea for transforming care coordination to help individuals with disabilities live more independently.[116] The concept called for expanding local initiatives, such as Villages, that could coordinate community services.

In order for more communities across the country to increase access for seniors to coordinated services, Congress should reestablish support for the Community Innovations for Aging in Place (CIAIP) initiative. The CIAIP initiative was first authorized in the Older Americans Act of 2006 and then funded by Congress from 2009 to 2012. The effort was dedicated to funding community organizations across the country that were working on innovative solutions for community-based aging in place. Each funded project was required to ensure access to specified community-based health and social services, to conduct outreach to older individuals, and to develop systems for the delivery and coordination of community-based health and social services. The 14 organizations that were funded through the CIAIP together developed a framework of lessons learned for being able to improve communities for aging, and that framework remains an important tool for organizations seeking to develop more "age-friendly" communities.[117] Replicating this initiative would help encourage greater innovation in efforts already underway to transform communities for aging.

Under the leadership of the ACL, this newly authorized and funded initiative should conduct a nationwide evaluation of community living concepts — such as the Village-to-Village Network,[118] Naturally Occurring Retirement Communities,[119] as well as any Area Agency on Aging programs[120] that coordinate the resident volunteers who provide services, like transportation, small home repairs or modifications, and health and wellness opportunities. Further, evaluating the innovative efforts underway in the private sector to develop housing and communities for lower-income seniors could lead to significant insight for the public sector.

This evaluation would aim to assess the impact these models have on community residents, including a "value-for-money" analysis and assessment of tiered costs for services. The review would identify the merits of the various programs and determine the costs of effectively replicating key elements in low- to moderate-income communities.

**Recommendation #6.** Congress should reauthorize and fund the Community Innovations for Aging in Place (CIAIP) initiative to assess community living models for possible replication in low- to moderate-income communities.

The Consolidated Plan is a tool used by HUD to help states and local jurisdictions assess their future housing and community-development needs. Those jurisdictions applying for block-grant funding through

**Figure 3-7. Examples of Community Living Models**

| | NUMBER ACROSS THE U.S. | AVERAGE ANNUAL FEES/COST |
|---|---|---|
| VILLAGE-TO-VILLAGE NETWORK | 190 operating; 150 in development[121] | Average around $500 per person |
| NATURALLY OCCURRING RETIREMENT COMMUNITIES | 54 programs in housing developments and neighborhoods[122] | Not applicable |

HUD's Office of Community Planning and Development must submit a Consolidated Plan based on a template provided by HUD. Though not explicitly targeted toward seniors, resources available through two of HUD's block-grant programs — HOME and Community Development Block Grant — can be used for home modifications. In order to better understand the housing needs of seniors, specifically for home modifications, the Consolidated Plan template and planning process should be updated to include a more explicit focus on the needs of senior households.

The Consolidated Plan offers a cooperative ongoing process for community dialogue and input on the housing and community needs of a jurisdiction. Plans are data-driven and aim to improve housing and community investment decision making. The findings of these plans are not only applicable to HUD programs, but act as a much broader tool for information and data that can impact policymaking, as well as private sector investment decisions.

The housing market analysis required as part of the Consolidated Plan should include an additional section assessing the availability of facilities, housing, and services for seniors. The planning effort should inventory facilities, housing, and services that are available to meet the needs of seniors within a jurisdiction. The inventory of facilities and housing, including skilled nursing facilities, assisted living, senior care centers, and affordable senior housing, should be presented in a form developed by HUD.[123] An inventory of services should also include health, mental health, and employment services to the extent those services are used to complement other services targeted to seniors.

The strategic plan required as part of the Consolidated Plan should be updated to include an additional section that requires a concise summary of the jurisdiction's activities to enhance the coordination of home modifications to assist seniors with aging with options. The summary should address the jurisdiction's efforts to coordinate housing assistance and services for seniors modifying their homes, as well as tools and resources available for landlords and tenants. The plan should describe the means of cooperation and coordination between the local government and private industry, businesses, developers, social-service agencies, and nonprofits involved in home modifications.

**Recommendation #7.** HUD should update its Consolidated Plan to require states and local jurisdictions to more explicitly assess the housing needs of seniors and the availability of age-friendly housing and community services.

In 2004, President George W. Bush signed an Executive Order establishing the Interagency Transportation Coordinating Council on Access and Mobility. The purpose of the Council was to coordinate the 63 programs across nine federal agencies that were providing funding for human services in transportation. More than ten years later, the Council still exists; there remain nine agencies that now oversee 80 federal programs that fund transportation services for disadvantaged populations. The level of engagement in the Council's work varies widely by agency.

The Council should establish a specific deliverable for better coordination of transportation services drawing on the existing requirements that were included in the most recent transportation authorization bill, the Fixing America's Surface Transportation Act. These include developing a policy to be able to share and allocate costs across different agencies responsible for providing services. Developing a one-call/one-click platform aims to take full advantage of existing services and data platforms that offer real-time information, support, and referrals to help seniors navigate the complexities of securing rides. This program could be modeled on the Federal Transit Administration-led Veterans Transportation Community Living Initiative program, in which grants for one-call/one-click centers aim to connect veterans to transportation services. Federal agencies should work through the Council to share information about transportation services and funding available to seniors, through programs such as the Centers

for Medicare and Medicaid Services' Medicaid Non-Emergency Medical Transportation, Medicaid Waivers, and Money Follows the Person programs.

Further, the Council should work with private-sector partners with innovative ride platforms, such as Google, Uber, Lyft and others, to develop a user-friendly interface tool for seniors that makes choosing the best mode, provider, and route seamless and stress-free. Connecting seniors to transportation services with a single call or click would provide real-time information and make a wide range of safe, effective, affordable choices in travel much more accessible.

A survey of senior households, in 2010, found one in five missed activities because of limited driving ability. Only 16 percent of households 65 and over live within walking distance of a store.[124] A one-call/one-click platform can help ensure seniors have access to essential services, work, volunteer opportunities, health systems, education institutions, cultural amenities, and other social engagements, thereby improving overall quality of life.

**Recommendation #8.** The federal agencies involved in the Interagency Transportation Coordinating Council on Access and Mobility should develop a one-call/one-click platform for door-to-door transportation services for older adults.

The ability of seniors to successfully age in their communities will require thoughtful and deliberate action by local governments, planners, and developers to take into account the mobility and accessibility needs of individuals as they age. The long-term health and well-being of seniors can be enhanced by ensuring that affordable housing is in decent proximity to transportation and other necessary services, as well as near social and recreational activities. A number of municipalities have made efforts to include meeting the accessibility needs of seniors in their long-range planning. However, most jurisdictions do not take into account how zoning and land-use decisions and property siting can impact accessibility for seniors.

Through the adoption of "senior overlay zones," local zoning boards with authority over land-use decisions and development regulations can help rectify this situation, while demonstrating to the public and development community where the specific needs of an aging population are being considered. These zones can help local decision-makers work with developers to more effectively evaluate locational trade-offs when deciding where to site facilities like educational institutions, hospitals, medical centers, and assisted living communities.

Parcels in a senior overlay zone should be evaluated based on their accessibility to important amenities like transportation, health care, social services, retail, and open space. Residential and commercial buildings in this zone should be constructed in accordance with universal design or visibility standards. Tenancy in the zone should be mixed age and mixed income, with a certain amount of housing dedicated to residents 65 and over. The overlay, depending on location, might dedicate a portion of market rate units to households at or below area median income in exchange for allowing greater density to accommodate multifamily supportive housing structures, as well as single-family dwellings.

**Recommendation #9.** HUD, in partnership with the American Planning Association, should develop a model senior zoning ordinance that local jurisdictions across the United States could adopt.

There are a series of somewhat predictable patterns in human physical and psychological decline that should be taken into consideration when designing the next generation of housing stock and community spaces. A diverse network of professionals and organizations must come together to create a housing and community suitability rating system with indicators including design accessibility and adaptability for a range of human frailties. The working group should collect both national and international research and best practices on age-friendly

housing and neighborhood design.[125] There are a number of creative configurations for senior living in local communities, existing industry standards for livable and age-friendly communities, and incredible technological innovations that should be considered as part of this rating system. The group should devise solutions for retrofitting existing homes and communities as well as for new construction. The effort could be modeled on the U.S. Green Building Council's LEED rating system for energy-efficient buildings and neighborhoods.

**Recommendation #10.** A wide range of professionals and organizations in the health care and housing fields should establish a working group to develop a suitability rating scale for age-friendly housing and communities.

## *Task Force Takeaway*

To lead healthier, more productive lives, the nation's seniors will need to age in homes that are safe and in communities that provide an array of accessible services. Achieving this vision will require widespread modification of the existing housing stock and a commitment by cities and towns across America to ensure that seniors have access to the essential services they need. Accompanying these efforts must be a major rethink of how Americans design and build new homes and plan communities. With millions of Americans about to enter their senior years, collaboration among the government, the private sector, and the nonprofit community will be critical.

# Chapter 4. Integrating Health Care and Supportive Services with Housing

*"When I suffered a stroke, I didn't know whether I would be able to cook my own meals, listen to my music, or travel back to Jamaica. Moving to NewCourtland [a nonprofit provider of affordable housing with supportive services] has helped me be independent. I love everything about it. There are good, skilled attendants, and they take me on shopping trips. There is good food. You get a lot of attention."*

—Dudley Bryan, 75

One of the most important public health findings over the last two decades has been that there are a number of factors, beyond medical care, that influence health status and contribute to premature mortality. Of these factors, social circumstances and the physical environment (particularly the home) impact an individual's health.

Housing takes on even greater importance for older Americans since they spend a significant portion of their day in this setting. Thus, as discussed in Chapter 3, ensuring a safe, age-friendly home is critical. In addition, the home is increasingly being seen as a potential site of care for seniors to receive health and wellness services and as an essential tool in chronic care management.

By virtue of the rapid expansion of the senior population, more and more Americans will be living with multiple chronic conditions and experiencing limitations in activities of daily living. Today, 68 percent of Medicare fee-for-service beneficiaries have multiple chronic conditions, resulting in 93 percent of total Medicare spending.[126] In addition, about 70 percent of adults over 65 will eventually need LTSS at some point in their lifetimes and those turning 65 can expect to incur $138,000 in future LTSS costs.[127]

Models and interventions that deliver health care and other services to seniors with multiple chronic conditions or disabilities in their own homes have the potential to improve health outcomes and reduce health care utilization and costs. At the same time, the management of certain chronic conditions, such as asthma, require a healthy home setting to avoid triggers that can lead to exacerbations of the condition. Bundled payments for care of asthmatics could support funding of home remediation services that remove triggers of asthma. With health care transformation increasingly focused on paying for value, health care entities are beginning to think about patients beyond the four walls of the clinical setting.[128]

***In addition, the home is increasingly being seen as a potential site of care for seniors to receive health and wellness services and as an essential tool in chronic care management.***

Fortunately, there are several policy opportunities that can help accelerate the integration between health care and housing. Each involves one or more key actors in the nation's health care system: Medicare, Medicaid, and hospitals.

## The Health Plan of San Mateo: Integrating Health and Housing to Reduce the Need for Institutionalization

**The Health Plan of San Mateo's (HPSM)** Community Care Settings Pilot (CCSP) is an innovative program aimed at reducing institutionalization for vulnerable HPSM members, primarily individuals who are dually eligible for Medicare and Medicaid.[129] By enabling community living, rather than residency in long-term care (LTC) facilities, HPSM is delivering a higher quality of life and improved health outcomes for its members while simultaneously reducing or avoiding costs to the system. A key finding of the program has been that for the less than 20 percent of current LTC residents who do not require a skilled level of care, along with many of those at risk of institutionalization but residing in the community, housing and social issues are the main factor driving institutionalization. Once these individuals are either referred to CCSP or identified for enrollment by HPSM, they receive intensive transitional case management at a 1:20 ratio, along with an array of supports, including housing services, to either migrate out of or avoid LTC residency.

The housing services, delivered by contracted partners, include landlord liaison, unit modification, housing location, on-call availability, affordable housing waitlist management, assisted living services, and the potential for temporary rental subsidy. Of 129 members enrolled in CCSP to date, 83 percent have required the procurement of a new residential setting, while the 17 percent able to remain in an existing community setting have often required services such as Section 8 voucher extension or landlord dispute resolution in order to retain that housing. As of December 2015, 96 percent of clients enrolled for more than six months have remained in their identified community setting with the assistance of CCSP case management and housing services. Though early in its efforts, CCSP has so far delivered high levels of enrollee satisfaction, utilization shifts to managed long-term services and supports, and cost reduction or avoidance ranging from 35 to 72 percent.

## *Medicare*

The Centers for Medicare and Medicaid Services should take into greater consideration the importance of the home as a site of care. From Health Risk Assessments to post-acute care to care for those with multiple chronic conditions, CMS should seek to incentivize the home as a place of clinical care. Current regulations and restrictions on what is reimbursable care can inhibit the use of care appropriate to the home. Assessment of social and environmental factors that contribute to the health status and capacity of the patient to adhere to clinical recommendations can be enhanced by assessment and care provided in the home. In addition, for particular patients, CMS should consider allowing managed care entities under Medicare Advantage and, possibly, alternative payment models to pay for home modifications and transportation and to consider these allowable costs under Medicare.

***Several service demonstration models intended to support aging in place are currently showing significant promise.***

The Medicare program should begin by focusing on vulnerable seniors for whom services at a home setting could yield improved outcomes and reduced health care costs. One population of focus should be the approximately 1.3 million older adult renters living in publicly assisted housing, the vast majority of whom are dually eligible for the Medicaid and Medicare programs. HUD-assisted dual-eligible beneficiaries have more chronic conditions and higher health care utilization compared with unassisted beneficiaries.[130] HUD has a history of supporting service coordination at properties it finances and recently issued a funding opportunity for current grantees to provide enhanced service coordination coupled with wellness services (see: Chapter 2).[131] While this effort deserves praise, there should be a larger initiative funded through the health care system to demonstrate that this approach helps to prevent or delay health and functional declines in seniors and results in savings for taxpayer-funded health insurance programs. Such an effort would address the "wrong-pocket problem" by ensuring the health care system bears the cost of implementing a practice from which it can potentially benefit. If successful, the effort could serve as the foundation for a more robust set of activities.

More specifically, CMS — through its Center for Medicare and Medicaid Innovation and Medicare-Medicaid Coordination Office — should solicit proposals from health care entities (e.g., accountable care organizations, managed care plans, and provider groups) willing to be accountable for quality, health outcomes, and total costs of care for Medicare beneficiaries in publicly assisted housing (Section 202 projects, senior-restricted public-housing projects, LIHTC properties, USDA Section 515 projects, and other assisted units in congregate settings where seniors predominate). Applicants would have to partner with a large housing property or a network of housing organizations within a particular service, or "catchment," area to achieve the volume of participants necessary to conduct and evaluate the demonstration. In addition, partnerships with state Medicaid programs and local community-service providers would be encouraged.

Eligible applicants would ensure the delivery and coordination of health care, LTSS, and preventive services and wellness programs within a congregate housing setting, using housing-based service coordinators and evidence-based models or programs that have a track record of helping beneficiaries remain in their homes and reduce health care utilization.

Several-service demonstration models intended to support aging in place are currently showing significant promise. For example, the Support and Services at Home (SASH) program in Vermont relies on an onsite service coordinator and part-time wellness nurse team per 100 residents to coordinate and integrate services and supports in 130 low-income senior housing properties across the state. The program offers seniors comprehensive health and wellness assessments, creation of individualized care plans, on-site one-on-one nurse coaching, care coordination with primary care medical homes and hospitals, and health and wellness group programming.

Initial data demonstrate positive impacts on resident health, health care utilization, and a slowing of the growth in Medicare expenditures relative to two control groups.[132] Another example is the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) model. CAPABLE is a patient-directed, team-based intervention that includes an occupational therapist, a registered nurse, and a handyman to decrease hospitalization and nursing home usage of community-dwelling older adults with functional limitations who are dually eligible for Medicare and Medicaid. Activity of daily living limitations improved in 79 of the first 100 people who completed the intervention, and the disability level of the average participant was cut in half.[133]

There are also a number of evidence-based programs addressing the specific health issues of senior populations that could be delivered to the senior residents of publicly assisted housing. These include falls-management programs, such as A Matter of Balance; programs to reduce depression symptoms, such as a Program to Encourage Active and Rewarding Lives for Seniors (PEARLS); and programs to help manage multiple chronic conditions, such as the Chronic Disease Self-Management Program. Several of these programs have been shown to reduce costs to the Medicare program and are currently available in the SASH model and other housing-plus services programs.[134]

Eligible applicants would receive advanced payments (e.g., an amount per beneficiary on a monthly basis), which they could use to make important investments in their care-coordination infrastructure — including financially supporting housing-based service coordinators to enhance this function — and to provide the models and programs described above. The demonstration would look at health outcomes and costs over a five-year period and be matched with comparable control groups. Specifically, the demonstration would expect savings from reduced hospitalizations, hospital readmissions, and nursing home stays for beneficiaries.
An important aspect of the payment model would be that any realized savings would be shared among participating entities and partners, including Medicare and Medicaid.

**Recommendation #1**. CMS should launch an initiative that coordinates health care and LTSS for Medicare beneficiaries living in publicly assisted housing to test the potential of improving health outcomes of a vulnerable population and reducing health care costs.

Another vulnerable Medicare subpopulation for whom in-home health services are important includes frail beneficiaries with multiple chronic conditions and limitations in activities of daily living. The Affordable Care Act created the Independence at Home demonstration under the Medicare program to test a service delivery and payment incentive model that uses home-based primary care teams to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic illnesses.[135] Medical practice staff are required to make in-home visits and to be available 24 hours per day, seven days per week to implement care plans tailored to the individual beneficiary's chronic conditions.

In the first performance year, 17 participating practices served more than 8,400 Medicare beneficiaries, and the program met quality-of-care performance standards and saved $3,070 per participating beneficiary — totaling more than $25 million in the demonstration's first performance year.[136] In July 2015, Congress and the president enacted legislation that extended the existing Independence at Home participant agreements by two years.[137] Congress should expand this program nationwide once CMS:

- Analyzes at least the second year of data to ensure cost savings are sustained for the Medicare program and outcome measures

are improved for beneficiaries. This is important to ensure that first-year savings are not a result of onetime "low-hanging-fruit" savings or a reflection of statistical regression to the mean. CMS should also attempt to estimate the number of beneficiaries who might have needed to spend down to become Medicaid eligible and transition into a nursing home setting if it were not for the primary-care home-based intervention. Such a finding could also potentially demonstrate savings to the Medicaid program.

- Performs subgroup analyses to determine characteristics of beneficiaries who gained the most from the intervention in terms of health improvements and cost savings and to inform whether patient eligibility needs to be adjusted. Correctly matching the acuity of the patient to the intensity of the care management intervention is critical to maximizing potential cost savings.
- Analyzes the practices that performed the best to identify characteristics of practices best suited to deliver the intervention. For example, in the first year, although all participating practices improved quality in at least three of six quality measures, only four practices met all six quality measures.

**Recommendation #2.** Congress should consider expanding the Independence at Home Demonstration program into a permanent, nationwide program to maintain optimal health status and to reduce health care costs of frail, medically complex Medicare beneficiaries.

The Medicare program should also focus on preventing declines in health status of older adults in the home setting. One of the most worrisome outcomes for an older adult is a fall. Approximately one in three older adults fall annually resulting in approximately 2.5 million emergency-department visits, 700,000 hospitalizations, and approximately $34 billion in health care costs.[138] Falls are the leading cause of injury-related deaths in older adults, and most falls occur in the home setting.

There has been an increasing focus on falls prevention for the last decade through the Falls Free Initiative, a national effort led by the National Council on Aging. The Initiative includes the National Falls Prevention Action Plan, last updated in 2015, a national coalition, and 43 state coalitions on falls prevention.[139] While there has also been an increased focus in the public sector through the U.S. Administration for Community Living and the Centers for Disease Control and Prevention (CDC), federal programs and policies are not uniformly oriented toward falls prevention. The nation, at the very least, should strive to reach the Healthy People 2020 goal of a 10 percent reduction in the rate of emergency-department visits due to falls among older adults.[140] There are several efforts that could help further orient federal programs toward falls prevention and make this a top priority:

- Medicare now covers an Annual Wellness Visit providing personalized prevention services to beneficiaries. CMS should clarify with providers that falls risk assessments are a mandatory element of the Annual Wellness Visit.[141] While there is no one standard falls risk-assessment tool, CMS should share CDC's Stopping Elderly Accidents, Deaths and Injuries (STEADI) algorithm for falls risk assessment with providers.[142] In addition, for those found at risk of falls, referrals to falls-prevention programs as well as personalized health advice are required elements of an Annual Wellness Visit prior to submitting a claim. Specifically, this advice should be consistent with current U.S. Preventive Services Task Force recommendations for exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling older adults who are at increased risk for falls.[143]
- CMS should ensure that quality measures related to falls

***Falls are the leading cause of injury-related deaths in older adults, and most falls occur in the home setting.***

prevention are embedded in all of its quality-measurement programs. Specifically, these measures should be incorporated into the new Merit-Based Incentive Payment System created through the Medicare Access and Reauthorization Act of 2015 and into measure sets for alternative payment models. Quality measures should go beyond screening for falls, as is currently required of accountable care organizations, and also include quality measures that reduce the actual incidence of falls. These actions will further incentivize health care entities to focus on falls prevention.

- CMS's Quality Improvement Organization program is one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries. CMS should ensure that falls prevention becomes a key part of the next "scope of work" of its Quality Improvement Organizations, groups of health-quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. Taking this step will help create a national focus on falls-prevention screening and on building important clinical-community linkages on behalf of falls prevention.
- A final rule published by CMS on July 15, 2013, included a change to the Medicaid regulatory definition of preventive services.[144] As a result, practitioners other than just physicians and other licensed practitioners can be reimbursed for furnishing preventive services that are recommended by a physician or other licensed practitioner. There are a number of evidence-based falls-prevention programs in the community that could benefit older Americans. States, through state plan amendments to their Medicaid programs, could ensure that these services are provided and reimbursed. If the programs reduce falls-related health care expenditures on dual-eligible beneficiaries, consideration should be given to sharing any Medicare savings with the state Medicaid program. Such an arrangement could entice further interest by state Medicaid programs.
- While the Administration for Community Living already funds a National Falls Prevention Resource Center and administers grants to support community-based falls-prevention programs, an additional focus on home safety could help reduce falls. As discussed in Chapter 3, a Modification Assistance Initiative (MAI) could assist senior households with home modifications necessary for aging in place. Many of these modifications — such as bathroom grab bars, no-step entry, and eliminating the need to use stairs — will be central to falls prevention.

### CDC's STEADI (Stopping Elderly Accidents, Deaths, and Injuries) Initiative

CDC's STEADI initiative has established clinical guidelines for health care providers who treat older adults who are at risk of falling, as well as those that have fallen in the past.

**STEADI's algorithm for Falls Risk Assessment and Intervention provides a three-step outline:**

1. Screen for falls with a few basic questions.
2. Evaluate the risk level of any patient based on gait, strength, and balance.
3. Recommend the proper interventions to reduce the patient's risk of falling.

**The CDC estimates that for every 5,000 health care providers that adopt the STEADI system, over a five-year period:**

- Six million more patients could be screened for falls risk;
- One million falls could be prevented; and
- $3.5 billion in medical costs could be saved.

Source: CDC's STEADI. Available at: www.cdc.gov/steadi. STEADI's Algorithm for Falls Risk Assessment and Intervention. Available at: http://www.cdc.gov/steadi/pdf algorithm _ 2015-04-a.pdf

- CDC should assist and encourage state health departments to optimize existing surveillance systems for falls by partnering with health care entities and health information-technology companies. These partnerships will help states collect improved epidemiological data to target STEADI resources and provider training to regions with high fall rates and ensure that community-based falls-prevention programs are available in localities where there is the highest need.

**Recommendation #3.** The administration should ensure Medicare and other federal programs and policies support substantially reducing the number of older adult falls and their associated financial impact.

Beyond preventing falls, the Medicare program has an opportunity to identify additional health risk factors that may exist in the home. As an example, UnitedHealth Group's HouseCalls program offered to Medicare Advantage plan members has demonstrated that a thorough home-based clinical assessment of a member's health and home environment combined with referral services can support aging in place and preempt costly institutional care.[145]

Health risk assessments (HRA) are health-related evaluations used by providers, insurers, and employers to collect data for individual and population health improvement. CMS requires Medicare providers to administer HRAs as part of the annual wellness visit. HRAs are also commonly used by Medicare Advantage plans and are occasionally administered in the home. With respect to Medicare Advantage plans, CMS does not require utilization of a specific HRA but, in its 2016 Final Call Letter, strongly encouraged plans to adopt recommended best practices, including components of a model HRA developed by CDC.[146] Though CDC's sample HRA included important questions on health behaviors, activities of daily living, and self-reported biometric measures, it did not include questions related to housing and/or LTSS.[147] CMS should encourage all providers, but specifically Medicare Advantage plans, through questionnaires or in-home visits, to include assessments of the following needs in HRAs: frailty and fall risk, living situation (e.g., lives alone), home safety/accessibility, and modifications.[148] This will ensure more attention to the effects of housing on health and lead to opportunities to enhance optimal aging in place.

**Recommendation #4.** CMS should incorporate housing-related questions in health risk assessments used by Medicare providers and Medicare Advantage plans.

## *Medicaid*

For the first time in 2013, the majority of Medicaid LTSS spending ($146 billion) was devoted to care in home- and community-based settings instead of institutional care.[149] Congress has supported rebalancing Medicaid LTSS in several ways over the last decade, most recently through the Affordable Care Act, by extending the Money Follows the Person (MFP) initiative. The MFP was first enacted in 2006 as part of the Deficit Reduction Act.

As of December 2014, the MFP has helped states safely transition nearly 52,000 institutionalized Medicaid beneficiaries to community settings in over 45 states. While the majority of those transitioned are younger individuals with disabilities, approximately 37 percent have been older adults. The last year states can request MFP funding is 2016, though they will have until 2018 to transition beneficiaries from long-term institutional care and until 2020 to use these funds to support participants in home- and community-based settings.[150] It is estimated that a significant number of senior nursing home residents could still be transitioned into communities if the MFP continues beyond its current funding cycle ending on September 30, 2016.

The program should be extended and funds appropriated at a level

similar to previous years until such time that a decision is made as to whether it should become a permanent part of the Medicaid program. This will ensure that states continue to build the necessary infrastructure that allows an older adult to transition from an institutional setting to a quality and stable community-based arrangement. In an effort to determine the appropriate funding level, analyses should be conducted to demonstrate whether transitioning beneficiaries from institutionalized settings to community settings results in cost savings to the Medicaid program.

States should also continue to think creatively about how to expand affordable housing options for beneficiaries ready to be transitioned from institutionalized settings. For example, Iowa has created a state-funded rental-subsidy program administered by the Iowa Finance Authority that specifically targets older adult Medicaid HCBS recipients. Similar initiatives may further increase the supply of affordable housing, a recognized barrier for people who want to leave institutionalized settings.[151] For its part, CMS should disseminate best practices from its Medicaid Housing-Related Services and Partnerships program to all states to support housing tenancy and accelerate Medicaid-state housing-agency partnerships. This effort is part of Medicaid's Innovation Accelerator Program and will run through October 2016.[152]

***States should also continue to think creatively about how to expand affordable housing options for beneficiaries ready to be transitioned from institutionalized settings.***

Finally, states should also think about how to provide enhanced case management and evidence-based programs (e.g., CAPABLE intervention) to older adults transitioning into community settings to ensure they have adequate supports. Older beneficiaries with multiple chronic conditions and multiple limitations in activities of daily living will likely have different needs as they transition into community settings compared with younger

individuals. One of the lessons learned by states as documented in the MFP 2014 Annual Evaluation Report is that early identification of an older adult's needs and preferences, such as assistance for mental health conditions, is essential to facilitate timely linkages to services in the community and to avoid reinstitutionalization.[153]

**Recommendation #5.** Congress and the administration should work together to extend the MFP program to support state efforts to rebalance their Medicaid long-term care systems.

The federal Medicaid program currently pays for housing in the form of nursing homes, but it does not otherwise allow capital funding for supportive housing and it does not pay for room or board. In a recent Medicaid Informational Bulletin, the agency laid out a number of opportunities through which states could be reimbursed for providing housing-related activities and services. These activities include individual housing transition services (e.g., assisting with the housing application process; identifying resources to cover expenses, such as moving costs; and ensuring that the living environment is safe) and individual housing and tenancy sustaining services (e.g., education and training on the role, rights, and responsibilities of the tenant and assistance with the housing recertification process). In addition, through home- and community-based waivers, states can cover environmental modifications to install necessary accommodations for accessibility.[154]

Medicaid does not have comprehensive knowledge of how each state is currently using these various opportunities and to what extent older beneficiaries — specifically beneficiaries dually eligible for Medicare and Medicaid who are at risk for institutionalization — are eligible to

utilize these services. Not only should Medicaid track this information, where possible, it should also seek to quantify the impact of these services on beneficiary outcomes and health costs. In doing so, Medicaid would also be satisfying the secondary objective of ensuring that coverage of housing-related services is supplementary to, and not duplicative of, other federal programs that provide housing assistance to vulnerable populations.

In addition, given the evidence suggesting that placing people who are homeless in supportive housing can lead to improved health, reduced hospital use, and lower health costs, especially when frequent users of health services are targeted, several states are contemplating using their own Medicaid dollars (nonfederal) to pay for housing. For example, New York funds housing in the form of both newly constructed supportive housing units and subsidies for use in existing units.[155] Medicaid should ask states that pay for capital expenditures and room and board to evaluate their respective interventions and share data on beneficiary health outcomes and potential cost savings. This information could help inform policies of other state Medicaid programs as well as future federal Medicaid policy with regards to the coverage of housing-related services.

**Recommendation #6.** Medicaid should collect data on state coverage of housing-related activities and services and, where possible, track its impact on beneficiary health outcomes and health costs.

## *Hospitals*

Medicare pays for more than 14 million hospital stays annually.[156] Each hospital discharge offers an opportunity for health care personnel to inquire about aspects of housing that may impact a senior individual's recovery at home. CMS has proposed a rule revising requirements for discharge planning for hospitals. The rule suggests that hospitals consider the availability of and access to non-health care services for patients, which may include help with home and physical environment modifications, assistive technologies, transportation services, meal services, household services, and housing for homeless patients.[157] Regardless of the final rule, hospitals should begin to more explicitly incorporate questions into their discharge process regarding both housing stability and falls risks.

***The nearly 3,000 nonprofit hospitals across the country could take a larger role in assessing the housing of seniors as part of their community benefit obligations.***

With respect to the latter, hospitals should underscore several home-safety recommendations from the National Patient Safety Foundation as patients are discharged.[158] These include:

- Plan to enter your home without climbing steps. If you need to climb steps to enter your home, determine if a neighbor, friend, or family member will be routinely available to provide assistance to you.
- Plan to make your bedroom on a floor with a bathroom if possible.
- Use night-lights in strategic areas to prevent falls at night.
- Place the telephone and emergency telephone numbers near you.
- Keep hallways, stairways, and pathways clear of clutter.
- Wear snugly fitting, nonslip, low-heeled shoes or slippers.

These issues are all the more important given that Medicare reimbursements to hospitals are now impacted by 30-day readmission rates. Specifically, since 2013, the federal Hospital Readmissions Reduction Program imposes payment reductions on hospitals considered to have excessive readmission rates for Medicare patients. The program was created in response to the fact that nearly one in five Medicare patients discharged from hospitals were being readmitted within 30 days, at a cost of more than $17 billion annually.[159] Many hospitals are now working in partnership

## Bon Secours Baltimore Health System: Integrating Health and Housing for Optimal Aging

Bon Secours Baltimore Health System is a full-service health system, providing primary and emergency care, as well as a host of other services to meet health care needs in west Baltimore.[161] It dedicates nearly 12 percent of its operating budget to community benefit. In addition to its 88-bed acute care hospital, what is noteworthy about this institution is that it owns nearly eight times that number of affordable homes. In partnership with Enterprise and HUD, Bon Secours has been developing and operating housing for several decades. As of 2014, Bon Secours owned 648 homes, with 530 designated for disabled seniors and 119 for families. The system's neighborhood-revitalization strategy has ensured that every project to date, whether a renovation or a new construction, has been a reuse of a formerly vacant space. The city of Baltimore and the state of Maryland have been critical partners with respect to both financing options and zoning approvals. In the future, Bon Secours is looking to roughly double their number of homes.

To ensure the health of seniors, most of the affordable homes have onsite service coordinators to link residents with services at the hospital and in the community. The design of the senior buildings also offers communal settings to maximize social interaction among residents. Transportation options provide residents with access to essential services. Key measures of success include ensuring that residents are able to successfully age in place so they have the support they need. Most residents stay long-term and most properties have long waiting lists, demonstrating the need the health system is meeting for seniors. Bon Secours exemplifies a health care entity that understands the connection between health and housing for optimal aging.

with community-based organizations to facilitate care transitions from hospital to home. Although some hospitals are also beginning to conduct outreach to public and private housing associations and Villages, most hospitals are still at the earliest stages of determining how to work with housing stakeholders to reduce readmissions; much more effort needs to be undertaken in this area.

Finally, the nearly 3,000 nonprofit hospitals across the country could take a larger role in assessing the housing of seniors as part of their community benefit obligations. Specifically, community health needs assessments, mandated by the Affordable Care Act, are a requirement hospitals must meet to maintain their tax-exempt status with the IRS. Each assessment also requires a community implementation plan. In this way, hospitals that uncover a lack of senior housing options in a community could consider working with partners such as city housing and planning commissions to address this issue as part of their community implementation plans. The IRS has recently clarified that housing-improvement expenditures that meet a documented community need can be considered as a community benefit activity.[160]

**Recommendation #7.** Hospitals should incorporate questions about housing as part of their discharge planning to prevent hospital readmissions, and nonprofit hospitals, specifically, should include housing in their triennial IRS-required community health needs assessment.

## *Task Force Takeaway*

In the years ahead, far greater integration of health care and supportive services with housing will be essential to improve health outcomes and will allow millions of seniors to age more successfully. A more integrated approach also holds the promise of substantially reducing overall medical costs. Fortunately, there are several important opportunities available today to test these propositions through Medicare, Medicaid, and the nation's hospital system. Seizing these opportunities is a critical step to realizing the full benefits of a more integrated approach that can transform homes into centers of senior health and well-being.

# Chapter 5. The Power of Technology to Support Successful Aging

Technology influences almost every aspect of American life, including how Americans shop, travel, socialize, and manage their finances. Technologies have been adopted widely among adults:

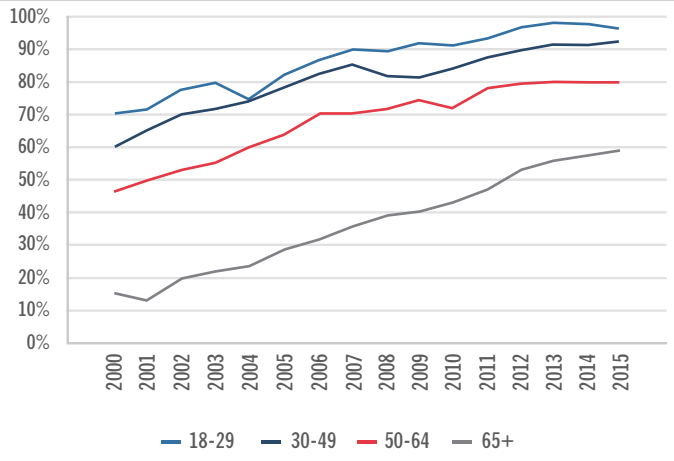
- 92 percent use a cell phone.
- 68 percent use a smartphone.
- 73 percent use a laptop or desktop computer.
- 45 percent use a tablet.[162]

And increasingly, Americans are using these technologies to help them navigate their health and health care:

- 72 percent of Internet users have looked online for health information.[163]
- Seven in ten American adults say they track at least one health indicator for themselves or for someone else.[164]
- 48 percent of Americans communicated via email or text with a health provider, used a health app on their smartphone, or looked at medical test results online.[165]

While older adults have lagged the general population in Internet use, today 58 percent of Americans over 65 use the Internet (see: Figure 5-1). For adults between 50 and 65 years old — younger baby boomers reaching retirement in the coming years — Internet use jumps to 81 percent. With increasing comfort and acceptance, health technologies have great potential to remove impediments to independent and optimal aging. These technologies can help manage

**Figure 5-1. Internet Use by Age**




Source: Pew Research Center.[166]

***For adults between 50 and 65 years old, Internet use jumps to 81 percent.***

chronic disease, reduce social isolation, support physical activity, and offset functional and cognitive impairments.

Public- and private-sector activities are now underway to enable consumer-facing applications, new medical devices, software, and clinical and administrative systems to work together seamlessly to enable the tracking, sharing, analysis, and use of health information. Electronic information sharing is expected to help people live healthier lives while also reducing costs by improving efficiencies and care delivery. A connected health care system will enable physicians to make medical decisions informed by real-time health information and complete medical records. And, in this ideal world, technologies would exist to detect and warn physicians when something goes wrong — for example, if medications were not taken on schedule or an older adult shows an increased risk of falling.

Examples of health technologies that are expected to achieve wider adoption include remote patient monitoring tools that connect blood pressure cuffs, blood glucose meters, and heart rate monitors to the Internet to support self-monitoring and ongoing monitoring by clinicians and care teams; telehealth and secure messaging tools that support care delivery to and from remote locations; and online tools that help individuals access educational and health information and connect with social networks through online communities.[167]

The benefits of these technologies are increasingly well-documented:

- Telehealth has been shown to improve access to care, reduce the cost of care (for example, through reductions in hospital readmissions and transportation costs), and increase the convenience of care.[168] Telehealth also improves access to specialists and extends provider capacity — an important benefit given the projected shortages in nurses and physicians.[169]
- Remote patient monitoring has been shown to reduce hospital readmissions.[170]
- Secure messaging has been shown to improve quality of care and outcomes.[171]
- Patients with online access to their health information are more likely to personally find and correct errors or incomplete information in their record, understand their health conditions better, and keep up with their medications.[172]
- Mobile health technologies have been effectively used in managing weight; increasing physical activity; quitting smoking; and controlling high blood pressure, high cholesterol, and diabetes.[173]
- Health IT-based fall risk assessments helped clinicians identify individuals who are at elevated risk for falls and facilitate appropriate intervention strategies for those patients.[174]

Older adults — a majority of whom suffer from multiple chronic conditions — and their caregivers will benefit considerably from the use of health care technologies, including telehealth and remote patient monitoring services, easy access to information contained in their electronic health records (EHRs), and tools that assist with medication management. There are also other technologies that may help older adults age in place. They include fall monitoring systems, home-based activity monitoring to address cognitive impairments,

speech-equipped or visually oriented "smart devices" to support sensory impairments, and social-networking applications to help loneliness and depression.[175]

While these new technologies offer great potential for improving health outcomes for all older adults, those residing in rural communities may particularly benefit. Transportation is a significant hurdle for older adults in rural communities — where the average travel for medical services is 17 miles, more than double that of urban residents.[176] In addition, public transportation may not be available and rural residents may become dependent on others, adding stress and unreliability. Some communities additionally face potential shortages in available caregivers, nurses, and doctors — particularly specialists.[177] Promising telehealth and remote monitoring technologies may alleviate some of these challenges, enabling rural seniors and chronically ill patients to live safely in their homes and communities for longer.

## *Addressing Barriers to Technology Adoption*

Despite growing interest in using these myriad technologies to improve health and the delivery of health care, a few key barriers continue to stand in the way of higher levels of adoption. These barriers include high costs for consumers, lack of reimbursement, interstate licensing requirements, limited Internet access (particularly in rural areas and among low-income Americans), and continued concerns about the privacy and security of sensitive health information.[178] There are also other barriers that prevent effective use of technologies by older adults, including: paying for devices on a fixed income, forgetting or losing the technology, low ease of use, physical challenges, skepticism about benefits, and difficulty learning to use new technologies.[179]

All levels of government, philanthropy, and the private sector have a role to play in removing barriers that prevent the widespread adoption of increasingly important health technologies. Figure 5-2 details a number of efforts that have recently emerged to help address some of these barriers.

New technologies show great promise for improving the health and well-being of older Americans. Momentum is building for widespread adoption, with recognition of benefits by federal and state policymakers and private-sector payers. More work is needed to address remaining barriers to adoption, including those faced by seniors. But the opportunity for better health, reduced costs, and greater convenience for Americans is significant. The following are some additional policy recommendations for the federal government to more effectively encourage, develop, and scale technologies that support healthy aging in place.

***All levels of government, philanthropy, and the private sector have a role to play in removing barriers that prevent the widespread adoption of increasingly important health technologies.***

Cost is a chief concern regarding technologies for aging in place.[189] In the Task Force's own survey on technology and aging, a majority of survey respondents cited cost and lack of options to pay for technologies as very significant barriers to scaling technological innovations that support aging in place and optimal health — far ahead of privacy issues, broadband availability, interoperability, and others. Similarly, a majority of respondents selected "encourage Medicare/insurance reimbursement" as one of the best ways for the federal government to encourage, develop, or scale technologies that support healthy aging in place.

While providers are increasingly recognizing the potential of leveraging electronic tools to improve health outcomes and to empower patients to improve their health, more must be done. For example, despite the cost savings and improvements in access that are enabled by telehealth, of the more than $600 billion in Medicare spending in 2014, reimbursements for telehealth

**Figure 5-2. Developments in Removing Key Barriers to Technology Adoption**

| | |
|---|---|
| **EHR INCENTIVES PROGRAM** | The Medicare and Medicaid Electronic Health Record Incentives Program (often referred to as "Meaningful Use") has provided more than $30 billion in incentive payments since 2011 to eligible professionals and hospitals for the adoption and meaningful use of EHR technology.[181] These technologies enable secure electronic messaging with patients on relevant health information and give patients the ability to view, download, and transmit health information online.[181] Despite increasingly rapid adoption, only 49 percent of eligible professionals and 77 percent of eligible hospitals had attested for stage 2 of "meaningful use" as of 2016.[182] |
| **DELIVERY SYSTEM PAYMENT REFORMS** | The federal government, states, and private-sector payers are increasingly adopting new delivery system and payment reforms that promote value and outcomes over volume in order to provide an environment conducive to the use of new health technologies. This includes not only accountable care models, shared savings, and bundled payments, but also provisions in the Affordable Care Act that require CMS to penalize hospitals for readmissions that occur within 30 days of discharge.[183] Also, several private-sector health plans, including Anthem, now include coverage of telehealth services in their benefits packages.[184] |
| **THE CONNECT FOR HEALTH ACT** | In February 2016, Senators Brian Schatz (D-HI), Roger Wicker (R-MS), Thad Cochran (R-MS), Ben Cardin (D-MD), John Thune (R-SD), and Mark Warner (D-VA) introduced the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, which allows telehealth and remote patient monitoring services to be used by qualifying participants in alternative payment models and Medicare Advantage without 1834(m) regulatory restrictions and clarifies other policies that would expand telehealth services through Medicare.[185] |
| **INTERSTATE MEDICAL LICENSURE COMPACT** | The Federation of State Medical Boards released an Interstate Medical Licensure Compact to streamline and expedite the pathway to licensure for qualified physicians who wish to practice in multiple states, which can help facilitate innovations in health care, such as telehealth. To date, 26 state legislatures have introduced the legislation and the Compact has been enacted in 12 states.[186] |
| **INTEROPERABILITY ROADMAP** | The Office of the National Coordinator for Health Information Technology has been tasked with advancing interoperability of health technologies, a key and often cited barrier.[187] In its effort, the Office of the National Coordinator developed a roadmap to nationwide interoperability that includes guiding principles and milestones, and sets a target date of 2024 for building an interoperable health IT infrastructure. |
| **PCAST REPORT AND RECOMMENDATIONS** | The President's Council of Advisors on Science and Technology (PCAST) released a report in March 2016 making 12 recommendations to support and enhance the role of technology in encouraging the healthy aging of older Americans.[188] The recommendations focus on actionable, near-term items for federal action. |

were less than $14 million.[190] The shift away from fee-for-service payment toward population health and other value-based delivery and payment models represents a key opportunity for broader integration of telehealth.

CMS is now allowing providers to use telehealth in the CMS's Next Generation Accountable Care Organization model and, after rulemaking with notice and a public comment period, is expected to allow telehealth waivers in the Medicare Shared Savings Program. In addition, BPC has previously recommended that the Senate Finance Committee Chronic Care Working Group consider:[191]

1. Authorizing CMS to test allowing Medicare Advantage plans in some states to include telehealth in their bids with the goals of improving care quality, outcomes, and value. This test could inform the range of telehealth services that should be permitted if the model is deemed eligible for expansion to a permanent, nationwide feature of the Medicare Advantage program.
2. Eliminating originating site requirements to ensure

## BPC Survey on Supporting Aging in Place and Optimal Health Outcomes through Technology

BPC's Senior Health and Housing Task Force conducted an online survey in March 2016 to inform its work and learn from practitioners in the field. (Note: see Appendix for a full copy of the survey.)

### Which technologies are the most effective and scalable?

Respondents ranked their top three choices. Below is the percentage of survey respondents that ranked that technology in the top three.

| | |
|---|---|
| Telehealth/telemedicine | 63% |
| Remote monitoring | 63% |
| Emergency detection and response | 58% |
| Health tracking devices & apps | 47% |
| Social networks/online communities | 36% |
| Secure messaging | 14% |
| Other | 7% |

**KEY TAKEAWAY** Nearly two-thirds ranked "telehealth/telemedicine" and "remote monitoring" among their top three.

### What are the key barriers to scaling innovations?

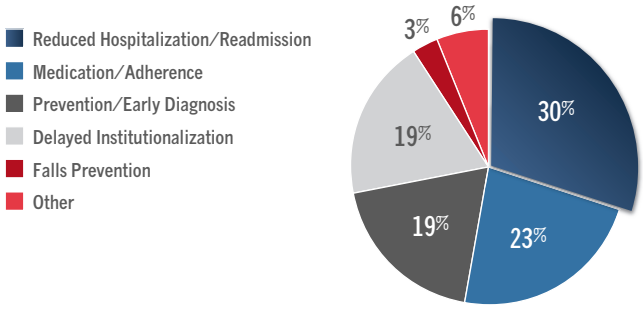
Below is the number of respondents that marked these barriers as "very significant."

| | |
|---|---|
| Lack of options to cover cost | 98 |
| Price/cost for perceived value | 82 |
| Interoperability | 73 |
| Consumer discomfort/limited tech literacy | 69 |
| Product complexity | 67 |
| Privacy/data security | 57 |
| Broadband availability | 49 |
| Other | 12 |

**KEY TAKEAWAY** Survey respondents had costs on their minds—a majority cited "lack of options to cover cost" and "price/cost for perceived value" as very significant barriers.

### What are achievable health outcomes using new technologies?

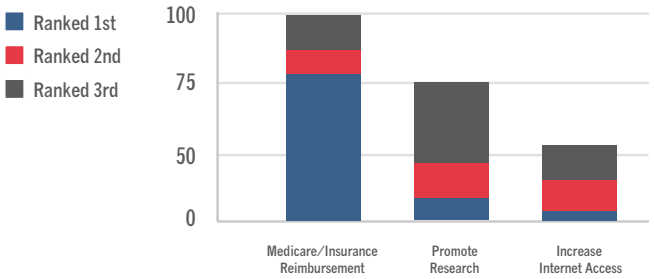
Respondents chose the most achievable outcome.




**KEY TAKEAWAY** Reduced hospitalization and readmissions was ranked most achievable (30 percent).

### What can the federal government do?

Respondents ranked their top three choices, as shown below.




**KEY TAKEAWAY** "Encourage Medicare/insurance reimbursement of aging in place technologies" ranked as the top choice of survey respondents.

**About the Survey:** The survey was voluntary and transmitted electronically to a wide range of stakeholder groups. As intended, this information is illustrative only and not meant to be statistically representative. One hundred seventy-nine (179) individuals responded to the survey, categorizing their organizations as follows: nonprofit (21%); consultant or advisory service (19%); health care or insurance provider (15%); housing agency, provider, or builder (10%); association or trade group (8%); government entity (8%); tech entrepreneur or developer (6%); academic (6%); investor or seed accelerator (1%); and other (10%).

broader access and flexibility to help plans achieve these goals. (Originating site restrictions constrain telehealth reimbursement since that patient can only be located at certain clinical sites.)

3. Encouraging more states to adopt the Interstate Medical Licensure Compact, which can streamline medical licensure to help facilitate innovations in health care, such as telehealth.

The CONNECT for Health Act recently introduced in the House and Senate would expand the use of telehealth and remote monitoring and should receive serious consideration given its potential to enhance quality of care and reduce health care costs.

With Medicaid, the onus is on individual states to pursue reimbursement of aging technologies that could improve health outcomes and reduce costs. According to the LeadingAge Center for Aging Services Technologies, personal emergency response systems (PERS) are the most commonly reimbursed technology with support in at least 44 states, followed by medication management and telemonitoring/home telehealth.[192] Pennsylvania, New York, South Carolina, and South Dakota are among the most active in using Medicaid waivers to support reimbursement programs for aging technologies. Along with using Older American's Act Title III funding, Medicaid state plan services, and Veterans' Administration programs, states should continue to consider how best to reimburse effective technologies that facilitate aging in place, positive health outcomes, and cost savings.

**Recommendation #1.** CMS and the states should encourage greater reimbursement of telehealth and other technologies that have the potential to improve health outcomes and reduce costs.

Enabling the use of these technologies by older adults is as important as the technology itself. Using technology has considerable value for older adults: improved health outcomes, access to Internet-based health care options, improved self-sufficiency, increased productivity, and less social isolation (reduced loneliness). Internet access is also critical for seniors attempting to navigate federal benefits and programs — which are increasingly online.

A number of recent efforts are working to expand access to broadband and related training programs to low-income Americans. In particular, the Obama administration's ConnectHome initiative is a pilot program launched in 27 cities and one tribal nation that works to deliver affordable Internet connectivity, particularly for children in HUD-assisted housing. It leverages existing federal resources while encouraging partnerships between Internet Service Providers, mayors, public housing authorities, nonprofits, and other companies to provide free or affordable Internet access, technical training, and digital-literacy training. HUD is also planning, through rulemaking, to require new and substantially rehabilitated HUD-assisted housing to include broadband infrastructure with limited exceptions.[193] These efforts, along with work at the National Telecommunications and Information Administration and Federal Communications Commission, are critical to expanding broadband access.

With a similarly strong federal commitment to preserve and leverage existing resources and build new partnerships with the private sector, Congress and the administration could ideally expand affordable, cost-effective, basic broadband connectivity to HUD-assisted and USDA-assisted seniors in rental housing properties. If states and local governments were committed to this goal as well, the effort could also reach LIHTC properties. This idea, though focused on lower-income seniors, dovetails with the recent recommendation from the President's Council of Advisors on Science and Technology, which recommended that HHS work with other agencies to develop a national plan to ensure all older adults have broadband Internet access. Internet access is fundamental to facilitating use of technologies that could potentially reduce costs, improve health outcomes, and enable aging in place.

**Recommendation #2.** Congress, the administration, and the states should work together to make broadband (with sufficient speed to use online education and training programs) available to as many HUD, USDA, and LIHTC properties where low-income seniors reside, including in rural communities, as possible.

With the proliferation of technologies that may contribute to optimal aging, one great need is further research, including research to quantify the value of senior households having access to the Internet. Recent administration efforts have prioritized Internet access for students and subsequently performance; this logically follows as the Internet is an increasingly critical tool in education. Yet older adults also benefit from Internet access, as this chapter has highlighted. Data does not currently exist quantifying the benefits or value of seniors having Internet access, though such information could provide evidence to policymakers and lead to enhanced funding where it would be cost-effective.

Along with home Internet access, more rigorous studies could further demonstrate the value of telehealth and remote monitoring technologies in effectively reducing preventable hospitalizations, hospital readmissions, and other negative health outcomes.[194] As evidence builds on how to best implement and deploy these technologies, alternative payment models should be able to increasingly incorporate them. PCAST has further recommended that several federal agencies support interdisciplinary and translational research on aging technologies.

**Recommendation #3.** Relevant federal agencies should work with the scientific research community and the private sector to demonstrate the benefits of home Internet access for very low-income seniors and the effectiveness of health technologies.

## *Task Force Takeaway*

The potential impact of technology on optimizing the health of seniors cannot be overstated. By utilizing this technology in the home setting, health care providers have the opportunity to promote healthy aging in place. We have not yet realized the promise of technology for this purpose; it is time to address and overcome the research, connectivity, and reimbursement barriers so that seniors can be empowered and engaged.

# *Concluding Thoughts*

The United States is in a crisis and must confront a number of challenges: increased demand for expensive LTSS, a high prevalence of chronic disease, grossly inadequate retirement savings, and a severe undersupply of affordable and suitable senior housing. These issues affect us all; if they do not yet affect us individually, they likely affect our grandparents, parents, neighbors, or friends.

The simple truth is that for too long the nation has recognized its shifting demographics — driven by the aging of a massive generational cohort, the baby boomers, coupled with rising longevity — but failed to make investments that preserve dignity and independence in old age. Structurally, U.S. homes and communities have not been built for seniors to live safely. And governmental structures too often prevent collaborations that recognize the importance of the home setting to wellness.

The implications of this failure cannot be understated. The statistics are clear: 10,000 baby boomers hit age 65 every day. But society at large has not considered what this means for the nation's systems and services: growing demand for housing, ambulances, meals on wheels, financial planning tools, and other infrastructures and products. As a society and as policymakers, we have to act. Not only is the ability to age in place a widespread aspiration, but it can have a huge upside for the U.S. economy, the national budget, and American communities.

The Senior Health and Housing Task Force has worked to provide valuable guidance and an actionable, bipartisan agenda. As proposed, our recommendations would:

- Preserve and expand the supply of affordable and suitable housing to protect the most vulnerable seniors;
- Increase awareness and intergovernmental collaboration to better deploy federal resources in creating and sustaining healthier home and community environments for all ages;
- Move the United States much closer to aligning incentives and breaking down silos to better integrate health and housing policy to save money and materially improve the quality of life of our seniors; and
- Advance the development and deployment of technologies proven to support optimal health outcomes and aging in place.

Better connections between health and housing are just the beginning. The focus of this report has been on the tangible benefits of a policy framework that recognizes the inherent value of housing and the built environment to the health and happiness of our nation's seniors. Yet the demographic transformation taking place has a much more profound impact on all facets of government and society. While the policy recommendations provided represent a positive step forward, the Task Force recognizes the limitations of a single report. Further research and effort is needed to:

- Provide additional support to the nation's caregivers;
- Explore new and innovative ways of bringing government agencies together, breaking down policy silos in Congress, and implementing policies that more deeply recognize costs and benefits to society; and
- Build the evidence base on the cost savings and health benefits of housing, home modifications, community supports, and aging technologies, and integrate the systems that support them all.

# *Survey: Supporting Aging In Place and Optimal Health Outcomes through Technology*

The Bipartisan Policy Center's Senior Health and Housing Task Force is chaired by former HUD Secretary and Senator Mel Martinez, former HUD Secretary Henry Cisneros, former Representative Allyson Schwartz, and former Representative Vin Weber. The purpose of this survey is to inform a report set to be released in later spring which will include bipartisan policy recommendations to better integrate health care and housing for America's older adults. We hope to learn from your perspective on an increasingly important topic the role of technology in supporting aging-in-place and optimal health for older adults. Your responses will be kept anonymous and private. Thank you for participating.

1. **Organization:** _____

2. **Name:** _____

3. **Position/Title:** _____

4. **Of the following list, please rank the top three types of technology you believe are most likely to be broadly adopted and effective in supporting aging in place and optimal health.**

| | 1 | 2 | 3 |
|---|---|---|---|
| Secure messaging | ○ | ○ | ○ |
| Health tracking devices and apps (e.g. nutrition, fitness) | ○ | ○ | ○ |
| Telehealth/telemedicine | ○ | ○ | ○ |
| Emergency detection and response | ○ | ○ | ○ |
| Remote monitoring | ○ | ○ | ○ |
| Social networks/online communities | ○ | ○ | ○ |
| Other | ○ | ○ | ○ |
| If you selected "Other" please specify: | ○ | ○ | ○ |

_____

5. **Below is a list of desired health outcomes. Which of these outcomes could be best achieved through the deployment of home-based technological innovations?**

- ○ Reduced hospitalization and readmission
- ○ Delayed institutionalization
- ○ Falls prevention
- ○ Medication adherence
- ○ Prevention/early diagnosis of frailty, chronic disease, cognitive decline, etc.
- ○ Other (please specify)

_____

6. **Please rank the significance of these barriers to scaling technological innovations that support aging in place and optimal health.**

| | Not Significant | Somewhat Significant | Very Significant |
|---|---|---|---|
| Privacy and data security | ○ | ○ | ○ |
| Broadband availability | ○ | ○ | ○ |
| Interoperability of devices/care | ○ | ○ | ○ |
| Price/cost for perceived value | ○ | ○ | ○ |
| Consumer discomfort or limited tech literacy | ○ | ○ | ○ |
| Product complexity | ○ | ○ | ○ |
| Lack of options to cover cost (e.g. financing, insurance, etc.) | ○ | ○ | ○ |
| Other | ○ | ○ | ○ |
| If you selected "Other" please specify: | ○ | ○ | ○ |

_____

7. **Of the following list, please rank the top three ways you think the federal government could most effectively encourage, develop, or scale technologies that support healthy aging in place.**

| | 1 | 2 | 3 |
|---|---|---|---|
| Encourage Medicare/insurance reimbursement of aging in place technologies | ○ | ○ | ○ |
| Support financing mechanisms for broader acquisition/consumer access to health-enhancing technologies | ○ | ○ | ○ |
| Increase access to high-speed internet and cell phone data plans among low-income older adults and those in rural communities | ○ | ○ | ○ |
| Reduce barriers to innovators' access to capital – including support for alternative sources of capital like crowdfunding | ○ | ○ | ○ |
| Create tax credits or other incentives for innovators with proven success in reducing costs and improving care of older adults | ○ | ○ | ○ |
| Support health technology literacy among older adults through training resources and/or professionalization/certification of technology advisers | ○ | ○ | ○ |
| Promote research on the savings and economic impacts of technological innovations that improve care and facilitate aging-in-place | ○ | ○ | ○ |
| Address inequitable availability and use of technological advancements among disadvantaged groups | ○ | ○ | ○ |
| Other | ○ | ○ | ○ |

If you selected "Other" please specify:

_____

8. **Please choose the most appropriate description of your organization.**

- ◯ Startup/Entrepreneur
- ◯ Investor or Seed Accelerator
- ◯ Software Developer
- ◯ Health Care Provider
- ◯ Insurance Company
- ◯ Consultant or Advisory Service
- ◯ Housing Provider or Builder
- ◯ Association or Trade Group
- ◯ Other (please specify)

_____

9. **Does your organization develop or market home-based technological innovations meant to improve care for older adults or facilitate aging in place?**

- ◯ Yes
- ◯ No

10. **Please select the purpose(s) of your product(s).**

- ◯ Vital Sign Monitoring
- ◯ Emergency Detection and Response
- ◯ Care Navigation
- ◯ Physical Fitness
- ◯ Diet and Nutrition
- ◯ Social Engagement
- ◯ Behavioral and Emotional Health
- ◯ Medical Management
- ◯ Caregiver Supports
- ◯ Home Automation/Monitoring
- ◯ Not Applicable
- ◯ Other (Please specify)

_____

**11. Please indicate the annual household income level(s) your product(s) is/are targeted toward.**

- ◯ Prefer not to say
- ◯ Under $10,000
- ◯ $10,000 —$39,999
- ◯ $40,000— $99,000
- ◯ Over $100,000
- ◯ Not applicable

**12. How long have you been developing and/or marketing your product?**

- ◯ Less than 6 months
- ◯ 6 to 12 months
- ◯ 1 to 3 years
- ◯ 4 to 6 years
- ◯ 7 years or more
- ◯ Not applicable

**13. Please rank the most important features that products or devices must have to be successful.**

| | Less Important | Somewhat Important | Very Important |
|---|---|---|---|
| Ease of use | ◯ | ◯ | ◯ |
| Tangible individual benefit | ◯ | ◯ | ◯ |
| Specificity | ◯ | ◯ | ◯ |
| Interoperability | ◯ | ◯ | ◯ |
| Privacy and data security | ◯ | ◯ | ◯ |
| Media interest/publicity | ◯ | ◯ | ◯ |
| Stakeholder validation | ◯ | ◯ | ◯ |
| Other (please specify) | ◯ | ◯ | ◯ |

14. Please provide additional information/data to support and amplify your answers above (if applicable).
If you have any reports or materials you are interested in sharing, **please email them to Jake Varn at housing@bipartisanpolicy.org**

Specifically, we are interested in:

a. State of promising technologies that support aging in place (and/or support caregivers)

b. Evidence-base behind these technologies as relates to improved outcomes, quality of life and reduced costs

c. Disparities with regards to access of these technologies

d. Policy barriers at the federal, state, and local levels to scaling the use of these technologies

e. Policy opportunities at the federal, state, and local levels to addressing these barriers

f. Opportunities for public-private partnerships to accelerate adoption of technologies that support aging in place

# Endnotes

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