

Identifying Risks to Healthy Aging in New York City's Varied NORCs

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Abstract

In 2006, the United Hospital Fund and New York City's Department for the Aging began a joint undertaking in 34 naturally occurring retirement community (NORC) programs to reduce risks to healthy aging. The Health Indicators in NORC Programs Initiative is a data-driven risk-identification tool and quality-improvement process designed to help community-based programs with limited resources identify key health risks among older adults in their communities, develop targeted and systematic responses, and measure those responses' effectiveness. This article presents findings from three NORC programs to illustrate the importance of understanding each community's risks to healthy aging in developing effective targeted responses.

Acknowledgments

This work was funded by the New York City Department for the Aging under contract with the Brookdale Center for Healthy Aging & Longevity of Hunter College of the City University of New York. The views and conclusions expressed herein are solely those of the United Hospital Fund.

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Introduction

Place-based programs have re-emerged as a strategic domestic public policy priority, following new emphasis from the Obama administration. With the expected growth and shifts in population over the next 30 years, the administration has asked federal agencies to take up the challenge of how best to prepare for these population changes in ways that are measurable, centered in specific communities, and able to improve administrative coordination and effectiveness (Orszag, Barnes, Carrion, & Summers, 2009). Focusing on the health of the community-dwelling older adult population is a useful way to direct such attention and effort. The phenomenon of naturally occurring retirement communities or NORCs (multi-age communities with large concentrations of older adults) and the emergence of the NORC program model, with its on-site services and partnerships, provide an opportunity to apply place-based principles to the organization and delivery of services to older adults to measurably improve their health status.

In the early 1980s Michael and Gail Hunt coined the term “naturally occurring retirement community” to describe an apartment building in Madison, Wisconsin, built originally for people of all ages and where half of the residents were 50 years old or older (Hunt & Hunt, 1985). Since then, “NORC” has become part of the lexicon to describe age-integrated neighborhoods or housing developments where older adults (60 and older) make up a significant portion of the residents. The Hunts observed that NORCs evolve over time as a result of several factors: the arrival of older adults (as happened in the Madison apartment building) seeking amenities and services that fit with their retirement lifestyle; aging in place; or the departure of young people in search of opportunities, leaving behind the older generations. The burgeoning older adult population and the mobility of people of all ages in the United States is giving rise to increasing numbers of NORCs. Analysis of the 2010 census will document the continuing growth of NORCs in urban centers and first-ring suburbs that was seen in the census data from 1990 and 2000 (Lansperly & Callahan, 1994; Puentes & Warren, 2006).

Over the last 20 years, the NORC program model has been seen as a promising effective, community-centered response to helping older adults age in place. From its beginnings in New York in the mid-1980s, to efforts in 25 different states through federal funds specifically designated by Congress for local non-profit organizations, and finally as one of the approaches in the US Administration on Aging’s 2009 Community Innovations for Aging in Place national demonstration program, the NORC program model has gained traction largely on the basis of compelling anecdotal stories. Until recently, the model has lacked a framework with corresponding tools to measure how and the extent to which NORC programs are helping older adults age in place. This article articulates the development of such a framework — the Health Indicators in NORC Programs Initiative (Health Indicators). It also reports on the findings from the first step of Health Indicators, focusing on one chronic condition (diabetes) among residents in three New York City NORCs (Co-op City in the Bronx, Elliott-Chelsea Houses in Manhattan, and

Ravenswood Houses in Queens) to illustrate how communities differ distinctly by risks to healthy aging and must consequently tailor their responses.

Background: NORC Programs

More than 80% of today's older adults live with a chronic condition and 62% have more than one (AHRQ, 2010). The ability to age in place is directly affected by how well chronic conditions are managed, to slow the progression of the condition and maintain or maximize function.

The current service delivery systems provide services “one hip fracture at a time.” Aging, health, and long-term care services tend to be individual in their focus: reactive, crisis-driven, or event-based; delivered to individuals in silos; and disconnected from the communities in which older adults live. Eligibility for services is based on age, functional status, and — for many who require long-term care services — on financial need as well.

Effective care and management of chronic conditions requires a complex set of coordinated activities among older adults, health providers, and community support systems. In order to help older adults age in place new strategies are needed that can integrate and provide the right things to the right people, in the right communities, at the right time. The density and proximity of older adults in NORCs makes it possible to shift the paradigm from delivering specific services to specific individuals to focusing on the health and well-being of older adult sub-populations within these heterogeneous communities (UHF, 2010).

New York City's NORC Program Model

The first identification of a NORC in New York City was in 1986 at Penn South Houses, a large moderate-income cooperative housing development built in 1962 for workers of the International Ladies' Garment Workers Union. Using a mix of philanthropic funds and support from the housing company itself (initially in-kind support that within three years included cash from its operating budget), the first comprehensive NORC Supportive Service Program (NORC-SSP, or simply “NORC program”) was established, integrating housing, social services, and health services.

Following the success of the Penn South NORC program and its replication in two other similar moderate-income housing developments, New York was the first state to pursue

this place-based approach to service delivery. A 1991 analysis of housing occupancy found that there were more than 400,000 units of low- and moderate-income apartments in New York City that were in potential NORCs (Schwartz, 1991). In 1995, New York State enacted legislation to support the establishment of NORC-SSPs in moderate- and low-income housing developments in which 50% of the heads of household are 60 years old or older, or in which at least 2,500 residents are older adults. New York City followed suit in 1999, but modified the eligibility criteria to that of housing developments with at least 250 older adults in which 45% of the heads of household are 60+ years old or a housing development with at least 500 older adult residents. In 2006 the state legislature expanded the program to include funding for neighborhood-based NORC programs (NNORCs) in low-rise communities with no more than 2,000 older adults, where there was no common ownership of the housing (Vladeck, 2004; New York Elder Law, Article 2, Title I, Section 209).

Today, there are 54 NORC programs (NORC-SSPs and NNORCs) operating across New York State, in low- and moderate-income housing developments and neighborhoods, both large and small. Slightly more than \$11 million in city and state funding leverages an equal amount in private-sector revenue and in-kind support. Forty-three of the 54 NORC programs are in New York City. Thirty-four of these receive public support from the city or from the city and state combined; the rest receive public funding only from the state.

NORCs in New York City: Diverse Communities with Diverse Needs

The image most people have of New York City is that of tall vertical buildings densely packed together. But in fact, New York City's neighborhoods vary enormously by footprint, topography, size, ownership structure, and demographics. New York City's NORCs reflect all of these types of variation. Thirty-two of the 34 city-funded programs are located in public and private housing developments across the city (the other two are neighborhood-based). The housing developments vary by ownership structure: nineteen are cooperatively owned by the residents, thirteen are rental buildings owned by a landlord, and the other two are in neighborhoods of single-family owner-occupied homes. They also range in size from a single building with a senior population of 276 of the 516 residents to a complex of 283 buildings in which 8,500 of the more than 50,000 residents are older adults. Ten programs are in public housing developments. Although most of the city's NORC programs are in vertical housing developments, two are in sprawling, two-story garden-apartment complexes.

New York City's NORC programs are structured partnerships between housing entities or neighborhood organizations, the residents, health and social service providers, and other community stakeholders. In most instances, the lead partner is a social service

provider from the network of aging services that has overall responsibility for managing the partnership and providing a full range of individual and group social work services. The health partner is typically a home care agency, a local hospital, a nursing home, or a combination of these. Many of the programs' health partners provide nurses as an in-kind resource with nursing hours per program ranging from two to 55 hours a week.

The NORC programs are located on site in the housing development or neighborhood and draw on the resources and assets found in the community to address the challenges to aging in place. Staffed by social workers, nurses, and the residents, the programs work at both the individual level and the community level to:

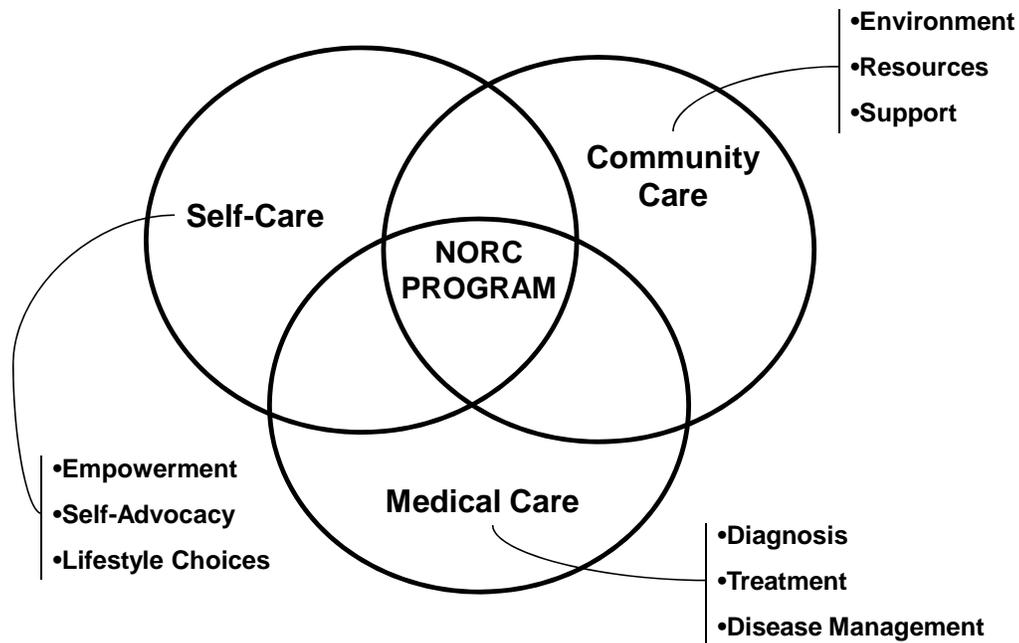
- Maximize the health and well-being of all the older adult residents;
- Foster social connectedness within the community; and
- Empower older adults to take on new roles (other than that of "client") in their community.

Until recently, it was hard to document the extent to which programs were maximizing the health and well-being of older adults. With no tools to conduct health surveillance for the identification of health risks, program staff responded to health problems of individuals as they were identified, usually as a result of a crisis. The health component of the NORC program consequently focused on providing health education and health promotion activities (lectures on specific topics and a range of physical and cognitive exercises); blood pressure checks (a very popular service); and monitoring of frail or medically complex residents to help them and their caregivers manage and negotiate the health care system maze. Compelling stories of individuals who had been helped supported the perceived value of NORC programs as helping older adults remain in their homes.

Health Indicators in NORC Programs

NORC programs are ideally situated to maximize the health and well-being of older adults. Health and social service professionals are based in the NORC and sit at the intersection of what older adults must do to manage and maintain their health (self-care), what the medical providers must do to effectively address the health issues of the residents (medical care), and what supports and services need to be available in the community to help older adults (community supports). Rather than starting at the health care institution or provider level to apply the principles of the chronic care model (Bodenheimer, Wagner, & Grumbach, 2002a & 2002b), a NORC program makes it possible to shift the locus of activity to the community, integrating the three systems of care that are essential to effective management of chronic conditions, as shown in Figure 1.

Figure 1. Community Chronic Care Model



Source: United Hospital Fund, 2008.

In 2006, New York City’s Department for the Aging (DFTA) contracted with the United Hospital Fund (the Fund), a research, policy and philanthropic organization focused on shaping positive change in the health care delivery system, to develop and implement Health Indicators—a tool and process to help NORC programs measure the extent to which they are maximizing the health and well-being of their clients (Vladeck, Segel, Oberlink, Gursen, & Rudin, 2010). To help develop the tools and the electronic database that programs would need for data entry and access to the program-specific reports, the Fund turned to the Center for Home Care Policy and Research of the Visiting Nurse Service of New York as its technical consultant and database manager.

The goal was to build the capacity of the NORC programs to gather evidence that could then be used to inform their own practice. This required a major culture change for NORC programs. They had to shift from providing crisis-driven reactive services to individuals and the lectures and activities for a general older adult audience, to proactive, targeted practice based on evidence. This shift required upgrading the skills of nearly 200 NORC program staff members. They needed to learn how to collect, interpret, and use relevant data to target their efforts to those individuals with a particular health issue; apply standards of practice to their interventions that reflected best practices and clinical guidelines with respect to self-care, medical care, and community supports; develop

strategies to leverage resources from and exchange information with other sectors; and regularly measure their effectiveness over time.

Health Indicators has two related parts:

- Identification of key health risks in a community or client population through a survey; and
- Use of a quality-improvement process to target, implement, and measure the effectiveness of interventions focused on a specific health condition.

For the survey, the Fund drew on the Centers for Disease Control's healthy aging framework to posit that effective NORC programs are those that ensure that older adults (1) have access to health care; (2) engage in health promotion, disease prevention, and wellness activities; and (3) are engaged in and receiving appropriate management of their chronic conditions. (See Appendix A for Domains and Indicators.) A 75-item survey instrument was developed corresponding to the three selected components of healthy aging and their relevant indicators. The instrument is substantively based on standardized questions from validated national and local surveys including the Behavioral Risk Factor Surveillance System (CDC, 2010), the National Health Interview Survey (NHIS, 2010), the U.S. Census, and the AdvantAge Survey (VNSNY, 2010).¹ Additionally, several questions were developed specifically for this questionnaire and pilot-tested in 12 NORCs. Several quality assurance features, including skip logic and the automatic rejection of incomplete surveys, are built into the instrument and the database programming in order to ensure that the data is of high quality. It takes 15 to 20 minutes for the NORC program staff to administer the survey to clients and approximately five minutes to enter it into the web-based database.

The reports developed for the programs focus on identifying the most prevalent health risks and conditions of the older adults served by each NORC program. Question-by-question frequency reports describe the characteristics of the NORC program's client population and profile reports more closely examine older adults with key health conditions by demographic, utilization, and other variables. Programs can view their own program data using the password-protected website. They can also see the aggregated data to see how they compare to the other participating NORC programs.

In 2006 the Fund piloted the survey instrument baseline data collection with 12 NORC programs. At each NORC program the staff was trained on how to administer the survey

¹ The AdvantAge Initiative is a project that has developed tools and processes to help communities measure their elder-friendliness (VNSNY, 2010).

and enter the data. Based on annual activity reports to DFTA, target numbers were established for each NORC program that represented 45% of their individual client population. Staff members were instructed to administer the survey during the course of their regular work with those clients receiving an individual health or social service visit over a three-month period. Technical assistance and support were available during the baseline data collection process. Once the data were collected, the Fund helped each program use the data to begin a conversation with their partners and community stakeholders about the findings. Each program was given comparative city, state, and federal data, when available, in a standard format that organized the program and comparative data side-by-side for ease of use and sharing with others.

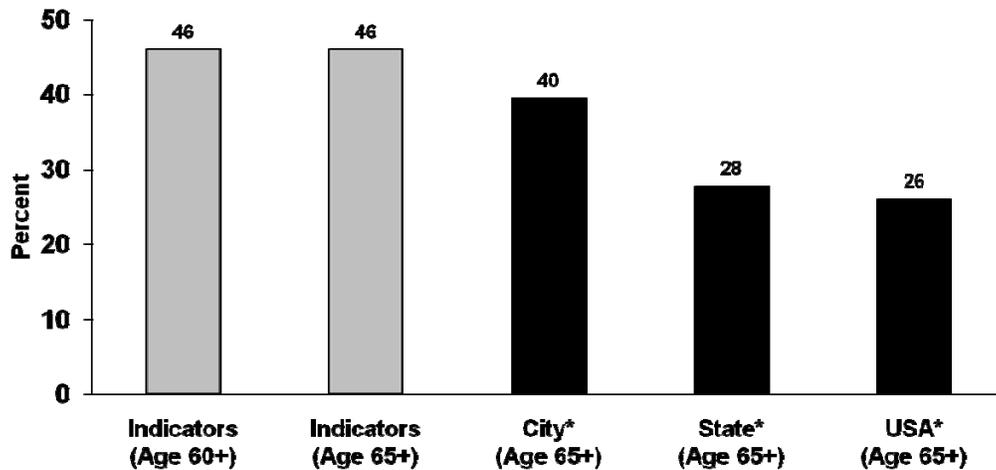
Although the 12 NORC programs approached this effort with trepidation, they were excited when they saw the results. For the first time, the NORC programs (and DFTA) had a valid picture of the older adults whom they served, their most prevalent health risks, and how they were faring. One program was surprised to learn that the prevalence of seniors at increased risk for falls was higher than the national average. The program staff had known about and reacted to the falls of individuals but never realized that this was in fact a community issue. Another example of how community-level data can be so variable, and so important in helping determine where to focus their efforts: 49% of clients at one NORC program had heart disease, and 27% of those clients were taking ten or more medications; at another NORC program right across the street, 38% of clients had heart disease, but only 15% of those clients were taking ten or more medications. The data provided a way to differentiate health risks and needs by community.

The Fund expanded Health Indicators to the remaining city-funded NORC programs using the tools, training, and support process described above. By the end of 2007, a total of 5,069 surveys were completed and entered into the database by the staff at 34 NORC programs. Each NORC program used its survey data to select a major health issue on which to focus its efforts: diabetes, heart disease, or heightened risk of falls. Collectively, the data has painted an informative picture of the health and well-being of the older adults served in each of New York City's 34 NORC programs and across all the NORC programs.

Health Indicators Survey Results

Overall, seniors served by NORC programs rate their health fair to poor at slightly higher rates than seniors in the city, state, and country as a whole, as shown in Figure 2.

Figure 2. Fair/Poor Health Status
(Indicators Data compared to City, State, and National Data)



* Percentages are rounded to the nearest whole number.

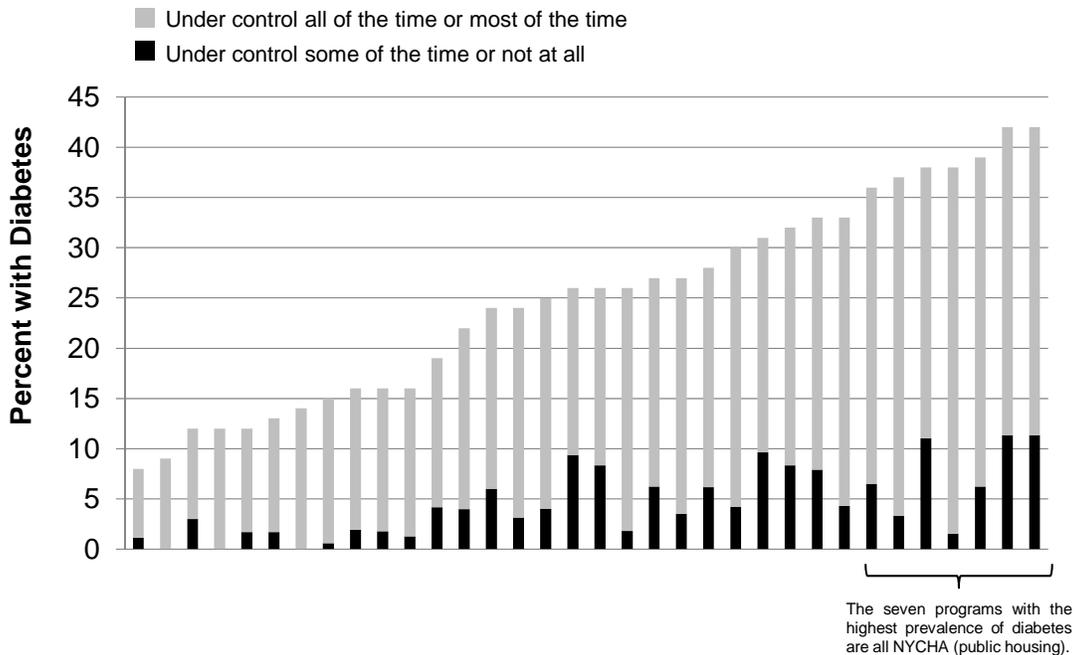
Sources: UHF Health Indicators in NORC Programs Initiative, 2007-2008; www.nyc.gov (city); <http://www.cdc.gov> (state); <http://www.cdc.gov> (USA).

The data also showed that NORC program seniors have access to care (99% of surveyed seniors have primary health insurance); make frequent visits to their doctors (22% of surveyed seniors with a regular source of care saw this provider seven or more times in the previous twelve months); and take a lot of medications (15% take ten or more). These rates intensify by chronic condition.

Looking more closely at one condition points up differences in communities, and how different NORC programs can help seniors manage multiple chronic conditions. For illustrative purposes, we focus on diabetes, which New York City has declared to be an epidemic (Kim, Berger, & Matte, 2006). Diabetes prevalence rates in NORCs mirror those in the city as a whole: they vary greatly by community, with diabetes rates higher in low-income and black and Hispanic communities.

Figure 3 depicts diabetes prevalence in the 34 NYC-funded NORC programs. As seen in the figure, there is great variation in prevalence (gray bars plus black bars). Diabetes prevalence ranges from a low of 8% in one program to a high of 42% in two programs, which is almost twice the rate for New York City’s older adults (NYC DOHMH, 2010). There is also wide variation in diabetes control (black bars only).

Figure 3. Diabetes: Self-Reported Prevalence and Control, by Program



Source: United Hospital Fund, 2007-2008.

This kind of data can arm individual NORC programs with the information they need about their own communities to identify priorities and tailor their responses based on the specific characteristics of their population; it suggests ways to make the best use of limited resources. The three NORC programs we present portraits of all have high rates of diabetes but differ greatly, as described below, in available resources, size, physical and demographic characteristics: Co-op City in the Bronx, Elliott-Chelsea Houses in Manhattan, and Ravenswood Houses in Queens (Table 1).

Table 1. NORC Program Characteristics, 2007

Characteristic	Co-op City	Elliott-Chelsea	Ravenswood
Year Established	1995	2006	1999
Borough	Bronx	Manhattan	Queens
Public Housing	No	Yes	Yes
Public Funding Source(s)	State & City	City	City
Total Population	50,000	2,654	4,568
Total Senior Population	8,500	594	940
Number of Seniors Served	490	204	233
Number of Housing Units	15,372	1,128	2,154

Source: United Hospital Fund, 2007-2008.

Co-op City, which is made up of 35 high-rise buildings and 248 townhouses, is the largest housing development in the country. Built in the mid-1960s for moderate-income families (many of them trade unionists), it is situated on swampy land in an isolated section of the Bronx. Co-op City has three distinct sections (neighborhoods) and the residents strongly identify with their respective neighborhoods. The developer also built three shopping centers and community centers (where the senior centers are located), five schools, recreational facilities, and a library. It has its own police and fire departments, and the local hospital operates a health center in Co-op City that is used by most of the residents. This is a community of activists, with numerous clubs, building councils, and political and civic organizations.

Elliott-Chelsea Houses, a public housing development on Manhattan's lower west side, is considerably smaller, with just two 21-story buildings with 426 apartments. It was built in 1964 on almost two acres in a part of the city that was thought then to be one of the worst neighborhoods in the city. Blue-collar workers and their families were its original tenants, and as federal and city housing policy changed over the years, the resident population became increasingly Latino and black. Bus and subway service is easily accessible. There is a public elementary school one block away, a community center across the street with recreational facilities and a mental health clinic, and a senior center

ten blocks away. Recently the neighborhood has seen enormous changes, including the closing of the local hospital and its satellite health clinics, and gentrification of the area, with upscale art galleries immediately to the west of Elliott-Chelsea Houses.

Ravenswood Houses in the Long Island City section of Queens is one of New York City’s largest public housing developments. Built in 1951, it is situated on 38.9 acres and comprises 31 buildings of six or seven stories. The housing development is surrounded by warehouses, many of which have been converted in the last ten years into film and television studios. Within the development there is a library and a large playground. Several nonprofit organizations operate two day care centers and a senior center on-site. Public buses are easily accessible and the subway is four to eight blocks away. The community surrounding Ravenswood Houses is a virtual league of nations; the local hospital notes that more than 64 different languages are spoken by its patients.

Table 2 compares basic demographic facts about each of the three NORC programs.

Table 2. Demographic Characteristics

Characteristic		Co-op City	Elliott-Chelsea	Ravenswood
		225 respondents	170 respondents	157 respondents
Age	60-64	8%	14%	4%
	65-74	20%	39%	34%
	75-84	36%	38%	40%
	85+	36%	9%	21%
Gender	Male	24%	19%	23%
	Female	76%	81%	77%
Race/ Ethnicity	White (Non- Hispanic)	43%	5%	22%
	Black (Non- Hispanic)	45%	17%	20%
	Asian	0%	0%	3%
	Hispanic	12%	77%	53%

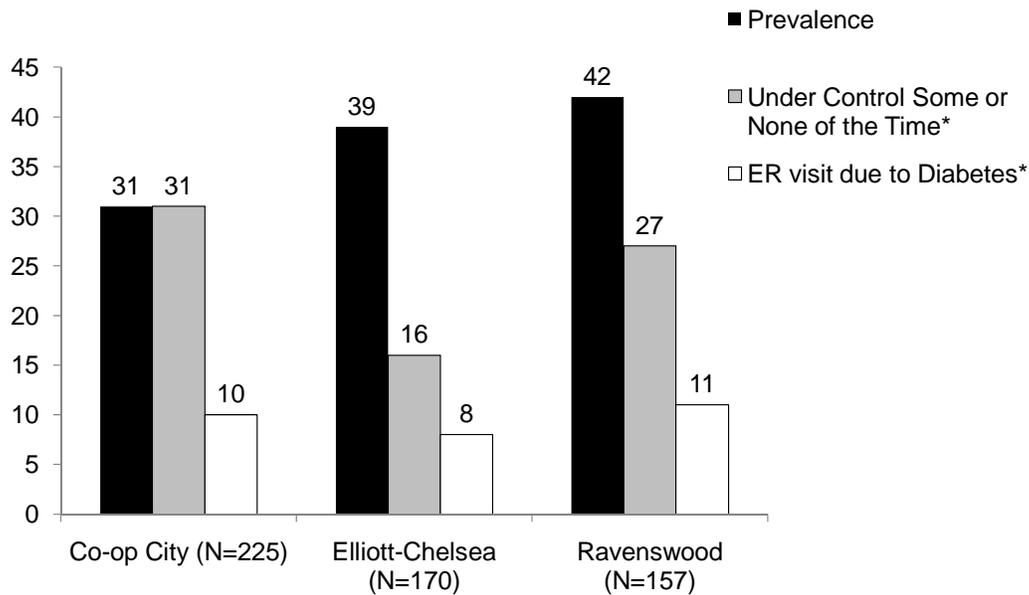
Source: United Hospital Fund, 2007-2008.

Note: Percentages may not add up to 100% due to rounding and/or missing information.

Seniors in all three of these communities rate their health fair or poor at noticeably higher rates than seniors in New York City, New York State, and the U.S. (58% at Co-op City, 53% at Elliott-Chelsea, and 45% at Ravenswood, compared to 40%, 28%, and 26% in city, state, and country, respectively). And all three programs have higher rates of diabetes (31%, 39%, and 42%, respectively) than the citywide rate of 23% (NYC DOHMH, 2010).

Figure 4 shows the diabetes prevalence and control in each of the three selected NORC programs. Clients were asked if a doctor had ever told them that they have diabetes; whether their symptoms were under control all of the time, most of the time, some of the time, or none of the time; and if they had been to an emergency room for their diabetes in the past 12 months.

Figure 4. Diabetes Prevalence and Control in Three NORC Programs



*Base changes to number of people told by a doctor that they have diabetes.

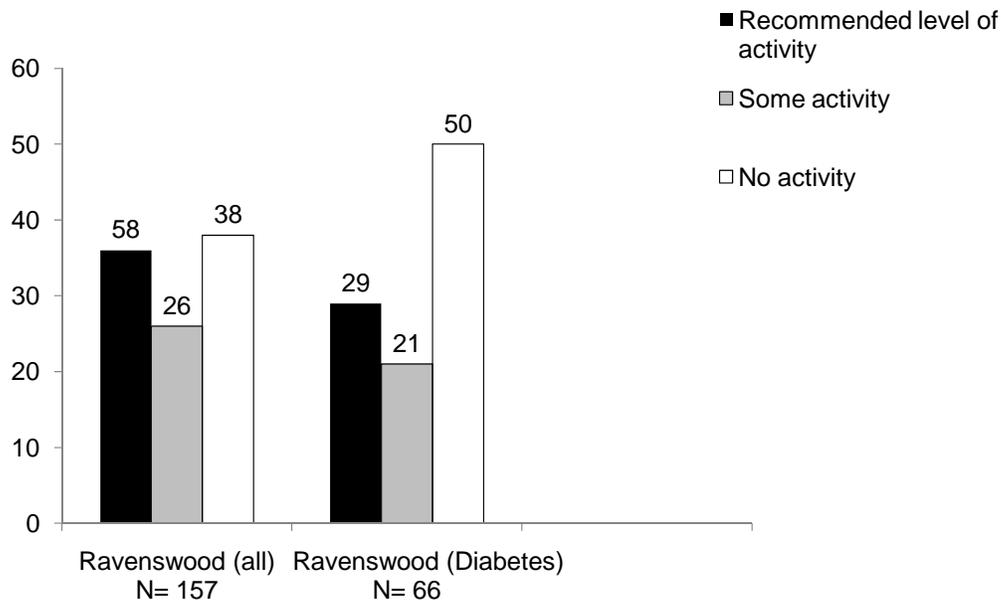
Source: United Hospital Fund, 2007-2008.

Beyond the basic information about diabetes in these three communities, there are distinct differences that these programs need to take into account in order to effectively target the population at greatest risk. In Co-op City, for example, only 12% of those surveyed were Hispanic, but 44% of Hispanics surveyed had diabetes. With such a high

rate of diabetes among Hispanic seniors, Co-op City’s NORC program may want to consider focusing on Hispanic seniors to ensure early identification and culturally appropriate interventions (NAHH, 2010). In Ravenswood, 37% of the respondents who live alone have diagnosed diabetes. Connecting to seniors living alone often requires outreach strategies that are more personal than putting flyers under doors or on bulletin boards. In order to connect to the live-alone seniors in Ravenswood Houses who have diabetes, this program may want to consider how best to use personal contact.

There are also important differences that can help programs tailor their programming and resources to improve the management of diabetes. In Ravenswood, respondents with diabetes are less likely to engage in any physical activity than respondents without diabetes. While this pattern (Figure 5) is not surprising or particular to Ravenswood, the degree of difference at Ravenswood is striking, and may suggest a particular response. (This difference is less pronounced at Co-op City and Elliott-Chelsea Houses.)

Figure 5. Ravenswood: Physical Activity



Source: United Hospital Fund, 2007-2008.

Armed with this information, Ravenswood may find it makes sense to focus on exercise programming for people with diabetes. The program can begin to ask more focused questions:

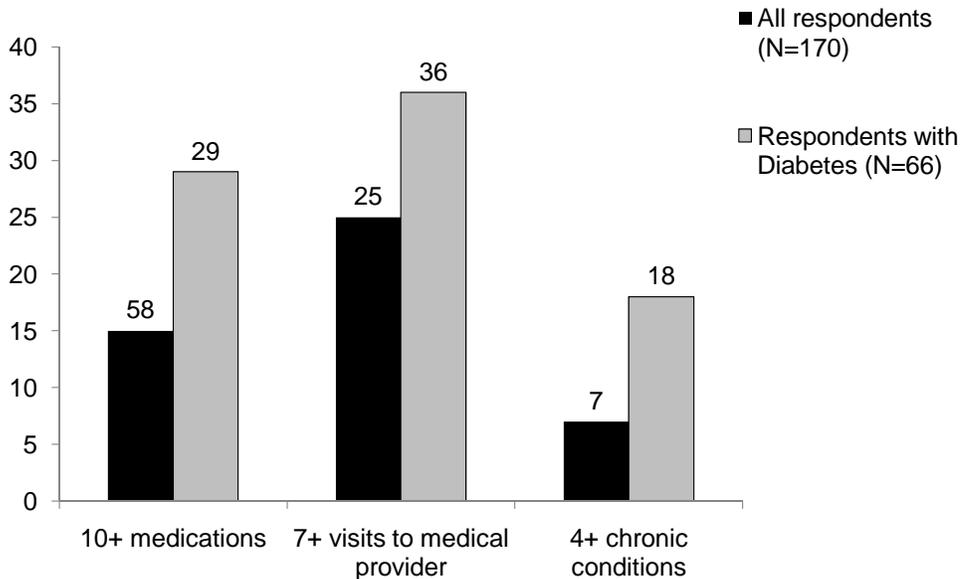
- Why are people not exercising?
- Are the streets safe for walking — “safe” meaning both free from crime and physically walkable?
- Are exercise programs offered at times that people can go?
- Are the facilities sufficient?

Answers to these questions arm the NORC program with the compelling information it needs to reach out to potential partners and stakeholders. If a building entrance is unsafe, can the NORC program serve as a catalyst to focus the community stakeholders on advocating for handrails leading to the steps into the building, as one NORC program did (United Hospital Fund, 2007)? If crime or fear of crime keeps people indoors and not exercising, is there a way to engage the local police? If lack of physical space prohibits exercise classes from being offered indoors, is there a local gym that would partner with the program and offer senior-friendly services for free, or at least at a discount? Data provide a starting point that helps confirm a problem and focus community conversations on what actions to take.

Co-op City might take a different approach. Thirteen percent of its respondents take ten or more medications. This number increases to 22% for people with diabetes. In fact, of the people with diabetes in Co-op City, 74% take five or more medications. This statistic is alarming and should prompt additional information gathering, especially because the respondents rate their health at levels far worse than the city, state, and country (58% characterize their health as fair or poor). The program may wish to consider instituting regular medication reviews. Many clients see multiple medical providers and fill prescriptions from all of them, increasing the chances of taking duplicate medications or harmful drug-to-drug interactions. The NORC program could direct efforts toward helping clients understand what medications they are taking, and why and how to take them; knowing who the medical providers in the community are and evaluating whether the clients are receiving consistent care; and establishing an information exchange between doctors, pharmacies, and the NORC program, as another participating NORC program successfully did (United Hospital Fund, 2007).

As shown in Figure 6, people with diabetes in Elliott-Chelsea Houses are taking lots of medications, are seeing their doctors frequently, and are more likely to have multiple chronic conditions.

Figure 6. Elliott-Chelsea: Selected Indicators



Source: United Hospital Fund, 2007-2008.

Elliott-Chelsea's problems are intensified by the community's language barriers. Respondents with diabetes are likely to be from another country and to struggle with language barriers. In fact, in Elliott-Chelsea Houses, 45% of the seniors who do not speak English well or at all have diabetes. The recent closing of the local hospital and its satellite clinics has placed the seniors in this community at increased risk. This NORC program now has the data it needs to advocate for culturally competent and linguistically appropriate health services for this community, a recommendation of the National Alliance for Hispanic Health² as it works to connect clients to new health providers.

² See page 46 of (NAHH, 2010).

Conclusion

We are at a crossroads in the field of aging. We can continue focusing on delivering services to individuals in need while offering health promotion activities to the general population or we can borrow from other fields to adopt place-based strategies that are responsive to and reflect the needs of a community.

Health Indicators provides a solid framework to make a real difference in the community. Armed with the detailed information from the Health Indicators surveys, the participating NORC programs are addressing the health risks in their communities with different responses.

The programs can now measure progress as they change practice to be systematic, targeted, and deliberate. Practice change is slow, and in this case multi-layered. It involves retraining a workforce, activating a community, and bringing together the various forces that have a stake in the senior population. NORC programs are now learning how to work proactively and how to use their resources most efficiently through a quality improvement process developed by the Fund.

Appendix A. Health Indicators in NORC Programs: Domains and Indicators

GOAL: To advance healthy aging in the community

I. Objectives

- Identify health risks among NORC residents aged 60+
- Plan interventions/programs
- Measure the impact of NORC program interventions

II. Data to be collected in pilot NORC sites

A. Demographics

- Age
- Gender
- Living arrangements
- Language
- Race
- Ethnicity
- Living children & their proximity
- Country of origin

B. Domains & Indicators

1. Access to Care and Information

- Health insurance status
- Regular source of care & frequency of MD and ER visits
- Source of information about health concerns and service needs
- Health care proxy

2. Health Promotion, Disease Prevention, & Wellness

- Self-reported health status
- Number of prescription & non-prescription medications
- Problems paying for prescription medications
- Immunizations (flu shot & pneumococcal vaccine)
- Screenings (blood pressure reading, hearing test, eye exam, mammogram, Pap smear, prostate-specific antigen, colonoscopy, bone mass)
- Physical activity
- Tobacco use
- Alcohol use
- Connection to family, neighbors & friends
- Frequency of leaving the home

3. Health Conditions

- Diagnosis and management of health conditions (diabetes, lung disease or breathing problems, high blood pressure, heart disease, stroke, arthritis, osteoporosis, obesity)
- Interference with activities of daily living due to poor health
- Falls
- Depression
- Use of assistive devices (eyeglasses, hearing aid, cane, walker, wheelchair, shopping cart, personal emergency device)

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