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Aging in Place at Harbor Point: Outreach Follow-Up of Older Adults Living in Independent Mixed-Income Apartments

Judith M. Conahan
University of Massachusetts Boston

Nina M. Silverstein
University of Massachusetts Boston, nina.silverstein@umb.edu

Kelly Fitzgerald
University of Massachusetts Boston

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Judith M. Conahan, M.S., Research Assistant
Nina M. Silverstein, Ph.D., Project Director
Kelly Fitzgerald, M.P.A., Teaching Assistant

Gerontology Institute and
College of Public and Community Service
University of Massachusetts Boston
Boston, Massachusetts 92125-3393

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(617)387-7300
Fax: (617)287-7080
Website: www.geront.umb.edu
E-mail: gerontology@umb.edu

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Many people contributed to the design and implementation of this project. It was implemented within the framework of the Spring 2004 elder action-research course, part of the requirement for the undergraduate and Manning certificate programs in gerontology at the University of Massachusetts Boston (UMB). The course was taught by Nina M. Silverstein, Ph.D., with research assistance from doctoral student Judith M. Conahan, M.S. and teaching assistance from doctoral student Kelly Fitzgerald, M.P.A.

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2004 Action-Research Class Members

Elizabeth Barton-Shields
Tina Craig
Michael Doran
Josephine Erewa
Leola Green
Daniel Huang
Kristin Labbe
Judith Lane
Keith Lawrence
Maureen Murphy
Imelda Nelson
Beatrice Noyes
Sheila Ronkin
Carolyn Rosenfeld
Patricia Thompson
Virginia Vockel
Ruth Whitman

EXECUTIVE SUMMARY

Introduction

The Boston Commission on Affairs of the Elderly launched its *Seniors Count* initiative to identify and reach out to elders in need. The program has disseminated information about services to over 5500 community-dwelling Boston elders since 1999. Their most recent targeted effort took place at Harbor Point Apartments in Dorchester Massachusetts in November 2003. This report describes the findings of a research project, conducted by students in the gerontology undergraduate and certificate programs at the University of Massachusetts Boston, that followed-up on that initiative five months later in April 2004. In addition to information about satisfaction with their *Seniors Count* contact, 50 respondents age 65+ shared information about health, caregiving, transportation, neighborhood/housing, and social support. The purposes of this project were to examine the outcomes of the *Seniors Count* outreach effort at Harbor Point, to assess the knowledge and use of selected services by elders at Harbor Point, and to describe "aging in place" in independent living mixed-income apartments at Harbor Point.

Data Collection

The sample consisted of residents of Harbor Point, a 1200 household, ocean-front community, which had been converted 16 years before from the largest public housing project in Boston to new private mixed-income apartments and townhouses. The interviewees were obtained from a list of 119 older adults 65+ residing in the apartments. Ultimately in-person interviews were arranged and completed at Harbor Point with a total of 50 people age 65+, yielding a response rate of 43%.

Results

Demographics

The older adults in this sample ranged from 65 to 99 years of age. Over two-thirds were female. Twenty-two percent were high school graduates. Over half (54%) had less than a high school education. Sixty percent had incomes of $20,000 or less. They represented diverse ethnic and racial groups. Over one-half were Black/African American, almost one-third were White/Not of Hispanic Origin, six percent were Hispanic/Latino/Chicano and six percent were American Indian/Alaska Native.

Seniors Count

The *Seniors Count* initiative conducted in November 2003 achieved its goal of reaching many elders in a specific neighborhood. When *Seniors Count* volunteers visited elder residents at Harbor Point, they gave them bags of printed information on services available to them through the city of Boston. They also assessed unmet needs or concerns and shared this information (referrals) with the Elder Commission. Over three-quarters (82%) of residents receiving referrals recalled receiving the bag of information

The data revealed that a greater proportion of elders who had received referrals in 2003 remembered the *Seniors Count* visit and receiving the bag of information five months later in 2004 than did elders receiving referrals in 1999 and being followed-up four years later in 2003. However, fewer elders in the more recent follow-up were satisfied with those referrals.

Service Knowledge and Use

When asked about fifteen selected services and activities available at Harbor Point, older residents knew about, on average, eleven of them. The most frequently noted services were Project Care and Concern (faith-based multi-service center primarily for low income households), the shopping bus, meals-on-wheels, the swimming pool/fitness center and Geiger Gibson Health Center. The majority of elders used, on average, four of those services and activities. The most frequently noted services actually used were Project Care and Concern, the shopping bus, Geiger Gibson Health Center and monthly blood pressure screenings. Approximately three-quarters reported that they would like to use on average five of the services or activities in the future. Many stated that they would be interested in using services such as home care or homemaker service, but only "if needed." The most frequently noted service that residents reported that they would be interested in using was the computer center. There may be a lack of uniformity in the way in which information about services and activities available to elders at Harbor Point is communicated. Older adults living in the age-segregated building were more likely to know about services and activities specifically for elders. Those living outside of that building were more likely to know about community-wide services not specifically for older adults. This contributed to perceptions of lack of community by some interviewees.

Health and Health Status

About a quarter of the Harbor Point elders who were surveyed said that they had physical conditions that interfered with caring for themselves. Interestingly, over one-third of all surveyed residents reported moderate to severe pain of 5 or greater on a scale of 1 (least pain) to 10 (severe pain). However, a majority (84%) stated that their health was the same or better than the previous year.

There was some inconsistency in health promotion activities among the older adults in this sample. Almost all residents reported visiting a health professional within the past year. However, only about one-half had visited a dentist in the past year. There seemed to be some misconceptions about the need for dentistry while wearing dentures. Over three-quarters of those without dentures hadn't visited a dentist in three or more years. Among the older adults in this sample a mean of five prescription medications were taken daily. However, ten percent of the respondents reported cutting back or skipping doses to be able to afford medications. Caregiving responsibilities may impact the health of older adults. Ten percent of this sample of elders had primary care responsibility for a child/grandchild less than 18 years of age.

Transportation

The most frequently used independent mode of transportation was the subway or bus. The second most frequent was driving. Of those who needed help with transportation within the previous month (48%), 40% received it from family and friends daily to weekly and 20% received it from an "agency" a few times a week to weekly.

Neighborhood/Housing Safety

A majority of respondents (84%) reported that they felt "very safe" or "mostly safe" at Harbor Point. Those who reported feeling less safe said that they were particularly concerned for their safety outside of their apartments at night and on weekends. Most did not indicate concern for their personal safety in their apartments. Two-thirds of respondents had checking

arrangements with family or friends, most commonly by a daily phone call. However, almost one-third of elder residents reported no adaptive equipment (grab bars) in their bathrooms. Over one-third reported that they did not have a plan for exiting their buildings in case of a fire. Many of those who said that they had a fire plan were not specific about that plan. Of those who didn't have a plan, over one-half reported using a walking device such as cane, walker, or wheelchair.

Social Support and Social Engagement

Isolation is a concern for elders in independent living apartments. Among older adults in this sample most socialized in some way daily to a few times a week. However, over one-half of the older residents lived alone and over half of them reported difficulty in walking. Of those living alone, one-third reported having no regular checking system. However, one-third of those living alone reported having relatives living in another apartment at Harbor Point and one-half reported having relatives living within a few miles. There was no differentiation reported between socialization with family or with friends. About one-half of the elders found people at Harbor Point very friendly and about one-half found people somewhat friendly. Only 12% reported currently using the Senior Center (Kit Clark). However, one-third of respondents were actively engaged in volunteer work at Harbor Point or in Greater Boston.

Recommendations

Regarding *Seniors Count*

- Clarify referral procedure of Seniors Count outreach program. Provide printed material to reinforce referral. Train volunteers to discuss referrals with interviewees.

- Expand outreach strategy. In addition to door-to-door outreach, consider phone contact to make appointments with those who have not answered their doors.

- Continue to follow 2003 recommendation for building timely follow-up studies into the *Seniors Count* program.

Regarding Aging in Place at Harbor Point

- Enhance safety for elders at Harbor Point. Review fire plan with residents regularly. Institute formal daily checking arrangement (phone or in-person contact) for those alone and at risk. Identify elders at risk and build awareness among security staff. Increase elder awareness of accident prevention strategies, possible apartment modifications, and access to installation help.

- Provide education programs targeted to "seniors." These include a computer education program for older adults and a public education program promoting oral health.

- Build Community. Provide more social and civic opportunities for socialization across groups of different ages, cultures, and incomes.

- Expand information and communication about support services and activities at Harbor Point and Greater Boston. Consider language and literacy barriers. Plan events at different buildings, but consider elder transportation needs within Harbor Point.

- Develop action steps with stakeholders to address study recommendations.

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INTRODUCTION

Most older people, despite functional impairments, plan to stay in their homes and/or communities as long as possible. According to an AARP survey, 82% of adults 65+ reported that they believe that they are "very likely" or "somewhat likely" to stay in their current homes or apartments for the rest of their lives (Greenwald, 2003). With increasing age, housing and community characteristics and services gain importance in meeting the challenges of "aging in place." Staying in their homes maximizes elder's independence, sustains their social connections, and reaffirms their identity and value (Lawler, 2001; Rowles, 1993).

Increased life expectancy, decreased mortality, and the aging of the baby boomers have contributed to the aging of communities and will continue to do so. In Massachusetts the number of adults age 65+ is expected to increase by 46% in the next 25 years (Boston Partnership for Older Adults, 2003). Today's elders are older, more diverse, and more consumer-oriented than in the past. Their demand for a variety of support options continues to increase. On-going identification of needs and dissemination of information about available community services and how to access them are necessary strategies to efficiently and effectively address this growing population.

The Boston Commission on Affairs of the Elderly has been involved in an outreach program since 1999 that utilizes such strategies. The name of that initiative is *Seniors Count*. Their most recent targeted outreach took place at Harbor Point Apartments in Dorchester, Massachusetts. This report describes a research project, conducted in 2004 by students in the Gerontology undergraduate and certificate programs at the University of Massachusetts Boston, that followed-up on that initiative. The purposes of this project were:

- To examine the outcomes of a *Seniors Count* outreach effort through the City of Boston at a private mixed-income housing community
- To describe "aging in place" in mixed income housing
- To assess knowledge and use of selected services by elders dwelling in independent living apartments in mixed-income housing

BACKGROUND

A Review of Literature on Aging in Place

The literature on "aging in place" suggests that people's attachment to "place" is highly significant with increasing age (Rowles, 1993). However, cost and convenience of housing are mitigating factors to this attachment. To understand better elders' needs and preferences in housing, researchers have described and analyzed the physical environment, the social environment, and the supportive services important to remaining at home.

Physical Environment

The physical environment includes living spaces and the buildings that house them. It also includes community features such as safety of the neighborhood and closeness of doctors' offices, grocery stores, drug stores, and places of worship. Environmental modifications can improve the quality of life of elders by easing the performance of every-day activities of daily living, reducing accidents, reducing health care, and preventing early institutionalization

(Pynoos, 2001). It has been estimated that over a million older people in the United States need housing modifications such as single lever faucets, bathroom access, and ramps to their homes and apartments (Pynoos, 2001). There is a significant interrelationship between features of an environment and the health of people living in that environment. Functional impairment can reduce the ability to maintain a home, while environmental features of a living space can become obstacles and create health problems (Lawler, 2001).

Barriers to housing modifications often include cost, the confusing network of providers who might fund modifications, landlords hesitant to make modifications, and tenants hesitant to ask, lack of up-to-date laws and codes that would mandate accessibility and retrofitting when needed, and lack of awareness of need for and availability of modifications (Pynoos, 2001). When asked how important certain environmental modifications might be to them in later life, people age 65+ in an AARP survey (Greenwald, 2003) indicated that the following items were "very important" or "somewhat important": a bathroom and a bedroom on the main floor (85%), easily usable climate controls (82%), non-slip floor surfaces (79%), bathroom aids, such as grab bars or a stool for bathing (79%), and a personal alert system to call for emergencies (76%).

Social Environment

Social environment includes the opportunities or potential opportunities for interaction with others. Aging in place allows people to continue relationships with family and friends in their neighborhoods or nearby communities. The AARP survey (2003) asked respondents age 45+ if they believed that they would be able to "rely on family or friends to help me with tasks that will allow me to stay in my home … when I get older." Over two-thirds "agreed" or "somewhat agreed" that they will.

Being part of a neighborhood or apartment complex can establish valuable resources in the form of social capital. This social capital, produced through connection to the community, is shared collectively by members of the community, often involving group and community activities, and is based on trust and norms established over time (Cannuscio, Block, & Kawachi, 2003). Aging in place allows elders to take advantage of accumulated social capital. Accessing social capital is a reciprocal process. Elders can maintain independence, health, and productivity by gaining support from their social connections, and by giving to the community through civic engagement and/or neighborliness.

The design of the community as well as the architecture of apartment buildings contribute to the promotion of social capital and successful aging in place. During an initiative to develop a model of an elder-friendly community, researchers (Feldman & Oberlink, 2003) conducted focus groups in several different areas of the United States with people of varying ages. Ultimately "objective measures or indicators" of elder-friendly communities were identified. These included 1) "addressing basic needs," with housing that is affordable and modified for mobility and safety, a safe neighborhood, knowledge about available services and how to access them and enough food, 2) "optimizing physical and mental health," with opportunities for physical activity, medical care, and palliative care, 3) "maximizing independence of the frail and disabled," with services such as accessible and affordable transportation, and formal or informal supports and 4) "promoting civic and social

engagement" by providing opportunities for volunteer work and developing communities where people help and trust each other. One young woman in a focus group commented that the elements identified as essential for successful aging in place were not necessarily age focused: "This is not something just for older people; this is something I want" (Feldman & Oberlink, 2003, p.272).

Support Services

Accessing information and services often involves navigating separate systems for housing and health care or aging service programs (Cox, 2001; Holmes, Krout & Wolle, 2003). Combining housing and social services to support people at the "margin of need" rather than when a crisis arises may be the most efficient and cost-effective way to assist older adults to "age in place" (Lawler, 2001). Researchers study community social services and housing by examining the variables associated with service knowledge and use. Rinehart (2002) demonstrated a statistical relationship between housing type and patterns of service utilization. She found that elders who lived in age-segregated housing were more likely to use "formal in-home support services" and were more likely to be satisfied with their environment. She suggested that the reasons for this might be that there were professional social workers with easily accessible information about services stationed in the age-segregated housing, that it was more "socially acceptable" to receive services in that setting, and that people with more needs might be more likely to live in "senior housing." Among elders in both age-integrated and age-segregated housing, the probability of using formal services was associated with the greatest need. In another study (Calsyn & Winter, 2001), researchers found that elders with physical health needs were most likely to be identified by others or by self-report as candidates for support services.

In another study, part of the larger *Pathways to Life Quality Study*, three groups of elders were examined for their use of community support services: those living in service-rich congregate housing (a continuing care community), those living in service-poor congregate housing ("government-subsidized public housing" or "independent living senior apartments"), and those living in homes and apartments in the community (Homes, Krout, & Wolle, 2003). All study participants were questioned twice, two years apart. Among all respondents, the most frequently used services were transportation, senior centers, and homemaker assistance. Service use was higher at senior housing settings than in the community. Community dwellers were younger, used fewer services, and gave more informal help to friends and relatives. The service-poor group was more likely to use meals and transportation services. Elders in that group used more services and were hospitalized more frequently. There was variation over time in the types of services used and in the percentage of the sample using particular services.

Harbor Point – The Study Setting

Harbor Point is a 1,283-unit private mixed-income apartment and townhouse complex in Dorchester, Massachusetts. The 51-acre oceanfront development is located on a peninsula in Boston Harbor. It shares the peninsula with the University of Massachusetts Boston, the John F. Kennedy library, the Massachusetts State Archives, a deserted pumping station, a church, two public schools, a parochial high school and other community institutions and businesses. The nearest rapid transit station is approximately 0.7 mile away, but once there, 15 minutes from downtown Boston.

Beginning in 1988, Harbor Point replaced Columbia Point, a 1,504-unit public housing development. Columbia Point, the largest public housing project in Boston, was built in 1954 for low-income families. By the 1970s the buildings there had deteriorated and a reputation for crime and drug activity had emerged (Kennedy, 1989; Schubert & Thresher, 1996; Roessner, 2000). By 1979, only 350 apartments remained occupied. Between 1988 and 1991, the dilapidated and mostly-deserted buildings were replaced or converted into approximately 1200 new luxury apartments and townhouses, housing over 3,000 residents. One-third of the new apartments were occupied by low-income or subsidized households (paying 1/3 of their family income in rent), and market-rate households occupied two-thirds. The subsidized residents included those who had lived at Columbia Point during the conversion. Today, residents also include students from nearby colleges among the community dwellers. The total population varies by age, income, race, and ethnicity throughout all of the apartments and townhouses. Safety is addressed by a security organization of uniformed people who have an office on the first floor of the "senior designated building." Cars that enter the development must stop at a kiosk and gate, identify their destinations within Harbor Point and be issued passes, visible through the front windshields.

Important aspects of this housing model are on-site management and resident empowerment. This includes a representative tenant organization and a social service component with a representative of a private social service agency housed at Harbor Point. The Harbor Point Community Task Force was incorporated as a non-profit organization in 1978 to "revitalize" the neighborhood. Ultimately, "working hand in hand with the developer, Corcoran, Mullins, Jennison, Inc., it was successful, not only in changing the site's physical structure, but in making itself 50% owners of the development."[1] The purpose of the taskforce is to represent all residents of Harbor Point and monitor life there. The social service component (Housing Opportunities Unlimited) is defined as a "resident services information center."[2] Its core mission was originally to help people successfully transition into life at Harbor Point, providing assistance in housekeeping, budgeting, conflict resolution, job search, substance abuse, and advocacy within or outside of the apartment community (Corcoran, 2002).

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Aging in Place in Mixed-Income Multi-Family Housing

The mixed-income neighborhood is not a new concept, but one that has naturally occurred in many urban locations (Corcoran, 2002). Harbor Point, although designated as mixed-income, contains residents in two income categories, subsidized and market renters. Elders at Harbor Point have apartments scattered throughout the complex and in the building designated for adults age 55+ and for the disabled. Although older people live in this building, with grab bars and emergency pull-cords in the bathrooms, they occupy independent living apartments without particular senior supportive services in place.[3] The approximate 119 elders 65 years and older, at the time of this study in 2004, no matter what buildings they occupied, had the rights and privileges of all tenants there. The advantage for elders, who would otherwise have lived in low-income community or public housing, is affordable housing in attractive, maintained, and safer surroundings. The

[1] One page information flyer entitled "Harbor Point Community Task Force, Inc."
[2] One page information flyer entitled "Your Resident Services Information Center."
[3] Nine formerly homeless elders and/or disabled persons over the age of 45, under the supervision of the Harbor Point Congregate Living Program, funded under H.U.D. Shelter Plus Care Program, are provided "service-enriched housing."

advantage for all elders is the location on the ocean and the proximity to the resources available in Boston.

METHODOLOGY

Action-Research Model

An action-research model was used to conduct this project. This model brings university faculty and students together with community leaders and agency representatives to address issues of public concern (Bass & Silverstein, 1996; Silverstein, Moorhead & Murtha, 2002). The research team for this project included the faculty and students who participated in the Spring 2004 Elder Action-Research course. This course is offered to undergraduate gerontology students and Manning Certificate students through the College of Public and Community Service with support from the Gerontology Institute at the University of Massachusetts Boston. The community partner for this project was the City of Boston's Commission on Affairs of the Elderly. The Commission also contributed financial and in-kind support. An advisory board consisting of stakeholders, who were representatives of the Commission on Affairs of the Elderly, faculty from the University of Massachusetts Boston, Harbor Point residents and administrators, and interested Harbor Point community members, reviewed and commented on the questionnaire during its development and later commented on the project's preliminary findings.

Community Partnership

Seniors Count is an outreach initiative begun by the Boston Commission on Affairs of the Elderly in 1999. Since then over 5000 community-dwelling elders in Boston have been contacted on a door-to-door basis by trained volunteers. The protocol for the *Seniors Count* outreach is that visits be conducted in the presence of two trained volunteers, one asking assessment questions, the other acting as an observer. Their goals are to identify needs of Boston elders and disseminate information about the services available to them. In November 2003, *Seniors Count Phase III* targeted elders at Harbor Point. At the same time plans were being made at the nearby University of Massachusetts Boston Gerontology Institute for the Spring 2004 Semester Elder-Action Research annual project. From this, there emerged discussion about exploring the living and aging experiences of elders at Harbor Point.

It was suggested by Joyce Williams-Mitchell, then Boston Commissioner on Affairs of the Elderly, that a follow-up of the Harbor Point *Seniors Count* outreach would be useful in strategizing about future programs. A partnership had already existed between the University of Massachusetts Boston Gerontology programs and the Elder Commission. The 2003 Action-Research Project had been a follow-up phone survey of a *Seniors Count* outreach conducted four years previous in 1999 (a full report of that study, "*Seniors Count* Follow-Up Study," is available at *www.geron.umb.edu*). Consequently, *Seniors Count* volunteers contacted elders at Harbor Point in November 2003, and gerontology students, as part of the action-research course, followed-up with in-person interviews of those elders five months later in April 2004.

Questionnaire Preparation

The survey instrument used for this project built upon the 2003 *Seniors Count* follow-up questionnaire. Spring 2004 gerontology students and advisory board members provided input. It included both structured close-ended questions and more general open-ended

questions. In preparation for the Spring 2004 Semester, during Fall 2003, a graduate research assistant interviewed key informants who lived, worked, or provided services to elders at Harbor Point to obtain historic context and to identify areas of concern and potential research that could be beneficial to the community. A brief video of a University of Massachusetts Boston faculty member recounting her experiences (as an architect and social researcher) with Columbia Point residents during the early 1970s was produced for classroom use. During Spring 2004 class readings and speakers on elder housing, *Seniors Count*, and Harbor Point expanded student and faculty understanding of salient issues. Trainers from the Center for Survey Research at the University of Massachusetts Boston conducted preparatory sessions on interviewing techniques. During Spring Break (March 2004) students informally pilot-tested the questionnaire on friends and relatives. The final 21-page questionnaire included 251 variables in the domains of service knowledge and use, health and mobility, caregiving, neighborhood/housing satisfaction, and social support. All research activity on this project was approved by the Institutional Review Board of the University of Massachusetts Boston for the protection of human subjects. In accordance with the regulations of the Commonwealth of Massachusetts, all students and faculty who had direct contact with Harbor Point elders passed a Criminal Offender Record Information (C.O.R.I.) check processed through the Boston Commission on Affairs of the Elderly.

Data Collection

Fifty in-person interviews of persons age 65+ residing at Harbor Point were conducted by 17 gerontology certificate and undergraduate students over a three-week period in April 2004. Interviews ranged from 25 to 105 minutes (mean = 49 minutes). Students were based in the resident lounge of the "senior designated" building within the Harbor Point complex. This seven-story apartment building housed people age 55+ and the Harbor Point Security Office. Of the 116 people 65+ residing in all buildings at Harbor Point, 60 elders lived in this age-segregated building and 56 resided in age-integrated apartments and townhouses scattered throughout Harbor Point. Interviews occurred in the age-segregated building lounge or in residents' apartments according to residents' preferences. Two students, one reading the questions, the other recording the responses, conducted interviews in apartments. One or two students in close proximity to faculty and graduate student supervision conducted interviews in and around the lounge. Residents signed consent forms before the surveys were conducted (Appendix A).

The first contact with potential interviewees was by letter one to two weeks before the actual in-person visits (Appendix B). In this letter the Commissioner on Affairs of the Elderly explained the project, that a research liaison from the university would call to set up an appointment, and that a number could be called to remove one's name from the calling list. In order to encourage participation, flyers were distributed announcing students' presence twice during the three weeks of interviewing, and refreshments were available in the lounge each day that students appeared. Some door-to-door solicitation occurred with community members who introduced residents to the university liaison who then set up appointments for interviews. Ultimately, interviews were arranged and completed with a total of 50 people age 65+ residing at Harbor Point, yielding a response rate of 43%.

Reasons for non-response are explained in Table 1. Of an original list of 119 names, one person died and two moved away during the project period (n=116). Illness included people who attended rehabilitative day care and those who became ill on the day of the appointment and could not reschedule.

Table 1. Reasons for Non-Response (n=116)

Respondents	***f***	**%**
Completed Surveys	50	43.0%
Non-Respondents		
Refused Meeting	18	15.5%
Scheduling Barriers		
Language Barrier	8	6.9%
Phone Communication Barrier		
Phone out of Service	5	4.3%
No Answer to Numerous Calls	13	11.2%
No Phone Number	11	9.5%
Illness	5	4.3%
Working	4	3.5%
Travel Out-of-State	2	1.7%
Total	**116**	**100.0%**

The only variables for which data were available for identifying differences between respondents and non-respondents were age, gender, and location (residing inside or outside of the age-segregated building). These differences were not statistically significant, and thus, there is confidence that the respondents were similar to the non-respondents on those variables. However, due to the low number of variables for comparison and the small sample size, caution should be exercised in assuming that the respondents and non-respondents were alike on all domains and in fully generalizing the results of this study to all elders residing at Harbor Point .

RESULTS

Sample Characteristics (See Table 2)

The final sample (n=50) consisted of English-speaking community-dwelling males and females age 65 and over, among whom 58% resided in the senior-designated building and 42% resided in age-integrated apartments and townhouses within the Harbor Point apartment complex. They ranged in age from 65 to 99 years with a median of 73.5 years. Over two-thirds (68%) were female. Over half were African-American, almost one-third were White (not of Hispanic origin) and 6% were Hispanic/Latino/Chicano. The Hispanic/Latino residents may have been underrepresented because translation of the questionnaire and a translator were not available for this modestly funded student project. Fifty-four percent of the residents had less than a high school education. Almost a fifth (18%) had less than an eighth grade education. Over half of the sample lived at Columbia Point and transitioned into Harbor Point. More than

80% had lived at Harbor Point for 10 years or more. Almost one-third had incomes of less than $10,000 and almost two-thirds reported incomes below $20,000.

Table 2. Sample Descriptives (n = 50)

	f	%
Gender		
Male	16	32.0%
Female	34	68.0%
Age (years)		
Range	65-99	
Median	73.50	
Mean	74.70	
Standard Deviation	6.94	
Race/Ethnicity		
White, Not of Hispanic Origin	15	30%
Black, African-American	20	52%
American Indian/Alaskan Native	3	6%
Hispanic/Latino/Chicano	3	6%
Multiracial (Greek & African-American)	1	2%
Other (Cape Verdean)	1	2%
No Answer	1	2%
Marital Status		
Married/Partner	10	20%
Never Married	5	10%
Widowed	18	36%
Divorced	10	20%
Separated	5	10%
Other (“single”)	2	4%
Education		
Eighth Grade or Less	9	18%
Some HS, But Did Not Graduate	18	36%
HS Graduate or GED	11	22%
Some College/Technical School/ Associate Degree	6	12%
Four-Year College Graduate	2	4%
More than Four Years of College	4	8%

Table 2 Continued. Sample Descriptives (n = 50)

	f	*%*
Household Income		
Less than $10,000	16	32%
$10,000 to $19,999	14	28%
$20,000 to $29,999	6	12%
$30,000 to $39,999	2	4%
$40,000 to $49,999	1	2%
$50,000 and over	2	4%
Refused to Answer	9	18%
Subsidized Rent	37	74%
Market Rate Rent	13	26%
Employment Status		
Paid employment	5	10%
Volunteer	16	32%
Harbor Point Residence		
Age-Segregated/Disabled Building	29	58%
Age-Integrated Buildings	21	42%
Years of Occupancy		
Range	1-16	
Mean	12.5	
Standard Deviation	3.8	
Transitioned from Columbia Point Harbor Point		
Yes	27	54%
No	23	46%

***Seniors Count* Visits and Referrals**

When *Seniors Count* volunteers initially visited the homes of elders at Harbor Point in November 2003, they conducted outreach assessments and made observations. They gave each elder a bag with printed information about services available to them through the City of Boston and Commonwealth of Massachusetts. They wrote down any particular concern a senior had and/or observation of an unmet need (e.g., safety bar in bathroom) and shared this information with the Elder Commission. These were called referrals. During training the volunteers were taught to recognize some 84 different issues (Appendix C). Except in an

emergency, *Seniors Count* volunteers were instructed to provide referral information to the senior in the form of a pamphlet found in "the bag" or a telephone number. The senior then was expected to use that information to access the appropriate service on his or her own. Not all elders received referrals. One of researchers' tasks was to find out about the respondents' experiences with *Seniors Count,* including whether or not the received referrals were resolved.

Originally, the Boston Commission on Affairs of the Elderly identified the names of 16 elders at Harbor Point who had received referrals from volunteers during the *Seniors Count* visits in November 2003 and who met the criteria for this project. Follow-up interviews were conducted with eleven of those elders, who all together received 22 referrals. Reasons for non-response of those who had been listed as receiving referrals included refusal to participate, language barrier, illness, and inability to locate. The three most frequent referrals were for legal questions, volunteer information, and city tax exemptions.

Over three-quarters (82%) of residents receiving referrals recalled receiving the bag of information. Over one-third of the residents receiving referrals stated that their referral issue(s) had been resolved. There seemed to be some ambiguity in the respondents' statements about the referral process. Almost two-thirds stated that either the referral(s) had not been resolved or they "did not recall" or "did not know" that they had been referred. This was consistent with a finding from the Silverstein, Connors, and Jawad 2003 follow-up study where elders did not uniformly recall that referrals were made on their behalf. A recommendation from that 2003 follow-up report was that such referral information be received in written form. That recommendation was not implemented by the time of the 2003 *Seniors Count* initiative at Harbor Point.

Of all 50 elders that students interviewed, 40% (20 people) remembered receiving the bag of printed materials. One-fourth of them (5 people) reported that they had shared information from the bag with other family members or friends. Although each volunteer carried some printed information in languages other than English, one woman stated that she expected someone to return with more information in Spanish, but, according to the elder, that never happened.

Harbor Point Residents' Contacts with the Commission on Affairs of the Elderly

During the Spring 2004 follow-up visit by the University of Massachusetts students, the study participants were asked whether they ever called the Commission's telephone number. Of the 16% who said that they had, approximately one-third was "very satisfied," one-third was "somewhat satisfied," and one third were "not at all satisfied." When the elders were asked "why [they had] called," the responses included seeking information about transportation/discounts, caretaking services, brochures on SHINE (Serving the Health Information Needs of Elders), and legal assistance.

Another form of potential contact was through television and radio broadcast. The Commission produces weekly cable television and radio programs. Of the 72% of respondents who had cable television, over one-third (36%) reported that they watched the weekly television program. Only 6% reported listening to the weekly radio program. These percentages are comparable to the responses by Boston elders in other communities described

in the follow-up study in 2003 (Silverstein, Connors, & Jawad). Only 8% of the Harbor Point elders reported not knowing about the TV and/or radio programs.

Harbor Point Residents' Knowledge and Use of Services

Service use is dependent upon knowledge of available services and understanding how such services relate to individual needs. Residents were asked about 15 services available to elders at Harbor Point (Table 3). The services are described in Appendix D. For each service they were asked: "Do you know about the service?" "Are you using the service now?" "Have you used the service in the past?" and "Are you interested in using the service in the future?" The fifty elders in this sample knew on average eleven of the services (ranging from 4 to 15 services). The most frequently noted services were Project Care and Concern, the shopping bus, meals-on-wheels, the swimming pool/fitness center and Geiger Gibson Health Center. Almost all, 90%, used on average four of the services (ranging from 1 to 9 services). The most frequently noted services actually used were Project Care and Concern, the shopping bus, Geiger Gibson Health Center and monthly blood pressure screenings. Approximately three-quarters (76%) reported that they would like to use, on average, five of the services (ranging from 1 to 14 services) in the future. Many stated that they would be interested in using services such as home care or homemaker service, but only "if needed." The most frequently noted services that residents reported that they would be interested in using were the computer center, home health care, homemaker service, and weekly movie.

Further, Table 3 describes knowledge and use of specific services. Small sample numbers limit analysis of statistical significance of these. However, it is interesting to note that even though almost three-quarters of the elders knew about the computer center, none used it. However, almost half (44%) reported that they would like to use it in the future.

Statistically significant associations were found between knowledge and/or use of some services and the location of residence of elders. Those living in age-integrated apartments and townhouses were more likely to know about and use Geiger-Gibson Health Center ($p<.05$), H.O.U. ($p<.01$), and the Tenant's Taskforce ($p<.05$). Those living in the senior-designated building were more likely to know about and use Weekly Exercise Classes ($p<.05$) and Weekly Movies ($p<.05$), and were more likely to use Project Care and Concern ($p<.05$) and the shopping bus ($p<.05$).

Informal comments by long-term residents suggest that there were services for older adults available in the past that are no longer offered. Specifically, residents remembered activities available at the newly constructed Harbor Point through the Kit Clark Senior Center. Only 12% reported currently using the Senior Center, that is, going to the Center regularly.

Table 3. Service Knowledge and Utilization of Residents at Harbor Point Apartments: 2004

Service	Know About Service	Currently Using Service	Have Used Service in the Past, but Not Currently Using	Interest in Using Service in the Future
Project Care and Concern	48 96%	33 66%	11 22%	12 24%
Shopping Bus	45 90%	27 54%	5 10%	10 20%
Meals on Wheels	45 90%	5 10%	5 10%	13 26%
Harbor Point Swimming Pool/Fitness Center	43 86%	5 10%	8 16%	12 24%
Geiger Gibson Health Center	43 86%	21 42%	15 30%	11 22%
Kit Clark Senior Center	41 82%	6 12%	5 10%	11 22%
Tenant's Task Force Help	40 80%	10 20%	9 16%	13 26%
Homemaker Service	39 78%	8 16%	3 6%	15 30%
Harbor Point Computer Center	36 72%	0 0%	4 8%	22 44%
Monthly Blood Pressure Screening	35 70%	19 38%	4 8%	13 26%
Weekly Exercise Classes	35 70%	9 18%	3 6%	10 20%
Home Health Care	33 66%	5 10%	7 14%	10 32%
HOU (Housing Opportunities Unlimited)	31 62%	8 16%	2 4%	15 30%
Weekly Movie	28 56%	9 18%	2 4%	15 30%
Friendly Visitor	18 36%	4 8%	0 0%	14 28%

Health Status and Health Issues

Self-Reported Physical Health and Functional Ability

By age 65, 80% of adults have at least one chronic disease, and 50% have two or more chronic diseases (CDC, 2004). The physical changes that occur with age and the presence of disease contribute to increased risk of disability (difficulty with or need for help with daily tasks). Self-reported health may be more an indication of disability than of a diagnosis.

Respondents were asked to rate their own health from poor to excellent (see Figure 1; note: all figures appear after the appendices). Forty-four percent reported "fair" to "poor"

health. Approximately one-half (52%) reported "good" or "very good" health. Only 4% reported "excellent" health. The majority (84%) stated that their health was either the "same" or "better" than the previous year.

Self-rated health does not respond to the question of how well an elder with chronic conditions manages daily living. More than one-fourth (28%) reported that they had "physical health conditions that limited their ability to care for themselves." However, among those who reported this limited ability, the level of self-rated health varied from "poor" to "very good." Over half (52%) of the elders reported difficulty walking within the past month. Of those who reported difficulty walking, over three-quarters used a device to help with walking ($p<.001$) (Figure 2).

Many elders live with chronic pain. The presence of pain can be disabling. Current research has suggested that many older people experience pain and are being under-medicated for it. Over half (52%) of the older respondents at Harbor Point reported that they were "currently experiencing pain" (Figure 3). On a scale of 1 (least pain) to 10 (most pain) approximately one-third of all surveyed residents, or 65% of those who reported pain, reported pain of 5 or greater.

Nutrition

Adequate food intake may be an issue for elders living independently because of problems with food purchase or preparation due to physical or psychological limitations and/or because of inadequate income to purchase food. The data revealed that 80% of surveyed respondents typically ate three meals a day, but almost one-half of all respondents said that they skipped a meal more than one time a week. Four residents (8%) reported that they skipped meals four to six times a week. One respondent reported eating no meals, but getting nourishment via a gastrostomy tube. Why residents skip meals and the impact of doing so could be an important issue for further investigation.

Medical Care

Primary health care by the same health care professional over time is important to the administration of regular screenings/immunizations and to accurate expedient diagnosis of disease. Most respondents (94%) had visited a doctor within the past year and reported that they were seen by the same health care professional on sequential visits. Survey results from the 2003 *Seniors Count* Follow-Up Study, which consisted of a larger sample from a broader area of Boston, reported similar results (Silverstein, Connors, & Jawad, 2003).

Approximately one-third of the respondents reported that they had stayed over night in a hospital in the past year. This is similar to the rate of hospitalization reported by the Boston Public Health Commission (Boston Partnership for Older Adults, 2003). The literature reveals concern over use of the emergency room for routine care, particularly by the uninsured. Only 4% (2 people) in this sample reported not having medical insurance (Medicare, Medicaid, or private insurance). Over one-third (36%) of all respondents at Harbor Point (n=50) visited an Emergency Room one to three times within the previous year. Of those who had visited their doctors "less than one year ago," over one-third (38.3%) also visited an Emergency Room. Of the small number (6%) who had not seen their doctors in over a year or more, none reported

visiting an Emergency Room in the past year. Of those who visited an Emergency Room in the past year, all (100%) reported having visited the same provider over multiple visits for check-ups or illnesses.

Dental Care

Research has demonstrated that individuals who are edentulous (toothless) and of lower income are less likely to visit a dentist (Manski, Goodman, Reid, & Macek, 2004). One-half of the respondents at Harbor Point reported visiting their dentists within the previous one to two years. Over two-thirds, (68%), of the respondents reported wearing dentures. Of those who had not visited a dentist in three or more years, over three-quarters (77%) wore dentures. No questions were asked about dental insurance. Similar to the 2003 report, when asked the last time they visited a dentist, some respondents replied, "I wear dentures," suggesting to the interviewer that going to the dentist was not necessary with dentures. In fact, changes in bone and gums over time affect the fit of dentures that can adversely impact chewing and nutrition. Even without teeth elders are at risk for cancer and diseases of the salivary glands and mucous membranes of the mouth (Lamster, 2004). Determining the oral health needs of this population and their knowledge of oral care are issues for further investigation.

Prescription Medications

Adults 65 years and older constitute 12.4% of the population (Hetzel & Smith, 2001). Yet they purchase 35% of the prescription medications and 40% of the over-the-counter medications. They take on average three to five prescription medications each day (U.S. Food and Drug Administration, 2003). Harbor Point elders reported taking from 1 to 21 prescription medications each day with a mean of 5.31 medications (S.D.=3.72). These data may be skewed by the one resident who reported taking 21 medications per day while all others reported taking 10 or less. However, over two-thirds (69%) took four or more prescription medications per day. Three elders (4%) reported taking no prescription medications. On the first day of administration of the survey, when elders were asked "How many prescription medications are your suppose to take on a daily basis?" some confused the number of doses with the number of prescriptions. Interviewers clarified this as they asked the question later on during data collection.

There is increased public awareness of the cost to older adults of taking multiple prescription medications. Five respondents (10%) reported that they either cut back on necessities or skipped doses to afford medication. Two (4%) noted that they sometimes "forgot" to take their medications.

Mental and Emotional Health

It has been estimated that approximately 20% of community dwelling older adults experience minor depression, and 1% experience major depression (Hooyman & Kiyak, 2000). When asked about their mental and emotional health during the previous month, respondents in this sample were mostly positive. Seventy percent said that they were satisfied or content "all of the time" or "most of the time." Similarly, 72% reported that they felt depressed or unhappy "a little of the time" or "not at all." Only 8% reported feeling depressed or unhappy "all of the time" or "most of the time." Men were less likely than women to feel depressed or unhappy in the previous month. Over two-thirds (68.8%) of men compared to almost one-third (29.4%) of

women reported not feeling depressed or unhappy at all in the previous month ($p<.05$). Both men and women who perceived themselves in fair to poor health were less likely to be satisfied or content ($p<.05$) (Table 4).

Table 4. Feelings in the Past Month (n=50)

	Depressed or Very Unhappy	**Satisfied or Content**
All of the Time	2%	20%
Most of the Time	6%	50%
Some of the Time	20%	18%
A Little of the Time	30%	12%
Not at All	42%	0%

Caregiving Responsibilities

One-third of older adults at Harbor Point reported providing companionship daily to monthly to a relative or friend (See Table 5). Of those providing care for a child or grandchild under 18 years old, 39% (5) were primary caregivers. In our sample, 80% of those who reported primary responsibility for grandchildren lived with those children ($p<.01$).

Table 5. Caregiving by Harbor Point Elders 65+ (n=50)

	Frequency	**Percent**
Provided direct care to relative/friend	4	8%
Provided companionship to relative/friend	17	34.7%
Provided care to child/grandchild <18 years of age	13	26%
Primary caregiver to child/grandchild <18 years of age	5	10%

Transportation

Maintaining mobility in the community as well as in the home is key to quality of life in old age. Often the dominant modes of transportation change as people grow older (Sterns, Burkhardt, & Eberhard, 2003). Almost one-half (48%) of the respondents at Harbor Point reported that they needed transportation help to get where they needed to go. Of those who needed help, approximately 40% said that they received daily to weekly help from friends or relatives, 20% said that they got help from an "agency" "a few times a week" to "weekly."

Harbor Point is located on a peninsula far enough from a grocery store or other shopping stores to require transportation for most older adults. The most frequently used independent mode of transportation reported by the respondents was the Massachusetts Bay Transit Authority (MBTA), providing subway, bus, or commuter train transportation (Table 6). The second most frequent independent mode of transportation was driving. One-third of the respondents owned a car.

Table 6. Modes of Transport in Previous Month
Familiarity with Transport Discounts of Harbor Point Residents 65+ (n=50)

Mode of Transportation	Used Mode of Transport (Frequency)	Used Mode of Transport (Percent)	Familiar with Discount	Of Those Who Used Transport, Percent Familiar with Discount
MBTA transit*	27	54%	80%	92.6%
Car (driven in 6 mos.)	17	34%		
Taxi	9	18%	70%	88.9%
MBTA-The Ride***	7	14%	76%	100%
Senior Shuttle***	9	18%	70%	100%

* p<.05; ** p<.01; *** p<.001

Many residents were familiar with discount coupons for the different forms of transport, and these were significantly associated with use of the MBTA transit, MBTA-The Ride and the Senior Shuttle. Many respondents positively mentioned the recent change of the location of the bus stop at Harbor Point for the bus to the MBTA transit station. This change was the result of a community effort, and it reduced the amount of walking from the senior-designated building to the stop. Over one-half of the respondents (54%) also reported using the "shopping bus," which picks up residents four days a week from the age-segregated building and brought them to grocery and adjacent stores. Those who lived in the senior-designated building were more likely to report using the shopping bus than those living outside of that building ($p<.05$).

Neighborhood and Housing

Friendliness

Almost half of the respondents found people at Harbor Point to be "very friendly" (48%), and almost half found them to be "somewhat friendly" (46%) (Figure 4). Because half of those age 65+ live in the age-segregated building, they may have more opportunity to interact with each other. Occasional holiday events planned by residents in the lounge or the courtyard of the "senior" building were described. However, the data revealed no significant difference in residents' responses about friendliness by location, inside or outside of the age-segregated building. Comments by those who reported "somewhat friendly" suggested a casual friendliness based on a smile or a look in passing. Others reported lack of a smile or lack of a look with eye contact as signs of unfriendliness.

> *"A person can be laughing and talking with you, but their actions let you know if they're really friendly."*

> *"Among friends everyone says 'hi' but that's all."*

Some complained about a lack of community. Some residents, who had originally lived at Columbia Point, said that despite its reputation, they felt a stronger sense of community then than they did currently at Harbor Point. Others felt that former Columbia Point residents currently had their own sense of community.

"People from Columbia Point seem to look down on those who came later."

Some residents at the Harbor Point apartment complex are college students. Although they attend different colleges in the Boston area, many of the student residents attend the University of Massachusetts Boston that is visible from their apartments (less than 0.5 miles). More than three-quarters (76%) of the respondents said that they do not have any contact with these students. The data revealed no significant difference in reaction to college students by location, in or outside of the age-segregated building. Some reported contact with students "on the bus from here to the JFK station [John F. Kennedy subway station]" or "in the computer lab."

"I've talked a lot with them. They are from all over the world. There are some problems treating the place like a dorm, a little rowdy."

Safety

A majority of respondents reported that they felt "very safe" (71.4%) or "mostly safe" (9.5%) at Harbor Point (Figure 5). None said that they felt "not at all safe." Only one person said that he/she "does not go" out at all in response to the question on safety. The security office is housed on the first floor of the senior-designated building. However, there was no significant difference in feelings about safety between respondents who lived inside or outside of the senior-designated building. Respondents who had transitioned from Columbia Point to Harbor Point were more likely to feel "somewhat safe" than those who moved into the apartment complex later ($p<.05$). Comments among those who felt less safe included:

"I'm not afraid in the day, but scared in the night. We need more security at night and on holidays."

"Outsiders come in and sometimes cause problems. You have to be aware when coming from the station."

Checking Arrangements

There is a reassurance knowing that someone is aware if you vary from your usual routine. This reassurance is often provided informally among friends and family members. In other cases, there may be formal agency involvement. Almost two-thirds (64%) of the respondents in this sample reported that they had arrangements for someone to check on them and one-half reported that they checked on others. Family members most frequently checked on them. However, there was a significant association between those who reported being checked on and those who reported checking on others, indicating a mutual arrangement. This association was particularly strong with friends and neighbors. Eighty-eight percent of residents checked others while being checked themselves ($p<.001$). The most common arrangement for checking was a "daily phone call" from a family member or friend and then "knocking on a door if a person is not seen during the day." Some relied on agency check-up calls or lifeline, an "emergency phone" worn like a necklace. There was no significant difference in resident location (inside or outside of the age-integrated building) and the existence of a checking arrangement.

Use of Adaptive Equipment

Adaptive equipment in apartments is particularly important to preventing accidents and maintaining independent living. Almost one-third (32%) of the elders at Harbor Point reported no adaptive equipment (grab bars, tub rails, emergency cords) in their bathrooms (Figure 6). There was a significant association between lack of equipment and location, those in the senior-designated building having the equipment (90%) and those outside of that building lacking it (62%) ($p<.001$). Adaptive equipment, including emergency call cords to the security office, was installed in the bathrooms and bedrooms of the senior-designated apartments during the conversion of that building. Adaptive equipment in bathrooms outside of that building had to be requested by residents.

Fire Plan

Security and rapid evacuation concerns are being addressed nationwide. Understanding protocols for fire safety can assist in addressing other rapid evacuation needs as well. Over one-third (38%) of respondents reported that they did not have a plan for exiting their buildings in case of a fire (Figure 7). There was no significant association between those without a plan and their location, inside or outside of the senior-designated building.

Most of those with a plan said that they would "run out the door" and "go down the stairs."

"In the hall the sign says, 'do not enter elevator,' just get down stairs fast from the third floor."

"Each floor knows how many people live there, have a designated meeting place."

"I would walk downstairs into the lobby. I don't do fire drills."

There was no awareness among the respondents of a particular plan for the disabled or wheelchair bound. Over one-half of those without a fire plan reported using a walking device such as cane, walker, or wheelchair ($p<.05$).

Apartment Maintenance

A majority of elders (84%) reported that maintenance of their apartments was performed "well" or "very well." They responded that they were able to maintain a comfortable apartment temperature during the winter and the summer. From the 16% who indicated dissatisfaction, there were complaints about the timeliness of the response to calls for repairs. One elder lamented that management was …"*slow in making repairs. In the last four years service has dropped, not enough workers. They have to respond to emergencies first*." Most of the complaints about maintaining a comfortable apartment temperature were about adequate air conditioning in the summer and came from residents of the senior-designated building. Some elders commented that the air conditioning does not "*go on early enough in the spring*" or "*stay on long enough*" in the fall.

Social Supports

Contact with Family and Friends

Respondents were asked, "with whom do you live?" Over one-half (56%) reported living alone. Almost half of those who lived alone reported difficulty walking within the previous month. Among those who lived alone, approximately one-third had no regular checking system, that is, had no one checking on them on a regular basis. However, of those living along, one-third reported having relatives living in another apartment at Harbor Point and one-half reported having relatives living a few miles away. A significant association was found between self-rating of health and living alone. All (100%) of those who rated their health as "poor" lived alone, and one-half who rated their health as "fair" lived alone ($p<.05$). However, a moderately strong association was found between self-reports of deteriorating health in the previous year and not living alone ($p<.05$). The association between living alone and being in poor health suggests the need to identify those more vulnerable older adults for a daily checking arrangement and for assistance in an emergency.

Elders were asked about the contact and communication that they had with family and friends in the previous month (Figure 8). Most of them reported some social contact on a "daily" to "few times a week" basis. A majority (90%) reported that they leave their apartments daily or a few times a week. Over 50% talked on the phone with family/friends daily, and 64% got together with them daily or a few times a week. Some respondents (6%) reported never receiving phone calls, and some (12%) reported never getting together with family and friends. Very few received letters within the previous month. The least frequent form of communication for these Harbor Point elders was email, evidenced by 85% reporting that they did not have/use computers.

Another source of connection and an opportunity for contact with others and social support is religious participation. Half of the respondents reported attending religious services daily to once a week and one-third (34%) indicated that they never attended or only attended a few times a year.

Community Participation

Several elders reported being active in the Harbor Point and greater Boston communities. One-third reported that they volunteered inside or outside of Harbor Point 1 to 30 hours a week. Almost all respondents (92%) were registered to vote. Three-quarters (72%) reported that they voted in a government election in the past year. Only three people (6%) reported that they had difficulty getting to the polling place located at the "club house" in the Harbor Point apartment complex. One person reported voting by absentee ballot.

Informal comments by residents and stakeholders indicated that more activities for elders (and others) at Harbor Point would build community. It was also remarked that response to an elder bus outing had been sparse. Respondents were asked what activities they would like to participate in if they were offered at Harbor Point (see Appendix E). Over half responded to this question. These suggestions ranged from book clubs to card games to trips to the theater or country or sporting games to fishing. Of the sixteen male respondents, only five offered suggestions: swimming, golf, bowling, and painting and drawing classes.

Satisfaction with Housing at Harbor Point

When asked "What one thing do you like best about living at Harbor Point?" over one-half unhesitatingly answered the *"convenience of the location"* and the *"view of the ocean."* Other responses included the individual's apartment, friendliness, safety, privacy, and diversity.

When asked "What one thing do you like least about living at Harbor Point?" one-half of the respondents could not think of anything they disliked. Of those who responded, the most frequent complaints were related to noise, particularly at night, and *"young people congregating"* on the sidewalks.

> *"I don't have anything against kids and it's not that they cause trouble or anything, but if they could congregate in the park it would be better for the elderly."*

A few indicated that they thought that there may be drug activity.

> *"I know things go on here, but you would find that anywhere."*

Other concerns included:

> *"walking to the garage and shoveling,"*
> *"not enough to do,"* and
> "*the smoking room in [the senior-designated building]*" odor permeating other rooms.

DISCUSSION

***Seniors Count* Follow-Up**

In this follow-up of the *Seniors Count* outreach initiative (five months after volunteer visits at Harbor Point), 40% of the sample remembered the volunteer visits and receiving the bags of information. This was lower than the 59% reported in the 2003 follow-up project (four years after volunteer visits to six Boston communities). However, during that follow-up only those who had received referrals were questioned. In the current follow-up in April 2004, when only those receiving referrals were examined, a majority (82%) of respondents remembered receiving the bag of information. Since this is higher than the proportion reported in 2003, it could reflect the effectiveness of a much shorter follow-up time. Caution must be used in making assumptions because of the small sample size.

Comparison of the sample population (n=50) for this follow-up project to the larger sample of the 2003 follow-up project (n=271) reveals some differences. This sample is slightly younger, consists of over twice as great a proportion of people who represent ethnic/racial minorities, has twice as many people with less than a high school education, and is slightly poorer than the 2003 follow-up sample. A greater proportion (44% in 2004 compared to 36% in 2003) reported fair to poor health. They reported taking more prescriptions per day. However, the samples were similar in the frequency of their health care and dental visits. A smaller proportion of the 2004 follow-up sample reported driving as their major mode of transportation, and a larger proportion used the MBTA, The Ride, and the Senior Shuttle.

Interestingly, the samples were almost identical in their level of accessing of the Commission's cable TV and radio programs.

Aging in Place

With increasing age, older adults need a supportive environment to age in place. A supportive environment encompasses information about and access to home safety, health, and social services.

Although the majority of respondents felt "very safe" or "mostly safe" at Harbor Point, there were varied responses to questions about safety in their apartments. Of those living alone, over one-third had no regular checking system by family, friends, or agency. Over one-third reported no adaptive equipment (grab bars) in their bathrooms, and most who reported no equipment lived outside of the age-segregated building. Over one-third reported that they had no plan for exiting their buildings in case of a fire. Many who said that they had a plan were not specific about it.

Over one-half of older adults at Harbor Point reported "good" to "very good" health. Almost all had visited their health care professionals within the previous year. However, about one-third had also visited emergency rooms. An unexpected outcome was the respondents' responses to a question about pain. One-third reported that they were currently in moderate to severe pain. Similar to the 2003 follow-up results, many respondents with dentures appeared to believe that they did not need dental check-ups. Knowledge of the importance of good dental care appeared to be lacking among the elders in this sample as in the 2003 study. Further investigation is needed to determine the oral health needs of this population. Most respondents reported eating three meals a day. However, half said they skipped a meal more than one time a week. Why these elders skipped meals and whether or not their nutrition was impacted by doing so are areas for further study.

The elders at Harbor Point knew on average about 11 of the 15 available services and activities at the apartment complex. Results about the knowledge and use of those services were somewhat significant when comparison was made between those living in the age-segregated apartment building and those living outside of it. Not surprisingly, elders living in the "senior" designated building were more likely to know about services and activities provided specifically for older adults. Those living outside of that building were more likely to know about community-wide services not specifically for older adults. Perhaps the reputation of the age-segregated building as the "senior" building makes it a locus for announcements and notices about services or activities of particular interest to older adults. However, about one-half of those Harbor Point residents age 65+ live outside of that building.

Among the 50 older adults in this sample, five reported being primary caregivers for children or grandchildren under the age of 18 years. They represent 10% of the entire elder population 65+ at Harbor Point. It is feasible that more elders are primary caregivers for their grandchildren. Identification of these households for support services necessary to age in place and raise grandchildren may be appropriate.

Limitations

Limitations to this project include the small size of the sample and the absence of representative non-English speaking older respondents. Accessing elders for in-person interviews by phone was limited by the lack of phone numbers, out-of-service numbers, and language barriers. Informal comment was made by advisory group members about the possible over-saturation of residents with surveys. Experience with other surveys might have influenced residents' willingness to participate in this project and might have generated some cautiousness in answering questions during the interviews. It is unknown whether or not the demographics of the sample population (other than age, gender, and location) were representative of the entire group of elders 65+ at Harbor Point. For example, more than one-half of the interviewees had lived at Columbia Point and transferred into Harbor Point. Almost three-quarters of the elder sample were subsidized renters.

RECOMMENDATIONS FOR SENIORS COUNT AND AGING IN PLACE AT HARBOR POINT

Regarding *Seniors Count*

- **Clarify Referral Procedure of *Seniors Count* Outreach Program**

  The referral process seemed to generate confusion among some residents. Two-thirds of those who were designated as receiving referrals either did not know that they had received them or, if they knew they had received them, had not resolved them. During the outreach initiative when the volunteer identifies an issue for referral, he/she needs to communicate that to the interviewee and explain the process for beginning to resolve that issue. Printed material explaining the procedure and whom to call for each referral should be given to the interviewee. This material should meet language, literacy, and visual needs of the older adult. The training session for volunteers should stress the importance of the referral stage of the outreach program and reinforce the procedure. Role-plays should include the steps of making a referral.

- **Tailor Outreach Strategy to Match the Needs of a Particular Community**

  Some residents may not have received a bag because they were not home or because they did not answer their doors. No bags were left outside of doors. It was believed by the Harbor Point management and the Boston Commission that something left outside of a door would be unsafe, a "red flag" that no one was in the apartment. Since the outreach at Harbor Point was planned as a three-day event, those who were not contacted on the first or second day might have been phoned to request permission for volunteers to visit and deliver a bag of information.

- **Continue to follow 2003 recommendation for building timely follow-up studies into the *Seniors Count* program.**

  Follow-up within four to six weeks after a *Seniors Count* outreach effort may

reinforce information about available services and facilitate elders to comply with referral recommendations made during the initial visit.

Regarding Aging in Place at Harbor Point

- **Enhance Safety for Elders at Harbor Point**

  Fire Safety. Most elders reported that they felt "safe" or "mostly safe" in their apartments. Nevertheless few had specific fire plans. One-half of those who did not have fire plans used devices to assist them in walking. It is likely that they would need assistance to exit their buildings in the event of a fire or other emergency. It is important to review the fire evacuation plan for each building with elder residents in person and in writing when they move in and at least yearly. Fire drills should be part of this education process. Those who cannot follow the plan (bed- bound, physically too impaired to navigate stairs, visually impaired, mentally impaired) or cannot be alerted in an emergency (hard of hearing, deaf) should be identified, and a plan should be developed to address their needs. Work with the Boston Fire Department and the Elder Commission should be considered to develop plans further and to communicate those plans to the residents.

  Daily Checking System and Identification of Elders at Risk. Approximately one-third of all elders, inside and outside of the senior-designated building, reported that they had no one who regularly checked on their well-being. Also, one-third of those who lived alone had no regular checking system. No formal system of checking was identified for any of the apartment buildings in which respondents lived. Only those in the senior-designated building had emergency call pulls (monitored in the security office) in their bathrooms. A simple, unobtrusive, formal checking system could be instituted for those who are alone or living with an ill or disabled spouse, sibling, or adult child. With the permission of the elder resident, the security staff should maintain a list of elders who are particularly at risk from disease or disability.

  Adaptive Aids and Modifications to Apartments. The average respondents in this study have lived at Harbor Point for 12.5 years and are aging in place. Many relatively simple and inexpensive modifications can help people to maintain independence as they age. Programs to increase elder awareness of accident prevention strategies (eliminate throw rugs), possible modifications (grab bars, lever door handles, touch lights) and access to installation help should be developed. Those living outside the senior-designated building, who were less likely to have safety modifications in their bathrooms, should be considered priorities.

- **Provide Education Programs Targeted to "Seniors"**

  Computer Education Program for Older Adults. Although no respondents reported currently using the computer center, over 40% indicated that they would

like to use it in the future. Those who had experienced tutoring by college students in the past spoke favorably about it. A weekly computer education course at the computer center, developed specifically for older adults and advertised as elder-friendly might attract the elder residents of Harbor Point. www.Seniornet.org is a helpful resource.

Public Educational Program Promoting Oral Health. One-half of the respondents had not visited a dentist in three years or more. Over three-quarters of those who had not visited a dentist in that period of time wore dentures. Many indicated that without their natural teeth they did not need dentistry. This is a popular misconception about the maintenance of a healthy mouth, gums, and teeth in old age. Although this project did not address the cost of dental care, the literature targets lack of dental insurance as well as lack of education as primary to inadequate oral care. An educational program focusing on dental and oral care, as well as how to access it, is needed. The Elder Commission in cooperation with the Department of Public Health should be approached to work with the Harbor Point community to address dental care.

- **Build Community.** Many elders voiced the need for more social and civic (volunteer) opportunities within Harbor Point. Community activities can help elders avoid isolation, build social networks, and enhance quality of life. Activities that meet peoples' interests and needs can bridge differences and bring together elders inside and outside of the "senior building," elders who have lived at Harbor Point for many years and newly arriving elder residents, and older adults with people of all ages. Suggested activities are listed in Appendix D. Opportunities for intergenerational projects, like the computer mentoring by college students that has occurred in the past, would help to build positive relationships. Provision for transportation for elders to events within the Harbor Point complex may be helpful.

- **Expand Information about Supportive Services at Harbor Point and in Greater Boston.** Address language barriers and possible literacy barriers. Distribute information and announcements of events for older adults to all elders. Have events at the "senior" building and in other buildings. Provide transport within Harbor Point to those events.

- **Develop Action Steps.** The results of this project suggest that there is a need for stakeholders, that is, representatives from Boston Commission on Affairs of the Elderly, Harbor Point Management, Tenants' Task Force, and possibly the Boston Fire Department, to meet to develop action steps to address the safety needs of the most "at risk" older adults at Harbor Point.

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Appendix A

SENIORS COUNT PHASE III: AGING IN PLACE AT HARBOR POINT

CONSENT FORM FOR RESEARCH STUDY

You are being asked to take part in a research project designed to learn about elders who are living in their own apartments in the community. We are also following-up on information and referrals you may have received during the *Seniors Count* outreach effort conducted by the Commission on Affairs of the Elderly last November 2003. The project is also designed to learn about your experiences living and aging at Harbor Point and where the Elder Commission may be of assistance to you.

Contributing to this study will involve participating in an interview of approximately 30-40 minutes with Gerontology students from the University of Massachusetts Boston.

All information provided by participants will be kept confidential. Any information linked with your name will be seen only by the research team.

Your participation is completely voluntary. You may decline to answer any question. You may stop the interview at any time. Your responses will in no way impact services you are now receiving or prevent you from receiving services in the future.

I HAVE READ THE CONSENT FORM. MY QUESTIONS HAVE BEEN ANSWERED. MY SIGNATURE ON THIS FORM MEANS THAT I UNDERSTAND THE INFORMATION AND I CONSENT TO PARTICIPATE IN THIS STUDY.

_____	_____
Signature of Participant	Signature of Researcher
_____	_____
Printed Name of Participant	Printed Name of Researcher
_____	_____
Date	Date

Appendix B

Commission on Affairs of the Elderly

THOMAS M. MENINO
Mayor

JOYCE WILLIAMS
Commissioner

March 26, 2004

Dear Harbor Point Resident,

Last November, 2003 approximately 120 households at Harbor Point opened their doors to *Seniors Count* volunteers. Currently, the Commission on Affairs of the Elderly is asking researchers at the University of Massachusetts Boston Gerontology Institute to do a follow-up study to identify how well seniors' needs were met through the *Seniors Count* program efforts. If you were one of the many households we visited through *Seniors Count*, we are interested in knowing your satisfaction with the *Seniors count* visit and your thoughts about the service recommendations that were made on your behalf. If you were not visited by *Seniors Count* volunteers, we would like to take this opportunity now to learn about your experiences living and aging at Harbor Point and where the Elder Commission may be of assistance to you.

Your insights are very important to us. We hope that you will be willing to speak with the Gerontology students when they come to Harbor Point to carry out their follow-up survey. They will be on-site from 12:30 p.m. to 4:30 p.m. to conduct in-person interviews. The interviews should take about 30 minutes. They will take place on the following days:

- Wednesday, April 7, and Thursday, April 8
- Wednesday, April 14, Thursday, April 15, and Friday, April 16
- Wednesday, April 21, Thursday, April 22, and Friday, April 23

During the week of March 29 you will receive a phone call to set up an appointment for an interview. Your participation is completely voluntary. All information that you provide will be kept strictly confidential. You may decline to answer any question. Your responses will in no way impact services you are now receiving. UMass Boston Gerontology researchers will only share overall information with the Elderly Commission. The Commission will not be given any information that can be linked to you personally.

If you are unable to participate or would like your name removed from the list of Harbor Point residents to be interviewed, please leave a message for Dr. Nina Silverstein, Research Project Director at 617-287-7317 or e-mail Judith Conahan, Research Assistant, at jconahan@aol.com. We look forward to your participation in this study.

Sincerely,

Juanita B. Wade

Juanita B. Wade, Chief of Human Services

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Appendix C

Seniors Count Follow-Up
Spring 2004
Action Research

REFERRAL CODES

Referral code	Problem Group	problem description
Other	Other	Other
1	City Tax Exemptions	deferment
2	City Tax Exemptions	elderly
3	City Tax Exemptions	other/ general
4	City Tax Exemptions	survivor
5	City Tax Exemptions	veterans
6	Cultural	language
7	Cultural	other
8	Dental Problems	dental problems
9	Elder Abuse	care giver neglect
10	Elder Abuse	emotional
11	Elder Abuse	financial exploitation
12	Elder Abuse	physical
13	Elder Abuse	sexual abuse
14	Elder At Risk	addiction
15	Elder At Risk	dementia
16	Elder At Risk	loss of housing
17	Elder At Risk	medical
18	Elder At Risk	other
19	Elder At Risk	psychological
20	Fire Safety	batteries
21	Fire Safety	bed ridden
22	Fire Safety	hazard
23	Fire Safety	smoke detectors are missing
24	Fire Safety	other
25	Government Benefits	food stamps
26	Government Benefits	fuel assistance
27	Government Benefits	medicaid/masshealth
28	Government Benefits	medicare
29	Government Benefits	other/ SHINE
30	Government Benefits	pharmacy
31	Government Benefits	SSI
32	Government Benefits	veterans
33	Home Care	home health
34	Home Care	home maker
35	Home Care	money management
36	Home Care	nutrition Needs meal delivered
37	Home Care	respite
38	Utilities problems	Utility payments
39	Home Repair	grab bars
40	Home Repair	gutters
41	Home Repair	hand rail

Referral code	Problem Group	problem description
42	Home Repair	locks
43	Home Repair	general
44	Home Repair	painting
45	Home Repair	ramps
46	Home Repair	roof
47	Home Repair	steps
48	Home Repair	weatherizing
49	Home Repair	other
50	Housing	code violation
51	Housing	eviction
52	Housing	tenant law
53	Housing	vacant rentals
54	Intergenerational	intergenerational
55	Legal	legal
56	Neighborhood Issues	crime
57	Neighborhood Issues	lighting
58	Neighborhood Issues	other
59	Neighborhood Issues	parking
60	Neighborhood Issues	sewer
61	Neighborhood Issues	sidewalks
62	Neighborhood Issues	signs
63	Neighborhood Issues	snow removal
64	Neighborhood Issues	speeding
65	Neighborhood Issues	streets
66	Neighborhood Issues	trees
67	Medical	Medical general
68	Physical Disabilities	hearing
69	Physical Disabilities	mobility / escort
70	Physical Disabilities	other
71	Physical Disabilities	vision
72	Transportation Problems	medical
73	Transportation Problems	other
74	Transportation Problems	shopping
75	Work / Volunteers	work opportunities
76	Social Isolation	loneliness
77	Housing	information/other
78	Work / Volunteers	volunteer opportunities
79	Work / Volunteers	work opportunities
80	Neighborhood Issues	trash
81	Home Care	system for emergency response
82	Neighborhood Issues	cross walks -- paint
83	Fire Safety	evacuation
84	Health Maintenance	memory assistance

Appendix D

Description of Selected Services and Activities

Blood Pressure Screening – Monthly monitoring of blood pressure offered at the "senior-designated" building by a visiting nurse from a local community center.

Computer Center – Computers with web access available to Harbor Point residents on weekdays and Saturdays.

Exercise Classes – Twice-weekly sessions offered at the "senior-designated" building.

Friendly Visitor – Volunteers who visit elders in their homes on a regular basis providing primarily companionship and often available through faith-based organizations or area agency on aging volunteer programs.

Geiger Gibson Community Health Center – The Center, established in 1973, was one of the first community health centers in the United States. It is located on the periphery of the Harbor Point Apartment complex. Services include primary medical care (pediatrics, adult, geriatrics), women's health, urgent care, dental, optometry, mental health and smoking cessation.

Home Health Care – Provision of care by a variety of levels of trained nursing professionals. This includes skilled care ordered by a physician under the supervision of a registered nurse to personal care services by a home-health aide delivered through a variety of agencies.

Homemaker Service – Assistance with activities of everyday life such as food preparation, laundry, light housekeeping and shopping, subsidized through the Massachusetts State Homecare Program for eligible older adults or through private pay.

HOU (Housing Opportunities Unlimited) – "Resident Services Information Center" offering orientation to new residents, mediation/conflict resolution between residents, and assistance with housekeeping, budgeting, job search, voter information, substance abuse and/or mental health treatment, and resident issues. They also assist residents in dealing with outside agencies such as Social Security, housing, utility and transitional assistance. Elder services include monthly coffee hours, monthly blood pressure screening and limited transportation.

Kit Clark Senior Center – Kit Clark Senior Services, with two senior center locations, offer recreational and fitness activities, socialization opportunities and meals. They also have programs for adult day health, memory loss day care, health services (medical, mental and addiction counseling), food services, volunteer services, homemaker services, assistance for seniors with limited English, home repair, mental retardation and transportation.

Meals on Wheels – Home delivered meals funded through the Older Americans Act and distributed by senior centers and area agencies on aging.

Movie – Weekly video shown in the lounge of the "senior-designated" building.

Project Care and Concern – Faith-based multi-service center primarily serves low-income households, historically those households that transferred to Harbor Point from the former Columbia Point. Services include emergency food pantry, dinners for elderly, holiday baskets, food vouchers, weekly bread and pastry surplus distribution and youth programs. Elder services include transportation to doctor's appointments, home, hospital and nursing home visits, and advocacy with other agencies.

Shopping Bus – Grocery buses that pick up residents at the "senior-designated building" for shopping four days a week. On alternating days, one delivers residents to "Stop and Shop" and adjacent stores and the other to "Star/Shaws."

Swimming Pool/Fitness Center – This includes two outdoor swimming pools available to all Harbor Point residents from Memorial Day to Labor Day. Also there is a cardiovascular room with a treadmill, life cycles, rowing machines and ellipticals. There is a nautilus section and a free weight section. Yoga and Body Work (for strength and tone) classes are offered to people of all ages. There are no programs designed specifically for older adults.

Tenant's Task Force (Harbor Point Community Task Force, Inc.) – A resident elected, non-profit organization incorporated in 1978 that represents all residents in the Harbor Point community. It monitors all aspects of Harbor Point Apartment life, including maintenance, management, security and social affairs. This includes a concern for the appropriate provision of services for residents. It also includes a focus on providing "opportunities for resident involvement in community programs and activities."

Appendix E

What kinds of activities would you enjoy participating in at Harbor Point that may not be currently available?

Game night
Church
Bridge game
Fishing
Drawing and Painting
Group trips to theater/musicals
Book club
Cards/Pinochle
Sing-a-longs
Bowling
Bingo
Crocheting
Trips to sporting games
Walking club
Trips to country, around New England
Swimming
Art museums
Golf
Gardening
Planning activities for children
Arts and Crafts (Knitting, Ceramics)
Watch football
Trips to lunch

Figures 1 through 8

Figure 1. Self-Rated Current Health of Harbor Point Residents 65+: (n=50)

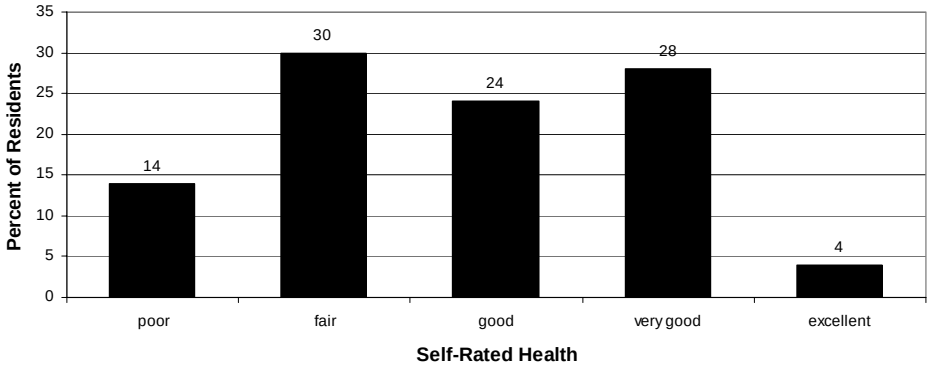


Figure 2. Devices Used When Walking by Harbor Point Residents 65+ (n=50)

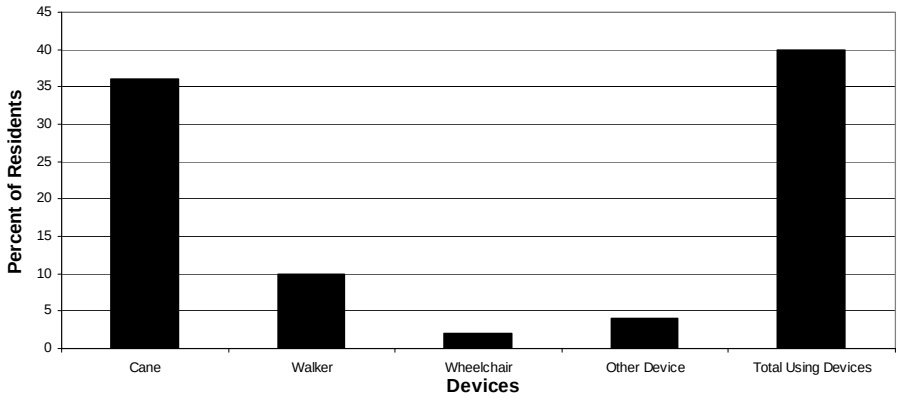


Figure 3. On a scale of 1 (least pain) to 10 (most pain), how would you describe your pain? (n=26)

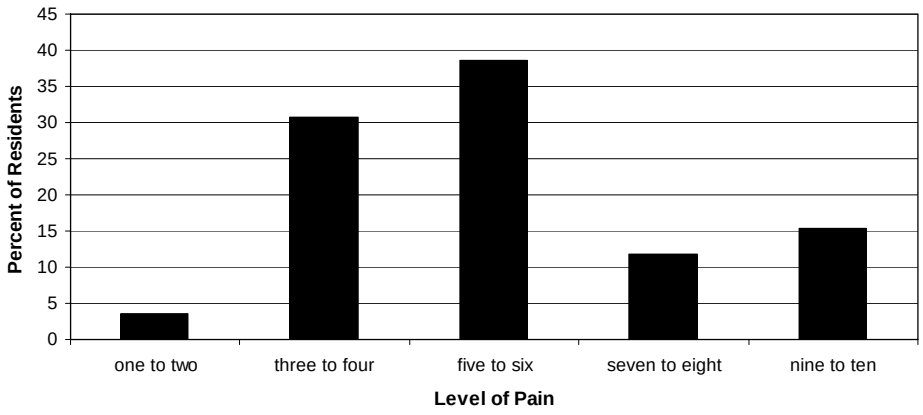


Figure 4. Perception of Community Friendliness Among Harbor Point Residents 65+ (n=50)

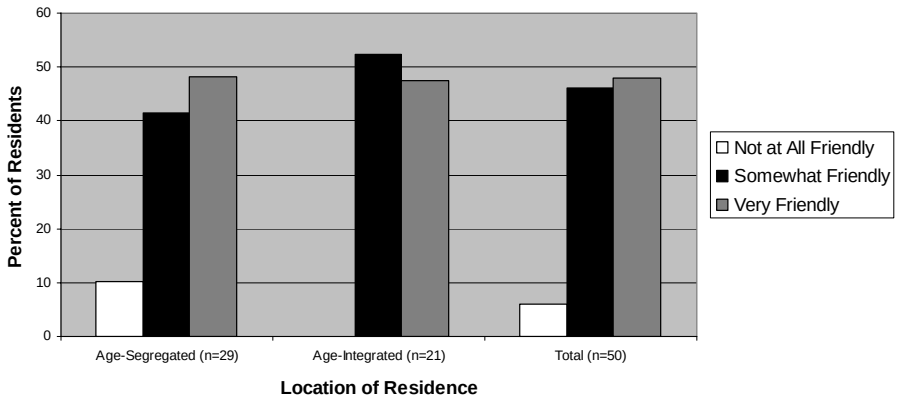


Figure 5. Perception of Safety Among Residents 65+ at Harbor Point (n=50)

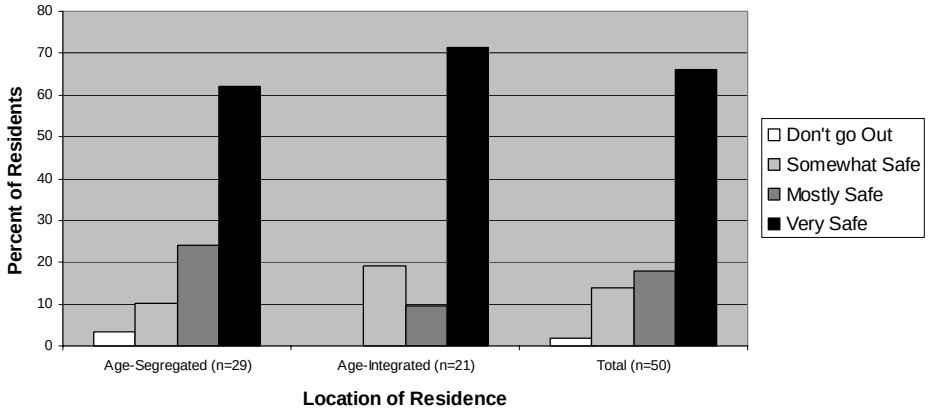


Figure 6. Presence of Safety Equipment in Bathrooms of Harbor Point Residents 65+ (n=50)

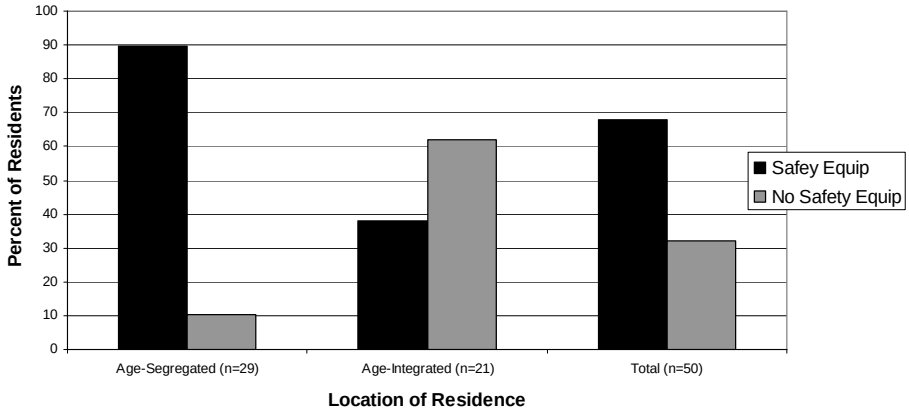


Figure 7. Fire Plan and Use of a Walking Device Among Harbor Point Residents 65+ (n=50)

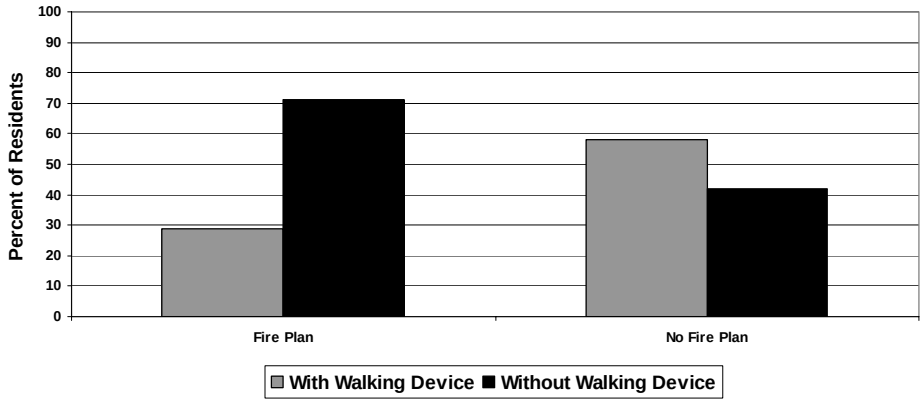
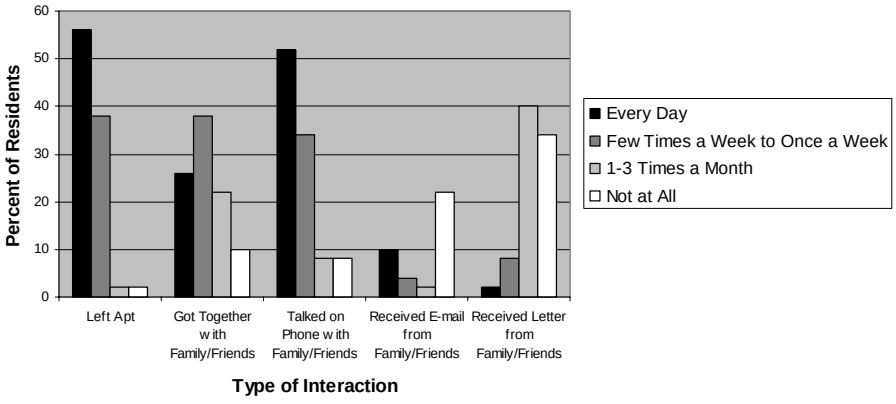


Figure 8. Frequency of Interaction with Family/Friends in Previous Month of Harbor Point Residents 65+ (n=50)



THE GERONTOLOGY INSTITUTE

University of Massachusetts Boston

The Gerontology Institute at the University of Massachusetts Boston addresses social and economic issues associated with population aging. The Institute conducts applied research, analyzes policy issues, and engages in public education. It also encourages the participation of older people in aging services and policy development. In its work with local, state, national, and international organizations, the Institute has three priorities: 1) productive aging, that is, opportunities for older people to play useful social roles; 2) long-term care for the elderly; and 3) economic security for older people. The Institute attempts to pay particular attention to the special needs of racial and ethnic minority elderly.

Established in 1984 by the Massachusetts Legislature, the Gerontology Institute is a part of the University of Massachusetts Boston. The Institute furthers the University's educational programs in Gerontology. One of these is a multidisciplinary Ph.D. program in Gerontology. Through the Institute, doctoral students have the opportunity to gain experience in research and policy analysis. Institute personnel also teach in the Ph.D. program.

The Institute also supports undergraduate programs in Gerontology. Foremost among these is the Frank J. Manning Certificate Program in Gerontology, which prepares students for roles in aging services. Most students are over 60 years of age. Each year the Institute assists this program in conducting an applied research project. An advanced certificate program is also supported by the Institute. Its in-depth courses focus on specific policy issues.

The Institute also publishes the *Journal of Aging & Social Policy*, a scholarly, peer-reviewed quarterly journal with an international perspective.

Information about recent Institute activities can be obtained by visiting the Gerontology Institute's web pages: www.geront.umb.edu or e-mail: gerontology@umb.edu

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Publications, Gerontology Institute
University of Massachusetts Boston
100 Morrissey Boulevard
Boston, MA 02125-3393
Call (617) 287-7300
Fax (617) 287-7080
E-mail: gerontology@umb.edu