Healthy Housing:

An Evaluation of Selfhelp Active Services for Aging Model (SHASAM)

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The evaluation was conducted by Dr. Michael K. Gusmano of Rutgers University and The Hastings Center; Dr. Victor G. Rodwin of the New York University Robert F. Wagner Graduate School of Public Service; and Dr. Daniel Weisz of the Columbia University School of Public Health.

Data was provided by the New York State Department of Health, Office of Health Insurance Programs, and by the Center for Medicaid and Medicare Services.

Residents who lived in the buildings during the time period of the study were identified by Dorothy Kern of the Selfhelp Realty Group and Henry Dubro of Douglas Elliman Property Management.

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All pictures used throughout this document are of Selfhelp clients and staff.

Selfhelp

Selfhelp is a not-for-profit organization dedicated to maintaining the independence and dignity of seniors and at-risk populations through a spectrum of housing, home health care, and social services and will lead in applying new methods and technologies to address changing needs of its community. Selfhelp will continue to serve as the "last surviving relative" to its historic constituency, victims of Nazi persecution.

EXECUTIVE SUMMARY

SELFHELP COMMUNITY SERVICES, INC. (SELFHELP) owns and operates eleven residential buildings that provide affordable housing for nearly 1,500 older adults living in New York City. These buildings include on site health promotion and social services, available if and when requested by residents during their tenancy, that address a range of physical and emotional concerns.

In the past few years, there has been increasing recognition that economic and social conditions – the "social determinants of health" – can make a substantial impact on the physical health of individuals. Selfhelp serves a low-income and primarily immigrant population in its buildings, many of whom have experienced difficult and often traumatic conditions. We asked whether the services we make available on site could enable residents to be healthier than other older adults who do not have direct access to these supports, and thus yield lower health care costs.

Selfhelp received funding from the JPMorgan Chase Foundation to conduct a retrospective, three-year evaluation of the hospitalization rates, emergency department use, and cost of care for residents of six Selfhelp buildings in Queens, New York, compared to other older adults living in the same zip codes. The evaluation was conducted by Michael Gusmano, PhD, then of the Hastings Center and now at Rutgers University.

The retrospective study examined Medicare and Medicaid claims data for residents in Selfhelp buildings between 2012-2014, and for the comparison group during the same time period. Both sets of data yielded consistent results: Selfhelp residents experienced fewer hospitalizations and used the emergency room less frequently than the comparison group. The effect was particularly pronounced for those with chronic diseases. And, the claims for payment submitted by providers to Medicaid and Medicare were lower for Selfhelp residents than for the comparison group, suggesting that the investment in supporting services ultimately reduces the total cost of care.

Selfhelp residents, especially those with chronic diseases, experienced fewer hospitalizations, used the emergency room less frequently, and had lower total claims for payment submitted to Medicaid and Medicare.

The results of this evaluation also have implications for the ways that we think about and support the aging process. It has become common to think of "aging in place" – in one's own home and community, instead of a nursing home – as the preferred outcome for older adults who face increased levels of need. Selfhelp's model suggests a movement towards "aging on pace" – providing an environment that supports the optimal health of residents with the appropriate level of targeted services at the appropriate time.

BACKGROUND

IN OCTOBER 2015, SELFHELP COMMUNITY SERVICES, INC. (SELFHELP) received a grant from the JPMorgan Chase Foundation to conduct a third-party evaluation of the health of older adults living in affordable housing in New York City, and to understand whether services provided proactively on site could reduce the utilization of hospitals and emergency rooms and the total cost of care.

At the time, Selfhelp owned and operated seven affordable apartment buildings designed specifically to foster independent living for older adults; this number has since expanded to 11. The seven buildings, which were all based in Queens, New York, had 954 units and housed approximately 1280 residents between the ages of 62 and 105. Then, as now, residents were primarily immigrants from more than ten different Eastern European, Asian, and South American countries, with fewer than ten percent speaking English as their first language. While many once held professional jobs in the medical, legal, creative, or teaching professions, they qualified for affordable housing because they met specific income limitations.[1]

In all its affordable senior housing, Selfhelp offers the Selfhelp Active Services for Aging Model (SHASAM). SHASAM is a comprehensive set of supports appropriate for different stages in the aging process and are available to residents, if and when chosen and requested, throughout their tenancy. The model grew out of Selfhelp's eight decades of experience working with older adults.

SHASAM supports include:

- A culturally competent social worker in each building
- Assistance and advocacy for all appropriate entitlements and benefits
- Educational and recreational programming
- Health and wellness programming
- Physical activity
- Social events
- Aging services technology
- Volunteer opportunities
- Referrals to partners for home-delivered meals, home care, subsidized housekeeping, mental health, case management, and a variety of other services and programs.

Like many older adults, residents of Selfhelp buildings experience chronic diseases. In a sample of 100 SHASAM residents in 2017, 64% reported having been diagnosed with arthritis, 67% reported hypertension, and 32% reported

diabetes. While the sample was skewed towards older residents, it is worth noting that these results are on the higher side; nationally, 50% of older adults report arthritis,[2] between 50% and 77% report hypertension,[3] and 23% report diabetes.[4]

As well, approximately half of those living in the oldest Selfhelp building reported some degree of functional limitation which made it difficult for them to perform chores, climb stairs, or prepare meals without assistance.



To establish whether the services provided through SHASAM are successful in enabling residents to grow older at home in spite of these health issues, Selfhelp has for many years collected data about the number of residents who transferred from the SHASAM buildings to nursing homes. Each year, this rate has been lower than two percent.[5]

As we can assume that residents would leave Selfhelp housing for a higher level of care if they required more intensive support, this statistic indicates that SHASAM provides residents with appropriate supports for their aging-related needs. However, it does not indicate in more than general terms whether SHASAM could also make a positive impact on their overall health, the objective of the evaluation reported here.

Several factors drove the current evaluation. First, there is a long history of research demonstrating that appropriate housing can make an impact on the health of specific populations who have more severe needs than the general population of older adults living in SHASAM buildings. Second, the "social determinants of health" approach (see page 8) sheds light on how social services can and do impact physical health through a variety of mechanisms. Third, Medicaid reform initiatives in New York State, and elsewhere in the country, put increasing focus on finding new ways to save money on expensive health care services, including hospitalizations and emergency room visits.

RESEARCH CONTEXT: HOW HOUSING AFFECTS HEALTH

THE ROLE OF ADEQUATE HOUSING in supporting positive health care outcomes has been documented since at least the early 1990s. At that time, the focus was largely on what has now become known as supportive housing, which targets individuals who either require specific services to remain living in the community, or who would benefit from affordable and stable housing in order to connect with and utilize supportive services. (In contrast, SHASAM buildings are considered "independent living" because the services offered are neither mandatory for residents, nor seen by them as required.) Decades of research in this area have created a solid evidence base that supportive housing can and does affect the health of residents, including those who have been homeless, live with HIV/AIDS, or suffer from substance abuse or mental illness.[6]

The impact of supportive housing on the health of residents is so clearly established that it was incorporated into New York State's Medicaid Redesign Team (MRT) initiative,[7] leading to the creation of 1,482 new units of supportive housing across New York State and the development of 19 rental subsidy and supportive service programs.[8] And, indeed, early evaluation of the MRT initiative has shown strong results. Across New York State, formerly homeless residents in MRT housing had 26% fewer emergency room visits and 40% fewer inpatient hospital days, while overall Medicaid spending fell from an average of $41,118 to $34,988 per person. The largest savings were found for those with the highest initial expenses.[9]

There is much less of a tradition of research regarding the importance of housing for a general population of older adults. Yet this population – particularly those "dual eligibles" whose age and income qualify them for both Medicare and Medicaid – is also likely to have high needs for health care. Nationally, dual eligibles have a greater rate of multiple chronic conditions (e.g. congestive heart failure, pulmonary disease, stroke and diabetes) than do other Medicare beneficiaries.[10] These needs can and do lead to greater spending. Dual eligibles in 2007, for example, made up 18% of the Medicare fee-for-service population yet 31% of spending, and 15% of the Medicaid population yet 39% of spending.[11]

The largest evaluation on the health outcomes of housing for a general population of older adults comes from the statewide Vermont Support and Services at Home (SASH) program. This program began in 2011 with the goal of bringing health services and community partnerships to the homes of older adults. Initially designed for frail individuals living at the Cathedral Square Corporation's affordable housing network, SASH was later rolled out on a voluntary basis to Medicare Fee for Service beneficiaries across Vermont, and reached 4,741 participants in June 2015. Yearly evaluations were conducted, with the most recent evaluation published in March 2017 on 2014 data. This evaluation found that Medicare Fee for Service

beneficiaries who participated in SASH for three or more years had lower rates of hospitalization and a lower rate of growth in Medicare spending when compared to other Medicare Fee for Service beneficiaries living in affordable housing.[12]

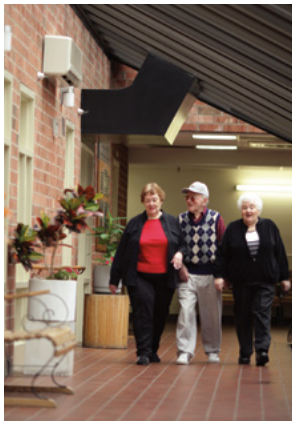
More recently, the LeadingAge Center for Affordable Housing Plus Services examined health outcomes for older adults living in HUD-assisted properties that provide on-site health education, exercise, primary care, mental health, and medication management, as well as a service coordinator to link residents to services. The authors found that, compared to older adults living in HUD properties without such services, residents had a lower likelihood of hospital admissions.[13]

Other evaluations are currently underway on the health impact of living independently in affordable housing, for populations beyond older adults. Enterprise Community Partners, in collaboration with NeighborWorks America, is conducting a three-year Health Outcomes Demonstration Project involving 20 affordable housing projects across the country. (Five participating organizations, including Selfhelp, are focusing on older adults; the other 15 are not.) Stewards of Affordable Housing (SAHF) has developed a list of outcome measures for affordable housing that includes school graduation rates, employment statistics, and community engagement responses as well as health indicators.[14]

The current study extends the previous literature by exploring the impact on Medicaid and Medicare spending for a general population of older adults who are living independently in a housing with services model. Selfhelp's services are distinguished from supportive housing because, although they are available to all residents as needed, they are not presumed necessary for all residents. For example, unlike some living in MRT supportive housing, SHASAM residents have not experienced the traumas of life on the streets,[15] although many have experienced relocation and significant stress in their countries of origin which precipitated their emigration to the United States. Their history of immigration also distinguishes them from many SASH participants. As well, the current project differs from the HUD analysis because the comparison group includes people who do not already live in affordable housing.

The current study extends the previous literature by exploring the impact of social services on Medicare and Medicaid spending for a general population of older adults who are living independently in affordable housing.

A CLOSER LOOK: SHASAM AND THE SOCIAL DETERMINANTS OF HEALTH



IN THE PAST TEN YEARS, there has been increasing focus on the ways in which "the conditions in which people are born, grow, live, work, and age"[16] affect their long-term health. This concept, known as the *social determinants of health,* has become a part of Medicaid reform policy under the Patient Protection and Affordable Care Act of 2010. As of 2018, Managed Care Organizations operating in New York State are required to address at least one social determinant in each of their Medicaid contracts.[17] Estimates of the impact of social and economic factors on health outcomes range from 21% to 55%;[18] what is certain is that these factors make a difference.

The SHASAM model directly addresses those social determinants of health that are most important for older adults. Specifically:

- **ECONOMIC STABILITY:** Each building has a social worker who assists residents with applying for all appropriate benefits and entitlements. These may include Medicaid, SNAP, Medicare, Medicare Savings Programs, SCRIE, SSI, HEAP, Lifeline, utility bill reduction, PERS, and housing income recertification, among others. Social workers are also skilled in setting up Medicaid Supplemental Needs Trusts so that eligible residents may qualify for Medicaid while reserving income to meet their basic needs. Emergency financial assistance is also available for procedures, such as dental work, which are not covered by insurance. These income supports reduce the stress of economic instability, and also ensure that the resident can pay for important supports to their health such as nutritious food and insurance co-payments.

- **NEIGHBORHOOD AND PHYSICAL ENVIRONMENT:** Selfhelp's buildings are attractive, well-maintained, and planned with the health of residents in mind. Care is taken in the design of the building envelope to ensure that they are well-insulated. Windows are placed to allow as much natural light as possible. Each building has appealing areas for socialization, and although located in busy areas of New York City, they include quiet garden spaces that encourage both exercise and mindful reflection. Apartments and common areas are designed for the safety of frailer residents, with features such as roll-in showers and hallway railings to encourage walking indoors.

  The maintenance staff work in close partnership with the social workers to prioritize the housing stability of residents and prevent eviction. Annual apartment inspections are conducted jointly by maintenance staff

SHASAM services target five different social determinants of health. We examined whether the model impacts hospitalization rates, emergency room use, and cost of care for older adults.

and the building's social worker, while the janitorial and maintenance staff serve as additional "eyes and ears" and alert the social worker if a resident could be in need of additional support. If needed, social workers work closely with residents to ensure that their rent is paid on time and may refer those with deteriorating vision to a service that helps review their mail and pay their bills.

- **FOOD:** Access to nutritious food is widely recognized as an important factor in the prevention and maintenance of chronic diseases common to old age, including cardiovascular disease,[19] type 2 diabetes,[20] and osteoarthritis.[21]

  SHASAM staff are available to assist with Supplemental Nutrition Assistance Program (SNAP) benefits for eligible residents. On occasion, with grant funding, SHASAM also offers nutrition workshops and cooking demonstrations to help residents understand which food is healthiest for their specific health conditions.

- **COMMUNITY AND SOCIAL CONTEXT:** Social isolation places older adults at greater risk for mortality.[22] SHASAM offers many opportunities for residents to connect with others, including holiday celebrations from residents' countries of origin, and fosters a community of health

by offering classes in yoga and tai chi as well as stress reduction, chronic disease self-management, and other evidence-based programs. Pastoral counseling is also available. Residents can contribute to the building by serving on a Resident Council or by volunteering to teach classes. A Skype room and computers are available so that residents may connect with their families and wider world, including access to a unique Selfhelp program, the Virtual Senior Center, which provides video-based group classes to encourage socialization. The seven Queens buildings also incorporate a senior center on their campuses which offers additional opportunities for health, wellness, artistic expression, recreation, and exercise.

- **CONNECTION TO HEALTH CARE:** Each building's social worker acts as a health coach, integrating community-based health supports with residents' social service plan. Depending on a resident's desires and needs, social workers may make referrals to chronic disease self-management classes or to exercise classes and walking clubs on site or at the adjacent senior center. Workshops are offered on topics such as preventing falls, managing high blood pressure, or more generally in health literacy and overall well-being. Telehealth kiosks and memory fitness stations are available at many sites. Social workers also ensure that residents have appropriate health coverage – Medicare, Medicaid, or both.

With these factors in mind, it is logical that SHASAM's services could impact the health of residents. For these reasons, Selfhelp set out to explore whether this was in fact the case, and if so, the extent of the impact.

The SHASAM model operates at the intersection of Health and Wellness, Social Services and Housing. SHASAM addresses five primary social determinants of health: economic stability, food, neighborhood/physical environment, community & social context, and access to health care. The combination of these supports improves resident wellness and supports optimal "aging on pace."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METHODOLOGY

WITH FUNDING FROM THE JPMORGAN CHASE FOUNDATION, Selfhelp contracted with Michael Gusmano, Ph.D., Associate Professor of Health Policy at the Rutgers University School of Public Health and Research Scholar at the Hastings Center.

Two retrospective analyses were conducted, one of Medicare claims data and one of Medicaid claims data, for the period 2012-2014. Both analyses examined the following questions:

1. Are SHASAM residents less likely to be hospitalized than a comparison group of older adults in the same zip codes?
2. Will SHASAM residents have a shorter length of stay in the hospital than the comparison group?
3. Are SHASAM residents less likely to use the emergency room than the comparison group?
4. Are there differences for Ambulatory Care Sensitive Conditions (ACSCs) – chronic diseases such as those experienced by many Selfhelp residents?

For each question, Medicare and Medicaid claims data was compared for SHASAM residents and for the general population of older adults living in the same Queens zip codes as the SHASAM buildings (11355 and 11360). Both analyses were approved by the Rutgers University Institutional Review Board, which oversees the protection of research participants.

DATA SOURCES

MEDICARE CLAIMS DATA WAS OBTAINED from the Centers for Medicare and Medicaid Services (CMS) using their carrier and vital status files. CMS protocols do not require participants to sign informed consent forms, and thus this data included all 1,244 residents of Selfhelp housing in 2014, regardless of whether they still lived there when the study began. The comparison group of 15,947 was also larger because it was not limited only to those older adults who were eligible for Medicaid.

Medicaid claims data was obtained from the New York State Medicaid Office in 2017. The process required obtaining the informed consent of SHASAM residents, and information sessions were held at all participating buildings to review the study content and the consent form. Selfhelp social workers assisted with translating this information into Korean, Russian, and several dialects of Chinese. As a result of these efforts, 389 residents provided their informed consent for participation, comprising 54% of the 721 residents who not only lived in Selfhelp housing between 2012-2014, but who still lived in the buildings and thus could provide their consent for participation. The New York State Medicaid Office provided claims data on 317 SHASAM residents and on 8,411 residents, aged 62 and over, of the same zip codes in Queens. This latter population was the comparison group for the study.

Both the Medicare and Medicaid data demonstrated decreased hospitalizations and emergency room use for SHASAM residents.

To protect resident privacy and adhere to HIPAA standards, all Medicare and Medicaid claims data was scrubbed of names and addresses before delivery. SHASAM residents were identified by a “1” to designate that their address matched that of a SHASAM building; all other participants were designated with a “0.” The data was provided directly to the research team and was not shared with Selfhelp.

Both sets of analyses demonstrated decreased hospitalizations and emergency room use for SHASAM residents. The Medicare analysis is statistically stronger than the Medicaid analysis because it uses data for all SHASAM residents and all members of the comparison group, while the Medicaid analysis relies on a self-selected sample of SHASAM residents. However, the fact that they both tell the same story lends additional support to the effectiveness of Selfhelp’s model.

RESULTS

AGE OF RESIDENTS

FOR BOTH DATA SETS, the SHASAM residents and the comparison group had similar ages.

Medicare

The median age for SHASAM residents was 80, and that of the comparison group was 74.

Medicaid

The median age of the SHASAM residents was 82, slightly older than the median age of the comparison group which was 78.

These differences are notable because the outcomes examined – hospitalizations, length of hospital stay, and emergency department visits – tend to occur more frequently at older ages. For these reasons, the analyses described below control for age. They also control for gender.

INCIDENCE OF HOSPITALIZATION

BOTH THE MEDICARE AND MEDICAID ANALYSES showed that SHASAM residents were hospitalized less frequently.

Medicare

SHASAM residents were hospitalized at a rate of 88.1 per thousand (8.8%), compared to 129 per thousand (12.9%) for other residents of the same zip codes. **Likewise, the odds of being hospitalized were 51% lower for SHASAM residents.**

Medicaid

A lower percentage of SHASAM residents (24%) were hospitalized than the comparison group (32%). This difference remained when age and gender were controlled for. **The odds of being hospitalized were 68% lower for SHASAM residents**. For those who were hospitalized, both groups were roughly similar in terms of the number of diagnoses: 39% of both groups had three diagnoses or fewer, 50% of both groups had four diagnoses or fewer, and slightly more than 50% had five diagnoses or fewer.[23]

The study found that SHASAM residents were 51% less likely to be hospitalized than non-residents.

LENGTH OF HOSPITAL STAY

AGAIN, BOTH THE MEDICAID AND MEDICARE claims data indicate that SHASAM residents are spending less time in the hospital, controlling for age, gender, and number of diagnoses.

Medicare

The median length of stay was 6.38 days for SHASAM residents and 9.23 days for the comparison group.[24]

Medicaid

The median length of stay was 4 days for SHASAM residents and 5 days for the comparison group.

Another finding: SHASAM residents with chronic diseases were 43% less likely to be hospitalized than non-residents.

HOSPITALIZATION FOR AMBULATORY CARE SENSITIVE CONDITIONS

AMBULATORY CARE SENSITIVE CONDITIONS (ACSCS) are those chronic diseases which respond well to interventions delivered in community and outpatient care settings. For Selfhelp residents, the most common conditions include cardiac arrhythmia, arthritis/back pain, congestive heart failure, dizziness, pneumonia, and chronic obstructive pulmonary disorder. **Both the Medicaid and Medicare claims data showed that SHASAM residents had a lower incidence of hospitalization for ACSCs**, controlling for age, gender, and number of diagnoses**.**

Medicare

Among SHASAM residents, the hospitalization rate for ACSCs was 15.2 per thousand (1.5%), which is 30% lower than the comparison group rate of 21.6 per thousand (2.2%).[25] **The odds of being hospitalized with an ACSC were 43% lower for SHASAM residents.**

Medicaid

Hospitalizations for ACSCs comprised 15.4% of hospitalizations for SHASAM residents, and 18.4% for the comparison group. **The odds of being hospitalized with an ACSC were 12% lower for SHASAM residents.**[26]

ODDS RATIOS

Many of the results cited in this study utilize the concept of odds ratios.

Essentially, this is a means of comparing the likelihood of one event taking place to the likelihood of another event.

Weather reports are a familiar example. If there is a ¼ chance of rain on Tuesday and a ½ chance of rain on Wednesday, the odds of getting wet on Tuesday are 50% lower than those of getting wet on Wednesday.

Our finding, that the odds of being hospitalized for SHASAM residents is 68% lower than for the comparison group, means that SHASAM residents have a lower probability of being hospitalized.

The cost of hospitalizations for residents with chronic diseases was half as much for SHASAM residents.

COST OF HOSPITALIZATION

THE DIFFERENCE IN LENGTH of stay between the two populations was reflected in the overall cost of hospitalization, as measured through claims submitted by health care providers. **Notably, the cost of hospitalization for ACSCs was half as much for SHASAM residents as for the comparison group, in each data set.**[27]

Medicare

The average cost per hospitalization was $14,226 for SHASAM residents and $15,122 for other older adults in the same zip codes.

The average cost per hospitalization for ACSCs was $13,972 for SHASAM residents, and $29,798 – more than twice as much – for the comparison group.

Medicaid

The average cost per hospitalization was $1,778 for SHASAM residents, and $5,715 for the comparison group.

The average cost per hospitalization for ACSCs was $611 for SHASAM residents, and $1371 – more than twice as much – for the comparison group.

USE OF EMERGENCY DEPARTMENTS

IN BOTH DATA SETS, while the percentage of people visiting emergency departments was roughly similar for SHASAM residents and the comparison group, the odds of doing so were much lower for SHASAM residents.

Medicare

In the Medicare analysis, 8.7% of SHASAM residents visited the emergency department, compared to 9.7% for the comparison group. The odds of doing so were 23% lower for SHASAM residents.

The average cost per emergency department visit was $104 for SHASAM residents and $101 for the comparison group.

Medicaid

23% of SHASAM residents and 24% of the comparison group used the emergency room during the study period. However, controlling for age and gender showed that the odds of a SHASAM resident using the emergency room were 53% lower than the odds of a comparison group member doing so.

The odds of a SHASAM resident visiting an emergency department for an ACSC were 76% lower than the odds of a non-Selfhelp resident doing so.

The average cost per emergency department visit was $49 for SHASAM residents, and $99 for the comparison group.

CONCLUSION

ACROSS THE THREE YEARS OF THIS STUDY, there are clear and consistent results showing that SHASAM residents experience health crises less frequently, and appear to cost the health care system less money. These results are especially true for Ambulatory Care Sensitive Conditions – chronic conditions that respond to community-based care.

Flushing and Bayside, the two neighborhoods in Queens, New York where Selfhelp's buildings are located, house at least 14 senior centers, two case management programs, and more than 60 adult day centers – all of which provide access to services for older adults. However, the Selfhelp buildings are unusual in that they reduce barriers to care by locating these services **where people live**. The combined approach of providing instruction about wellness-promoting activities, and improving social determinants – economic stability, appropriate food, physical environment, social and community context, and access to health care – all make a real and demonstrable impact on resident health.

Across the three years of this study, SHASAM residents experienced health crises less frequently and cost the health care system less money. The results were especially clear for chronic diseases that respond to community-based care.

For example, the Medicaid claims data showed that proportionally more SHASAM residents utilize primary care physicians and specialists. Eighty-five percent of SHASAM residents visited primary care physicians at least once during the three years of the study, compared to 74% of the comparison group. Ninety-four percent of SHASAM residents visited a specialist at least once, compared to 79% of the comparison group.

The impact on the progression of chronic diseases is particularly notable. While arthritis, hypertension, and diabetes are all prevalent among SHASAM residents, each of these can be addressed by a tailored program of health care and community supports. By locating services where people live, and tailoring them to support social determinants, the SHASAM model directly impacts the health of residents – a very exciting result.

FURTHER REFLECTIONS

THE AUTHORS OF THIS REPORT bring decades of experience providing services to older adults. During this time, it has become generally accepted that "aging in place" – typically in one's own, familiar home and community – is both less expensive and emotionally healthier than, and the preferred option to, growing older in an institutional setting. Public policies have supported this approach, first by encouraging the development of home and community-based services as alternatives to long-term residential care, and more recently by proposing redesigns in city infrastructure and health care reimbursement methodologies to meet the needs of an aging population.[28]

The Selfhelp model takes this approach one step further. It not only supports aging in place for its residents, but also recommends a turn towards *aging on pace*: not just growing older, but continuing to flourish through accessing activities and interventions on pace with one's individual desires and abilities. The concept of *aging on pace* makes explicit the assumptions behind the preference for aging at home: an appropriately, multi-faceted supportive environment and community can make all the difference as the needs of older adults change over time. Such changes can often be unexpected, and are costly if they are not anticipated.

The value proposition is clear: Locating appropriate social services on site in affordable housing can save the health care system money.

The SHASAM model encourages residents to remain engaged in social activities that give their lives meaning, while making available preventive and acute care services so that residents can take charge of their own health and reduce long-term health issues. With these appropriate supports operating in the background, residents can and do grow older at home without experiencing costly and preventable institutionalization.

The value proposition of services in affordable housing for older adults is clear. It is also very much in line with current thinking about the important role of addressing social determinants of health. Ultimately, these results suggest that locating and utilizing appropriate services in affordable housing can cost the health care system less money and improve quality of life.

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23 Except where otherwise reported, throughout this discussion, all results are statistically significant at the 0.001 level.

24 Statistically significant at the 0.05 level.

25 Statistically significant at the 0.01 level.

26 Statistically significant at the 0.02 level.

27 Cost data reported here reflects claims that were submitted by hospitals to Medicaid and Medicare for treatment provided. It does not reflect the final amount paid to providers.

28 New York City's Aging-Friendly NYC, for example, offers recommendations in housing, public safety, media, the arts, medicine, pharmacy, and banking, to foster the participation of older residents.

ABOUT SELFHELP COMMUNITY SERVICES, INC.

EACH YEAR SELFHELP SERVES more than 20,000 older New Yorkers, through its 46 programs located throughout New York City and Nassau County, helping them to live with dignity and avoid institutional care. Our trauma-informed services for the larger community of older adults have been uniquely developed from our historical work with Holocaust survivors. Among our program highlights, Selfhelp:

- **Owns and operates eleven affordable housing residences in Queens, Brooklyn, the Bronx, and Long Island,** that house nearly 1,500 low and moderate income residents in attractive, functional apartments with supportive services as needed. New buildings are currently being developed in Brooklyn, Nassau and Suffolk Counties, two with designs by internationally renowned architect Daniel Libeskind.
- **Operates the oldest and largest program serving Holocaust survivors in North America,** providing comprehensive services to over 4,500 low-income elderly and frail individuals.
- **Manages five city-funded Senior Centers,** including one of the first to be designated by the City of New York as an Innovative Senior Center. Selfhelp also offers an **Alzheimer's Social Day Program** to care for those coping with Alzheimer's and related disorders.
- **Trains and employs 1,800 home health care workers** who provide approximately 2 million hours of service each year to the elderly, infirm, and families at risk.
- **Offers comprehensive services for seniors living in four Naturally Occurring Retirement Communities (NORCS)** in Queens, and one in Nassau County.
- **Serves as legal guardian for hundreds of individuals in need** through three Court-Appointed Guardianship Programs.
- **Is a leader in providing groundbreaking aging services technology,** enriching the lives of elders living independently through telehealth monitoring and Selfhelp's internationally acclaimed Virtual Senior Center.
- **Operates NY Connects program in Queens –** New York City's point of entry for information and referral into long-term services and support systems for older adults and people of all ages with disabilities.

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