HOUSING OPTIONS FOR LOW-INCOME ELDERLY

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Part I of a series of III.

Executive Summary

This report was undertaken in response to questions which emerged over the course of two years community nursing experience with residents of public housing in the city of Minneapolis. It is directly related to the High Rise Nursing Project of the University of Minnesota School of Nursing. This project was initiated in 1984 as a joint effort between the city of Minneapolis and the School of Nursing through the Center for Urban and Regional Affairs. It is based on a reciprocal relationship in which residents receive health services and students receive educational credits leading to a degree in nursing.

This is the first in a series of three reports exploring issues which posed particular questions related to service provision: 1. Transitional Housing Options for Low-income Elderly; 2. Chemical Abuse Among Elderly; and 3. Mental Health Services to Residents of High Rises. The central objective in exploring these issues was educational; to enhance awareness of and access to the organization and delivery of services in these areas.

In this first report, the expressed need for transitional housing options for low-income residents is explored. By placing the issue into the context of national, regional, and local planning for current and projected housing needs, students will be assisted to understand the resident experience as a broader issue, which includes decision-making at many levels of political organization and program implementation. The case studies include residents from each of the three high-rise project locations. These give the students the direct opportunity to examine how planning decisions affect the needs of individuals within the context of the students' own high-rise practice setting. Further, these case studies promote student understanding of the process of communicating resident needs to decision makers so that meaningful options can be developed. It is anticipated that this report can become the basis for student-faculty discussion of the potential role nurses can take in this question. Public health nurses have a tradition of social action which, in recent years, has been diverted by preoccupation with medical treatment of disease in individuals. Addressing the needs of low income elderly and disadvantaged populations requires a broader view of health care delivery.

A central finding of this report is that housing options for low-income elderly who are seeking an intermediate facility between independent high rise living and the nursing home are scarce. The concerns residents voiced in the case studies substantiate this finding.

The project faculty gratefully acknowledges the cooperation of the high-rise residents and agency personnel from MCDA and Senior Resources, Inc. who agreed to be interviewed for this study. In addition, we thank Tom Anding, the Assistant Director of CURA for his invaluable assistance in initiating this study.

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The purpose of this paper is to address the issue of housing options for the low-income elderly in Minneapolis. The original impetus for the investigation came from the University of Minnesota School of Nursing high-rise project, in conjunction with the Center for Urban and Regional Affairs.

Since the School of Nursing deals with the population of elderly in public housing, the focus of this report will be on housing options available to those elderly with low incomes. The report will present options currently available in this country as discovered in a search of the recent relevant literature (since 1977). It will then address options available in the Twin Cities metropolitan area as described in literature published chiefly by the Metropolitan Council. A description of interviews with four residents of public housing will be presented in an effort to illustrate the perspective of a person living in the present system and some of the problems encountered. The last section will discuss approaches to some of the problems as have been documented in the literature with suggestions for local interventions. Finally, more specific suggestions for intervention strategies by nursing students presently working with the population in public housing will be presented.

One of the reasons that there has been an increasing emphasis on housing in the past few years is the realization that too many of the elderly are institutionalized in nursing homes. Currently approximately 5% of people over 65 are living in long term care facilities. It is

estimated that 20-30% of people over 65 will be institutionalized at some time (Ham, 1980). Studies have demonstrated that perhaps half of the people in institutions could live independently if alternatives were available and supported. There exists some controversy about exactly how many people could live independently, about exactly what kinds of services would be needed to support that independence, about who should decide, about where the support should come from, and about how much money can be saved by preventing unnecessary institutionalization (Lawton, 1977; Hamm, 1980; Huth, 1983).

One thing is certain, however, and that is that institutionalization is expensive. Nursing home care costs about $17,000 per year right now. One estimate states a need for 300,000 additional nursing home beds over the next decade at a cost of between $5 and $6 billion. Decreasing government resources suggest that this cost is prohibitive for federal support. David Banks, the President of Beverly Enterprises, a major chain of nursing homes, says that the private sector cannot afford it. The only idea that makes sense is to try to discover alternatives to institutionalization.

Approximately 70% of the older population are homeowners (Lawton, 1977). Most of these people have paid for their homes and want to stay in them. Even though the homes are older, the quality is poorer than the general population, and more of them are located in central metropolitan areas and small towns. Generally it is true that older people prefer an independent living arrangement (Lawler, 1977, Rossman, 1978, and Hare and Haske, 1984).

There are constraints on living alone and constraints on offering home health care to people in order that they might continue to live

alone with support. Major constraints on the availability of home care are the expense of formal providers, the need to travel to provide care for elderly living alone, the desire for privacy, and an increasing participation by women (primarily caregivers) in the workforce. Living alone limits the security one feels, limits the ability of others to provide security, and increases the likelihood that medical needs will go undetected and untreated (the "discovery effect"), (Hare and Haske, 1984). Despite the problems associated with living alone, the fact is that most people prefer it and, given the cost of institutionalization, it must be investigated as an alternative. There is obviously a national need for innovative living arrangements that can preserve privacy as well as reduce the financial and personal costs of providing in-home long-term care to the elderly.

The American Association of Retired Persons has published a booklet describing housing options. The pamphlet entitled "Housing Choices for Older Homeowners" is available from the Housing Department of the federal government. Included are descriptions of "... a number of things homeowners can do to help achieve the goals of continued independence, financial security, comfort, and safety." (p. 1). Although the booklet is aimed at older homeowners who at least have the asset of a paid mortgage, it recognizes the problems of people on a fixed income when the asset of a home has potential to become a liability given problems of maintenance and upkeep. Options listed include home equity conversion, a plan whereby a person may continue to live in his dwelling after "selling" it to an investor. The owner receives cash for the value of the property and contracts with the new

owner for living arrangements. Advantages and disadvantages of each option are presented.

Other choices described include ECHO housing, accessory apartments, house-sharing, and room-rental. ECHO housing, ECHO being an acronym for Elder Cottage Housing Opportunities, refers to manufactured housing units installed on the property of a single-family residence in order to accomodate an elderly relative. The idea is derived from a European concept referred to in the literature as "granny flats." The units are designed to be temporary and can be removed when no longer needed. Accessory apartments are additional living areas built on to existing homes. This presents an option for an older homeowner who needs additional income (by taking in a boarder), or for younger homeowners who wish to provide housing for an older relative. House-sharing refers to the concept of several unrelated adults living together in a large house and sharing living expenses and housekeeping duties. All of these options are available depending to a great degree on local zoning laws. The American Association of Retired Persons, in fact, cites as the most immediate need for solving the problem of housing for the elderly, a "critical re-examination of zoning laws," (p. 11). Options listed by AARP, once again, describe choices chiefly for elderly homeowners. Low income elderly have fewer housing options available and generally experience more health problems. Their situation seems to point to the need for low income housing in which support services can help maintain independent living.

Low-income elderly generally reside in public housing or with relatives. Lawton states that only about 3 per cent of elderly in 1977 resided in "housing designed explicitly for the elderly," (Lawton, 1977).

Despite what seems like a low residency rate, indications are that increasingly large numbers of elderly are choosing the option of planned housing for the elderly. There are at least half a million subsidized units for low and moderate income elderly and a much larger number already developed or being developed by both commercial and non-profit sponsors, usually for the more affluent elderly (Lawton, 1977, Schultz, 1979, Greenbaum, 1979).

The literature seems to reflect a national awareness of the need for housing options for the elderly. But where to live is only one of several complex and interrelated problems facing the elderly person in society today. If trends continue as predicted, not only will this country have many more elderly facing the problem within the next two decades but will have fewer resources that can meet the demand. If the issue were merely numbers of places to reside, the solution would be relatively simple. But because of the many other problems of old age such as chronic illness, fixed or declining income in an inflationary society, lack of sufficient public transportation, scattered family support systems, changing Medicare financing, declining Social Security funding, the issue of where our older Americans shall live becomes intertwined with ideas about long-term care and how best we, as a society, can plan for the future.

There is evidence of effort on the part of some state and local governments to address the issue by examining the whole area of long-term care as it reflects the problems of the elderly population. In Minnesota, the state is divided into 13 regions each of which has responsibility for its own development and for decisions about how to allocate state and federal monies to address such problems within that

region. In the Twin Cities, Region 11, the regional authority is the Metropolitan Council. The Council has recently completed several studies which address the issues involved in long-term care and housing of the elderly.

As a result of these studies, the Metropolitan Council has published two guides which explain options to institutionalization for Minnesota elderly. The chief source of information for the elderly about housing options in the Twin Cities is the "Consumer Guide to Housing Options for Older People," published in December, 1985. The guide is similar to the pamphlet prepared by AARP in that it presents housing options; it is much broader in scope, however, as it provides five sections including some discussion about the decision of whether or not to give up one's house, options available if one stays in one's house, options available if one decides to move, support services available to allow independent living and a detailed directory of housing available in the Metropolitan area.

The decision section presents questions to ask - a type of needs assessment - before choosing to give up one's present home. It lists questions about health status and directs the reader to look at remaining independent for as long as possible. All of the options described in the AARP pamphlet are available locally and can be investigated further through First Call for Help, whose number is listed in the booklet. The other publication is the "Consumer's Guide to Nursing Homes" presented in a similar format describing comparative costs, services available and a complete directory to all local nursing homes.

After reading the guide to housing options, one becomes aware of the number of choices available to elderly people of moderate income levels and above. The metropolitan area has the largest number of retirement units in the "market-rate rental" and "owned housing" categories. There are, however, 17,000 units available as subsidized rentals or public housing for people of low income. The publication states that for any of these units there is a waiting list and that for the more desirable locations, such as the units in the suburbs, the waiting lists are long.

The issue of availability is only one of the problems facing low income elderly looking for housing. Once established in a subsidized unit or high rise, the elderly face other problems many of which have been documented in the literature. In the next few pages will appear summaries of interviews done with four people who now live or have lived in public housing in Minneapolis. The interviews are presented as a means of identifying some of the issues that arise as the system attempts to solve the problem of appropriate living arrangements for increasing numbers of elderly.

A. is a fifty-eight year-old male, caucasian resident of an inner city, subsidized high rise. He is single, in a wheelchair because he has trouble maintaining his balance while walking, and speaks with a slight slur to his speech as if he has had a stroke.

He states that he has been in public housing for seven or eight years, and that when he became ill, he had to quit his job and was not eligible for retirement benefits. He previously resided in another high rise unit which was being renovated. He says he liked it there, but

that after his illness, he was encouraged by friends and by his social worker to apply to this building. He was eligible for a transfer because of the renovation of his old building and because of medical problems resulting from his illness and hospitalization. He is a resident of one of the two Congregate Housing units available in the metropolitan area.

A. has never been married, but he does have a sister and brother-in-law in town who visit him once a week and take him shopping or bring groceries to him. He has a friend with whom he used to work that takes him to his clinic appointments. He is on SSI and pays one third of that income for housing. If his SSI benefits increase, so does his rent, in proportion. He lives in a one-bedroom unit with a living room, full bath with a shower, and a kitchen complete with appliances. He receives one hot meal a day in the congregate dining room at midday. The county supplies him with a home health aide twice a week who assists him with bathing and other personal hygiene. A public health nurse visits his apartment once a week. He also has the service of a homemaker once a week who cleans and does laundry.

A. states that he is depressed. He has, in fact, been diagnosed as suicidal at one time and has been treated for depression at the clinic to which he goes for medical care. He states that he does not "...like it here." The elevator, he says, is too far away from his apartment and that he is exhausted by the time he gets down to the dining room. The cost of an electric wheelchair is prohibitive, he says. In his apartment, is is unable to fix food for himself as he is "too weak to stand that long," and the countertops are not the right height for accomodating a wheelchair. He says he gets hungry about 5:00 p.m. and

is usually hungry all night. He states that he is incontinent of urine and stool and worries that he will have an accident and will have to "sit there for days until the aide comes." This, he says, has happened before. A. says he is unhappy, but that he does not know where else to go. He feels that he does not need care 24 hours a day "like, in a nursing home," and besides, he says, "...they take all your money." He states that he is worried and confused. "I've got to do something else. I just don't know what it is."

B. is an 81 year old single, black female who resides alone in a one bedroom apartment in the inner city. She has been a resident of this building for 15 years. She applied "downtown at the housing authority," for an apartment when units were first available. She states that she was placed on a waiting list for a year and subsequently was assigned to a building. She lived in that unit for "a few years." until that building "lost its lease." She was then transferred to this building.

At interview, B. presented as an elderly woman, able to ambulate independently, able to communicate clearly and effectively. The apartment was small but very clean and tidy. B. stated that neatness was very important to her. She was waiting the arrival, in fact, of her new homemaker who had been assigned by her social worker. "I have a new social worker downstairs here that I haven't met yet," she said. She stated that she pays thirty per cent of her income for housing and volunteered that the amount was 43 dollars. B. stated that she has family in town, "...daughters and granddaughters," who visit her frequently. They take her shopping, to the doctor, and out to lunch.

"I don't want to live with them," she said, "because I believe that if you can do for yourself, you should." She talked about a recent unspecified illness which frightened her and which caused her to think that she should go to a nursing home. She was admitted to a nursing home recommended by her social worker. She stated many concerns about the nursing home most of which seemed to center around a lack of independence. She stated that she finally convinced the nursing home staff and the social worker that the nursing home was not the place for her (yet) and she was able to move back into her apartment. She says that she fears losing her eyesight and becoming weaker and that soon she will need to go back to a nursing home.

Living in the high rise for B. has been good, she says. She likes the apartment and likes her independence. She is becoming increasingly dissatisfied, however, because of the problems that have come up in recent years. She states that the building is dirty and that she never goes outside her own apartment because, "...you never know who will be out there." She says she looks out her window and that she has seen people beaten, raped and murdered. She has witnessed drug sales and has been kept awake by noises in the halls and in the streets at all hours. She used to know the caretaker of the building, but does not know the new one. She says that the security guards are hired through a private agency and are not allowed to carry guns. People sit in the apartment lobby all night and, "...let anybody in they feel like." She states that she doesn't "...talk to anybody anymore; I don't trust anybody." She says that she feels that the (housing) "authority" has tried to make buildings safe for people. She has had her locks changed three times.

They have changed the locks on the mailboxes, too, because "people kept breaking in."

B. is faced with decreasing physical capabilities and some continuing deterioration of her health. She obviously enjoys her independence and has some concerns, based on experience, about what options she has besides a nursing home. She says she has heard that people in the high rise can get services like grocery shopping, Meals-on-Wheels and home health aides but she does not know anyone who has them and is not sure where to get them. She is not sure who her new social worker is as she has not met him since he was appointed. She worries, she says, about the new homemaker. Will she be efficient, reliable and responsible enough to show up when she is supposed to, or "...will she steal my things, like some of the others?"

Mr. and Mrs. C. are a couple in their late sixties who have both been handicapped since birth. Mr. C. walks slowly, without assistance and speaks in an audible but halting and slightly slurred manner. Mrs. C. walks with a cane and speaks more clearly than Mr. C. At interview, they were residents of a private communal-type residential home in the suburbs owned and operated by a lodge to which both of them belong. They had been residents of an inner city high rise subsidized apartment building for 26 years. They were some of the first residents of the building, eligible because of being displaced from their private home due to freeway construction. As long time residents of public housing, they witnessed many changes, some of which they cite as reasons for moving out.

Initially, when Mr. and Mrs. C. moved in to the high rise, there were many couples. "...close to our age with children." The building was neat and clean, they were close to the buslines, could walk to the store, and had a car for longer trips to visit relatives. Over the last ten years, they said, "the number of blacks had tripled" in their building and the average age of the residents seemed to be much younger. Mr. C. said that his wallet was stolen three times in the last 10 years, that a friend of his was assaulted in the building entry way, that 2 people were killed in their building and that both he and Mrs. C. had witnessed "drug deals" on the premises. The rent, again 30% of their SSI, continued to increase during this time and their car began to deteriorate. Both Mr. and Mrs. C. have aged parents that they visit frequently for which they needed the car.

During the last few years, Mrs. C. was very active as chair of the building's resident council. She worked with the council to appeal to the housing authority for better security for the building and often called the police to report crimes she had witnessed. She spoke of mounting frustration and feelings of being unable to deal with the overwhelming problems that seemed to be facing them and their friends.

Mr. and Mrs. C. began to feel that they needed to get out of the environment. They contacted their social worker and wanted to discuss options. Mainly because of their handicapped status and because of safety issues, they considered a nursing home placement as the solution to their problems. The social worker, they said, was concerned about their having so little independence in a nursing home and tried to convince them to consider staying in public housing with the help of available support services. At about the time that the couple were

investigating other possible housing, they heard about the availability of housing at their present residence. Because of membership in the organization that owns the residence and apartment openings at that time, they were able to take advantage of an option which has turned out to be ideal for them (in their estimation).

They live together in a one room "apartment" and are afforded many amenities because of their residence. They are given three meals a day in the congregate dining area. Their room is cleaned and laundry done once a week. There is a nurse on the premises twenty-four hours a day who checks on them once every hour during the night. There is a call system in their room so that they may summon help if they need it. Another building on the grounds houses an infirmary for residents needing nursing care. Volunteers provide transportation to doctor's appointments or to visit relatives; otherwise, the city bus stops at the front gate for transportation in the downtown area. In exchange for these services, Mr. and Mrs. C. turn over their total SSI payment to the home and are each given $30-$40/month for personal expenses. Each resident is expected to contribute time to some activity around the residence. For instance, Mrs. C. takes care of all the plants and Mr. C. fills the bird feeders. They reside in the country now, have each "gained a few pounds," and smile a great deal.

Problems expressed by the people interviewed are ones experienced by many residents of public housing (Bradshaw, et al., 1976; Lawton, 1977; Ham, 1980). Many of the buildings in existence since the late fifties, were built in areas of the city which have since deteriorated. Residents like B. and Mr. & Mrs. C. worry about safety and are

frustrated by their inability to move around freely and without fear. The elderly residents who have been in the high rises for years find themselves surrounded by younger minority singles and by mentally retarded adults or chronically mentally ill people placed in public housing to fill the vacancies. Residents speak of increasing crime and violence in their environment. Interviews with people at the Minneapolis Community Development Agency revealed that the metro area seems to have enough units available to meet the need for housing eligible low income elderly, but that the existing problems make placing people to their satisfaction and meeting their needs very difficult.

For example, co-ordination of services for any given resident is the responsibility of the building social worker. This social worker is usually a person hired by Senior Resources, Inc. which contracts with the housing authority and who has responsibility for three or four buildings. Support services are available to allow for elderly residents to remain independent in their apartments, examples being home health aides and homemakers, but co-ordination of the services is very difficult when the person co-ordinating has responsibility for hundreds of residents. The social worker has responsibility for screening residents for services, for approving transfer requests, for arranging for and evaluating services and for participating in any pre-admission screening that might take place for a person in his or her caseload.

The system of public housing is large and has been complicated by recent increasing vacancies. Vacancies have been filled by allowing single low-income people into high rises. This new population includes people with chronic mental illness. Residents complain about having to deal with changing populations, but the real problems seem to have more

to do with resulting isolation, fear and deteriorating health. These problems, ones that have been documented as generalizable to the population of elderly at large, are probably manageable within the system. The metro area seems to have enough housing available (42 buildings in Minneapolis) and has taken steps to provide incentives for development of enough units to meet the growing need. The Metropolitan Council has sponsored a contest to encourage development of units designed specifically for the elderly. The newspapers also regularly present ads for housing as well as articles on housing for the elderly. Studies have been done by the Metropolitan Council to identify and to anticipate factors affecting long term care; one of the factors is housing the elderly.

One report prepared by the Metropolitan Council's Program on Aging is titled , "Plan for Service Delivery to Minority Older People in the Twin Cities Metropolitan Area." This report explores current service delivery to minority elders and makes recommendations for future support to this population. The Program on Aging has been federally funded since 1972, and designated as an area agency on aging with responsibility to plan and co-ordinate services for older people in the seven county Metro Area. The program is also responsible for administering federal Title III funds. Title III is the Older Americans Act which provides service funds to the area for social services, senior centers and congregate and home delivered nutrition services. The report indicates that the percentage of ethnic/minority persons in the population of the Twin Cities over age 60 is lower than in the U.S. population as a whole. However, we have a much higher proportion of those living below the poverty level. The report cites the 1971 study

by the U.S. Senate Special Committee on Aging that said that compared to white elderly, minorities are, "...less well educated, have less income, suffer more illnesses and earlier death, have poorer quality housing and less choice as to where to live and where to work and in general have a less satisfying quality of life." The report describes current service utilization by minorities and goes on to make recommendations in several areas, one of which is housing. These recommendations suggest the need for more options such as "...small congregate housing developments or board and care homes..." (p. 23).

These studies point to the need for development of more options available to people of all income levels, but specifically for low income elderly. The idea of congregate housing is one which has received much attention (Ward, 1984; Hare, 1984). This concept of housing the elderly together who require support services makes sense. In practice, only two such arrangements exist in the metro area as pilot projects. Based on interview data, there appears to be some confusion as to what criteria are used to admit people to the congregate housing program and about what really makes this program unique. Social workers within the system questioned whether some people admitted to congregate housing were placed appropriately as well as whether or not some of their own clients would be better recipients of the services available. The program offers what seems to be an ideal solution to the problems of maintaining people independently who require the support of an aide and homemaker as well as meal preparation and skilled nursing care. Major drawbacks seem to be the cost of administering the program, limited units available within the program and lack of clarity about who is eligible. A., one of the clients interviewed is a resident of

Congregate Housing. He experienced frustration with the Congregate Housing Unit not being equipped for wheelchairs. He also spoke of concerns about service delivery associated with home health aides and homemakers. His fears were related to past experience with aides not showing up or showing up but giving less than quality care. These are one client's perceptions, but they seem to reflect areas of concern related to the efficiency and effectiveness of the Congregate Housing Program.

Low income elderly who are already in the system present one set of problems, but people trying to get in pose another. Waiting lists cause delayed entry, but lack of information seems to be one of the major blocks to appropriate use. Not knowing the options has been cited as a general problem across the country (Huth, 1983). The Metropolitan Council has published information and the Minnesota Senior Federation puts out a monthly paper which regularly addresses the issue of senior housing. Once a person is placed, however, one of the problems is that if her status changes and she requires additional services, she may encounter a general lack of knowledge about choices available or she may encounter long delays in acquiring satisfactory services to meet her needs. B. talked about the frustration associated with not knowing the name of her new social worker and of not being certain of the choices she had available to her. Part of the problem again, lies in the size and complexity of the system. But part also is a result of the lack of information about options available within the system. First Call For Help is an option, but, it seems that most residents of the system rely on the social worker to refer them - something which may take time and

may never happen, depending on the urgency of the request and the size of the worker's caseload.

What seems to be an immediate approach to the problems presented is a discussion of strategies one might use to increase the likelihood that low-income elderly residents of public housing have more information available and have as much help as they need to make their choices. It does seem that choices are available and it does seem that the metro area has attempted to provide for the support of its elderly residents. More options, such as shared housing, board and care, and adult foster care are becoming increasingly available. There are, at the present time, however, only a few units in existence and costs may be prohibitive. One problem may be that social workers in the system are not aware of the array of options available beyond the nursing home, or that they lack the time and energy to explore options with the many residents who need help.

One strategy that nursing students might use with residents is to make them aware of the resource books put out by Metro Council. One set of books might be purchased for each high rise site. The booklets are readable, inexpensive and present as complete a current list of options as is available. The students should discuss these options with the residents and work with them to investigate their options. Questions students have could be referred to First Call for Help or may be best explained in some of the references cited within the text of this report.

Another strategy that has been cited as increasing seniors feelings of control (Birnbaum, 1984) is to involve those interested and those needing to change some part of their living arrangements in a group

information session which could serve dual purposes. Members of the group would feel some support from other members through sharing the same experiences as well as learning about options actually available to them. Increasing people's level of knowledge and understanding would hopefully lead to feelings of control and self-confidence. This should improve their ability to make decisions and to maintain an independent living arrangement for as long as possible. Students would benefit as well by learning about the system while enhancing the self-care capabilities of the residents.

In conclusion, it seems that we as a society are beginning to recognize the multiplicity of problems facing us as we experience increasing numbers of elderly in the general population. We are starting to identify ways of meeting needs and solving problems. Some solutions are being tested; others have yet to be discovered. What is readily apparent, however, is a need for greater attention to the growing needs of our elderly on the part of both the public and private sectors if we are to provide effective, andefficient quality approaches to meeting those needs.

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