

TOWARD A 21ST CENTURY CITY FOR ALL

PROGRESSIVE POLICIES FOR
NEW YORK CITY IN 2013
AND BEYOND

The Aging City

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Three elderly observers were sitting quietly in the front row at the Aging 2.0 Meet-Up in Lower Manhattan in late 2012. They were special guests of the subgroup of a popular networking organization for IT entrepreneurs and innovators with an interest in health care, aging, and technology. The community room at The Hallmark assisted living residence was filled with sharply-dressed business people and investors sipping Chardonnay and discussing the fine points of health IT, when moderator Stephen Johnston asked the guests from the residence to say a few words about themselves and how Aging 2.0 might cover future topics that would interest older adults.

"Well," began one gentleman, "I think you should do an event where you invite The Hallmark residents not as observers, but as presenters. This place is full of accomplished, brilliant people who have a lot to say and teach, and I think you'd learn a lot by listening to us."

He went on to explain that he and his two friends – all three in their 80s – were still publishing academic articles, teaching at a local college, and staying up to date on trends in medical research: "We have so much to offer, but very few opportunities to engage with people like yourselves." His two companions spoke in the same vein, their voices faltering a bit but their words clear as they described feeling marginalized and isolated, frustrated that they still had so much to contribute and so little opportunity to connect with the mainstream.

This episode underscores a central issue in aging policy today: older New Yorkers are breaking out of traditional roles and challenging economic, social, and public institutions to rethink their strategies, policies, and practices in light of demands from older adults for greater inclusion, mobility, influence, and impact. Today's "senior citizen" turning 65 is entering a phase of life that will likely last 20 years or more, with ambitious expectations of physical and mental capacity, economic and social productivity, and civic and cultural engagement.

Increasingly, older New Yorkers plan to continue working past the traditional retirement age, remain living in their homes longer than prior generations, take charge of their health and wellness, participate fully in social, political and community activities, and continually advance their personal development. An aging policy for all, then, must meet these individuals in the myriad settings where they seek to thrive and

contribute, and must align public and private resources to support their constructive engagement as agents in successful and active aging.

At the same time, we must recognize the critical needs of tens of thousands of frail elderly, many of them home-bound and socially isolated, who depend on social services, meals, and neighborhood-based programs to be able to remain safe and independent in their own homes. A caring and comprehensive policy approach will preserve and enhance services, case management, and caregiver support for the most vulnerable, while simultaneously enabling all older adults to achieve their maximum potential.

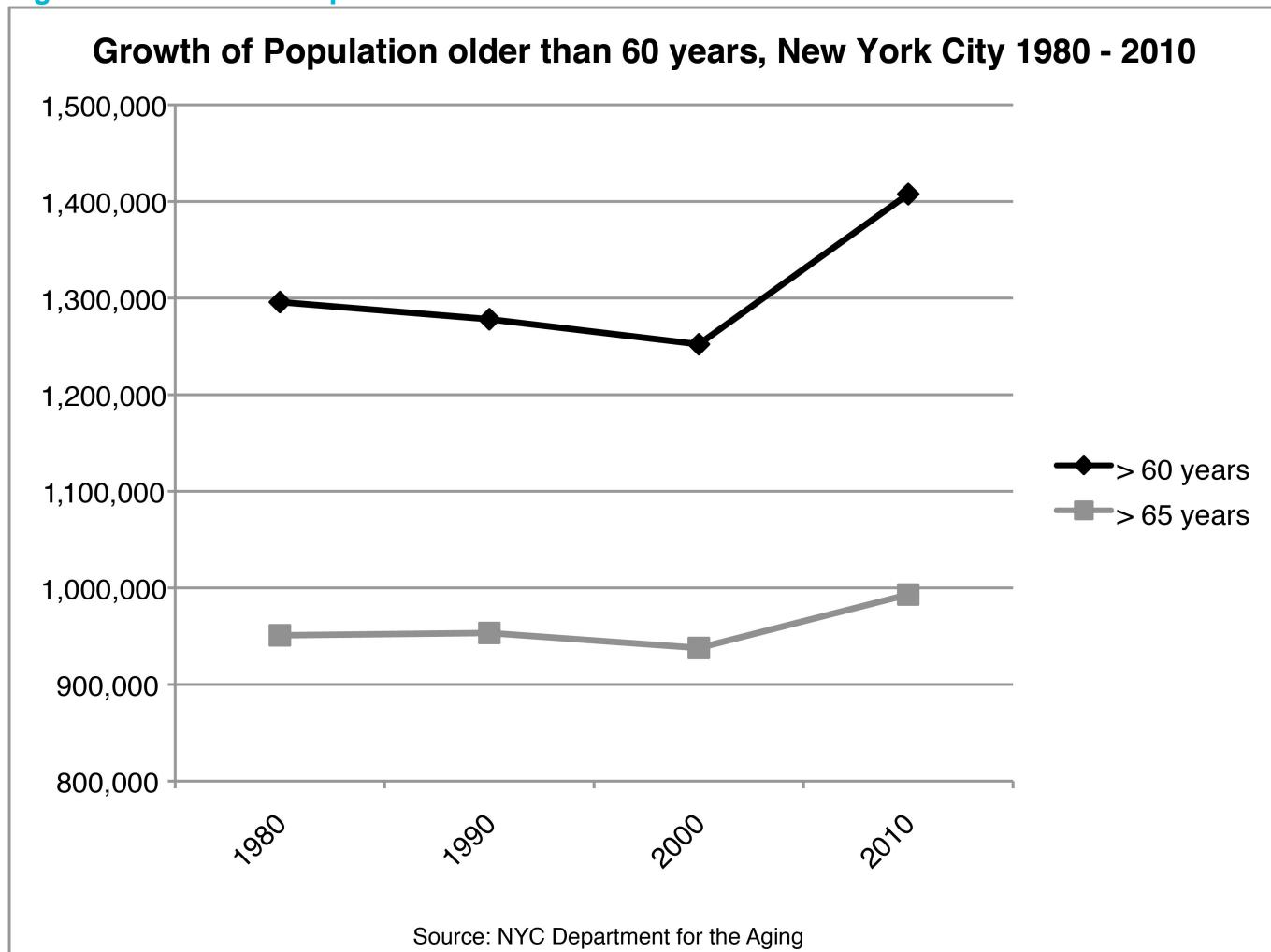
A strategic orientation is needed to meet these complex challenges that crosses sector, agency, regulatory, and institutional boundaries to invest scarce public and private resources for maximum impact. It must support older adults as agents in their own success, while also providing critical services for the needy and frail.

1. Current City Policy Framework and Proposed Shift

Our policy approaches to the aging of our population have lagged behind the seismic shift in its composition. Three trends converge to create this shift: people are living longer (life expectancy increased from 70.8 in 1970 to 78.7 in 2010); the falling birth rate (the U.S. birth rate is 14 per 1,000 women, down from 23.7 in 1960) means an ever increasing proportion of the population is old; and the “baby boomers,” the largest cohort in U.S. history, have begun to reach age 65. The sum effect of these trends is driving the over-60 proportion of our population rapidly upward; this growing segment of the population also has higher expectations about their “third age.” This dynamic applies equally to New York City, where the number of seniors increased by 150,000 over the past decade and will grow even more rapidly in the next.

National and local policy assumptions and priorities toward the aging are severely outdated. Current statutory retirement ages and pension plans were all designed in an earlier era with different assumptions about life expectancy (and the quality of life and health for older adults). Similarly, each of the “buckets” of health services and their financing and central purpose is out of date. Beliefs that prevention and early intervention should dominate in pediatrics, acute care for intermittent illness dominate for adults, and long-term care dominate for older adults are outmoded. Prevention and early intervention (both lifestyle and clinical) are now recognized as critical throughout the life course. The prevention and management of chronic conditions are principle health challenges of the adult years, yet models of health services financing and delivery designed for this are just beginning to be adopted.

Medicare as currently configured and financed is unsustainable because it was designed to solve a different problem in a different time (reimbursing hospitals to care for people during their short retirements). Medicare must actively transform (as it is beginning to do) into an integrated wellness-producing system, emphasizing primary and secondary prevention and integrated care. Nothing, however, is more broken than our long-term care system, which is currently an inadequately financed patchwork of health and social services, backstopped by long-term institutional care, a service framework least desired by older adults and most expensive to public and private payers.

Figure 1: Growth of Population Over 60 Years

The issues – income support and health services for retirees (Social Security, pensions, and Medicare) – that dominate the policy discourse on aging are predominantly federal issues. States have critical roles to play filling gaps in the federal social insurance structure, and New York State has historically been a leader in providing income support and Medicaid coverage to people far beyond what is required and reimbursed by the federal government. It is a period of transformation and uncertainty in these services as concurrent policy initiatives and trends drive in different directions. And while New York City has a significant population that is uncovered by federal programs due to their immigration status, planning to fill gaps in services and financing is a challenging task in the face of rapidly changing economic and policy frameworks.

At the local level, advocacy to preserve senior centers and the other Department for the Aging-funded services, including home-delivered meals and a (non-Medicaid) case management program dominated the policy discourse on aging prior to 2008. These programs have been funded at between \$219 million and \$236 million over the last twelve years, much of the money coming from the federal Older Americans Act and smaller state programs. City tax levy investment has ranged from \$145 million to \$181 million, declining over the period. Given the growing prominence of the senior citizen population, the well-documented benefits of investing in senior services, and the range of program opportunities (for health, workforce, social engagement, transportation, etc.) available, this level of public funding counts as severe underinvestment in a \$67 billion city budget. The 218 Department for the Aging (DFTA) senior

centers provide social engagement opportunities as well as a meal and some services linkages. In doing so, these senior centers reach a few older adults (an estimated 2.5 percent of older adults are in a senior center on a given weekday while 15 to 20 percent of older New Yorkers are reported to have been in a senior center), providing a limited set of activities that address specific dimensions of life.

In 2008, with support from the mayor and City Council, the New York Academy of Medicine launched the Age-friendly New York City initiative, joining more than 100 cities across the world that are participating in the World Health Organization's (WHO) Age-friendly Cities program, in which cities assess their current friendliness toward the aging population and develop an implementation plan to improve the environment based on the information from older adults themselves.¹ The WHO program identified eight domains as essential urban resources for older adults worldwide: housing, transportation, community support and health services, communication and information, outdoor spaces and buildings, social participation, respect and social inclusion, and civic participation and employment. Results from New York City's assessment, including those from community forums, focus groups, interviews, feedback forms and expert roundtables, are helpful in describing how the city's characteristics affect people as they age.

When The New York Academy of Medicine consulted with thousands of older adults about their daily lives (in all five boroughs, in six languages, and in meetings large and small, including the homebound and people with mental and physical health challenges), a new understanding of older adults (with different priorities) emerged. People spoke passionately about their love for New York City, their antipathy to leaving it (many told tales of failed transplantation to be near their children elsewhere and grateful return), their deep and textured connections to their neighborhoods. They also spoke about their other communities – built from professional and occupational ties, communities of faith, identify, and interest – and their challenges in maintaining those ties as they age. After a year of consultation, the core finding was that people wanted to continue to be themselves as they age, but they face challenges in doing so. This realization must be at the core of a new approach to aging policy – one that enables older adults to engage constructively with their own processes around aging and to help them overcome barriers that may exist to their success.

2. Status Report: Older Adults in New York City

Demographics

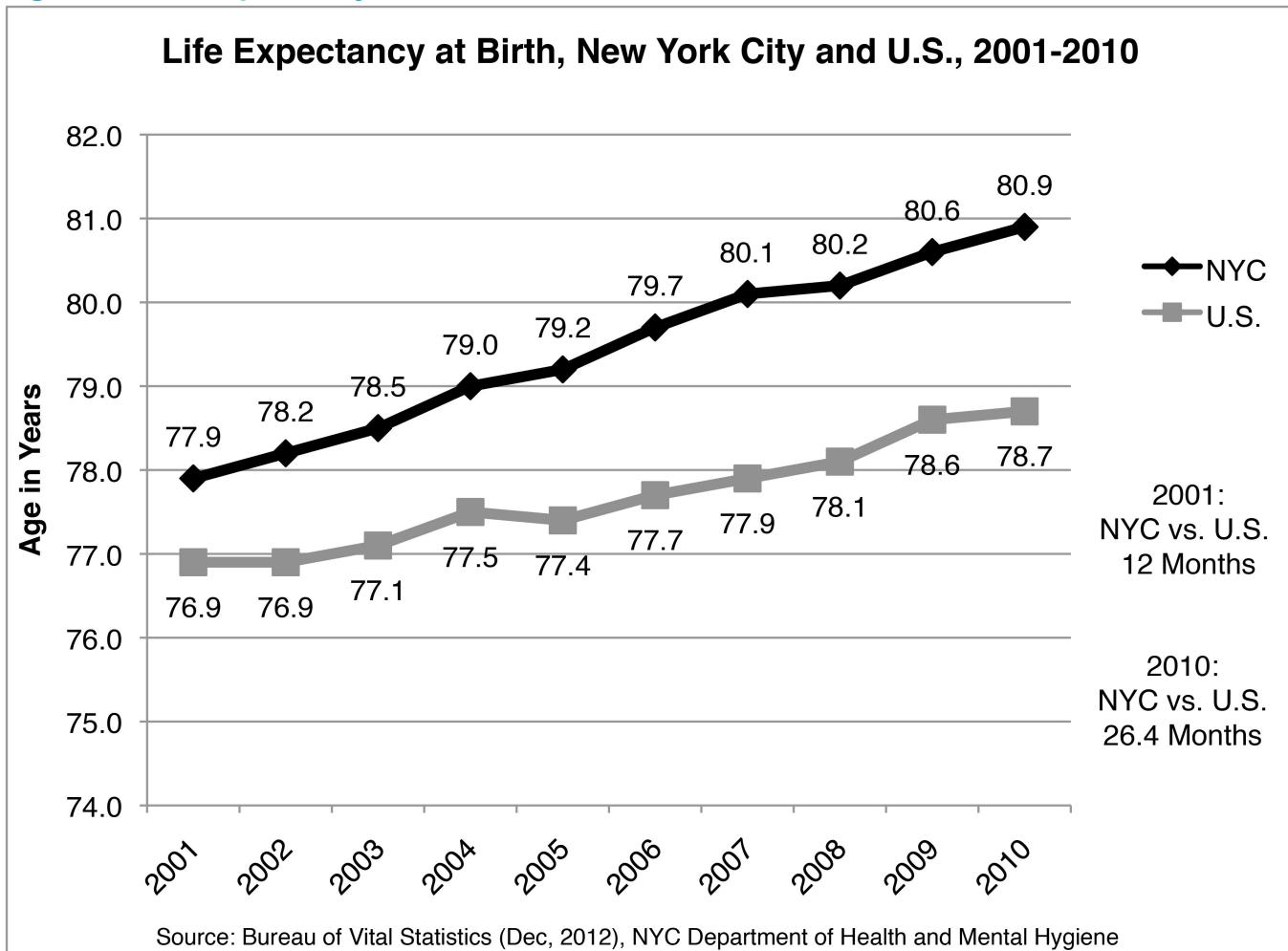
New York City's older population is growing and growing older. More than 1.3 million people, or 16 percent of New York City's inhabitants, are currently over 60 years old.² It is expected that by 2030, this age group will increase by nearly 500,000 to 1.8 million people, outnumbering school-aged children for the first time in history. Older adults are distributed similarly to the overall population throughout the city, with Queens and Brooklyn being the city's most populous boroughs, each having approximately 30

¹ New York City's participation was a joint initiative between the office of the mayor and City Council and the New York Academy of Medicine (NYAM). More information about the initiative is available at <http://nyam.org/agefriendlyNYC>.

² Except as noted otherwise, the source of all data in this section is DFTA's analysis of the 2005-2007 American Community Survey (ACS) three-year estimates.

percent of New York City's seniors. Manhattan, the next largest borough, has 20 percent of the city's seniors, the Bronx has 14 percent, and Staten Island has just 6 percent.³

Figure 2: Life Expectancy at Birth, NYC and the US



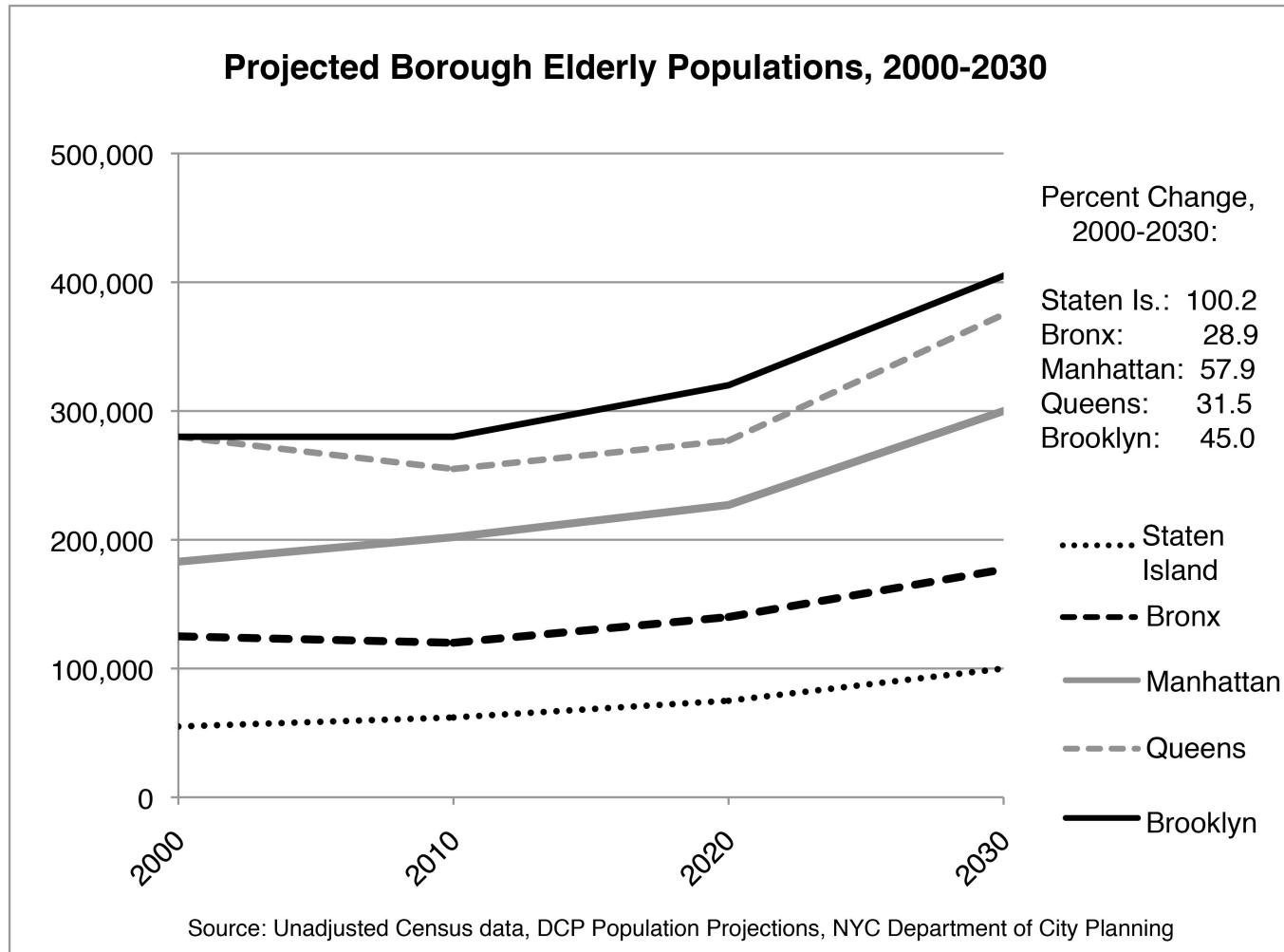
Like the city as a whole, New York's older adults are a diverse group. They speak an estimated 170 languages, and 44 percent are foreign born. While the vast majority of those who were born in another country (93.5 percent) have lived in the United States for more than ten years, only 56 percent of all New York City's seniors report using English as their primary language. The remaining language breakdown is as follows: 19 percent speak primarily Spanish, 5 percent use Chinese, 4 percent speak Russian, and 4 percent communicate in Italian. French Creole, French, and Greek, along with a multitude of other languages, make up the balance.

Across the city, about 46 percent of those aged 60 and older identify as white; 21.1 percent identify as black; 19.5 percent identify as Hispanic; and 9.1 percent identify as Asian/Pacific Islander. Older adults of these self-identified racial groups are clustered in certain boroughs and neighborhoods. Of the city's senior population who identify as black, Brooklyn has 41.8 percent; Queens has 24.9 percent; the Bronx 18.7 percent; Manhattan 13.4 percent; and Staten Island 1.2 percent. Of those who identify as Hispanic, the Bronx, Brooklyn, Manhattan, and Queens share relatively equal percentages. Of those

³ "Older adults" refers to people over the age of 60 when data comes from the ACS and in general in this report, because it is the age DFTA uses to determine eligibility for senior centers. Several other data sources use age 65 as a cut-off point, as that is the age when people become eligible for federal benefits like Medicare and Social Security.

who identify as white, almost 34 percent live in Brooklyn, while just 8 percent live in the Bronx. And while the Bronx has just 5.1 percent of those who identify as Asian/Pacific Islander, Queens has 48.1 percent of New York City's seniors who identify with that group. Brooklyn Community District 16 (Brownsville) and four community districts in the Bronx hold a percentage of whites so small that it is statistically zero percent.

Figure 3: Projected Elderly Population by Borough



Shifting to education levels, approximately one-third of New York seniors (36.5 percent) have some schooling beyond a high school diploma. Manhattan has one of the most educated senior populations in the country, with 40 percent holding a bachelor's degree, which is nearly double the national average. Despite this, stakeholders' accounts and statistics show that a large portion of the city's population of older adults does not understand basic written English instructions. According to the U.S. Department of Education, Queens has the lowest literacy rate in the city, with 46 percent of adults of all ages lacking basic prose English literacy skills (U.S. Department of Education 2003). This is followed by the Bronx (41 percent), Brooklyn (37 percent), Manhattan (25 percent), and Staten Island (14 percent).⁴ New York

⁴ These percentages are strongly connected to the percentage of non-English language speakers living in each borough, but also include native English speakers who are illiterate as well as adults who speak a language other than English, but are unable to read or write.

City's older adults have a range of work histories, which in turn affect their current income level and assets, their access to benefits, their lifestyle and interests, their social and community connections, and their overall health. Some had careers spanning decades. Others worked jobs on and off, or worked in the underground economy. Statewide, 17 percent of those ages 65 and older continue to work at least part time. In the greater New York City area, 73 percent of older adults over age 60 receive Social Security benefits, which is less than the national average of 80 percent.⁵ In the same region, only 37 percent receive private retirement income of some kind, also less than the national average, which is 46 percent.

Participants participating in the Age-friendly New York City initiative emphasized over and over that poverty among older adults is overwhelming in many of the city's neighborhoods and permeates even the wealthiest community districts. Statistics support these observations. According to the ACS, nearly 18 percent of those aged 60 and over in the city live at or under the federal poverty line, which in 2009 was defined as \$10,830 of annual income for a single-person. When the expenses and benefits particular to New York City are used to calculate poverty, the number of those aged 65 and over living in poverty becomes nearly 32 percent.⁶

Every community district has at least 2,000 older adults living in poverty, but the concentration of poverty ranges widely across the city's neighborhoods. Large concentrations of older adults living in poverty are particularly present in the Bronx, Brooklyn, and Manhattan. The Greenpoint-Williamsburg area of Brooklyn has the highest percentage of older adults living in poverty in the city (63 percent). The eastern-most community district of Queens, which includes Queens Village and borders Long Island, has the lowest percentage of older adults living in poverty (16 percent).

Health outcomes

As people age, they develop new and more severe health problems, and existing chronic health conditions often become more difficult to manage. The prevalence of severe health problems and chronic health conditions is also not evenly distributed throughout the city. The burden falls on neighborhoods with the highest levels of poverty. Poverty is both an underlying cause and an effect of the disproportionate distribution of health problems and disabilities.

Data indicate a high need for community-based prevention for older adults. New York City's Community Health Survey (CHS) found that 38 percent of older New Yorkers are overweight and 22 percent are obese. In addition, 9.7 percent of older men and 8.2 percent of women smoke, and 65.9 percent of participants in a 2009 Health Insurance Plan (HIP) study said they never engage in even moderate physical activities. All of these behaviors are strongly associated with chronic health conditions, including heart disease, diabetes, cancer, and arthritis. In addition, the CHS found that 17 percent of older adults in New York City are socially isolated, which has been shown to be a risk for lower general

⁵ The "greater New York City area" referred to in this report is the ACS NY-NJ Metropolitan District, which includes all New York City counties as well as Putnam, Westchester, Rockland, Bergen and Hudson counties, in short, the greater New York City area, excluding Long Island.

⁶ The New York City CEO poverty calculations adjust for income from benefit programs such as Earned Income Tax Credit, food stamps, housing support; and subtracts for expenditures such as medical out-of-pocket expenses, food, clothing, shelter, utilities, tax liabilities as well as work-related expenditures, such as transportation costs and childcare. These are calculated at the rates paid in New York City rather than on national averages, taking into account local differences such as housing costs, and it uses ACS data in its calculation. In 2008, the CEO poverty line for a single-person household is \$12,114.

health, mental health issues, and failure to get care for chronic conditions. Overall, 36 percent of those aged 60 and over living in the greater New York City area experience a disability of some kind. Twenty percent are frail – meaning they have difficulty caring for themselves or leaving their homes unaided.

The CHS found that 56 percent of those aged 65 and older have diagnosed hypertension, the major underlying cause of strokes and heart attacks.⁷ The rate of diagnosed hypertension among blacks was 10 percentage points higher than any other ethnic group. Rates of diagnosed hypertension also vary widely between neighborhoods. For example, 39 percent have been diagnosed with hypertension in the Upper East Side and Gramercy as compared to 70 percent in the South Bronx, Northeast Bronx, Bed-Stuy, Crown Heights, and East New York.

The CHS also found that 23 percent of seniors over age 65 have been diagnosed with diabetes, which is a significant portion of the population, but on par with the national average. Twenty-six percent of men are diagnosed as diabetic and 21 percent of women. Only 17 percent of those identified as white are diabetic, whereas 31 percent of blacks and 32 percent of Hispanics over 65 have been so diagnosed. Diabetes is also more prevalent in poorer communities. The Upper East Side and Gramercy, for example, report a diabetes rate of only 8 percent, but the South Bronx reports a diabetes diagnosis rate of 42 percent.

These high rates of chronic conditions are especially worrisome since data indicate that many older adults are not accessing primary care and preventive services. Citywide, CHS data show that nearly 12 percent of New York City's population aged 65 and older does not have a regular primary care provider, a key to preventative health care. Twenty-six percent of Hispanics do not have one. CHS found that overall 6.1 percent of those aged 65 and older did not get needed medical care in the last 12 months. Additionally, those 65 and older experience a high rate of preventable hospitalizations. The statewide Planning and Research Cooperative System (SPARCS) data reveal that during 2006, total preventable hospitalizations in this population were 69,832, or 70.5 per 1,000 seniors, with 1.15 women hospitalized for every man.

Vision loss is widespread in the aging population, but no population-based data on prevalence in New York City was available to the authors of this report. Most blind adults lose their sight during adulthood from disease, in particular age-related eye diseases such as glaucoma, cataracts, age-related macular degeneration, and diabetic retinopathy. Partial, progressive vision loss, which affects far more people than blindness does, often also has a substantial impact on daily activities and well-being. Across the country, 18 percent of people over age 70 have a vision impairment, and 92 percent, almost the entire population, use corrective lenses (CDC 2006, Heine and Browning 2002, Maylahn and Melnik 2008, Prevent Blindness in America 2008, Zuckerman 2004).

Since preventing vision loss is most achievable through early intervention, services to promote vision care are imperative. Not all are getting this care. Among those living in New York State in 2006, 36.7 percent of those aged 60 to 69 had not visited an eye care professional during the last year (Maylahn

⁷ These percentages are limited to diagnosed conditions self-reported in the CHS phone survey. They do not capture conditions likely to exist, but conditions that remain undiagnosed because of insufficient access to health and medical care. While Medicare and Medicaid give older adults greater access to health services than their younger cohorts, rates undiagnosed disease or insufficient access to or utilization of primary and preventive health care remains a problem, as evidenced by the data on preventable hospitalizations that follows.

and Melnik 2008). Brookdale HIP research found that 70.1 percent of those participating in New York City senior centers reported having an eye exam within last year. Another 17.1 percent had one within the last two years.

Hearing loss is widespread and often unidentified and untreated among older adults. The most relevant and startling data come from the Center for Hearing and Communication, which conducted a mobile senior hearing program from 2000-2004 under the auspices of DFTA. During the four years that the program operated directly under DFTA, almost 3,200 seniors received hearing screenings. Of those screened, no individual had a previous test and none had hearing aids, but about 62 percent failed the screening. Among those who failed, almost 1,000 seniors received complete audiological evaluations. Results showed that about 72 percent of those actually had a hearing loss that required treatment, including 450 seniors who had bilateral mild to moderate hearing loss (meaning that they miss as much as 50 percent of what is said in a group setting, in restaurants, and meetings) and 180 seniors had more severe hearing loss.

The state's Office of Mental Health estimates that one in five of New York City adults aged 55 and over experience a mental disorder of some kind, mirroring the national average estimated by the U.S. Surgeon General (HHS 1999). From year 2000 to year 2030, the number of adults over 65 in New York State with mental disorders is expected to increase by 50 percent from about 500,000 to 775,000, both because the population is growing and because the population itself and the environment are changing (HHS 1999).

Dementia is a tremendous concern for older adults, with prevalence of dementia doubling every five years after age 60, until it is nearly 40 percent for those aged 85 and over. With Alzheimer's disease specifically, an estimated 50 percent of those diagnosed also show serious depressive symptoms and 30 percent of those diagnosed have anxieties, including generalized anxiety, fear of leaving home or of changes in routine, and suspiciousness, sometimes to the point of paranoia (Friedman, Kennedy and Williams 2009).

As with the general population, depression is the most highly diagnosed mental health disease affecting older adults. New York City's Community Health Survey (CHS) found more than 13 percent of those aged 65 and over were diagnosed with a depression at some point in their life. The Brookdale HIP survey also included questions to capture current symptoms of depression and found nearly 25 percent of their respondents experienced mild to moderate symptoms of depression.

Employment

Older adults identify employment (part- or full-time) as extremely important to their ability to live a secure and rewarding life. In an economic climate far more favorable than that of today, many adults of 'retirement age' found the prospect of full retirement to be neither financially viable nor personally desirable. It is not surprising, then, that a majority of adults ages 55 to 64 intend to remain in the workforce beyond traditional retirement age (MetLife Mature Market Institute 2006, Towers and Perrin 2005). For many, financial concerns are primary and reflect the erosion of worker-friendly policies (e.g., defined benefit plans or retiree health benefits), low saving rates, and the decline in housing, 401k, and stock market values. Although older adults are healthier, better educated, and living longer than

previous generations, many doubt their ability to support extended retirement periods (DeLong 2006, DeLong and Zogby 2007). In addition to meeting financial needs, work serves other non-economic, but equally important functions. Many aging baby boomers derive their sense of identity and self-worth from work, and depend on work to remain socially engaged, productive, and mentally active (Toossi 2004, Toossi 2007). Being active and socially engaged, in turn, has positive effects on the health and well-being of older adults.

Job dislocation, prolonged unemployment, and/or exclusion from the labor market present significant health risks to older adults, many of whom already have one or more chronic diseases. Low income, a major risk factor for ill health, has been shown to impact interpersonal and family health as well as the health of the displaced worker (Krieger et al. 2011). All too often, job loss is accompanied by the loss of health insurance (for those under 65), and can lead to inadequate or delayed treatment-seeking, inappropriate use of urgent care facilities, and overall worsening health. Other health risks associated with or worsened by unemployment include social isolation, depression, interpersonal stress, and domestic violence (Krieger et al. 2011). Clearly, the unemployment situation among adults ages 55 to 64 presents a critical public health challenge.

Unfortunately, this age group has been one of the hardest hit by changes in the economy and the current recession. Length of time to re-employment grew disproportionately longer for adults 55 to 64 compared to younger age-groups in the 1990s. The trend is more pronounced today. As of January 2011, time spent searching for work was almost 45 weeks for workers ages 55 to 64, more than twice as long as entry level workers ages 22 to 24. The employment-to-population (EPOP) ratio directly reflects the number of job holders relative to the workforce population (ages 16 to 64), and includes discouraged adults who dropped out of the labor market. According to the EPOP, only one-third (33.4 percent) of the working population ages 5 to 64 currently hold a job compared to younger age groups with EPOP ratios of 65 percent or more, which strongly suggests that older adults have far fewer opportunities to enter or remain in this soft labor market compared to younger colleagues.

Underserved populations, special interests, and special needs

While each person has a unique combination of attributes and there is wide variability within the following groups, these groups are repeatedly identified as benefiting from particular consideration in planning and services. These include several groups described above: immigrants, those with sensory impairments, those with mental illness, and those with low-levels of literacy. Lesbian, gay, bisexual and transgender adults have historically not been counted as special needs populations and are therefore statistically difficult to describe, but they also have clear special needs.

As already stated, nearly 44 percent of those aged 60 and older in New York City are foreign born. Although the majority of this group has lived in the United States for more than ten years, some members of this population retain attributes that make them more vulnerable and their needs different from their nonimmigrant counterparts. Key factors that cause differences in need include cultural perspective, language differences, geographic distance from community and family, and limited access to benefits, services and opportunities, depending on immigration status.

Access to many government services and benefits requires permanent residency and, sometimes, citizenship. Some of New York City's older immigrants do not fall into either of these categories. For example, an estimated 16 to 20 percent of New York City residents aged 65 and older lacked Social Security or Medicare coverage (Gray et al. 2006). Some are in this category because they did not work in the United States long enough to qualify for these benefits, and others worked "off the books" or in the informal sector. Research found that only after immigrants had lived in the United States for 50 years were they as likely as native citizens to report receiving Social Security income (*Ibid*). This is particularly concerning for Asian American older adults in New York City, nearly all of whom came to the United States in middle or late-middle age, according to the Asian American Federation of New York and the Brookdale study.

Older adults participating in the Age-friendly New York City community forums repeated what researchers have found: older immigrants especially feel that they are not well-informed and do not understand social welfare and public services here, especially when they do not understand English. Others commented that information and activities must become more accessible to a wider group of older people by making them available in various languages and through the use of translators.

Literacy and technology literacy are also critical special needs for many older adults. Thirty-six percent of all adults in New York City lack basic prose literacy skills, according to the U.S. Department of Education. Queens has the lowest literacy level, with 46 percent of adults lacking basic English literacy skills, followed by the Bronx with 41 percent, Brooklyn with 37 percent, Manhattan with 25 percent, and Staten Island with 14 percent. While some agencies have made information and applications for benefits and services more accessible and easier to read, this work remains far from complete.

Similarly, older adults have limited access to and understanding of computers and the Internet, compared to younger generations. According to the Pew Internet and American Life Project, barely half (53 percent) of seniors over age 65 and 34 percent of seniors over age 75 are using computers compared to 77 percent of people ages 50 to 64, 91 percent of those ages 30 to 49, and 97 percent of 18 to 29 year olds. In addition to lagging behind in adopting these technologies, older adults report having fewer skills and are less confident in their abilities to use computers than younger cohorts. According to a study commissioned by the New York City Economic Development Corporation, only 5 percent of senior-headed households in NYCHA have internet access (a rate twelve times lower than younger NYCHA households). Many stakeholders in the NYAM report felt that the lack of computer ownership and training are critical obstacles for seniors, given that essential life activities such as social engagement, health care, finances and commerce, and workforce development are all increasingly mediated through technology.

Finally, LGBT older adults are a key constituency that requires support and services. A March 2010 report authored by the Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) outlines three broad reasons LGBT older adults' have different needs than their heterosexual peers: first, is the stigma associated with lesbian, gay, bisexual and transgender identities, particularly among the elderly; second, is their generally greater reliance on friends or community members rather than biological families, which evidence shows are more likely to assist with long-term care; and third, is their unequal treatment under laws, programs and services, which prioritize legal and biological family. For New York City's LGBT seniors, social isolation is a pressing problem. LGBT older adults are less

likely than their heterosexual contemporaries to have children and more likely to live alone, increasing their need for social support outside of their biological family (Pearlberg 2004). The need for culturally competent health, mental health, and social service providers is acute (Frazer 2009, NYAM 2008, New York City 2009, Pearlberg 2004).

LGBT older adults often need particular help with end-of-life planning, wills, and legal matters. Families of choice and partners often have no legal standing in healthcare or inheritance without specific legal arrangements. LGBT older adults are not eligible for a long list of benefits granted to heterosexual peers including: spousal and survivor benefits under Social Security, spousal impoverishment protections under Medicaid, spousal inheritance of tax-qualified retirement plans and employee-sponsored pensions, exemptions from estate taxes for surviving spouses, and veterans' benefits given to heterosexual spouses. Despite New York State's recent recognition of same sex marriage, same-sex couples also face a number of legal and attitudinal barriers in planning for maintenance of housing, assisted living or long-term care, especially institutional care, where their partnerships may be unrecognized or even prohibited.

3. Status Report: Existing Services and Resources Available to Older Adults

New York City is the largest city in the country in population. It is often considered the financial, media, cultural, and international capital of the United States, and has historically been the welcome gate to millions of immigrants from across the world. As such, the city has an enormous base of resources available for its citizens. The city's strong neighborhoods; social support system; health care system; cultural, educational and religious institutions; non-profit organizations; philanthropies; businesses; parks; and transportation system create the potential for New York City to be an ideal place to age.

The city's network of senior centers overseen by the Department for the Aging (DFTA) provides meals and services to seniors in all five boroughs. The centers offer a place for socialization, nutrition, and access to services for 25,000 seniors daily and in recent years have been the focus of several initiatives designed by DFTA to improve efficiency, modernize services, and support innovation. In 2013, DFTA funded ten new "Innovative Senior Centers" as part of a program to provide enhanced services at higher-capacity centers and expand support to include underserved populations such as LGBT seniors and seniors with vision impairment. These efforts complement other services provided by DFTA such as home-delivered meals for the frail elderly and job training for unemployed individuals. At the same time, DFTA is chronically under-funded from the city budget and must steward very limited resources in an annual struggle to keep existing senior centers from closing due to budget cuts. Since 2011, DFTA has been forced to close at least 29 senior centers, and many centers would not survive without significant annual donations of in-kind space, services, labor, and supplies.

Neighborhoods and housing

New York City has some of the most expensive housing in the country, and many of the housing situations of older adults are shaped by a complex web of rent stabilization and control guidelines and public housing programs. While 48 percent of New York City's elderly own their homes (a higher

percentage than the general population), among those who rent, 50 percent are protected by either rent control or rent exemption.

Government-subsidized and government-run housing units – some specifically for the elderly, some open to anyone – are some of the greatest assets for the poorest of New York City’s older adults. Categories include adult homes, which provide long-term residential care, including personal care and meals; public housing built and managed by New York City Housing Authority (NYCHA), which include 42 developments designed for the elderly; Mitchell-Lama housing; U.S. Department of Housing and Urban Development (HUD) funded Section 202 housing for low-income seniors, with 170 projects in New York City; and the federally-funded Section 8 Housing Choice Voucher Program. Conditions in these buildings vary widely, from new construction, on-site security and social service workers to buildings, which are in dire need of repairs.

Outside of housing specifically for older adults, New York City is home to many naturally occurring retirement communities (NORCs). These are apartment buildings, complexes, or small neighborhoods that have developed over time as areas where significant populations of older adults live. A NORC is a unique housing model, which began in New York City in 1986, was formalized in 1999, and allows older adults to live in the community or age in place, rather than in an institutional setting by bringing shared social, health, personal care, and other services into the community. According to the United Hospital Fund, there are 43 NORC programs in New York City. Of those, 29 are funded by DFTA and another 10 are funded through New York State. Many NORCs also receive private contributions.

New York State-funded programs that help older adults remain in their homes include the Home Energy Assistance Program (HEAP), the Weatherization Referral and Packaging Program (WRAP), the Senior Citizen Homeowners’ Exemption (SCHE), and School Tax Relief Program (STAR). At the city level, a number of initiatives are aimed at making housing more affordable for low-income families in general and for seniors in particular. The Senior Citizen Rent Increase Exemption (SCRIE) prevents some or all rent increases for those aged 62 and older whose incomes are less than \$29,000 per year. The Home Improvement Program (HIP) of the Department of Housing Preservation and Development (HPD) works with private banks to provide home improvement loans at reduced rates to small homeowners. Another HPD program, the Senior Citizen Home Assistance Program (SCHAP), offers home improvement loans at reduced rates to those aged 60 and over with low to moderate incomes.

Health care

New York City’s health care system is a leader in the world, and older adults frequently cite it as an essential resource and reason to live in New York City. Care ranges from acute care delivered in hospitals and care delivered by primary care physicians, specialists, and out-patient clinics to long-term care delivered in homes, assisted-living facilities, and nursing homes. This includes the New York City Health and Hospitals Corporation (HHC). According to its website, HHC serves 1.4 million New Yorkers every year, making it the largest municipal hospital and health care system in the country. Of the 1.4 million served every year, more than 475,000 of those are uninsured. New York’s health system also includes the largest not-for-profit home health care agency in the country, Visiting Nurse Service of New York, which serves 30,000 patients a day.

On the state level, the New York State Partnership for Long-Term Care combines long-term care insurance with Medicaid Extended Coverage, which helps New Yorkers protect some or all of their assets if the long-term care that they need exceeds the period covered by private insurance. The state also administers the New York Prescription Saver Card program; the program covers some prescription drug costs for those with low incomes aged 50 to 65. Additionally, the New York State Assisted Outpatient Treatment Program assists older adults with mental illness, including allowing Medicaid dollars to be used to pay for money management services.

On the city level, the Human Resources Administration serves more than 83,000 city residents through its community-based long-term care programs, which provide coordinated medical, nursing and rehabilitative care to people in the home rather than in an institution. The city also administers Elder Pharmaceutical Insurance Coverage (EPIC), which pays for more than half the cost of prescription drugs for low-income individuals aged 65 and over who do not participate in Medicaid.

Food

Throughout New York City, affordability and access to healthy food are major issues of concern. High prices, a small number of supermarkets in poorer neighborhoods, and a shortage of fresh fruits and vegetables are problems for the entire population. Older adults bring an additional set of challenges to buying, preparing, and eating in a healthy way. For example, many older adults are on fixed incomes and have mobility impairments that affect shopping and cooking. They also have dietary restrictions, or are living alone for the first time in their lives, or are socially isolated and living in neighborhoods where stores they used to frequent have gone out of business or have been replaced.

To help people of all ages living in poverty (including older adults), the federal government administers the Supplement Nutrition Assistance Program (SNAP), commonly referred to as Food Stamps. Eligibility determinations have a number of contingencies, with special rules for those aged 60 and older. Generally, gross income cannot exceed 130 percent of the federal poverty line or, in 2010 terms, \$1,174 per month for a single-person household. The maximum monthly allotment for a single-person household is \$200. To assist older adults in applying for and recertifying their food stamps, the city's HRA makes it possible to do both processes over the phone. HRA is also launching an initiative through Age-friendly New York City to reach out to older adults enrolled in SCRIE and encourage them to apply for food stamps.

For older adults who have difficulty shopping, cooking, or who are homebound, the city administers home meal delivery programs. These meals are culturally appropriate, meet dietary restrictions, and are either hot meals delivered daily or frozen meals delivered twice a week, depending on the preference and level of functioning of the older adults. More than 17,000 older homebound adults currently receive meals under this program. However, no current estimate exists of how many older adults meet the criteria for home-delivered meals but do not receive them. (Such an estimate is beyond the scope of this report.)

New York City also has emergency food providers, including the Food Bank for New York, which supplies food to pantries, soup kitchens, senior centers, and youth programs at over 1,000 locations, and City Harvest, which rescues food that would otherwise go to waste and distributes it to similar programs.

The New York City Coalition Against Hunger's 2008 Annual Hunger Survey showed that emergency food programs report widespread and increasing use by older adults.

Public Spaces

New York City's transportation system is one of the most important resources the city provides for older adults. The city contains North America's largest transportation system, serving more than 7.4 million daily through its network of buses and subways (New York City 2009). Fares are reduced by 50 percent for those aged 65 and over. Although the lack of elevators or escalators in many subway stations limits subway use for some older adults, the bus system is accessible to the disabled and frail, and this network is extensive, reaching into most corners of the city. Obstacles, such as distance to stops in isolated neighborhoods, are negatives. However, Access-A-Ride specifically addresses the transportation needs of people with disabilities, offering door-to-door transit, often using a vehicle designed to accommodate wheel chairs. For those older adults who have cars, a scarcity of parking in general, a dearth of parking near homes and businesses, and strong parking regulations also pose problems.

Walking is the most common mode of transportation within neighborhoods, and New York City neighborhoods have a highly organized system of sidewalks, crosswalks, and traffic signals. However, the Age-friendly New York City reports remind us that barriers such as uneven sidewalks, litter, crowding, and lack of benches and safe crossings are a problem for the frail and disabled in some neighborhoods.

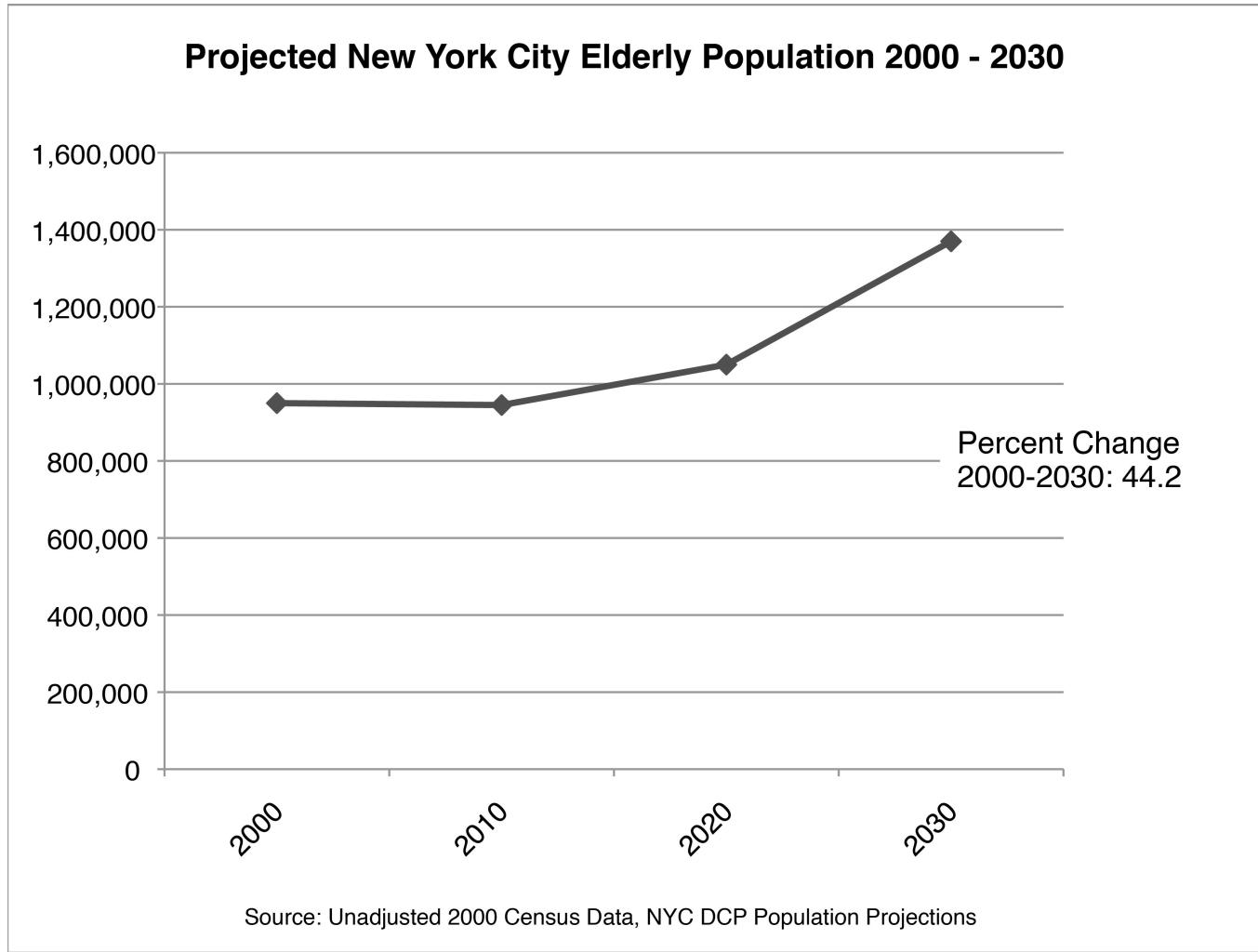
The city's Department of Parks and Recreation oversees 5,000 individual properties covering 29,000 acres or 14 percent of New York City. Parks, beaches, waterfront, community gardens, and walking paths are tremendous assets to older adults, as places of recreation, relaxation, communal gathering, and environments that promote physical and mental health in areas that otherwise have almost no grass to walk on or trees to sit under. While a major resource, parks are unevenly distributed throughout the city, many are difficult for those with physical disabilities to travel to, to enter, and to use; and most were designed with a focus on youth. The parks department is currently working on an agency-wide transition plan to make all aspects of its parks, beaches, and recreation centers more accessible to people with disabilities and has established a committee to advise them on Americans with Disability Act issues. The mayor has also set a policy goal that all New Yorkers should live within a ten-minute walk to a park.

Educational and cultural institutions

The New York City Public Library has 89 locations throughout the Bronx, Manhattan and Staten Island. The Brooklyn Public Library has 65 locations, and the Queens Public Library has 64 locations. All three systems provide free and open access to their physical and electronic collections and information, which include millions of items. For example, all three systems offer free access to Internet-connected computers, have books by mail programs for those who are homebound, have materials for the visually impaired and hearing impaired and offer assistive technologies. They also host public events and programs designed for older adults and host classes in technology, literacy, and English for speakers of other languages. In response to the growing aging population, all three library systems have launched special programs and outreach campaigns for older adults.

The city is also home to an outstanding public university system, including City University of New York (CUNY), the largest urban public university in the country with a number of colleges, institutions, and libraries in all five boroughs. At CUNY's seven community colleges, study is tuition-free for senior citizens. At their four-year colleges, seniors may audit classes on a space-available basis for \$70 per semester.

Figure 4: Projected New York City Elderly Population



New York City is enriched by hundreds of cultural institutions, ranging from some of the world's most famous museums, theaters, and orchestras to neighborhood galleries and small performing groups. Cost, accessibility, and language differences are barriers for many older adults, but many institutions have free admittance days for the general population, and in general, offer discounts for seniors, arrange performances or programming for older adults, offer programming in different languages, and run outreach in the community. Often, the only barrier is that seniors do not know what is offered or how to access it. The Museum of Modern Art, for example, has programs for older adults with Alzheimer's disease and their caregivers, those who are homebound, and those with hearing or vision impairments. It also has free wheelchairs for visitors and offers several free days every year for seniors. The Brooklyn Academy of Music (BAM) has a free monthly senior cinema series. At the Pregones Theater in the Bronx, where many of the performances are in Spanish, tickets are 30 percent off for seniors and 50 percent off for those who live in neighboring zip codes. Similarly, New York sports teams, which have

played an important role in the life of many seniors for their entire lives, offer senior discounts, special seating, and assistive listening devices for those with disabilities.

In some ways, every street, business and facility in New York City is a resource for older adults, just as it is for the general population. The city's gyms, movie theaters, restaurants, retail stores, bars, newspapers, green markets, nail salons, barber shops, delivery services, stoops, and sidewalk domino tables all benefit from and contribute to the lives of older New Yorkers. The problem is that barriers to access are often greater for older people. Stakeholders, older adults, and senior center directors all expressed a desire to better learn about, connect to, share, refer, and use these resources to serve New York City's older adults.

4. Challenges in Constructive Engagement

The years after age 65 are a time of heightened instability for most people. Longstanding routines of employment, social and family relationships, civic involvement, and physical activity are often disrupted and must be maintained or re-established. People change jobs, spouses and friends pass away, and health conditions increasingly shape personal choices. In a more positive light, individuals intentionally seek new patterns of living and personal development in their later years – pursuing dreams of travel, cultural experiences, improved relationships, and increased community involvement.

Public policy must recognize that the most important agents working on behalf of older adults are the older adults themselves. As individuals confront and address both problems and opportunities in their senior years, they employ a complex array of personal and social tools to establish priorities, evaluate alternatives, dedicate resources, assess progress, and seek support. Seniors demonstrate great determination in working to solve problems and improve their quality of life, but they encounter formidable barriers that impede success in a wide variety of contexts. Recognizing and minimizing these barriers should be one of the highest priorities for an inclusive aging policy in the 21st century.

Health barriers

People aged 65 to 75 are managing, on average, two chronic diseases such as diabetes or high blood pressure, and are taking approximately 11 different medications. New Yorkers are living longer and more independent lives than ever before, but the personal and economic costs of health care are taking a serious toll. Limitations on coverage for prescription drugs, dental care, preventive therapy, wellness programs, home care, and tele-medicine services force seniors to choose between basic health needs and financial security. At the same time, our health care delivery system places little value on the opportunity cost for patients who are forced to spend countless hours shuttling between provider institutions, pharmacies, and community service providers. For many older adults, the barrier to successful aging is not poor health, but rather a health care system that extracts unreasonable costs from patients in both financial and personal terms.

Two areas of particular concern for older adults are depression and dementia. High rates of depression, often undiagnosed, continue to afflict older adults and present a persistent barrier to their quality of life. The incidence of Alzheimer's disease has surged in the past two decades as Americans live longer, with about 320,000 older adults in New York State now estimated to be experiencing symptoms of dementia.

Both of these conditions carry a stigma for patients that compounds the actual effects of the disease, leading to widespread shortcomings in diagnosis and treatment. In many cases, depression can be successfully treated with therapy and medication, and dementia services can greatly improve a patient's quality of life (as well as relieve strain on caregivers), yet the incidence of treatment and services lags other conditions, creating a major barrier to independent living for older adults.

Financial barriers

As discussed above, poverty and financial insecurity are the most commonly recognized barriers facing older adults working to improve their quality of life. New York seniors experience poverty at a rate that is double the national average, and the combination of low incomes and high costs of living in the city create severe conditions for many older New Yorkers. When New York City-specific expenses and benefits are used to calculate poverty, the number of individuals aged 65 and over living in poverty is 32 percent, and the level of income is often so restrictive that individuals can become virtually home-bound even if they are physically mobile. Financial insecurity, like poor health, has negative consequences that go far beyond the immediate experience of poverty. Low incomes limit social engagement, civic participation, and opportunities for lifelong learning, mobility within the city, and even access to health and wellness options. Increasing numbers of older New Yorkers are seeking to work past the traditional age of retirement, but they face an employment environment that is tipped against the interests of older workers. Workforce discrimination is commonplace and, once out of the workforce, older adults stay unemployed nearly twice as long as younger people before finding a job.

Social barriers

In many cases, the social barriers to constructive engagement for older adults are the most challenging. Senior citizens often experience wrenching dislocations caused by the passing of a spouse, close friend, or family member. Social ties can be disrupted by moving from a long-time home or neighborhood or by immigrating to New York from another state or country. Ageism presents perhaps the most insidious barrier of all, as stereotypes regarding older adults continue to achieve wide dissemination through media and popular culture.

In each case, the capacity of the individual to organize his or her own system of support is challenged. On a personal level, individuals who outlive their friends and family members must develop new sources of intimacy and trust or face increasing isolation. A 2012 study by the AARP Foundation found that life transitions contribute to isolation and estimated that as many as 20 percent of older adults are at risk of isolation and loneliness. For recent immigrants whose closest social ties may reside an ocean away, these risks are magnified and sources of social capital are attenuated.

The link between social isolation and other indicators of health and resilience has been well documented. Socially isolated individuals have higher rates of morbidity and depression, shorter life spans, and less access to networks of support and engagement that are critical for healthy aging. For older New Yorkers with limited social connectedness, seemingly mundane tasks can be daunting – such as getting a referral for a physician, getting help with a delivery, or finding volunteer opportunities. Barriers presented by limited social networks can relate to both the quality and the extent of the connections. Individuals may share physical space with others, but experience little stimulation or meaningful influence over social

dynamics. Or they may have very strong ties with a few people, but very limited contact with wider networks that may be essential to extending their social capital resources.

These limitations are powerfully reinforced by a pervasive ageism that flows through virtually every point of contact between older individuals and the broader culture. An understanding of the social barriers faced by seniors must be framed by the recognition that bias and discrimination against older adults are widespread in America today, and they place powerful constraints on the lives of older citizens. Negative stereotypes in media, arts, and popular discourse casually characterize older adults as befuddled, irrelevant, dependent, and decrepit, while more concrete manifestations of ageism occur in employment discrimination, patterns of criminal targeting, and elder abuse. With the widespread acceptance of terms like “senior moment” and “geezers” in American social discourse, ageism holds the dubious distinction as an arena of bias, which is still acceptable for discourse in polite company.

Instrumental barriers

As older adults work to enact patterns of active aging in their lives and communities, they face system-level constraints on personal mobility and use of technology, barriers that together can translate into near-complete isolation and obstruction of options for self-directed problem solving. These twin challenges mediate access to social networks, employment, civic and commercial activities, and health opportunities. These challenges also function as powerful leveraging agents across institutional, geographic, and sectorial boundaries. A simple issue such as loss of driving capability can disrupt access to a wide array of resources that are critical to independent living, while lack of access to the internet limits or blocks participation in mainstream tools for information management and communication. Consequently, transportation and technology policies are of critical importance to reducing barriers for older New Yorkers.

Constraints on physical mobility are visible and concrete obstacles for virtually all seniors, and include inadequate surface transit, poorly designed subway access, unwieldy and unreliable para-transit services, poor sidewalk maintenance, and a general lack of point-to-point wheelchair accessibility. For an older individual who uses a chair or walker, the experience of navigating from home, to sidewalk, to transit vehicle, to a destination and back can be a harrowing and even life-threatening experience.

Meanwhile, technology use presents less visible yet equally restrictive limitations on activities for many older adults. With just over half of senior citizens going online today, lack of access to email, internet, electronic health tools, e-commerce, social networking and digital media present serious obstacles to constructive engagement with a variety of resources for successful aging. This “digital disconnect” for older adults has many causes, including poor technology design, lack of affordability, inadequate training and support, and a failure to communicate the value proposition for older prospective technology adopters.

Therefore, an “aging policy” in the 21st century does not centrally focus on Social Security, Medicare, pensions, or senior centers. Aging policy must address all of the barriers that prevent people from continuing to be themselves as they age by maximizing their opportunities for engagement. As will be developed below, this ranges from concerted emphasis on making it possible to cross streets and walk down the sidewalk to creating effective information hubs and discounts for the city’s great cultural centers

to changing pension policies and workplace practices to make it possible for more people to choose to remain engaged in the work that they love. A 21st century aging agenda recognizes that an aging agenda is integrated into a life course agenda, creating neighborhoods and a community that works better for people of all ages.

5. Recommendations

As aforementioned, older adults currently make up 17 percent of New York City's population and this number will increase dramatically in the next eight years. However, New York City's policy-making has not made the "demographic transition" to re-envision itself as making the city work effectively across the life course. To do so requires investment in a new policy-making entity, leadership from the new mayor and City Council leaders driving a new kind of collaboration between departments in city government, committees of the City Council, and neighborhood and community leaders. Equally imperative is the inclusion of older adults themselves. Because effective aging policy in the 21st century requires that every feature of the built, social, and economic environment be re-examined through the lens of its effectiveness for people of all ages, the policy leadership must start at the top.

The existing construct of "Age-friendly New York City" has much that is right – understanding aging as part of the life course that affects all domains of city life, understanding that older adults must be at the center of planning for their own lives and are an asset in this process as well as to the city, involving directly a deputy mayor and commissioner on aging, City Council Aging Committee Chair and other City Council leaders, fostering consultation and planning across departments and legislative committees, and creating an entity to oversee a coordinated effort with leadership from public and private sectors (the existing Commission for an Age-friendly New York City). However, this effort falls short in effectiveness in several ways. New leadership should invest this activity with new authority and infuse it with new resources.

The next mayor should convene experts from the public and private sectors and include older adults as critical informants and experts to assemble and organize the existing knowledge about older adults in New York City (including extensive consultations with older adults) into a briefing book for commissioners and City Council leaders to inform their development of aging plans for their departments and committees. It is critical that *all* commissioners and committees be engaged in this process, and that the process is led from top levels. For example, critical improvements are needed in plans for streets, sidewalks, benches, cultural institutions, parks, workforce and entrepreneurship training, colleges, benefits enrollment, ambulance protocols, disaster preparedness and recovery, and housing, as well as senior centers and meal delivery. Legislative and policy change will be necessary to reform how pensions are calculated, tax incentives earned, and fees assessed. Therefore, the development of the next plan for an Age-friendly New York City must be led by the mayor and speaker.

At the same time, the process led by government needs to facilitate and incentivize the private sector in the city to recognize the change in the demographic structure of the population as an opportunity and responsibility. Opportunities range from capturing market share of the largest living cohort to making better use of their talent, knowledge and entrepreneurial spirit in the work place, and their wisdom, experience and time in volunteer and civic activities. Responsibilities include examining programming

and policies in nonprofit, cultural and community development programs to be sure elders can participate in all facets of activities as well as looking at preparedness, evacuation, and emergency procedures in housing, institutions, and neighborhoods.

Government itself should play a major role in advancing the age-friendly agenda. The city as employer, purchaser, contractor, and property owner should incorporate recommendations from the plan for an Age-friendly New York City into widespread aspects of city operations. City employment and procurement policies should embrace equal opportunity, providing re-training and job flexibility to retain older workers. City-owned properties should be evaluated for age-friendly design. Vendors who do business with the city should be encouraged to adopt age-friendly policies. And city-supported health care agencies should be buttressed in adopting best practices for serving older patients with age-appropriate models of treatment, medication, and discharge policies. Existing government programs in senior centers should be linked to health networks.

Finally, this ambitious plan for an age-friendly New York City should drive resource investment. This should include direction for departments to make programmatic and capital investments to execute the plan; development of a legislative strategy to incentivize investments in public and private sectors consistent with the plan; advocacy from the mayor and City Council speaker to modify requirements of federal funding streams (when necessary) to implement the plan; direction to more local entities to consider this plan when setting funding priorities (local City Council districts, Community Boards, BIDs, etc.); and lastly, the creation of an aging investment fund. The aging investment fund should be funded by city tax levy at \$500 million per year for five years. Applicant initiatives would be direct execution of the plan and would, in each instance, be supplemental to investments made by the implementing entity from other sources. Eligible entities would include neighborhoods (to implement Aging Improvement Districts or other community-level initiatives), city agencies (to execute initiatives crossing multiple jurisdictions and exceeding their individual funding, like creation of an age-friendly technology development hub), or groups of non-profit, business, and/or cultural organizations to make existing assets work for older adults (like performing arts collaboratives for older adults). Aging Investment funds would not supplant existing expenditures into aging services.

Investing for impact

An investment of this magnitude represents a very significant departure from previous spending patterns and will take place in an environment of serious fiscal constraints. Why should the city prioritize the allocation of scarce resources to programs and initiatives for older adults? First and foremost, an aging investment fund allows for a rebalancing of budget priorities to match changing demographic and social conditions. Historically, New York City has met large-scale emerging challenges such as homelessness, violent crime, or housing abandonment with ambitious new strategic initiatives that succeeded in part due to non-incremental increases in available resources. The aging city represents just such a new challenge, as the longevity revolution presents us with a chance to create systems that make the most of our increasingly multi-generational society. An aging society requires investment in transportation, housing, health care, services, and education to maintain equitable access to opportunities for New Yorkers through all stages of life. Fundamentally, these are values questions: Will we make these investments to match the scale of emerging needs, or will we instead force older adults (and their

families and caregivers) to absorb the cost of meeting these challenges, as a sort of unfunded mandate, with little support from the public sector?

Secondly, many age-friendly initiatives have a very positive “social return on investment” profile. Efforts to reduce falls through barrier-free design and retrofitting, programs to reduce social isolation of the elderly, and initiatives to reduce elder fraud and abuse are just a few examples of areas where programs for older adults have achieved strong outcomes in recent years. Effective models exist for health and wellness programming, music therapy for seniors with dementia, intergenerational initiatives, caregiver support, and a host of other innovative and transformational strategies to improve the lives of older adults. Typically these programs benefit a wider group of New Yorkers than the seniors who are the direct recipients; caregivers find much needed support and relief; fewer trip hazards mean few people of all ages falling on sidewalks and doorways; and more active seniors translates into more productivity in their role as volunteers and civic stewards, to cite just a few examples. But decades of stagnating levels of funding have left few resources available to support such efforts. In short, the line-up of promising program opportunities is very strong right now and is well primed for returning strong outcomes as program resources increase.

Finally, investment in an age-friendly city has strong economic development prospects for all New Yorkers. The older adult market is an essential segment in the city’s health care industry, providing thousands of high-paying jobs. Older workers whose tenure in the workforce can be extended both contribute to the economy and reduce their consumption of public and private resources. Over 90 percent of grandparents provide some amount of child care for grandparents, contributing to the productivity of young parents. And older adults as a group possess a far greater share of consumer spending capacity than younger people—they are critical supporters of the city’s restaurants, cultural institutions, tourism sector, and durable goods industries. Even a program to retrofit residential and commercial facilities for older adults can be conceived as a “silver jobs” initiative, much as parallel efforts have combined job development with socially beneficial outcomes in the realms of infrastructure and the urban environment.

A comprehensive “age-friendly” plan would drive the policy agenda significantly and should provide the framework for priority investments that are both effective and fiscally prudent. However, a selection of specific examples are provided here that derive from the current consultations with older adults and key stakeholders, and which address the specific barriers and challenges identified above for older adults to participate as fully engaged members of the community. These barriers include financial challenges, health issues, instrumental barriers to retain social engagement, and challenges in housing and outdoor spaces.

Financial challenges

Almost one third of the older adults in New York City would be considered poor under Mayor Michael Bloomberg’s New York City-specific OMB poverty calculation. While many of the policy solutions to this problem lie within the federal domain (Social Security eligibility and payment levels) and are not solvable for this generation of older adults (less fixed pensions, loss of home equity, and value of retirement investments), some mitigating steps should be taken:

- ↳ New York City government should facilitate access to paid employment for older adults by investing in job training and placement, widely promulgating “age-smart employment” practices that help employers’ value and retain older workers, enforcing age discrimination statutes, and investing in the technology training that too often serves as a barrier to older adult employment.
- ↳ New York City should implement changes to public pension systems to help support phased retirement by calculating average salaries based on an employee’s highest three or five years of pay throughout overall service instead only considering the earnings in the five years just before an employee’s retirement date. This would allow for an employee to work a less than full-time schedule as part of a phased retirement program without concerns of losing a significant portion of future retirement benefits. Additionally, pension plans should allow for partial annuity payments to be drawn by beneficiaries as they continue to work. This allows for an employee who enjoys their job and wants to continue working on a reduced work schedule. This also can aid in the employer with supporting knowledge transfer methods can potentially save cost associated with training and filling position. In 2012, the federal government began implementing a phased retirement option for federal employees in order to give employees with years of experience more time to pass on their expertise and complete important projects. The White House estimates this will save the federal government \$720 million over the next decade.
- ↳ Create greater supports for older adult entrepreneurs. The highest rate of entrepreneurial activity belongs to people ages 55 to 64, while 20- to 34-year-olds have the lowest rate. Such entrepreneurs will be the job creators of the 21st century. Current supports for small businesses and entrepreneurs such as New York City Business Solutions, Small Business Development Centers, and specialty incubators could be enhanced to serve older entrepreneurs. Further, older entrepreneurs need increased access to Minority and Women-owned Business Enterprises (M/WBE) certification assistance and local and state government contracting opportunities. Finally, alternative lenders such as microfinance institutions and community development financial institutions should be encouraged to create tailored loan products for older entrepreneurs.
- ↳ Enhance access to benefits for older adults. Require offer of comprehensive entitlements access screening for all older adults who access any government service, including senior centers, public libraries, public hospitals, and NYCHA housing, etc. Expand use of the electronic benefits portal available in some places, but not all. Research shows that older adults lack information on the benefits available to them.
- ↳ Use the combined resources of the New York City’s Small Business Administration, Cultural Affairs, and Tourism Office as well as local business and hospitality associations to make a meaningful discount card available with a high number of attractive venues participating. Require recipients of city arts and other funding to offer discounts. Market the card to residents and visitors, for enhanced tourism dollars to the city as well as expanding affordability for residents. In addition, exempt older adults from increases in costs for city-run recreation facilities and other fees.
- ↳ Strengthen and broaden systems to detect financial fraud and abuse (not limited to elders, but highly prevalent there). Among other strategies, encourage banks to work with older clients on an alert protocol and to develop fraud detection systems for elder abuse. Expand education on financial literacy and fraud and abuse detection for older adults, care givers, and local businesses that may detect fraud but not know whom to call.

Health challenges

Despite high rates of chronic illness (half the people over 65 have two or more chronic conditions), older people are healthier than ever before (almost three quarters report good or very good health) and want to be connected and engaged with community and virtually all want to remain independent and in their homes. Currently, older adults in New York City enjoy reasonably good financial access to most primary, acute, and pharmacy services. At the same time, significant challenges exist with the institutional bias of long-term care services and the lack of insurance for such services other than Medicaid. There are also significant issues with mental health services as many more older adults require such care than receive it and as increases in longevity lead, inevitably at this point, to increases in dementia. Too little attention is paid to clinical and lifestyle preventive health services. And lastly, older adults, with their multiple chronic conditions, really need a service system that is centered on them rather than having to fit themselves into the structures and networks of their service providers. It is recommended that New York City:

- ↳ Expand access, availability, and information about city parks and recreation resources for older adults by expanding equipment, physical accessibility, and scheduling of pools, parks, and recreation centers appropriate for older adults. Recent pilots of “senior swim hours” demonstrate the demand is there if appropriate facilities and information are provided, but recent fee increases also demonstrate that this demand is extremely price sensitive, so older adults should be exempted from fee increases.
- ↳ Upgrade to electronic health records. Older adults, with their multiple health issues and multiple providers, could really benefit from electronic health records. However, the current development of such records and investments in regional health information exchanges have not focused on the interoperability issues necessary to appropriately serve older adults or on their health literacy (or HIT literacy) to make such developments useable by older adults, many of whom continue to manually transfer test results, prescriptions, and referrals from one provider to the next (or who require the previous diagnostic work to be repeated).
- ↳ Expand access to mental health services for older adults by supporting the expansion of tele-health video-counseling services for isolated seniors. These services have been successfully implemented by the federal Department of Veterans Affairs, but inadequate standards for licensing, clinical protocols and digital privacy have hampered widespread adoption (Novotney 2011). The city should support the establishment of these protocols and standards so that seniors who are home-bound or put off by the stigma of visiting a mental health facility can receive treatment from within their own home.
- ↳ Engage older adults in a participatory planning process about their own health and social services. Systems remain designed by providers, as incentivized by payers. Patients remain the recipients of care and services (at best) or are left out of the system entirely until emergent issues bring them to the most expensive and least responsive setting (the emergency room). Within the framework of the multiple changes occurring in the health system with the implementation of the Accountable Care Act, Medicaid managed long-term care, and the multiple services delivery demonstrations in Medicare, New York City should lead the last innovation to occur by asking older adults themselves to describe and help design the care system they would like to have.

Facilitate use of city resources, increasing engagement and lessening social isolation

Social isolation is associated with depression and reduced longevity and deprives older adults from the benefits of the city, and the city from the contributions of the older adults. The following policy recommendations to reduce social isolation caused by barriers to both information and physical access are suggested:

- ↙ Provide opportunities for targeted technology training and assistance in all venues where older adults assemble in numbers, including senior centers, NYCHA residences, assisted living facilities, public libraries, and even large medical providers. The implications of the “digital divide” for people’s daily lives grow more significant daily services become electronic, from check deposits and utility services to the announcement of community notices and employment opportunities (not to mention job applications). What’s more, children and grandchildren abandon traditional phone and letter communication for email, text messages, and other computerized communications.
- ↙ Require housing and service providers with city funding to provide Wi-Fi connectivity in their facilities and broadband-ready cabling in newly renovated and constructed apartments.⁸ Offer subsidy or significant discounts for older adults who cannot afford such services in their homes; in the 21st century, connectivity is as basic as other utilities. Invest in public-private partnerships that link public agencies, nonprofits, and cable/telecommunications providers in projects to train and support low-income seniors in using broadband service and devices.
- ↙ Provide ongoing support for the Senior Planet digital community network which provides technology services and training to thousands of seniors per year at the Exploration Center in Manhattan and manages over 24 technology labs in support of older adults in all five boroughs. Extend the network of technology labs to all senior services sites that are able to provide dedicated space, and expand the Senior Planet mobile lab to support tablet-based training for seniors. Promote disaster preparedness by linking participants in the online SeniorPlanet.org site with communications channels at the Office of Emergency Management.
- ↙ DFTA’s Innovative Senior Centers program is a promising model and should be expanded to additional sites throughout the city and to engage additional under-served populations and interest groups such as immigrants (particularly Asian-Americans, whose neighborhoods have fewer services at present), wellness associations, life-long learning programs, and digital efforts such as the Virtual Senior Center. Innovative Centers are developing new community partnership models (the JCC of Staten Island being one popular example) and these should be supported and expanded, and city tax-levy resources should be increased to achieve more balance between nutrition programs, services, and education/recreation efforts.
- ↙ Expand New York City Department of Transportation’s highly successful “Safe Streets for Seniors” program beyond its current focus exclusively on intersections where an older adult pedestrian fatality has already occurred. Instead, expand to a suite of design recommendations including to make the street as flat as possible and have a smooth transition to curb; to install wide median refuge areas with benches, planters, and shelters on wide streets; and to continue to expand buses and shelters.

⁸ This recommendation mirrors incentives that already exist in most states’ Low Income Housing Tax Credit program.

Studies have shown that only a quarter of older adults walk at the four feet per second standard used by transportation engineers in designing traffic flow. Therefore, it is no wonder that in New York City seniors constitute only 13 percent of the population, but represent 33 percent of pedestrian injuries and fatalities citywide.

- ↳ Many local businesses lack accessibility for wheeled assistive walking devices (wheelchairs, walkers). This deprives them of the custom of older adults and older adults of the benefit of their wares. Portable ramps are available; perhaps New York City could offer tax incentives for their installation and for other minor adaptations to make businesses more accessible to elders (also facilitating access to some with disabilities – or strollers).
- ↳ New York City's public transit system is one of its strengths for older adults, but improvement is also needed. While the "kneeling" buses are helpful, expansion of disability access to the subways is also needed. Furthermore, numerous policy modifications would help to make senior fare cards more accessible and information on route changes more available. Numerous older adults have requested that the public information campaign encouraging passengers to offer their seat be reinforced by training for MTA personnel.
- ↳ Similarly, the MTA's Access-a-Ride program is simultaneously one of the city's strengths for older adults as well as a source of great frustration. Numerous reports have recommended system modifications, but here it is encouraged that the successful "taxi voucher" program instituted in 2009 be continued and expanded. The taxi voucher program allows older adults who do not need intensive assistance to simply hail or call a taxi and submit the receipt for reimbursement. According to the city's analysis, this system was both appreciated and cost saving.
- ↳ Make bathrooms in all city buildings and in buildings owned by those who receive city funding public. Urinary incontinence affects between 20 and 40 percent of older adults. Many older adults have said the availability of a restroom determines their ability to leave the home and remain engaged in daily activities. As of April 2009, there were 666 park bathrooms and 78 subway bathrooms in New York City as well as the pay-per-use self-cleaning bathrooms in Herald Square. In contrast, Singapore, which has a land area nearly 200 square kilometers less than New York City, has 29,500 public toilets.

Housing, built environment, and community challenges

The single biggest challenge for older adults regarding housing in New York City is the same as for other New Yorkers – affordability. Nearly half of older New Yorkers pay more than a third of their income for housing. For older New Yorkers there are also other challenges, including housing that grows inappropriate as people age and household composition changes as well as physical ability (walk-up apartments are particularly challenging). In addition, older adults in many communities describe the experience of their family moving away, the community changing around them (most frequently, with outsiders moving in and prices rising), and people who have lived there for years feeling unwelcome or actually feeling pushed out by landlords. While further study is needed of these very challenging issues, some policy recommendations are clear:

- ↳ Encourage increased enrollment in Senior Citizen Rent Increase Exemption (SCRIE) and increase the maximum allowable income of participants. Just 38.5 percent of households eligible for (SCRIE)

were enrolled. According to the New York City public advocate, More than 72,000 eligible households do not participate. In addition, the \$29,000 household income threshold is not compatible with the cost of living in New York City. Apartments eligible for SCRIE include those with rent up to \$2,000 a month. Finally, SCRIE is only available for rent controlled and stabilized apartments; we recommend extending its coverage to market-rate units and controlling costs through use of Fair Market Rent standards (such as those used in the Section 8 program), or rent stabilization increase rates.

- ◀ The New York City Housing Authority (NYCHA) is actually the largest aging services provider in New York City, with more than 61,000 older adults living in NYCHA housing. There are 10,000 apartments designated for older adults in 42 senior-only developments and 15 senior-only buildings in mixed-age developments. The health of older adults living in NYCHA is slightly worse than older adults with comparable income levels not living in NYCHA and poor compared to the general population. At the same time, there are currently more than 160,000 people of all ages on the NYCHA waiting list, almost as many as there are NYCHA residents. Turnover rate is 3.29 percent a year. Multiple improvements are needed for older adults in NYCHA, including:
 - Expansion of supportive services including floor captains and senior resident advisors in all NYCHA senior buildings, with a focus on making sure that all residents have access to information about entitlements, services, and health prevention.
 - Retrofitting of buildings and apartments so that they are appropriate for older adults, including seating, lighting, grab bars, elevators, and laundry rooms. Laundry rooms were removed from many buildings in the 1990s because of safety concerns, vandalism, or broken equipment.
 - Development of a policy to allow older adults to move in to smaller apartments or apartments on lower floors in their same development to open up larger apartments for families on NYCHA's waitlist.
 - Consideration of making all lower floors of NYCHA housing designated for older adults, filling in lower-floor apartments with older adults as they become vacant, and grandfathering in existing residents.
- ◀ Supporting the expansion of and increase in use of home sharing options. In New York City, the New York Foundation for Senior Citizens and Project Share provide free matching services for seniors. As of 2011, they had matched over 2,000 older adults with housing (Willis 2011). The program is funded by the New York State Office for the Aging (SOFA) and DFTA. Policy changes in 2008 allow people of all ages to bring older adults in to share their homes. DFTA should facilitate cooperation between the shared housing organizations and Congressional Budget Offices that serve seniors who face housing insecurity. In order to encourage seniors to participate in home-sharing, the city should exempt any home-sharing income from the base income used to calculate eligibility for benefits.
- ◀ As we plan for a city where one in five (up to one in four) of the inhabitants are older, it is clear that we must speed up adoption of universal design principles and other age-friendly design principles, ranging from routine installation of bathroom grab bars to inclusion of inviting community space in all buildings. While it is not possible to retrofit all residential buildings, options for tax abatement and other incentives should be actively explored.

- ↳ Aging Improvement Districts are one model to make the various components of neighborhoods (older adults, civic organizations, businesses, and elected representatives) work together to identify the priorities of their older residents and to work collaboratively to make their participation in the life of the community easier. Aging Improvement District accomplishments are different in different neighborhoods, and have ranged from senior swim hours and placement of DOT benches in targeted areas, to expansion of fresh fruit and vegetable availability for older adults through community supported agriculture, farmer's markets, and community gardens, to expansion of availability of movies and other performances at discounted rates. The New York City government should encourage formation of Aging Improvement Districts (or other neighborhood improvement plans that benefit residents of all ages) by making such communities differentially eligible for specific services (seating for outdoor events, DOT benches, and community art installations, etc.) and by offering seed funding to districts where partnerships between non-exclusive older adult-serving organizations, businesses, and older adults are evident.

The “Longevity Revolution” is transforming the aging landscape in New York City and demands widespread innovation, commitment, and investment if we are to meet the challenge of creating a city for all in the 21st century. Older adults have broken the mold for what it means to grow old in the city and have infused their passion, creativity, and productive capacity into myriad venues where they are not only supporting their own development and independence, but also serving as vital sources of civic engagement, economic development, health care, and social support for all New Yorkers. To reimagine “senior services” as a diffuse system of flexibly managed activities, flowing through public, private and nonprofit channels, taking multiple forms and scales, is to challenge ourselves to look outside the box, bag, or basket for the “age-friendly” opportunity that lies unrealized in so many places. Yet this is the challenge we face today and as we rise to meet it, we may well find we are rising to meet our own destinies as well.

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