A Special Report from United Hospital Fund

A Good Place to Grow Old: New York's Model for NORC Supportive Service Programs

United Hospital Fund
Shaping New York's Health Care: Information, Philanthropy, Policy.

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The United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

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Executive Summary

The number of older people in New York City and across the nation continues to grow, presenting a challenge to health care and social service providers: how to develop a service model that respects seniors' strong preference for remaining in their own homes, acknowledges the importance of existing social networks, and recognizes that seniors themselves have much to contribute to the communities in which they live.

Over the last 18 years in New York State just such a model of care has emerged. The first Supportive Service Program (SSP) based in a Naturally Occurring Retirement Community (NORC) was established in 1986 at Penn South Houses in New York City. In 1995, New York State endorsed the model by providing funding to create 14 NORC-SSPs; New York City followed suit in 1999. Today 27 NORC-SSPs are spread through four of New York City's five boroughs, serving communities in which more than 46,000 seniors live.

This report describes New York City's NORC-SSPs, drawing on the experiences of the United Hospital Fund's Aging in Place Initiative, which since 1999 has provided grants and technical support to New York City's NORC-SSPs, and examined elements of successful programs.

The NORC-SSP model represents a significant departure from the current service delivery system based on functional deficits. From program development to the definition of client, the model expands the role of older people in their community from recipients of services to active participants in shaping their community as "good places to grow old." The model also assumes quite different approaches to financing services and to collaborations among health and social service providers.

This information is particularly timely as communities in other parts of the United States begin to implement NORC-SSPs, with federal funding provided through the Administration on Aging.

What Is a NORC-SSP?

New York NORC-SSPs are distinguished by the following hallmarks:

- NORC-SSPs organize and locate a range of coordinated health care and social services and group activities on site in the community.
- They draw their strength from partnerships that unite housing entities and their residents, health and social service providers, government agencies, and philanthropic organizations.
- The programs promote independence and healthy aging by engaging seniors before a crisis and responding to their changing needs over time.
- Residents themselves play a vital role in the development and operations of NORC-SSPs.
- Eligibility for services and programs is based on age and residence in the NORC, rather than on functional deficits or economic status, and the mix of services available is resident-specific, not program-specific.
- NORC-SSPs are financed through public-private partnerships that combine revenues and in-kind supports.

All NORC-SSPs provide social work services; indeed, in most NORC-SSPs in New York City, the lead agency is a social services agency. Most NORC-SSPs in the city have a health care partner as well; the partner may be a certified home health agency, nursing home, or hospital. Educational and recreational activities and volunteer opportunities are diverse and designed to engage as many community residents as possible. Although

organized and managed by the professional staff, many classes or activities are led by the seniors themselves.

Because success depends on the extent to which a NORC-SSP reflects the strengths, interests, and aspirations of community residents, thorough assessment, extensive and ongoing outreach, and the ability to adapt to changes in the community over time are essential.

New York's NORC-SSPs have developed various governance structures in order to manage the complex partnerships of housing corporations, social service agencies, health care providers, government agencies, and the residents themselves. NORC-SSPs must find a way to make the collaboration among these diverse partners work; strong leadership is key, as is an ability to redefine institutional boundaries and relationships.

As other regions of the country attempt to introduce the NORC-SSP model, important questions arise:

- What are the minimum and maximum thresholds of community size, population density, local infrastructure, and geographic coherence beyond which the development of successful SSPs will not be possible?
- How can health care and social service professionals be prepared to perform the complex tasks required by SSPs?
- What tools can be developed to assess NORC-SSPs, whose success cannot be measured merely in terms of units of services but in their ability to transform communities?

As significant as these questions are, the New York NORC-SSP experience has demonstrated that it can be done: public programs, service delivery organizations, and communities themselves can come together to create and operate totally new forms of senior services, organized around the seniors and their communities, which can make a positive and palpable difference in individual lives.

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Foreword

With the rapidly increasing number of elderly Americans, the dramatic medical and scientific advances saving and prolonging life, and new "epidemics" of chronic disease, the United States must find new models to respond to the needs of its aging and chronically ill populations. The key to this challenge is rethinking, and redesigning, the way services are organized, delivered, and financed.

At the United Hospital Fund, we have been focusing on these issues for many years, by means of our policy analysis, research, and support for innovative programs. Our Families and Health Care Project advances public and professional understanding of the 25 million Americans caring for seriously ill or disabled loved ones at home. Our palliative care initiatives have sought to improve end-of-life care both for those who die in the hospital and for those who spend the last months of life at home, in the community. And our Managed Long Term Care Quality Consortium focused on improving the Medicaid home care services available to the disabled as well as the frail elderly.

Another cornerstone of our efforts has been our Aging in Place Initiative, which focuses on those New Yorkers living in naturally occurring retirement communities, or NORCs, and helps develop the services and infrastructure to allow these seniors to remain in their own homes even as their need for assistance increases. This report, describing that Initiative, is written by project director Fredda Vladeck, an expert in practice, policy, and program development for the elderly, who was instrumental in establishing the first NORC Supportive Service Program (SSP) in New York City in 1986.

The 27 NORC-SSPs that exist today are an impressive public-private venture and a testament to the commitment of many different partners to rethink and move beyond the traditional service delivery system created in a different era for a different population. The NORC-SSPs receive significant support from New York City and New York State, as well as from local philanthropies and in-kind contributions from housing corporations and health care providers. Fund staff have done much of the hard behind-the-scenes work to make these complex partnerships work. They also provide ongoing technical assistance to SSP staff on the front lines.

Our work in this area has broadened our horizons. Not only are we working with health care organizations but with social service organizations, housing corporations, and the residents themselves. It is clear to us that such collaborations are the way of the future, the key to being able to deliver more efficient and patient-centered care to a changing population.

We are grateful to many individuals and organizations for their contributions to the Aging in Place Initiative. We thank our partner in the Aging in Place Initiative, United Way of New York City, as well as the philanthropies that have supported New York City's NORC-SSPs and the Aging in Place Initiative: the Fan Fox and Leslie R. Samuels Foundation, Stella and Charles Guttman Foundation, James N. Jarvie Commonweal Fund, New York Community Trust, Dorothy F. Rodgers Foundation and Dorothy Rodgers Supporting Foundation of UJA-Federation of New York, Spingold Foundation, and Isaac H. Tuttle Fund.

A special note of thanks is due to Anita Altman of the UJA-Federation of New York, who beginning in 1988 had the foresight to recognize the value of the NORC-SSP model and has helped shape the agenda and secure funding ever since. Finally, the New York City Department for the Aging has been an invaluable partner in this ambitious effort to transform life for elderly New Yorkers.

JAMES R. TALLON, JR.
President
United Hospital Fund

Over the last 18 years a model of care has emerged that is revolutionizing services for older people. The new paradigm recognizes the considerable strengths of the elderly, as well as their inevitably changing needs. It also recognizes seniors' overwhelming preference to remain at home, in the neighborhoods they have lived in for years, and the importance of community for successful aging.

The new model—Supportive Service Programs (SSPs) based in Naturally Occurring Retirement Communities (NORCs)—draws its strength from partnerships that unite housing entities and their residents, health and social service providers, government agencies, and philanthropic organizations (see box). Together, these groups assess the needs, interests, and resources of a community and its seniors and then organize and locate a range of coordinated health care and social services and group activities on site. The programs promote independence and healthy aging by engaging seniors before a crisis and responding to their changing needs over time. Eligibility for services and programs is based on age and residence in the NORC, rather than on functional deficits or economic status, and the mix of services available is resident-specific, not program-specific. NORC-SSPs do not ignore existing categorical or entitlement programs but use them as tools. Services are flexible, responsive to needs and interests identified by the individual, and, to a considerable extent, client-directed.

The first NORC-based SSP was pioneered in 1986 in New York City. Since then, with city and state support, the model has been replicated at 27 other sites in New York City, in a unique model of shared public-private financing. In 2001, the U.S. Congress, through the Administration on Aging, made grants to Jewish Federation agencies to develop NORC-SSPs in five cities: Philadelphia, Baltimore, Cleveland, Pittsburgh, and St. Louis. Jewish Federations in nine other cities (Albuquerque, Atlanta, Chicago, Detroit metropolitan area, Greater Washington DC, Las Vegas, Los Angeles, Miami, and Minneapolis) received grants in 2002.

This paper describes the evolution of the NORC-SSP model in New York City. It describes the programs' organization, structure, and basic characteristics; the services they provide; and the techniques

WHAT IS A NORC-SUPPORTIVE SERVICE PROGRAM?

NORC-SSPs

- Are partnerships that unite housing entities and their residents, health and social service providers, government agencies, and philanthropic organizations.
- Offer a flexible range of coordinated health care and social services and group activities on site in the community.
- Promote independence and healthy aging by engaging seniors before a crisis and responding to their changing needs over time.
- Rely on a mix of public and private funding.

they use to mobilize the skills and talents of participating agencies. It concludes with a discussion of the applicability of the New York City NORC-SSP model to other kinds of communities and in other parts of the country. The paper is based on the work of the United Hospital Fund's Aging in Place Initiative, a partnership with United Way of New York City. Since 1999, the Initiative has provided grants and technical support to New York City's NORC-SSPs, coordinated philanthropic support for the programs, and pursued a research agenda to determine what makes some programs more successful than others.

A New Approach to Services for the Aging

The NORC-SSP model grew out of a recognition of an emerging demographic phenomenon. In the early 1980s, Michael E. Hunt coined the term Naturally Occurring Retirement Community (NORC) to describe neighborhoods and housing developments originally built for young families in which 50 percent or more of the residents are 50 years old or older (Hunt 1985) (see box). Unlike purpose-built senior housing or retirement communities, which have their own entrance criteria, physical design elements, services, and supports, NORCs cannot be built or developed. They evolve over time. Hunt found that some communities become NORCs as people nearing retirement age relocate to them. However, because most seniors prefer to remain in their own homes of many years, NORCs typically evolve as the residents of a community "age in place."

Many U.S. communities are or will become NORCs as the number of people aged 65 years and older in the United States continues to grow, reaching an all-time high of 20 percent of the population (70 million people) by 2030. As far back as 1989, an AARP study found that 27 percent of U.S. seniors live in NORCs, which the study defined as age-integrated communities with large concentrations of seniors (AARP 1992). Recognizing that communities come in all shapes and sizes and that sufficient age-related density provides an opportunity to redesign service delivery to achieve economies of scale, Lanspery and Callahan identified nearly 4,500 census block groups across the United States as potential NORCs using data from the 1990 census (Lanspery and Callahan 1994).*

In addition to reflecting changing demographic patterns, the new service paradigm grew out of an understanding that connectedness to other people and the broader community is a determinant of well-being in old age and that seniors themselves have much to contribute to the community (Table 1).

DISTINGUISHING NORCs FROM NORC-SSPs

Although the terms NORC and NORC-SSP are sometimes used interchangeably, they are different. NORC is a demographic term; it describes age-integrated neighborhoods or buildings in which a large percentage of residents are elderly. NORC-SSP is a service delivery program developed by such a community in response to the demographic phenomenon.

The Emergence of a Model

These shifting paradigms coalesced in 1986, when Penn South Houses responded to the aging of its residents by establishing the first

* In 1990, there were 226,000 block groups in the United States, each containing, on average, 400 households. Lanspery and Callahan defined density as both a percentage of the population in a block group (40 percent or more of households where the head of household was 65 years of age or older) and a numeric count (minimum of 200 heads of household 65 years of age or older). Using these criteria, 4,437 block groups met the density requirement along both dimensions. Another 17,474 had only one of the threshold requirements: 9,406 block groups met the percentage requirement but lacked a sufficient number of seniors, while 8,068 met the numeric minimum but did not meet the percentage threshold.

Table 1: **Old and New Paradigms of Aging Services**

	OLD PARADIGM	NEW PARADIGM
Determinant of Client Status	Acute need, functional deficit, and categorical eligibility	Age and residence
View of Client	Emphasis on deficits	Focus on strengths
Role of Client	Passive patients	Active participants with multiple roles (constituent, leader, volunteer, consumer, and client)
Entry Into System	Reaction to crisis or functional deficit	Engagement before crisis, early participation in roles other than client
Relationship of Service Providers to Clients	Problem-focused, episodic, and intermittent intervention (one hip fracture at a time)	Ongoing engagement, continuing presence
Location of Provider	Off-site, in an office distant from the community	On-site, in the housing development
Relationship of Service Provider to Community	"Catch as catch can"	Ongoing partnership, with service provider accountable to community
Services Provided	Public program "menus"	Broad range of community-specific and -defined services, plus entitlements
Relationship to Housing	None	Integral relationship through location, governance, and financing
Governance	Bureaucratic and distant	Community coalition
Financing	Government entitlements and fee for service	Government grants, housing provider contributions, philanthropy, and user fees

professionally staffed NORC-SSP. Although several communities, including this one, had previously set up volunteer-led programs to help frail residents, these efforts were difficult to sustain as the number of elders' needs increased and the needs became more complex.

Built in 1962 under the sponsorship of the International Ladies Garment Workers Union, the ten-building complex of moderate-income cooperative apartments was home to 6,200 residents, the majority of them original "cooperators." Penn South had many residents who were trying to remain active and busy, dreading the day when a fall or other health problem might limit their ability to participate in the life of the community, but it also had its share of problems with confused residents who wandered, lost keys, fell, or forgot to pay their monthly maintenance charges.

Working with the author, who was then a social worker at a local hospital, the board of directors of Penn South Houses undertook a survey of the entire complex to understand the problems and needs of its older residents, as

well as their interests and aspirations. Based on what the residents said, the Penn South Program for Seniors was designed. It located on-site clinical teams from health care and geriatric social work organizations, who worked in partnership with the housing company and residents to create opportunities for seniors to remain active and involved in their community, and to provide an array of on-site health and social service supports to assist residents and their caregivers as needs changed over time. This design was quite a departure from the then-current practice of separating programs for the well-elderly from services for the frail based on payer source and functional status.

In 1986 UJA-Federation of New York recognized the potential of this new service model and provided significant funds to support the program and an eight-person staff of social workers and a nurse for three years. In 1989, UJA helped the program partners devise a more sustainable long-term financing mechanism that included financial support from the housing company's operating budget, in-kind contributions (such as nursing staff and administrative supports) from the provider partners, support from the residents in the form of membership and class fees for the various activities and educational programs, targeted philanthropic grants, and member items (modest grants from elected city and state officials).

Over the next ten years, the NORC-SSP model was broadly replicated. In 1992 it was implemented at two other housing developments. In 1995 New York State established the first public-private NORC-SSP Initiative targeting 14 moderate- and low-income housing developments where at least 50 percent of the heads of household (or, for the largest complexes, at least 2,500 individuals) were 60 years of age or older. Administered by the New York State Office for Aging (SOFA), the state's annual $1.2 million leverages an equal amount in matching funds and in-kind services from the 14 participating housing developments, their service provider partners, and philanthropies. Twelve of the 14 programs are located in New York City (two are in public housing and the remaining ten are in moderate income co-ops); a public housing project in Troy and a moderate-income rental in Rochester round out the list of sites.

Building on the state effort, New York City allocated $4 million in 1999 to strengthen the city's 12 existing state-supported programs and to establish 16 new programs in moderate- and low-income housing complexes. Although mirroring the state's program in most respects, the New York City program modified eligibility to include complexes where only 45 percent of residents were 60 years or older but added a requirement of at least 250 individuals for the smaller complexes and 500 for the larger ones. It also increased the financial role of government to two-thirds of a program's budget with the remaining one-third required from housing and other sources (Table 2). The New York City Department for the Aging (DFTA) assumed responsibility for all NORC-SSPs operating in New York City and coordinates with SOFA for the 12 New York City programs that also receive state funding.

Also involved is the New York City Housing Authority (NYCHA). With more than 70,000 seniors living in its 345 public housing developments, NYCHA had found that the senior service coordinator and resident senior advisor programs that it had pioneered and which were later adopted by the U.S. Department of Housing and Urban Development were insufficient and too reactive to address the complex needs of its older tenants. When the City issued its request for proposals in 1999, NYCHA identified eligible developments and linked its on-site housing managers and tenants' associations to social service agencies interested in partnering with them.

Table 2: **NORC-SSP Conditions for Participation: New York State and New York City**

				Sources of Required Financial Support			
	Population Threshold	**Type of Housing Development**	**Geographic Boundaries**	**Government**	**Housing Development**	**Other Required Support**	**Additional Sources of Support**
New York State	50% of units with heads of household 60 years old or older OR Minimum of 2,500 heads of household 60 years old or older	Built with government assistance for moderate- and low-income families (rentals, cooperatives, and public housing)	Housing development with one or more building under a single management structure	50% or up to $150,000 annually per program. Ranges from $50,000 to $143,000.	Minimum 25% cash match from housing company, owners, or residents. Public housing is exempt.	25% cash or in-kind contributions of dedicated staff time (for health care providers) and/or philanthropic support.	In-kind housing contribution of space Client fees for group activities Legislative grants Resident-directed fund raising Grants from local businesses Targeted philanthropic grants
New York City	45% of units with heads of household 60 years old or older and minimum count of 250 OR minimum count of 500 heads of household 60 years old or older	Built for moderate- and low-income families (rentals, cooperatives, and public housing)	Single or multiple housing developments within a 1/4 square mile radius	Two-thirds or up to $200,000 annually per program. Ranges from $45,000 to $200,000.	Minimum 1/6 of DFTA grant cash match required from housing company. Public housing is exempt.	Minimum of 1/6 of DFTA grant match required: philanthropy and/or contributed dedicated staff line (usually from health care provider)	Same as above

NORC-SSPs in New York City Today

As of June 2000, 28 NORC-SSPs were serving communities and housing developments in four of New York City's five boroughs. More than 46,000 seniors live in these communities.*

Most of the programs are located in high-rise apartment buildings, ranging from a 420-unit one in which 276 of the 516 residents are at least 60 years old to a 12,000-unit complex made up of 171 high-rise buildings spread over several acres, in which 4,300 seniors live. While ten of the NORC-SSPs are located on the dense island of Manhattan, two of the largest complexes are built on landfill in isolated sections of the Bronx and Brooklyn, and two are located in sprawling communities of two-story garden apartment complexes in Queens.

Programs reflect the diversity of New York's older population. Sixteen of the programs are in housing complexes where the population is predominantly white and includes Eastern European Jews, Irish, and Italian seniors, as well as recently arrived Russian immigrants. One program is in a primarily African-American community. The remaining 11

* In July 2003, one City Council-designated program in Queens closed due to lack of interest and support from the housing company.

programs are located in mixed communities in which the majority of seniors are of African-American, Caribbean black, Hispanic, or Asian heritage, and some are recent immigrants.

Seventeen of New York City's NORC-SSPs are in moderate-income cooperative developments led by a resident board of directors. Seven are in public housing developments, and four are in privately owned housing developments under the sponsorship of a private landlord/development company. Two of these are low-income subsidized rentals, and the other two combine low- and moderate-income rental and co-op buildings under a single private management structure. Six of the programs bring together contiguous but distinct housing entities (e.g., a public housing development and a moderate-income private non-profit cooperative) to form a single program that has sufficient density to achieve economies of scale for service provision.

New York has proved a particularly fruitful environment in which to develop new models of senior services reflecting the new paradigm of aging:

- The density of population makes it possible to serve a large number of seniors with heterogeneous needs from a single site in a relatively efficient manner.
- The single management/ownership structure of New York City's housing can serve as the initial focal point for program development. Building on the housing-based organizations can also permit development of financial resources not tied to individual fee-for-service reimbursements.
- Many of New York City's housing developments have some organizational structure, either boards or tenants' associations, to govern or address problems and community issues.
- Many of New York City's housing developments possess some degree of community identity and self-awareness.

Basic Program Components

Core Services

NORC-SSPs develop community-specific services and activities that promote a reweaving of the social fabric and provide "calibrated supports" as individual needs change (Lawler 2001). The intent is not to duplicate the existing services of Medicare, Medicaid, or the Older Americans Act. These categorical services are indispensable to NORC program clients who qualify, but by themselves leave significant gaps and are inadequately coordinated with one another, let alone connected to the community. The NORC programs identify the gaps and develop services and programs to fill them.

The New York model consists of four core services. These include a range of individual social work services; health-related services and programs; educational and recreational activities; and volunteer opportunities for the seniors in the community. Many NORC-SSPs are highly evolved and able to provide a full range of services in each of the four categories; others have struggled, for a variety of reasons, to establish a minimum level of services.

Social work services include information and referral; assistance with benefits and entitlements; advocacy; case management and service linkage and coordination based on clinical psychosocial assessments; education and support for clients, paid and unpaid caregivers, and family members; and monitoring for change in status of clinically complex or fragile clients. There is no fee for social work services because the goal is to maximize access and encourage use before a crisis. Ideally, these services are provided by well-trained social workers with expertise in aging, and bachelor's level staff under the supervision of highly skilled professionals.

Health care-related services range from direct care for individuals to programs

and activities that address specific health conditions prevalent in a community. Individual health care management services help seniors to live with and manage chronic diseases; address acute situations; and provide the non-reimbursable but necessary monitoring, care coordination, and support to help maintain frail individuals at home. Additional services include physical assessment, blood pressure monitoring, individual instruction, advocacy in negotiating the health care system, and coordination and integration with clients' physicians and the on-site social workers. Health promotion, prevention, and wellness activities include tai chi, aerobic exercises, walking clubs, water exercises, "brain exercises" for memory enhancement, and movement classes for wheelchair-dependent seniors. Health education programs may cover managing multiple medications, maintaining memory and cognitive functions, chronic illnesses, end-of-life planning, hearing health, and the like.

Educational and recreational activities and volunteer opportunities are diverse and designed to engage the widest groups of seniors in the community. Although organized and managed by the professional staff, many classes or activities are led by the senior volunteers themselves. These include choral groups; weekly discussion groups focused on books or current events; men's groups; painting, crafts, and language (Yiddish and Russian) classes; and bridge and chess. The list is limited only by the talents and interests of the seniors themselves.

The core services that each program offers reflect the specific characteristics of its community. For example, in a single-building development of retired professionals in Manhattan, the priority is on those educational, health promotion, volunteer, and recreational activities that promote social interaction, stimulate the mind, and engage the broadest group of seniors. Volunteer residents are central to the program's success. Social work services and one-day-a-week nurse consultation services are also provided, but they are not the focal point or the public face of the program.

One block away, in a large public housing development, social, recreational, and educational activities are important and valued by the seniors, but the emphasis is on the health and social service components. A full-time nurse and social service staff work together to improve access to primary care and address the significant social and chronic health conditions found in this community. The volunteer residents are their eyes and ears, identifying those who may need help in a community that historically has not had strong relationships with formal care systems.

NORC-SSPs develop community-specific services and activities that promote a reweaving of the social fabric and provide "calibrated supports" as individual needs change. They identify gaps and develop services and programs to fill them.

Ancillary Services

A hallmark of the NORC-SSP design is the flexibility to determine the kinds of services needed in a community, depending on the program's budget, geographic or other local conditions, the presence or absence of familial or other social supports, and other specific population characteristics. Ancillary services are those non-core services that are critical to advancing the goals of the program and are part of each program's operating budget. Ancillary services may include transportation, housekeeping, social adult day programs, and monthly money management assistance.

For example, transportation is essential for programs located in isolated low-income communities in Brooklyn or in car-dominated sections of Queens. But for most of the

programs in Manhattan, the availability of public transportation and the proximity of retail services to the apartment buildings make transportation less critical. Similarly, the presence or absence of family supports, locally or even at a distance, has implications for the kinds of services that may be needed in a community. Money management assistance makes the difference in the ability of some programs to maintain some frailer residents at home.

A hallmark of the NORC-SSP design is the flexibility to determine the kinds of services needed in a community, depending on the program's budget, local conditions, availability of familial or other social supports, and other population characteristics.

Leveraged Services

Beyond the borders of each NORC-SSP's housing development a larger community exists with other kinds of specialized resources and services. One indication of the effectiveness of a NORC program is its ability to leverage in-kind services or resources on behalf of its clients. These can include, for example, health-related services of occupational and physical therapy students, mobile health screening services, low-vision programs, on-site audiology testing and device-fitting services, and legal services for end-of-life-care planning. Rarely do such off-site providers have the resources to organize an outreach effort or proactively identify individuals who could benefit from what they do. So they either wait in their home office for a referral or do a mass community education program and hope that those in need of their services hear about them. The presence of a NORC program that has access to and is trusted by the seniors makes it possible to effectively connect a much-needed service with a target population.

One NORC-SSP with a significant number of clients with psychiatric and cognitive impairment symptoms negotiated with a local teaching hospital to assign its geropsychiatry fellows to the program one day a week to consult with the nurse/social worker teams and provide in-home psychiatric evaluations and treatment. At no cost to the program, it leveraged psychiatric services for its clients, while the local teaching hospital broadened its training curriculum to include community-based geropsychiatry.

Although leveraging free or in-kind services can measurably enhance a program's ability to serve its community, a word of caution is warranted here. The presence of an effective NORC program is very attractive to providers and businesses, from local podiatrists and lawyers to local retail businesses such as pharmacies, seeking new customers and low-cost opportunities to market their goods and services. Even researchers have recognized the benefits and economies of scale that NORC programs offer for studies on problems or health issues of the elderly (e.g., the impact of new technologies, Alzheimer's disease).

The challenge for NORC programs is to balance the desire to provide additional useful information, educational lectures, or services with the need to remain neutral in their endorsements of businesses or providers. Few programs have the resources to do a proper due diligence before sponsoring a lecture by private practitioners. Some NORC programs, in consultation with their advisory boards, have developed guidelines or strategies to handle such situations. One program hands out a list of elder law attorneys at all lectures given by lawyers. The advisory board of another program requires that all such offers be brought to the board for a decision. Other programs have established a policy of working only with non-profit organizations. Of course, some communities, such as those

located in isolated areas of Brooklyn and Queens, may have fewer resources from which to choose than those in the resource-rich neighborhoods of Manhattan.

How the Partnerships Work

In contrast to traditional service delivery models, NORC programs bring unlikely partners together—a social service provider, which is in most instances the lead agency; a housing corporation; a health provider; and the residents—each with their own objectives, language, and terminology—to develop a shared mission. Each partner plays a critical role in shaping the program and bringing to the program the resources it can best contribute.

Social Service Provider

The social work provider supplies the master's- and bachelor's-level social work staff for the program. In addition it generally serves as the program's lead agency (see box). Social work staffing levels, which range from 0.6 FTE to slightly more than 7 FTEs, are in general a function of the resources available rather than the size or particular characteristics of the communities. (See Appendix for program-specific detail.)

Housing Corporation

New York's NORC–SSP model requires the participation of housing corporations as partners in the financing of the programs and the provision of other key resources. Beyond the cash match required of non-public housing developments by the New York State and New York City oversight agencies, rent-free space for program staff and activities is a minimum—and significant—resource that the housing owner or manager must provide. This is not as easy as it may sound. Most apartment buildings were built with little if any communal space. In New York City, NORC programs are operating in basements, converted storage rooms, or apartments that have been taken off public housing's rent rolls.

Some housing entities have been active participants in the development and maintenance of a NORC program, helping to articulate goals, problem solve, and identify and help secure resources within both the housing complex and the surrounding community. In general, in the NORC programs based in moderate-income co-ops, the housing entity participates through either a board member or a committee of residents appointed by the board; in public housing programs, discrete staff from NYCHA's central office support the on-site housing manager and encourage the participation of representatives from each development's tenants' association; and in private rental

THE ROLE OF THE LEAD AGENCY

The lead agency, which is the government contractor, is responsible for facilitating the partnership and building community relationships; in most instances it manages the site and program finances, and coordinates and integrates the services offered. In most cases, the lead agency is the social service provider. At three NORC-SSPs, the lead agency function is accomplished through the housing corporations' own 501(c) 3 established for this purpose. At another, the lead agency is the health provider, a nursing home.

Each program has a director who is responsible for day-to-day operations and for facilitating the lead agency functions. In 25 of the programs, the director is an employee of the lead agency. Two programs have contracts with social service providers for the provision of the site director and staff for the social service functions. One program director is an employee of the housing management company.

buildings, the management office or landlord designates representatives. At a minimum, these identified representatives participate in the governance of the program (discussed below).

Health Care Provider

Health care institutions are essential partners in the NORC-SSP model. Although not considered primarily health care programs, the NORC-SSP model recognizes the impact health issues have on the well-being of older people and their ability to remain engaged in and connected to the life of their community. In most instances, the health partner is an important institution and long-time provider of health services in the community. As of July 2003, 15 of the 27 programs had a single provider health partner:

Health Partner	Number of Programs
Certified Home Health Agencies (CHHAs)	10
Nursing Homes	4
Hospitals	4
Shared (e.g., hospital or nursing home and CHHA, hospital-based visiting physician and CHHA)	5
None	4

As varied as the health care partner organizations are, so too are their staffing levels. The 23 programs with health care partners provide dedicated nurses or geriatric nurse practitioners, supported by in-kind contributions of the health care partner and/or purchased by the NORC program. Staffing levels range from a high of 1.7 FTEs to a low of four hours per week (see Appendix for program-specific details). Those programs with one day or less per week of health care staff are severely limited; they provide health promotion services only occasionally and have minimal ability to respond to critical situations.

Beyond the activities enumerated above, many of the health care partners help to identify emerging health care issues, seek creative solutions, and—through a designated administrator or manager within the health care institution—marshal additional resources. These include health educators, access to a memory and aging clinic, geropsychiatry and mammography services, transportation to the facility, and an in-home visiting physician program, to name a few. Programs without this level of commitment and health care partner leadership are limited to offering those services and activities the on-site staff can find and provide on their own.

Residents

As people age, immediate community takes on new importance. Too often, those who are able find they must go outside of the community to engage in meaningful activity. Those who remain behind, the old people sitting on benches with nothing to do, are a reminder of what happens when a community begins to "die." Revitalizing a community can only be done from the inside and requires the active participation of the residents themselves.

Residents are not just clients. They have multiple roles in NORC-SSPs and an ownership interest in their success. They play a key role in shaping programs through their participation in its governance structure. They are also program ambassadors, service providers, and consumers of services.

Their role starts at the point of program development, as they provide valuable input into the design and implementation of a community-wide assessment and information-gathering process (see discussion below). Their knowledge and understanding of their community help to inform the planning process, set program priorities, and identify resources within the community. A typical intergenerational program conceived of by professionals is having a group of children

Table 3: **Volunteer Roles for Seniors in NORC-SSPs**

Governance

Advisory board member
Program development committee member

Individual Support Services

Friendly visitor
Escort
High school volunteer
Translator
Clothes mender
Driver
Minor home-repair person
Mail reader
Shopping assistant

Programmatic Activities

Coffee hour leader
English as a Second Language instructor
Food service worker
Peer advisor
Lecturer
Teacher
Intergenerational activity organizer
Blood pressure volunteer
Community service provider
Social action leader
Computer lab/information technology support person
Support group leader
Entertainer
Choral/theater director

Administration and Program Development

Clerk
Receptionist
Librarian
Writer and designer of flyers, newsletters, and newspapers
Social adult day program volunteer
Notary
Resource acquirer
Fund raiser
Flea market organizer
Handy man for program office
Preparer of holiday foods/gift baskets for homebound
Organizer of birthday club for homebound (to send or hand-deliver cards)
Trips assistant
Surveyor
Floor captain
Gardener

come to "visit" seniors and perform a concert for them. However, when asked, an older person may have a very different idea of a successful intergenerational program. In one NORC-SSP where the on-site co-op nursery school couldn't afford to hire additional adults, the seniors took on the job, thereby keeping the cost of child care down for the young parents in the community. In another community, the students from a local design school worked with seniors to redesign their kitchens to be more functional.

Residents' participation can enhance the range of services and activities offered; those programs that rely solely on paid professionals to organize and provide activities are limited by the availability of financial resources. Most older adults have filled many roles during their lifetimes. They are artisans and artists, writers and actors, storytellers and singers, advocates and activists, nurturers, mechanics, cooks, and teachers. Across New York City's NORC-SSPs, more than 800 volunteers provide over 40 kinds of services and activities (Table 3). In one community in which 14 percent of the seniors report difficulty obtaining sufficient food and many are suspicious of formal providers, retired food-service workers organize and serve daily meals. They created a more communal and informal atmosphere through the "soup's-on" feature: pots of soup are available at 11 AM for any senior who wants a little something before the noon meal is ready. When another NORC-SSP wanted to survey residents to understand their needs and interests, a retired statistician helped develop the survey instrument and then analyzed the results. In some programs, retired accountants help with tax preparation and insurance coverage problems. Other resident volunteers teach classes, assist with transportation and shopping, and provide escort, friendly visiting, and telephone reassurance services. As administrative volunteers, residents organize social events and programs, produce program newsletters, and provide much-needed clerical assistance.

Several NORC-SSPs have resident volunteers who raise tens of thousands of

dollars each year through creative fund-raising activities, including plant-watering and pet-feeding services for vacationing residents; a theater ticket club that solicits ticket donations from nearby Broadway theaters and sells them to residents at significantly reduced prices; and asking local business for support.

How residents come to participate in the development, leadership, and maintenance of NORC programs is quite varied. Several communities had pre-existing resident volunteer services that developed successful partnerships with professional service provider organizations as the needs of the community changed. However, most of the NORC programs had to build partnerships with the residents from the ground up. For some, a community assessment process helped identify seniors interested in participating in new roles. For others, a variety of outreach activities increasingly engaged seniors in the work of the program. For still others, the partnership with the residents is limited to the point person designated by the housing corporation (usually a board representative or tenants' association president), who serves on the program's governance committee.

Building a partnership with the residents stretches the roles and boundaries of the traditional helping professional-client relationship. In the course of a single day, a resident can be a client, a volunteer, and a partner with an ownership interest in the success of the program. As a client, she is concerned about her fluctuating blood pressure and so comes to the program every Tuesday for the nurse to check her pressure and review her medications to make sure she is taking them correctly. While she is there, she meets with a social worker to discuss her growing concern about her husband's depression. Tuesday also happens to be the day that she volunteers by helping several legally blind seniors in the apartment building with their mail. When she comes back to the program office to report on her visits, she tells the director that the program needs to offer activities for the blind seniors and that she intends to bring it up at the next advisory board meeting.

The challenge for program staff is in valuing the wisdom, knowledge, and expertise of the residents and providing an environment that encourages growth and enables them to take on meaningful and active roles in their community. This working partnership between the residents and the professional staff promotes a sense of ownership on the part of residents. With the shift in dynamic, residents are no longer clients who are acted upon but partners who share some responsibility for making their community a good place to grow old. This requires staff to be able to forego the role of all-knowing professional and accept a blurring of the boundaries between client and partner.

Governance Structure

In the moderate-income cooperative developments where the majority of New York City's NORC-SSPs are located, leadership is provided by a resident board of directors. Day-to-day management of these developments is handled by a manager or management company hired by and under the direction of the board of directors. Decision-making authority to develop a NORC-SSP resides with the housing corporation's board of directors, which must commit financial and other resources from its operating budget to the endeavor.

The complexity of NORC-SSPs requires the creation of a mechanism that brings the parties together to establish the shared vision and responsibility for a program's success, determine the overall goals, and develop an integrated, coherent service delivery program. The old adage of the sum being greater than its parts holds true for NORC-SSPs. Without some integrating mechanism, programs run the risk of becoming just another group of service providers operating out of a satellite office in the "community," providing parallel

services, with each provider accountable solely to the parent office.

In the New York model, the lead agency (in most cases the social service provider) is responsible for facilitating the partnerships and community-building activities as well as for coordinating and integrating the services offered on site. How, and the extent to which, these partnerships are made real differs from program to program. New York City's programs are required to have an advisory committee or board with resident representation. However, the structure and function have been left up to each community to determine. In general, programs utilize one of three basic mechanisms:

Housing Partner Structure. Several housing entities have established separate non-profit 501(c)3 organizations to oversee their NORC-SSPs. Their boards of directors are made up of representatives from the boards of the housing cooperative and other interested residents. The 501(c)3 is responsible for organizing and facilitating the meetings to which the service providers are invited. The service provider partners attend to report on program activities and services and identify trends and issues for discussion and consideration by the 501(c)3 board. The board sets the broad policy direction and is responsible for approving and managing the annual budget. Trust between the 501(c)3 and the service provider partners is key to the success of this type of governance structure. Without it critical information may be withheld, making it difficult to reach consensus on budgets and allocation of resources.

Shared Partnership Structure. Several NORC-SSPs rely on an advisory committee or board consisting of representatives from all the partner constituencies (including government and philanthropy) to coordinate and integrate the partnership. The designated lead agency is responsible for organizing and facilitating the meetings, which are usually held quarterly, and for managing the annual budget that reflects the consensus on policy direction of the group. Those lead agencies that are clear about the program's mission and value what each partner brings to the table seem to be more comfortable in sharing the responsibility of making these partnerships work.

Resident Advisory Committee Structure. A few NORC-SSPs have established resident advisory committees that are organized and coordinated by the lead agency. Typically these committees meet monthly or quarterly to discuss ideas for activities, plan events, and solicit input about problems or issues the seniors in their community may be experiencing. Although this type of structure satisfies the letter of the city's requirement that a NORC-SSP have an advisory committee with resident representation, if it is the only mechanism used by a program, it does little to advance the reality of the partnerships.

The challenge for program staff is in valuing residents' wisdom, knowledge, and expertise. As the dynamic shifts, residents are no longer clients who are acted upon but partners who share some responsibility for making their community a good place to grow old.

Many programs combine elements of these three basic structures to organize and coordinate the partnership. In addition to the quarterly all-partners meeting, some programs have separate meetings with community service providers (Meals On Wheels, senior centers, home care agencies, etc.). Other

programs have found it helpful to establish resident program activity committees that send representatives to the partnership meetings. The key is finding the right mechanisms and structures that reflect how each particular community is organized, permits input from all the partners, establishes consensus on a shared mission and program identity, and supports the ability of the partners to pool their resources and wide-ranging expertise in service to the goals of the program.

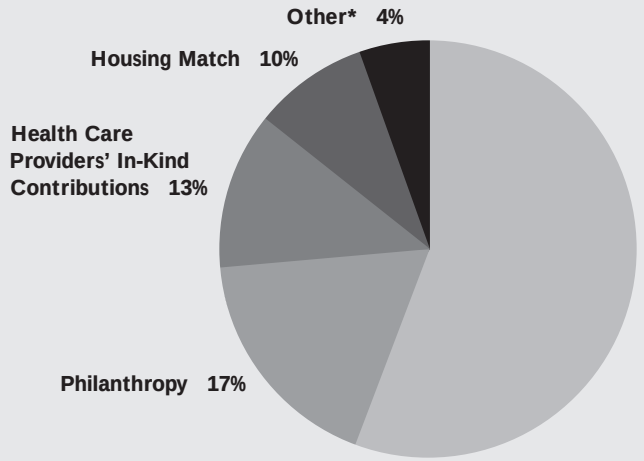
Financing Structure

New York City's NORC-SSPs are financed through public-private partnerships that combine revenues and in-kind supports. Operating budgets range from $148,000 for a coalition program of three moderately-sized cooperatives to more than $700,000 for a mature and multi-dimensional program.

The almost $5 million in government funding is the base upon which additional funding is leveraged. The 12 programs that began prior to 1999 receive both State funding totaling $1.1 million and City funding totaling $1.5 million, while the 16 more recently formed programs rely solely on City funding totaling $2.3 million. New York City government grants range from $45,000 to $200,000 a year. The size of the grants is a function of the specific requests made by each program, not a per capita formula. Private sector funds come from a variety of sources that include the housing corporation (with the exception of the public housing programs) according to State and City match requirements, although some entities exceed the required amount; program membership and activities fees; and local fundraising efforts. Philanthropy rounds out the State and City match requirements for many programs and provides additional targeted support for program enhancements and expansions (Figure 1). Philanthropic funds support basic staff or additional services such as transportation, emergency home care, professional volunteer coordinators, and specific health care initiatives for the homebound or cognitively impaired. These matching grants are tailored in response to each community's specific set of challenges and the resources available to address them.

Specific in-kind supports provide much-needed resources for the NORC-SSPs. From

Figure 1: **Funding for NORC-SSPs, New York City, Fiscal Year 2002-3**



* "Other" includes income from group, program, and membership fees; fees for NORC-program subsidized housekeeping, chore, and transportation services; local fundraising efforts; and annual legislative grants.

the housing corporation's provision of janitorial services and space for offices and activities, to the health provider's provision of dedicated nursing staff time, the partners provide a range of in-kind resources that extend a program's operations. Without such donated resources, programs must raise additional dollars or re-program funds from their existing operating budgets to cover the costs (as happened in four programs in Brooklyn when the health care provider was no longer able to sustain its provision of in-kind nursing staff) or scale back their operations.

Holding a Mirror up to the Community

NORC-SSPs are designed to reflect the communities they serve. Three distinct sets of activities—assessment, outreach, and adapting to community changes over time—are critical to achieving this goal.

Assessing the Community

Without an initial assessment of a community and its residents that identifies its strengths, potential resources, concerns, goals, and aspirations, efforts to develop a NORC-SSP run the risk of doing no more than locating a provider on site to react to crisis situations. Most providers know and understand the range of functional deficits that qualify a senior for a particular categorical service, but few understand the community context in which seniors live and the resources available within them. Each community is different and made up of distinct population groups, each with its own history, culture, formal governance structure, formal and informal social structures and supports, and ways of communicating.

A community assessment process serves two goals: It develops an in-depth understanding of a community and the needs and interests of its residents, and it engages the broadest base of community constituents, inviting them to become part of the process of building a supportive community.

The information-gathering process used is as important as the questions asked. It should include a mix of surveys, focus groups, and interviews with key informants and solicit input from seniors and non-seniors alike; from owners, the housing management, and its staff; from local retail and service providers; and from other community leaders and key informants.

Information-gathering tools should provide a picture of the residents (demographics and other descriptive information); their life in the community (how and the extent to which they are connected to one another); their interests; their aspirations (what would make the community a better place for seniors to live); and the human capital within the community (how can they and do they want to help build the program).

All too often survey instruments focus only on demographics and deficits—needs and functional limitations—hoping seniors will reveal their need for traditional in-home services. If this is the only area of inquiry, it may result in the identification of some seniors in need of in-home services, but it does nothing to identify the opportunities or invite the senior community to be a part of the process of building a supportive environment. Questions that seek to learn about the talents, skills, and interests of residents, and their willingness to get involved, convey a very different program intent than a needs-based questionnaire.

One community seeking to develop a NORC-SSP was overwhelmed by the response to its survey. In a community of 1,800 seniors, 90 seniors stated they wanted to volunteer their services to help with fund-raising, transportation, shopping, insurance paperwork, and office work. One resident in a public housing NORC-SSP was so surprised to be asked what she thought seniors in her community wanted that she responded, "Nobody has ever asked us that before...but this is not a bingo-playing crowd."

Questions about the frequency and nature of residents' interactions with their neighbors (providing assistance, speaking by phone or in person, or getting together) provide an important insight into the social fabric of a community. Such questions can identify the extent of natural supports within each community or they can uncover hidden problems (as happened in one public housing development in which the seniors lived in fear of financial, verbal, and physical abuse from some of the housing staff and leaders of the community) that will need to be addressed in order for a program to become relevant to the residents.

The heterogeneity of the senior population in a community requires that programs establish multiple access points and find strategies to accommodate the different ways in which people process and incorporate information.

Devising Effective Outreach Strategies

Outreach strategies must build on the information gathered in the assessment phase and must be community specific, relevant, and responsive to local events. They must take into account the languages read and spoken; the formal and informal connections in a community; the trusted information sources; the events and situations that can be transformed into outreach opportunities; and the natural and multiple access points.

As many of the NORC-SSPs got underway, they put a lot of time and effort into designing attractive large-type, senior-friendly flyers. After several months a number of the programs had to rethink this strategy when they realized they were not engaging seniors beyond the original ones who came when their doors first opened.

Understanding how residents get information in a community with high illiteracy rates is critical to developing effective outreach strategies and programs. One NORC-SSP, located in a multi-ethnic public housing development, translated its materials into three different languages. After five years of blanketing the community with its colorful and attractive materials, it decided to conduct a community survey using a different approach. Tables were set up outside of the management office. As seniors walked by, staff engaged them in conversation and encouraged them to complete the survey on the spot. Staff quickly realized that many of the seniors had difficulty reading, even in their native languages.

Recognizing the dependence on verbal communication in its community, another NORC-SSP developed a system of floor captains to engage the residents and verbally communicate information to them. Another program recruited bilingual Spanish-, Russian-, and Chinese-speaking seniors to help with face-to-face outreach efforts. After one NORC-SSP had a low response from putting surveys under each apartment door, it recruited seniors to go door-to-door to encourage residents to complete the survey prior to another distribution of the instrument. In another community distrustful of formal systems, the residents themselves helped other seniors complete the survey questionnaire.

Other strategies include holding "teas" in the lobbies of the different buildings in a complex; attending and presenting at the monthly tenants' association meetings; setting up weekly blood pressure checks at the mail boxes; broadcasting on the housing complex's internal cable channel; or holding outdoor events to engage the curious passers-by who want to see what's going on.

One also needs to assess how connections are made in each community. What are the formal and informal mechanisms in the community by which people get information?

In some communities, the housing managers, tenants' associations, or boards of directors have regular and official communication with residents. Flyers, monthly board minutes, and other notices are placed under apartment doors; posted in lobbies, laundry rooms, and elevators; or broadcast over the internal cable system. In other communities, formal and official communication from the housing entity is infrequent and so cannot be relied on as a regular mechanism for connecting to the residents. Informal mechanisms become critical in such communities.

Equally important is knowing which information sources are trusted by different segments of the senior residents and their caregivers. In some communities, anything coming from a housing manager is looked on with fear and suspicion, while in other communities, material that doesn't bear the housing entity's seal or logo is not read by the residents. Linkages to trusted information sources (printed or oral) become critical to NORC-SSPs trying to connect to residents in communities suspicious or distrustful of management, while in more formal communities, creating linkages with informal systems is less of a priority.

Within each community there are events that are relevant in the lives of its residents which can be transformed into opportunities to engage new groups of seniors and the wider community. For example, in one public housing complex, an 81-year-old NORC-SSP client was arrested as part of a drug sweep by the local police. Her son, who lived with her, was a suspected drug dealer and she was now at risk of eviction because of a U.S. Supreme Court decision (2002) permitting termination of tenancy rights for any public housing tenant who provides a home to a suspected felon. After securing appropriate legal assistance and successfully preventing the eviction, the NORC-SSP staff linked to other groups (formal and informal, the tenants' association and the different youth groups) to develop an outreach and education effort. It believed that other seniors were also at risk for eviction. Within the first week of the campaign, it uncovered six other seniors who were in the midst of eviction proceedings and had been too ashamed or did not know to contact the NORC-SSP for help. Recognizing that this was a systemic issue, program staff then formed a task force with the six other public housing NORC programs to share best practices and develop user-friendly materials for distribution throughout the public housing programs.

The heterogeneity of the senior population in a community, with its varied skill sets and functional capacities, requires that programs establish multiple access points. People process and incorporate information in different ways, from different sources, and at different times. Programs need to find ways to accommodate those differences. In every community there are individuals who do not wish to be engaged or who are difficult to engage because they are experiencing cognitive changes. As programs become aware that they are not connecting to certain segments of the senior population, they need to identify other natural entry points that either exist or that can be created in their communities.

Some NORC-SSPs with significant numbers of the oldest-old have focused their attention on identifying different entry points or opportunities to engage this segment of the population. They have set up help tables around the complex or designated program days devoted to assisting residents in filling out housing's annual income certification forms. Management has trained program staff on how to complete the forms and it helps link residents in need of assistance to the program. It is a natural and logical entry point to engaging the individual. It is then up to the professional staff to make the most of the interaction, to deepen the connection by beginning to establish trust, and to try to overcome resistance to other forms of graduated and calibrated help.

The Need to Reassess

Communities, like the people who live in them, are not static. Changes in health status, the percentage of seniors living alone, or the proportion of the oldest-old to the younger-senior residents all have implications for the kinds of services and programs that may need to be developed as change occurs. Unlike the traditional senior centers, with their prescribed set of programs from which seniors age-out as their health and functional status decline, NORC-SSPs must adapt to the changing characteristics of the residents in order to remain relevant, valued, and supported by the community. Programs must be able to identify changes, patterns, or trends and then develop appropriate responses. Over time, new services may need to be added or the emphasis on existing services may need to shift.

After seven years, one program established a social adult day program in response to the significant increase in the number of oldest-old who were physically frail or experiencing mild to moderate cognitive impairments. At the same time, a new group of young retirees was emerging in the complex that desired activities and programs tailored to their interests, which resulted in adding support groups (which had previously not interested the older seniors, whose life experiences did not include "therapy" as a normative experience) and computer classes to the program's portfolio of offerings.

Keys to Success

While a universe that contains only 28 cases doesn't yield quantifiable results, some common themes and challenges have emerged from the New York City experience that can be instructive as other groups seek to build supportive communities:

- As in many areas of human endeavor, strong and committed leadership is essential, not only from the lead agency, but from the community itself: both the housing sponsor and the residents must contribute substantively if a NORC-SSP is to get off the ground and function effectively over time.
- Program staff must have adequate professional skills. In all too many instances, staff have lacked the assessment, community organization, and clinical skills and experience to work with heterogeneous populations of seniors.
- The organizations participating in the program must be willing and able to work in partnership and to subsume their organizational identity under the umbrella of a community partnership. In this highly competitive era, partners must understand that no one provider can do it all and that each partner shares responsibility for the program's success.
- Public funding has been critical to the successful initiation and maintenance of NORC-SSPs. The availability of even modest public funding not only helps get NORC-SSPs off the ground, but also is the catalyst for financial participation by housing sponsors, provider agencies, local philanthropy, and the communities themselves.
- NORC-SSPs cannot be "cookie-cuttered." They must be community specific and engage as broad a range of residents and other key players as possible.

Extending the Model: Can We Get There from Here?

Over the last 18 years, the quality of life in many of New York City's NORCs and of the thousands of residents who live in them have been transformed. In NORCs with successful SSPs, residents at all levels of functioning are more engaged in the lives of their communities: those who remain capable of more extensive activities have a broader range

of choices available close to home, many of which permit them to make tangible contributions to their own communities and their own neighbors; residents who experience acute or intermittent crises have familiar and trusted sources of professional assistance close at hand; those with increasing disability have trusted neighbors and supporters assisting them in navigating the complexities of the formal, "old" service system, and in many instances are also able to draw on additional services that might not otherwise be available.

While the existing SSPs continue to evolve and mature, it is important to extend the model to NORCs that have lower population densities and are more horizontal than the existing sites. Given patterns of residential location throughout the United States, including parts of New York City and much of the New York metropolitan area, such an extension to suburban settings is essential.

In Northeastern Queens and in Plainview, Long Island, a quintessential suburban community of detached, single-family homes, the United Hospital Fund is working with UJA/Federation of New York to identify appropriate organizational structures and operational capacities on which to build SSPs in the absence of unitary housing corporations. In Brooklyn's Bedford-Stuyvesant, a very urban community with a very large proportion of seniors living in owner-occupied brownstones or single-family housing, the Fund has worked with the Development Corporations of the Bridge Street and Antioch Baptist Churches to define an appropriate SSP model for a community in which the churches could provide the backbone of an extensive system of informal services in a community notably lacking in strong formal service providers. And in the Riverdale section of the Bronx, the Fund has been working with the Association of Riverdale Cooperatives, a group of 79 small housing corporations spread over a considerable geographic area, to modify the SSP model to meet their community's special circumstances.

Although still in the exploratory phase, these initial efforts have underscored the difficulty of achieving economies of scale in low-rise, low-density communities. The absence of a single ownership/management structure means a unifying organizational structure must be created. The very heterogeneity of these communities makes it clear that successful development of SSPs will require varied organizational models. Critical in every instance, however, will be careful, systematic assessment of the characteristics of the individual communities, both to serve as the basis for service planning and to provide a vehicle around which to begin building appropriate organizational structures.

Successful developments of SSPs will require varied organizational models. Critical in every instance will be careful, systematic assessment of the characteristics of the individual communities, both for service planning purposes and as a platform for organizational structures.

Efforts to build on the success of the New York City NORC-SSP model are not confined to the New York area. Under earmark appropriations enacted by the U.S. Congress in 2001 and 2003, the U.S. Administration on Aging has made grants to the Jewish Federations of 14 cities to develop NORC-SSP models. Beyond administering the dollars, AOA is constrained in the extent to which it can shape a coherent approach across the sites. With limited exceptions, population densities in these cities are closer to those of Riverdale or Northeastern Queens than Manhattan, and the extent to which these sites can build on the principles of the New York City model to address the needs of their communities and their elderly residents remains to be seen.

Play It Forward

Despite the success of New York's NORC-SSPs, important questions remain unanswered, some of which speak to the future viability of the New York program as well as to its evolution and replication elsewhere in the country.

Seen One Community—Seen Them All?

In New York City, the presence of a large number of moderate-income and public housing communities with large populations of seniors who had aged in place presented a natural opportunity for the early development of NORC-SSPs. As the model is extended more broadly, however, the question of defining the community around which the SSP can and should be organized becomes more difficult. Questions of size, scale, density, geographical coherence, and community identity itself are all relevant.

Systematic study of the SSP model is required in order to determine the minimum thresholds of community size, population density, local infrastructure, and geographic practicality for the development of successful SSPs.

Given the extraordinary heterogeneity of the circumstances in which America's seniors live – heterogeneity that is only likely to increase in the coming years—it is clear that one size will not fit all: NORCs capable of sustaining effective SSPs will come in many different sizes and shapes. What's less clear, at this juncture, is how to define the community and the elements it must possess in order to support a successful program. Obviously, there are some minimum thresholds of community size, population density, local infrastructure, and geographic practicality below which the development of successful SSPs will not be possible, but so far, there is no empirical evidence of where those thresholds might lie. This is probably not a question that can be answered in the abstract; only experimentation with and systematic study of the SSP model in a variety of communities will yield the answers, as well as encouraging the development of specific adaptations of the model to fit the characteristics of communities radically unlike those in New York City.

A House Is Not a Program Home

New York City's large housing developments have provided the first generations of NORC-SSPs not only with sufficient quantity and density of residents, but with some of the critical organizational infrastructure. In particular, the housing corporations that manage such developments have been central partners in developing and maintaining programs. Although in its early stages, the current work in communities of dispersed, single-family housing in Long Island and Queens should provide a test of important alternative models that may be broadly applicable to the many communities in the United States in which most seniors reside in detached, single-family housing.

Is Small Beautiful?

Closely related to the issue of infrastructure is that of the minimum size necessary to permit successful development and evolution of a flourishing NORC–SSP. This question subsumes the population of the NORC, the minimum staffing requirements for an SSP, and the minimum financial base required. The essence of the SSP model as a partnership including community, social service agencies, and health care providers means that the common practice of seeking to serve communities of seniors by the outposting of a single professional or the intermittent provision of health promotion

and other educational activities is not adequate. But the complexities of starting up even a small SSP require the availability of sufficient committed funding from the outset, and the dynamics of SSP partnership-building all but require financial contributions from non-governmental partners at the outset as well, as a partial embodiment of their commitment. The smaller and less well-organized the community, the more difficult it is likely to be to elicit such commitments. But the resourcefulness and energies of America's seniors and some of the organizations that serve them should not be underestimated. Only widespread experimentation and time will support defensible conclusions about the minimum necessary size of a NORC or its SSP.

The People Problem

Perhaps ironically, in New York City, home to an extraordinary array of superb educational programs for the helping professions, the availability and quality of highly skilled staff have been a serious barrier to the successful development and operation of NORC-SSPs. The skills and orientations necessary to perform the complex tasks required by SSPs are not in adequate supply, at least at the moment. Part of the problem may be the historical underfunding and low professional status of service programs for the elderly, so that working in such settings has not been sufficiently attractive for many professionals, and the number of professionals with sufficient experience is limited. Part of the problem may also arise from the historical patterns of service organization and operation, at least in the New York metropolitan area, in which program eligibility, service characteristics, and operational protocols have been defined with increasing rigidity, leading to a de-emphasis on clinical skills and an over-reliance on bureaucratic routines.

These patterns have also affected the service-delivery agencies, which, by necessity, have been more focused on meeting governmental performance criteria and living within governmental budgets than on nurturing the development of professional skills needed to implement more flexible models of service delivery. Compliance with quantitative standards comes to take precedence over creativity and professional expertise in meeting the needs of individual clients. These characteristics do not fit well with the inherent flexibility, responsiveness, and client-centeredness which the new paradigm of service delivery requires, and which successful SSPs demand. At this stage of the evolution of the NORC-SSP model in New York City, service-delivery agencies, educational institutions, and the United Hospital Fund are just beginning to address the educational and training needs the new paradigm creates, but other communities can learn from the New York experience, and don't have to wait to begin.

The Sweet Smell of Success

No one can reasonably object to the principle of systematic, scientific evaluation of the performance of programs, but the history of New York's NORC-SSPs, and the very principles on which they are founded, suggests that current approaches to evaluation are themselves mired in the old paradigm of service delivery. Efforts to measure the performance of SSPs have focused on counting units of services (referrals, case management hours, etc.), and build on the data systems of public agencies pursuing entirely different agendas of formal accountability. They certainly do not measure SSPs' success in transforming communities, providing a supportive environment for seniors at all levels of health and functioning in a variety of circumstances, and engaging communities themselves as active partners in making NORCs good places to grow old.

Appropriate outcomes measures will require "before and after" assessments to understand the impact SSPs are having on the communities in which they operate, including program participants, potential participants,

and non-participants. It will also require an understanding of such objectives of SSPs as connectedness of seniors to the community, their confidence or anxiety about being able to obtain help when they need it, and the community's perceptions of the program.

Perhaps inevitably, little baseline data exist on any of these dimensions in the participating NORCs. If we are to more fully understand the potential of the NORC-SSP model, a systematic and comprehensive evaluation will need to be undertaken. Such an effort requires resources that are sufficient to develop appropriate tools and conduct the study.

The New York City NORC-SSP model stands out for its scope, the number of different projects and communities working on a single model, and the extent and the duration of support from state and local governments.

Absent such a commitment, descriptive information and anecdotes are the only sources for understanding the model. However, the AdvantAge Project of the Home Care Institute for Research and Policy of the Visiting Nurse Service of New York, while undertaken for different purposes, may contain some useful approaches to evaluating the impact of SSPs. The AdvantAge project seeks to measure the success of ten "elder-friendly" communities (including one New York City NORC-SSP) in addressing basic needs, optimizing physical and mental well-being, promoting social and civic engagement, and maximizing independence for the frail and disabled (http://www.vnsny.org/advantage). When results of the AdvantAge project become available, they should provide a foundation for longitudinal analyses of the impact of that program, and a model for future evaluation of other programs in New York City and elsewhere. Preliminary results show that 93 percent of the seniors in the public housing NORC-SSP say they know where to go and whom to call for help, compared to 76 percent of seniors in the surrounding New York City neighborhood.

Whatever the specific lessons from the AdvantAge project, future success and expansion of the NORC-SSP model require much more aggressive efforts to develop and employ appropriate evaluation techniques. In the meantime, however, as is so often the case in assessing the impact of real-world programs on their clients and communities, careful documentation of experiences is likely to provide more useful information than efforts to squeeze conclusions from available programmatic data collected and maintained for fundamentally different purposes.

Building Tomorrow's Supportive Communities for Seniors

Shifting paradigms is difficult. The system of services currently in place for America's seniors, while highly variable from one place to another and frequently inadequate, is large, complex, and entrenched. The development and testing of new service delivery models, based on the paradigm grounded in our richer understanding of the tasks of aging and the needs of older persons, cannot proceed quickly enough given the aging of the baby boomer generation.

All sorts of efforts at developing new service models and elder-friendly communities are underway throughout the United States—and, indeed, throughout the industrialized world. Among these, the New York City NORC-SSP model stands out for its scope, the number of different projects and communities involved with a single model, and the extent and duration of support from state and local governments. In qualitative terms, the New York City NORC-SSPs appear

to constitute a significant success, one that has commanded widespread support and increasing attention both within New York and throughout the nation. Closer to home, the New York City NORC-SSP model requires continued attention and effort to maintain progress, but whatever the future outcomes, some of the lessons learned have much broader applicability. The very diversity and richness of the New York experience suggest that it can be mined for additional lessons for many years to come. Perhaps most basically, over the last 18 years a variety of community groups, provider agencies, private philanthropic organizations, and public officials have come together in an effort to create something distinct and new that will better meet the growing challenges of a population aging in place. That process has not been one of unblemished success, but the successes have been more numerous, more instructive, and more gratifying than skeptical observers might ever have predicted, and the forward momentum continues. The New York NORC-SSP experience has suggested that it can be done: public programs, service delivery organizations, and communities themselves can come together to create and operate totally new forms of senior services, organized around the seniors and their communities themselves, which can make a positive and palpable difference in individual lives.

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Appendix

Characteristics of New York City's NORC-SSPs

Name (Year Founded)	Type of Housing	Number of Buildings	Number of Units
Bronx			
Amalgamated/Park Reservoir NORC (1995)	Moderate income co-op	14	1,800
Co-op City Senior Services Program (1995)	Moderate income co-op	35 *	15,372
Parkchester Enhancement Program (1999)	Moderate income condo and rental	171	12,200
Pelham Parkway NORC (1999)	Public housing rental	23	1,350
Brooklyn			
Sheepshead/Nostrand Supportive Services (1999)	Public housing rental	34	2,204
Spring Creek Senior Partners (1999)	Low and moderate income rental	46	5,881
Trump Outreach Program (1995)	Moderate income co-op	3	1,672
Trump for Us (1999)	Moderate income co-op	2	2,800
Warbasse Cares for Seniors (1992)	Moderate income co-op	5	2,585
Manhattan			
Co-op Village Senior Care (1992)	Moderate income co-op	25	4,450
Knickerbocker Village Senior Services (1999)	Moderate income rental	12	1,600
Lincoln-Amsterdam Senior Care (1999)	Public housing rental and moderate income co-op	15	1,440
Lincoln House Outreach (1999)	Moderate income co-op	1	420
Morningside Retirement and Health Services (1986)	Moderate income co-op	6	982
Penn South Program for Seniors (1986)	Moderate income co-op	10	2,820
Phipps Plaza West NORC (1999)	Low, moderate, and market rate rental	12	1,610
Stanley M. Isaacs Neighborhood Center (1995)	Public housing rental	5	1,164
Vladeck Cares NORC (1992)	Public housing rental	27	1,500
West Side NORC (1999)	Moderate income co-op	3	566
Queens			
Big Six Towers NORC (1996)	Moderate income co-op	7	981
Clearview Assistance Program (1996)	Moderate income co-op	82	1,788
Deepdale Cares (1999)	Moderate income co-op	69	1,396
Forest Hills Co-op NORC (1999)	Public housing co-op	3	429
Northridge/Brulene/Southridge NORC (1999)	Moderate income co-op	31	1,938
Queensview/N. Queensview NORC (1996)	Moderate income co-op	21	1,090
Ravenswood RISE (1999)	Public housing rental	31	2,167
Ridgewood Gardens NORC (1999)	Moderate income co-op	4	372
Rochdale Village (1999)	Moderate income co-op	20	5,600

* Plus 236 two-family townhouses

Note: Table reflects NORC-SSP-provided data as of June 30, 2003.

Total Population	Senior Population	Annual Operating Budget	Housing Contribution
5,000	900	$265,662	$25,000
50,000	8,500	$670,801	$185,000
30,000	4,300	$343,414	$52,414
2,534	791	$288,856	Exempt
5,145	900	$274,858	Exempt
14,000	2,700	$416,409	$108,409
5,270	2,740	$356,726	$25,000
7,000	2,240	$323,446	$25,000
5,500	2,100	$465,219	$100,000
8,455	4,060	$742,680	$99,100
3,720	1,055	NA	$25,000
3,190	804	$571,856	Exempt
516	276	$159,694	$7,500
1,700	700	$459,702	$50,000
5,000	2,500	$721,311	$125,000
2,565	558	$256,365	$44,615
2,288	678	$253,906	Exempt
3,000	860	$274,952	Exempt
903	475	$207,300	$30,000
1,779	897	$265,957	$28,000
5,364	1,797	$245,000	$35,000
4,187	634	$262,000	$25,000
850	289	$190,500	Exempt
5,000	2,400	$148,000	$20,000
2,900	1,600	$301,614	$32,000
4,532	1,000	$198,341	Exempt
780	170	$31,500	0
25,000	1,844	$258,000	$50,000

Appendix: Characteristics of New York City's NORC-SSPs (continued)

Name	Lead Agency	Health Partner
Bronx		
Amalgamated/Park Reservoir NORC	Bronx Jewish Community Council, Inc.	Jewish Home and Hospital Lifecare System
Co-op City Senior Services Program	Gloria Wise Boys & Girls Club	Visiting Nurse Service of New York; Montefiore Medical Center
Parkchester Enhancement Program	Beth Abraham Health Services	Beth Abraham Health Services
Pelham Parkway NORC	Bronx Jewish Community Council, Inc.	Jewish Home and Hospital Lifecare System
Brooklyn		
Sheepshead/Nostrand Supportive Services	Builders for the Family and Youth	Visiting Nurse Service of New York
Spring Creek Senior Partners	Jewish Association for Services for the Aged	Kingsbrook Jewish Medical Center
Trump Outreach Program	Jewish Association for Services for the Aged	Visiting Nurse Service of New York
Trump for Us	Jewish Association for Services for the Aged	Visiting Nurse Service of New York
Warbasse Cares for Seniors	Jewish Association for Services for the Aged	Visiting Nurse Service of New York
Manhattan		
Co-op Village Senior Care	Educational Alliance	Continuum Health Partners/Beth Israel Medical Center; Visiting Nurse Service of New York
Knickerbocker Village Senior Services	Hamilton-Madison Houses	Cabrini Center for Nursing and Rehabilitation; Visiting Nurse Service of New York
Lincoln-Amsterdam Senior Care	Lincoln Square Neighborhood Center	Continuum Health Partners/Roosevelt Hospital
Lincoln House Outreach	DOROT	Continuum Health Partners/Roosevelt Hospital
Morningside Retirement and Health Services	Morningside Retirement and Health Services	Visiting Nurse Service of New York; Continuum Health Partners/St. Luke's Hospital; Mount Sinai Medical Center
Penn South Program for Seniors	Selfhelp Community Services, Inc.	Jewish Home and Hospital Lifecare System; Visiting Nurse Service of New York
Phipps Plaza West NORC	Phipps Community Development Corp.	Jewish Home and Hospital Lifecare System
Stanley M. Isaacs Neighborhood Center	Stanley M. Isaacs Neighborhood Center	Visiting Nurse Service of New York
Vladeck Cares NORC	Henry Street Settlement	Visiting Nurse Service of New York
West Side NORC	Goddard Riverside Community Center	Visiting Nurse Service of New York
Queens		
Big Six Towers NORC	Selfhelp Community Services, Inc.	None
Clearview Assistance Program	Samuel Field YM&YWHA	None
Deepdale Cares	Samuel Field YM&YWHA	North Shore-Long Island Jewish Health System
Forest Hills Co-op NORC	Forest Hills Community House	Visiting Nurse Service of New York
Northridge/Brulene/Southridge NORC	Selfhelp Community Services, Inc.	None
Queensview/N. Queensview NORC	Selfhelp Community Services, Inc.	None
Ravenswood RISE	HANAC	Visiting Nurse Service of New York
Ridgewood Gardens NORC	Selfhelp Community Services, Inc.	None
Rochdale Village	Rochdale Social Services, Inc.	Visiting Nurse Service of New York

Note: Table reflects NORC-SSP-provided data as of June 30, 2003.

Nursing Hours	Social Work Staff	Special Features
18 hours	1.6 FTE	Coalition of two housing co-ops; education department for culture and activities since complex was built in 1938.
25 hours	5.45 FTE	Vast isolated complex. Social adult day program; numerous DFTA-funded traditional services including senior center.
37.5 hours	3 FTE	The only program with health care partner as lead agency.
1 FT	3 FT	NYCHA-funded senior center.
18 hours	3FT	DFTA-funded senior center.
1 FT	4FT	Private landlord initiated NORC program; isolated vast complex; program director employee of landlord.
10.5 hours	3.33FTE	
10.5 hours	3.33FTE	
14 hours	4 FTE	Social adult day program.
55 hours	7.6 FTE	Coalition of four different housing co-ops; the only program paying rent; social adult day program.
19 hours	2FT	Significant number of recently arrived Chinese elders.
1 FT	4.75FTE	Coalition between public housing and moderate income co-op; NYCHA contributes custodial care.
7 hours	1.71FTE	The only single-building NORC program.
1 FT	3FTE	Volunteer-led since 1966.
43.5 hours	6.77FTE	Original model program; social adult day program.
2 hours	2.43FTE	On-site activities funded by housing corporation prior to NORC program.
6 hours	3.83FTE	DFTA-funded senior center on site.
20 hours	4.5FTE	DFTA-funded senior center on site. Funded from 1992 to 1995 by HUD; thereafter by New York State.
6 hours	1.89FTE	Coalition of three different housing co-ops.
None	2FT	Community built space for program.
None	2FT	Garden apartment complex.
21 hours	2FT	Original residents founded the on-site YM-YWHA; garden apartment complex.
4 hours	2.8FTE	Only low-income public housing co-op in city; DFTA-funded senior center.
None	1.8FTE	Coalition of 6 co-ops; council-designated program.
None	2FT	Coalition of 2 co-ops.
	15.3FT	VNSNY's Community Nursing Org. program on-site from 1993 until NORC began; DFTA-funded senior center.
None	0.5FTE	Council-designated program; closed June 2003.
17.5 hours	3FT	Isolated part of Queens with higher than average concentration of African Americans.

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