Care for Aging Residents of Public Housing: Strategies for Rural and Urban Settings

Session 3: Understanding the Needs of Aging Residents

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

February 3, 2026 | 3 pm EST

Zoom Orientation

1 Captions

To adjust or remove captions, click the “Live Transcript” button at the bottom of your Zoom window and select “Hide Subtitle” or “Show Subtitle.”

2 Questions

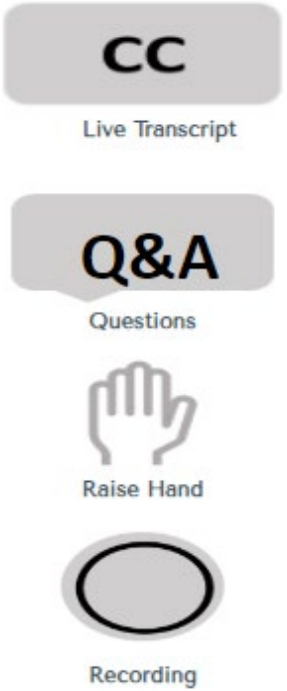
Please add your questions for the speaker in either the Q&A tab or in the Chat box.

3 Technical Issues

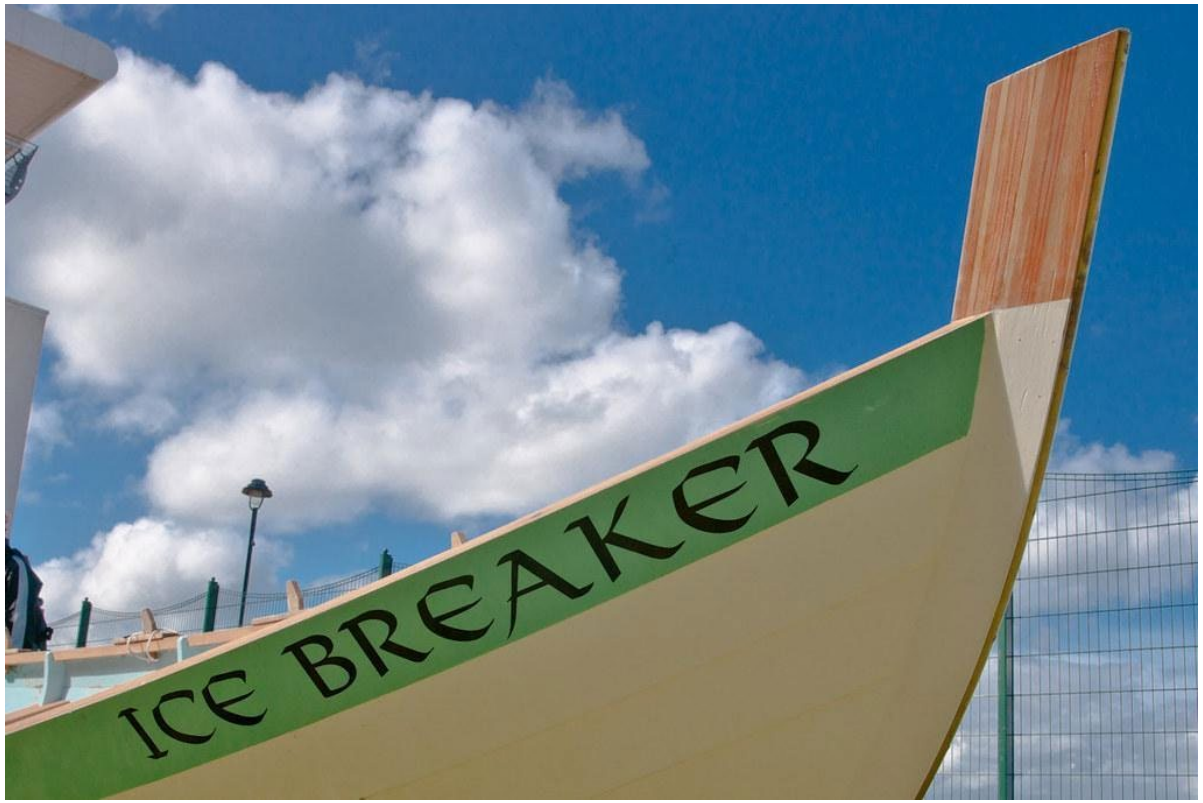
Please message us in the chat.

4 Recording

This session will be recorded and made available to participants.



Please say **Hi** in the chat and enter your name, credentials, location, role



NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

The National Nurse-Led Care Consortium (NNCC) is a nonprofit public health organization working to strengthen community health through quality, compassionate, and collaborative nurse-led care through:

-training and technical assistance
-public health programing
-consultation
-direct care

To learn more about NNCC, please visit our website at www.nurseledcare.org.

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

Accreditation Statement

Accreditation Statement: The National Nurse-Led Care Consortium is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Successful Completion Requirements: Nurses completing the entire activity and the evaluation tool may be awarded a maximum of **1.0 contact hour** of nursing continuing professional development (NCPD). To obtain nursing continuing professional development contact hours, you must participate in the entire activity and complete the evaluation following the session.

Relevant Financial Relationships: It is the policy of the National Nurse-Led Care Consortium to require nursing continuing professional development program faculty and planning committee members to disclose any financial relationship with companies providing funding or manufacturers of any commercial products discussed in the educational activity. The program faculty and the planning committee members report they do not have financial relationships with any manufacturer of any commercial products discussed in the activity.

NNCC National Training and Technical Assistance Partnership (NTTAP)

Jillian Bird, MS, RN
Director of Training and Technical Assistance

Matt Beierschmitt, MPP
Assistant Director of Training and Technical Assistance

Fatima Smith, MPH, CHES
Project Manager

Regina Brecker, MPH, CHES
Project Coordinator

Lucy Lunay
Program Intern

Anna Fry, MPH, BSN, RN
Clinical Nurse Educator

Today’s Agenda

5 min - Welcome

5 min - Key Health and Housing Challenges

- NNCC presenting on housing, hazards, risks, and chronic disease management

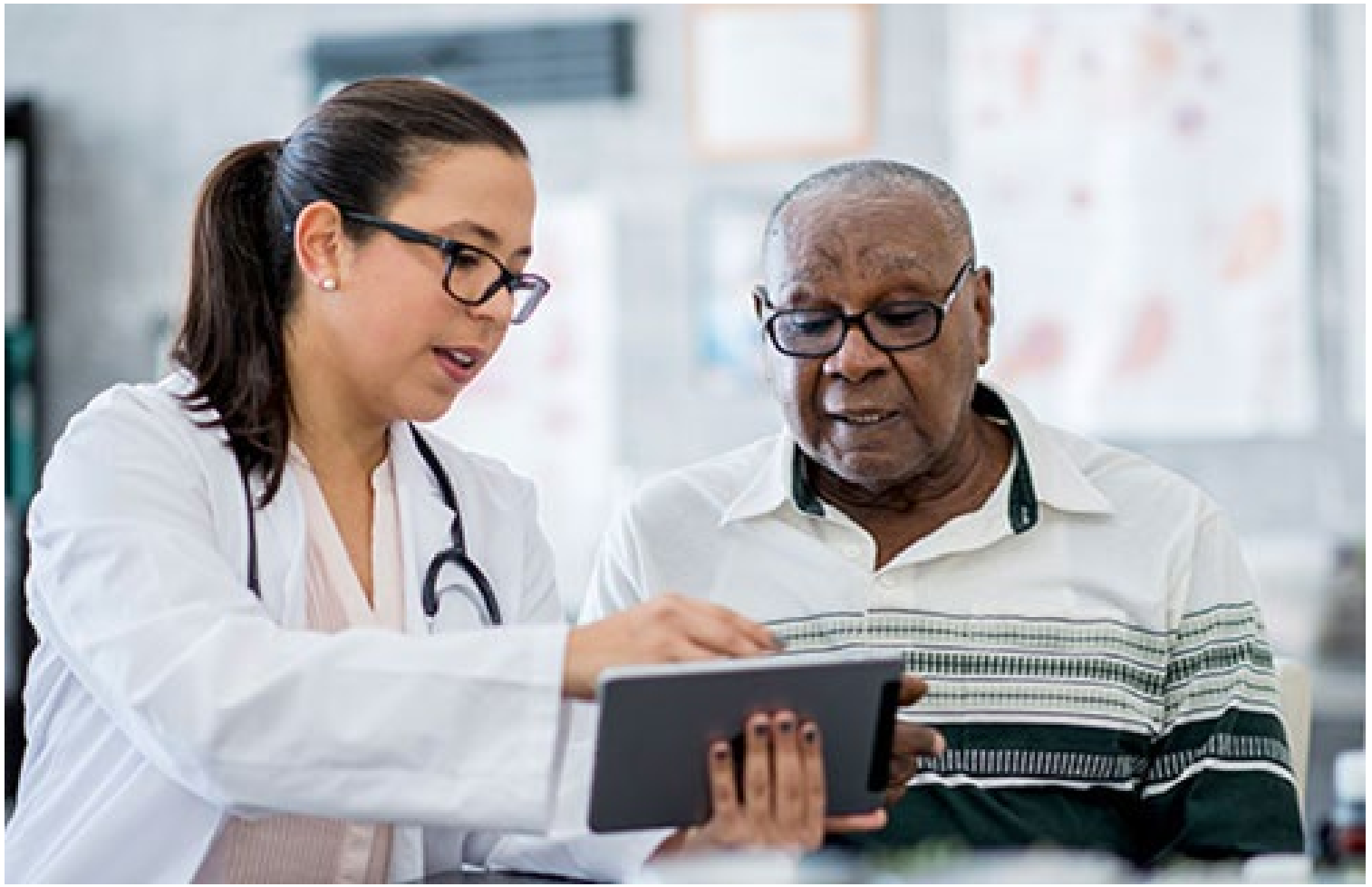
20 min- Susan J. Popkin & Mark Trekson, Urban Institute

- Evidence overview: health and housing needs of aging residents

20 min- Shawn Bloom - National PACE Association

- Sustaining impact through the PACE model

10 min - Questions & Wrap-Up



Key Health and Housing Challenges

Housing

- Nearly half of public housing households include an aging adult or person with a disability.
- Older adults often need assistance navigating the challenges of health, housing, and supportive services.
  - Benefits to equipping health centers as connectors between patients and services.
  - Proactive intervention can prevent emergency situations and homelessness in aging populations.
- Policy gaps leave many aging adults without accessible, appropriate housing.

Environmental Risks

- Aging and deteriorating buildings place older adults at heightened risk.
- Risks associated with pest infestation or mold are higher for aging adults who are more likely to have developed respiratory or other health conditions.
- Lack of accessibility upgrades in public housing, creating dangerous conditions for those with disabilities.

Key Health and Housing Challenges

Chronic Disease Management

- Stable, affordable housing is proven to protect against health decline associated with homelessness or unsafe living conditions.
- Older adults experience higher rates of chronic disease; conditions in public housing can exacerbate symptoms.
  - Often rely on support services for management.
  - Health centers become essential housing partners.
  - Services like wellness checks, case management, and engagement programs directly improve health outcomes for aging residents.

Mental Health Risks

- Depression, anxiety, behavioral challenges, and isolation are common in aging populations, specially for mobility-restricted residents.
- Older adults require stronger connections to supportive, community-based services.
  - Health centers should focus on proactive engagement with residents and connection to necessary treatment.

Subject Matter Experts

Susan J. Popkin, PhD

Institute Fellow and Co-Director Disability Equity Policy Initiative, Urban Institute

Mark Trekson, PhD

Principal Research Associate, Urban Institute

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

February 3, 2026

Health & Housing Needs of Aging Residents in Public Housing

Findings and Recommendations from Urban Institute Studies

URBAN INSTITUTE · ELEVATE · THE · DEBATE

For National Nurse-Led Care Consortium webinar:
Understanding the Needs of Aging Residents in Public Housing

Overview

Two Studies Examining Public Housing Resident Needs

Meeting the Challenge: Serving Older Adults and People with Disabilities in Public Housing (2022)

- Case studies of innovative housing authority services for older adults and people with disabilities.

District of Columbia Human Capital Need Assessment (2025)

- Comprehensive needs assessment of DC Housing Authority (DCHA) public housing residents to identify needs and recommend approaches to service provision.

Meeting the Challenge: Serving Older Adults and People with Disabilities in Public Housing

Serving an Aging Population

Public housing increasingly serves older adults and people with disabilities.

Goal: Identify best practices for serving this aging population in public housing.

Approach:

- Analysis of HUD data and case studies of 5 housing authorities.
- Identified innovative housing agencies through snowball sampling method.

Key Takeaways

- Older adult residents and residents with disabilities have a range of social, health, and functional circumstances.
- Service coordinators provide critical support, but housing authorities do not receive adequate funding for the role.
- Partnerships are key to helping address residents' needs.
- Even with multiple partnerships, housing authorities still experience gaps in services.
- Trust is key to engaging residents in services and programming.

Implications for Policy and Practice

- Provide public housing authorities with the resources they need to help address residents' service and support needs.
- Facilitate collaboration with health entities.
- Build opportunities to better support residents' behavioral health needs.
- Explore service delivery mechanisms that provide efficient and flexible care to residents in need of long-term services and supports.

District of Columbia Housing Authority (DHCA) Human Capital Needs Assessment

District of Columbia Housing Authority (DCHA) Needs Assessment Project Overview

Goal: Conduct a comprehensive assessment of resident needs for DCHA services and develop recommendations that center their preferences.

Approach: Leverage multiple sources of data and community expertise.

Two Phases:

- **Phase 1:** Field scans, interviews, data workshops with residents, evaluate providers, and staff.
- **Phase 2:** Resident evaluation (spring and summer 2025) and re-engagement.

Context: An Aging Resident Population

- Large drop in overall households and people.
- Growing share of senior residents.
- Substantial drop in children.

Year	Households	People
Count 2014	7,386	15,736
Count 2024	5,285	9,480
Change	-2,101	-6,256

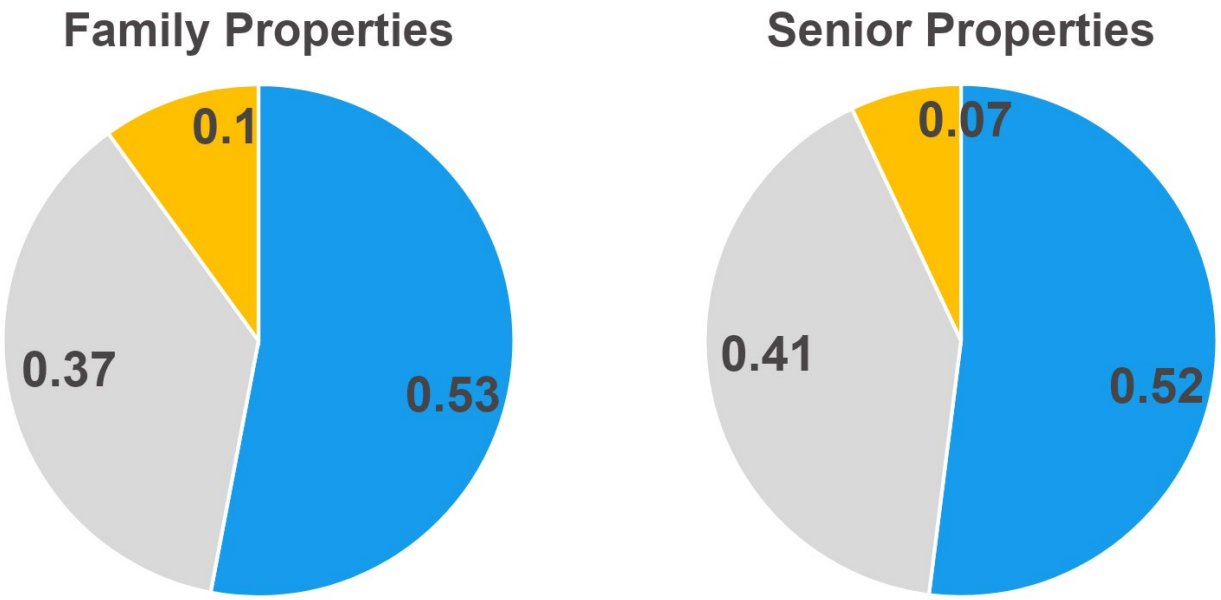
Year	Percent with Children	Percent with Head or Spouse 62+
Share 2014	35%	33%
Share 2024	22%	42%
Change	- 13%	9%

Source: HUD Picture of Subsidized Households

Physical Health Challenges

- 41% of residents in senior properties (and 37% in family properties) reported fair or poor health.
- Nationally, 24.3% of adults over 65 reported their health was “fair” or “poor“.

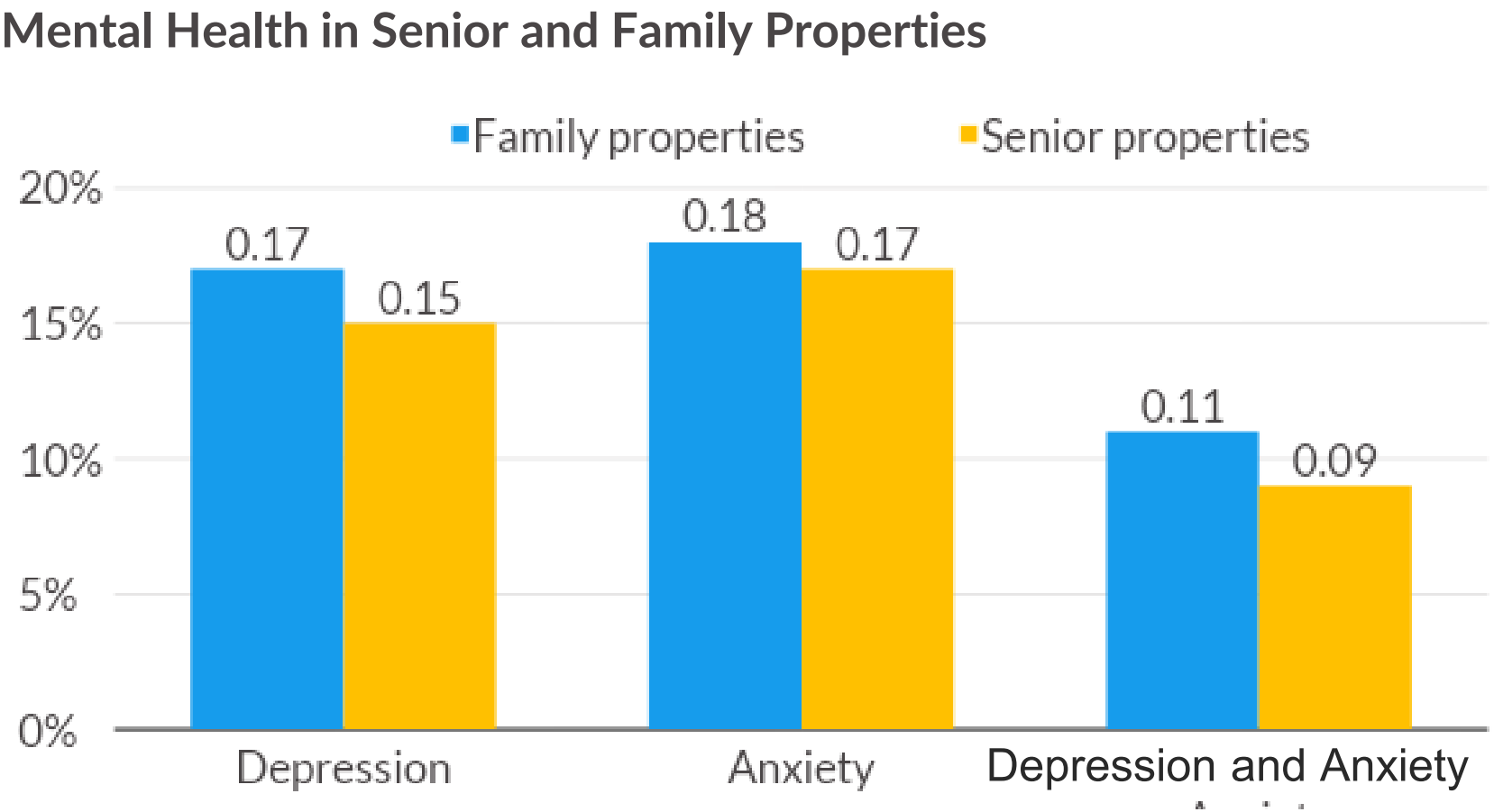
Self-Rated Health Status



Source: 2025 DCHA Human Capital Assessment Resident Survey

Many Residents Report Mental Health Issues

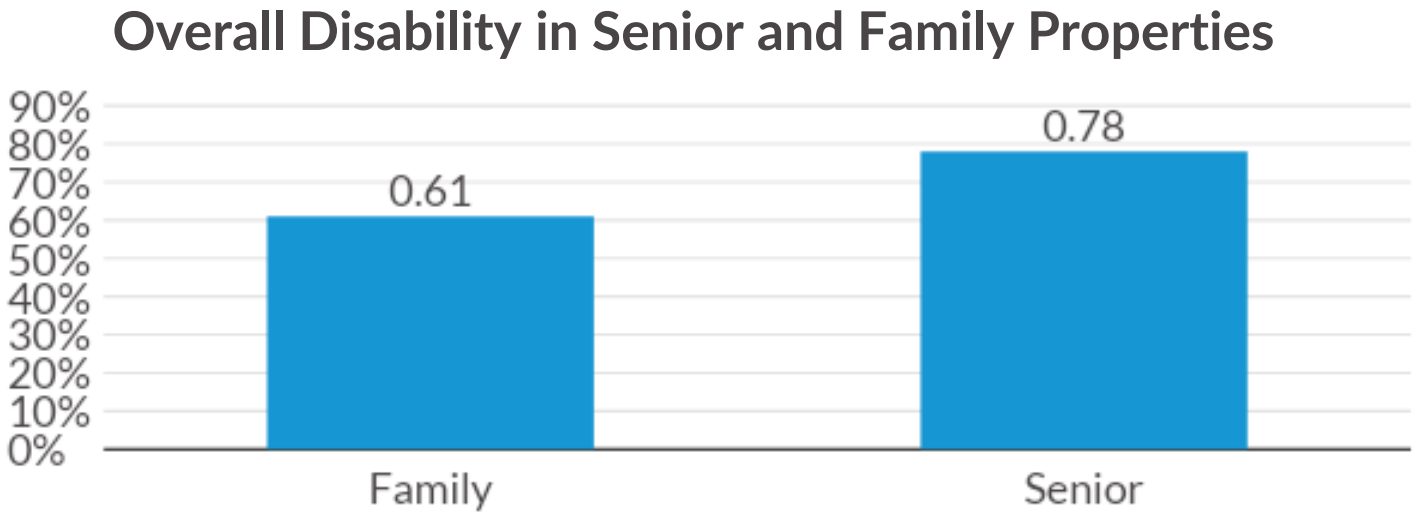
- For comparison, in the 2016 survey of family properties, 1 in 5 scored clinically depressed.

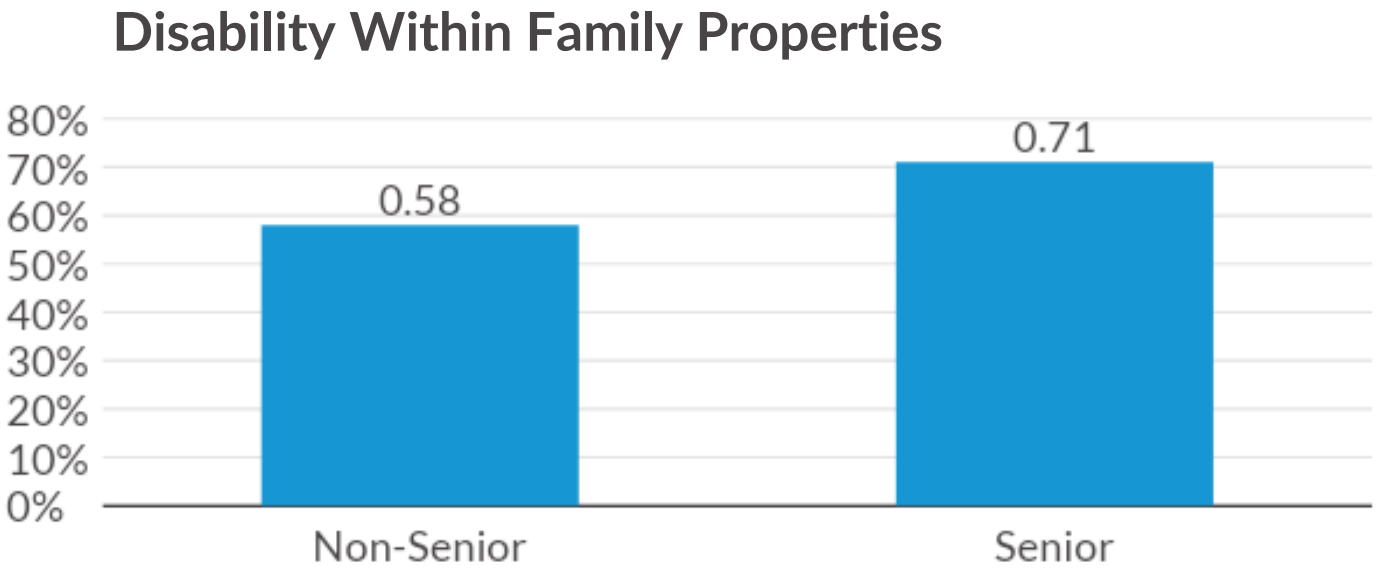


Source: 2025 DCHA Human Capital Assessment Resident Survey

High Share Report Having a Disability

- Nearly 80% of respondents in senior properties reported having a disability.
- Reports of disability are higher than those found in administrative data, in part due to how and when data are collected.





Source: 2025 DCHA Human Capital Assessment Resident Survey

Large Proportion of Residents Report Food Insecurity

- In the senior property survey:
  - 41% said food did not last sometimes or often in the last 12 months.
  - 27% had cut meal sizes in the last 12 months (half of whom did so almost every month.
- In the family property survey, 54% of respondents reported food insecurity:
  - (28%) Low food security – reduced quality or variety of meals.
  - (27%) Very low food security – reduced meal sizes.

Main Takeaways: Context

- Dramatic change in DCHA public housing resident population:
  - Substantial drop in households, residents, and children.
  - Growing share of older residents, including in family properties.
  - Substantial share of disabled residents.
- Issues around unit and property conditions, management, communication, and safety contribute to the stress that residents (and staff and providers) face.

Recommendations

- **Tailoring Services to Residents' Needs**
  - Build on examples of local partnerships.
  - Identify needs of older residents throughout all properties.
  - Continue workforce training and services for children in family properties.
- **Addressing Food Security and Material Hardship**
  - With resource cuts this may become even more acute; local coordination is key.
- **Building a More Systematic Service Delivery and Engagement Approach**
  - More active coordination with partners: providers and resident leadership.

Conclusions and Implications

Subject Matter Expert

Shawn Bloom

President and CEO

National PACE Association

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

Sustaining Impact Through Comprehensive Care: Lessons from Programs of All-Inclusive Care for the Elderly (PACE)

National Nurse Led Care Consortium

February 3, 2026

Shawn Bloom, CEO

National PACE Association

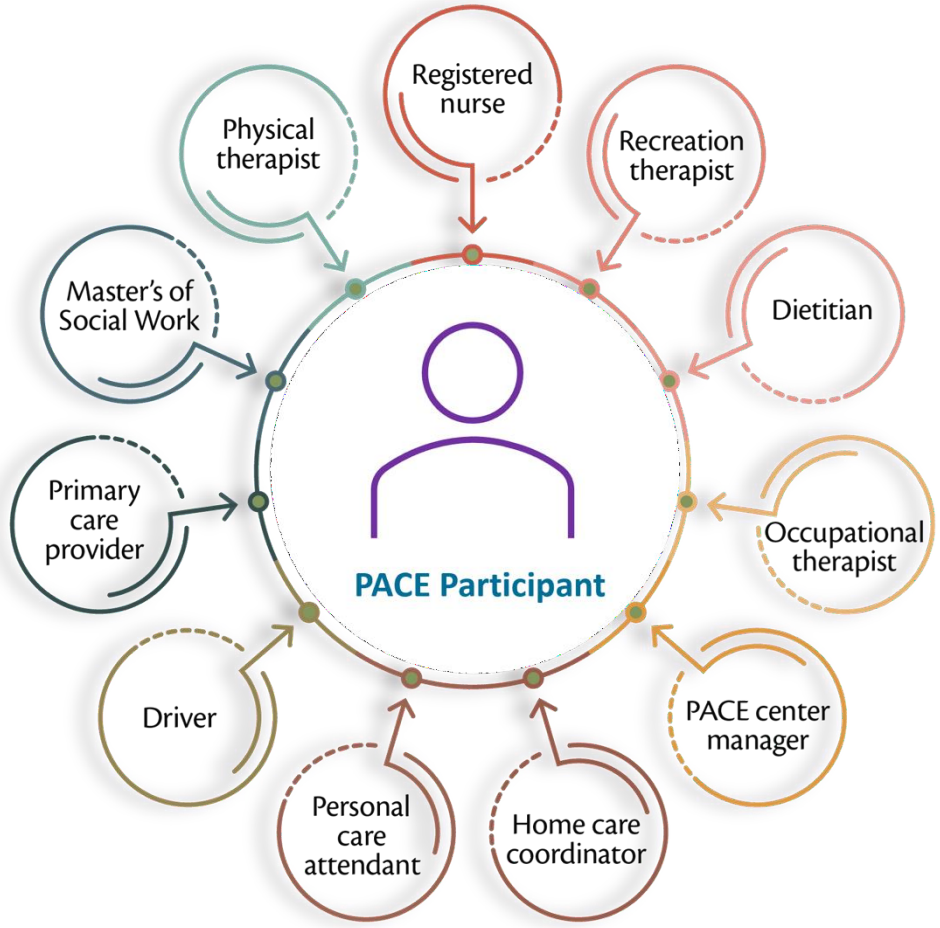
What is PACE?

***P**rogram of **A**ll-Inclusive **C**are for the **E**lderly*

- A Medicare program and Medicaid state option that gives community-based care and services to people 55 or older who otherwise would need a nursing home level of care.
- Integrated system of care for the frail elderly that is:
  - Community-based
  - Comprehensive
  - Capitated
  - Coordinated

Source: https://www.npaonline.org/what-is-pace-care

The PACE Model of Care



- PACE participants are served by an 11-member interdisciplinary team
- PACE participants receive services at the PACE center and at their homes
- PACE programs provide all Medicare, Medicaid, and medically necessary services with no benefit limitations, copays, or deductibles
- PACE programs receive capitated payments per participant and are at full risk for the services provided; payments do not change based on the utilization patterns of participants

The PACE Model Philosophy

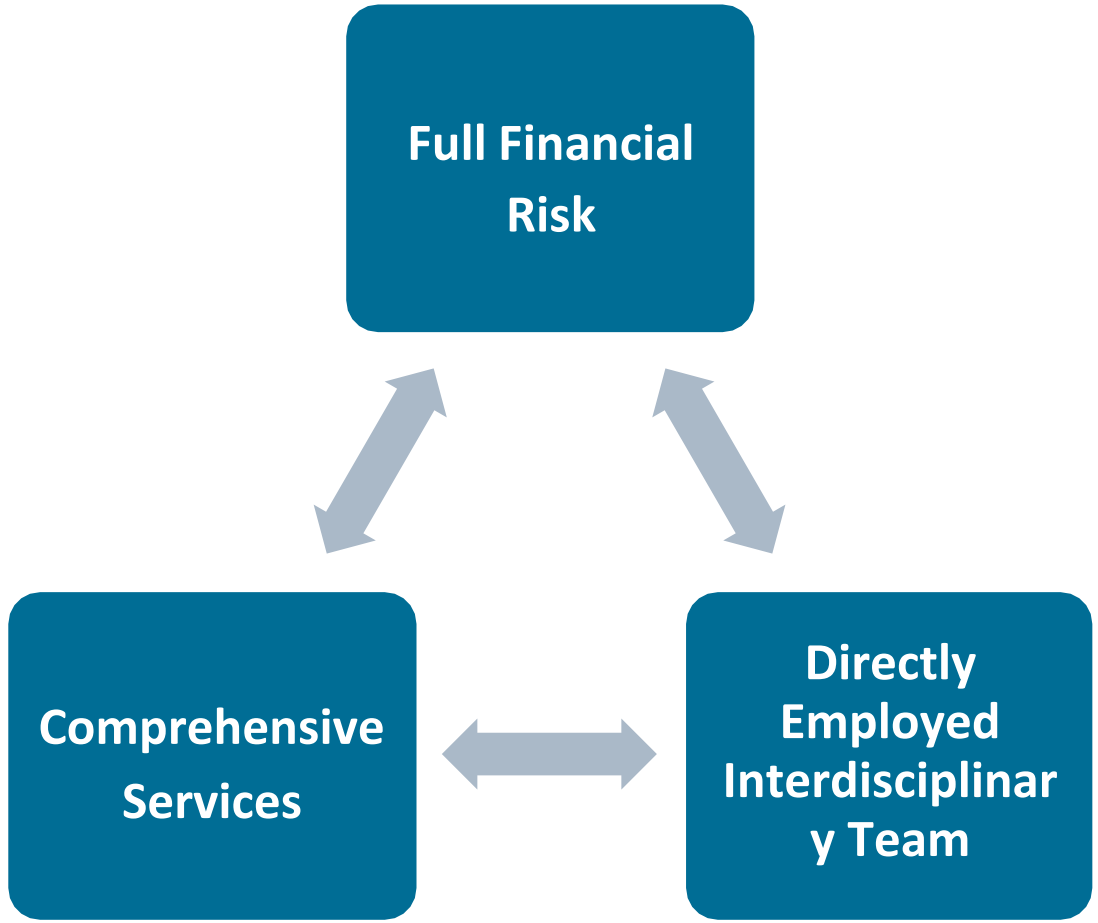
The PACE Model of Care is centered on the belief that it is better for the well-being of frail elders with chronic care needs and their families to be served in the community whenever possible.

Honoring the wants and needs of frail elders and their families

- To be cared for in familiar surroundings
- To maintain autonomy of their care
- To maintain a maximum level of physical, social, and cognitive function

Why Does PACE Work?

- PACE is both a **health provider and a health plan**
- Why does PACE Work?
  - Full financial risk
  - Comprehensive services
  - Directly employed interdisciplinary team that manages each participant's care
- The Four C's:
  - Community-based
  - Comprehensive
  - Capitated
  - Coordinated



Who Does It Serve?

PACE Participants

80.5%
are dually eligible for Medicaid & Medicare

19.1%
are Medicaid-only

0.4%
pay a premium (Medicare-only or other)

- Participants are eligible to join PACE if they are…
  - 55 years of age or older
  - Live in a PACE service area
  - Certified as needing nursing home care
  - Able to live safely in the community with the services of the PACE program at the time of enrollment

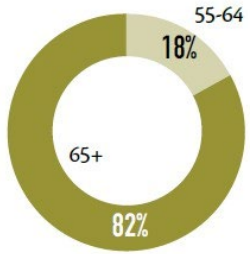
Source: NPA PACE by the Numbers, June 2025

Who are PACE Participants?

PACE SERVES OUR SENIORS[ii]

94% Live in the community

75 Average age



65% WOMEN

MEN **35%**

PACE HELPS WITH ACTIVITIES OF DAILY LIVING

TOP 5 CHRONIC CONDITIONS OF PACE PARTICIPANTS

- Vascular Disease
- Major Depressive, Bipolar and Paranoid Disorders
- Diabetes with Chronic Complication
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease

6.1 Chronic Conditions

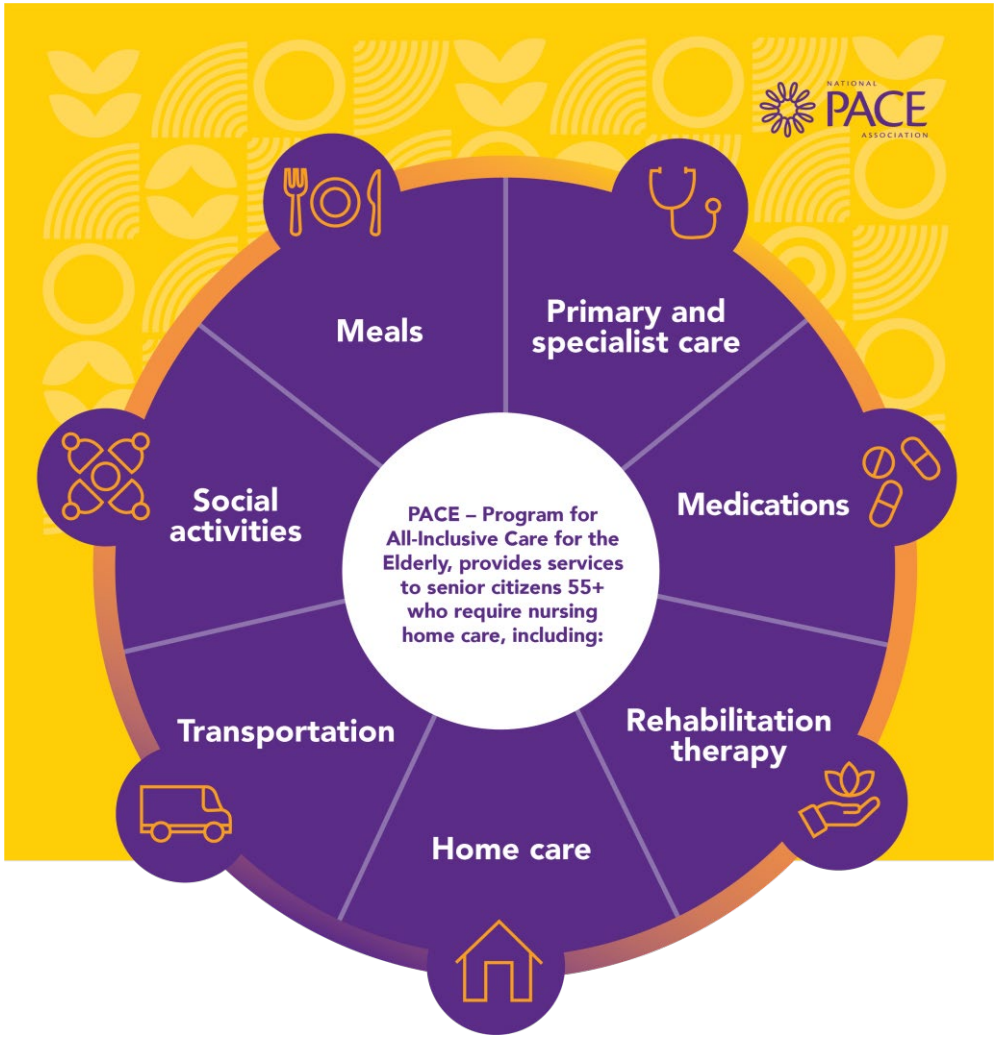
IN AN AVERAGE MONTH

6 Prescriptions

46% Dementia

Source: NPA PACE by the Numbers, February 2025

Comprehensive Services Provided



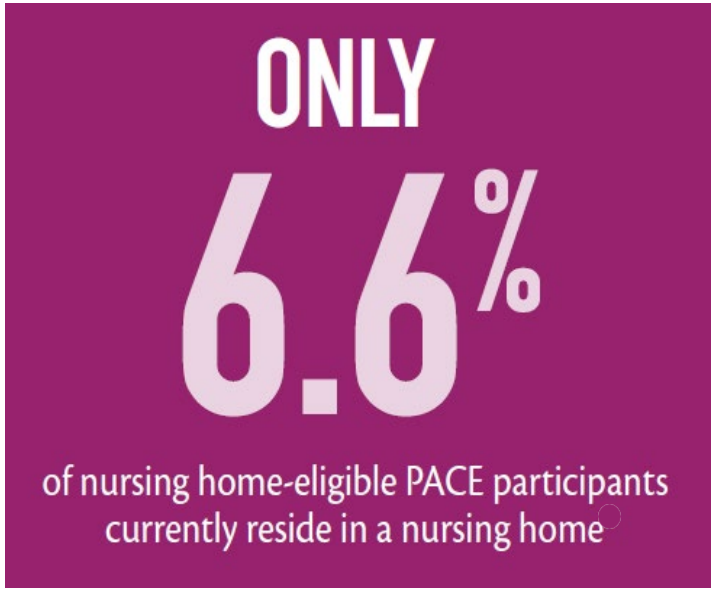
- Nursing
- Nutritional Counseling
- Social Work
- Medical Care
- Personal Care
- Social Services
- Audiology
- Dentistry
- Optometry
- Podiatry
- Respite Care
- Care Management

- Hospital, nursing home care and medical specialty services are provided when necessary (under contract and at the expense of the PACE organization)
- Any other care, services, or supports deemed medically necessary to maintain or improve the health status of participants.

PACE organizations are responsible for providing and financing all Medicare, Medicaid and medically necessary services.

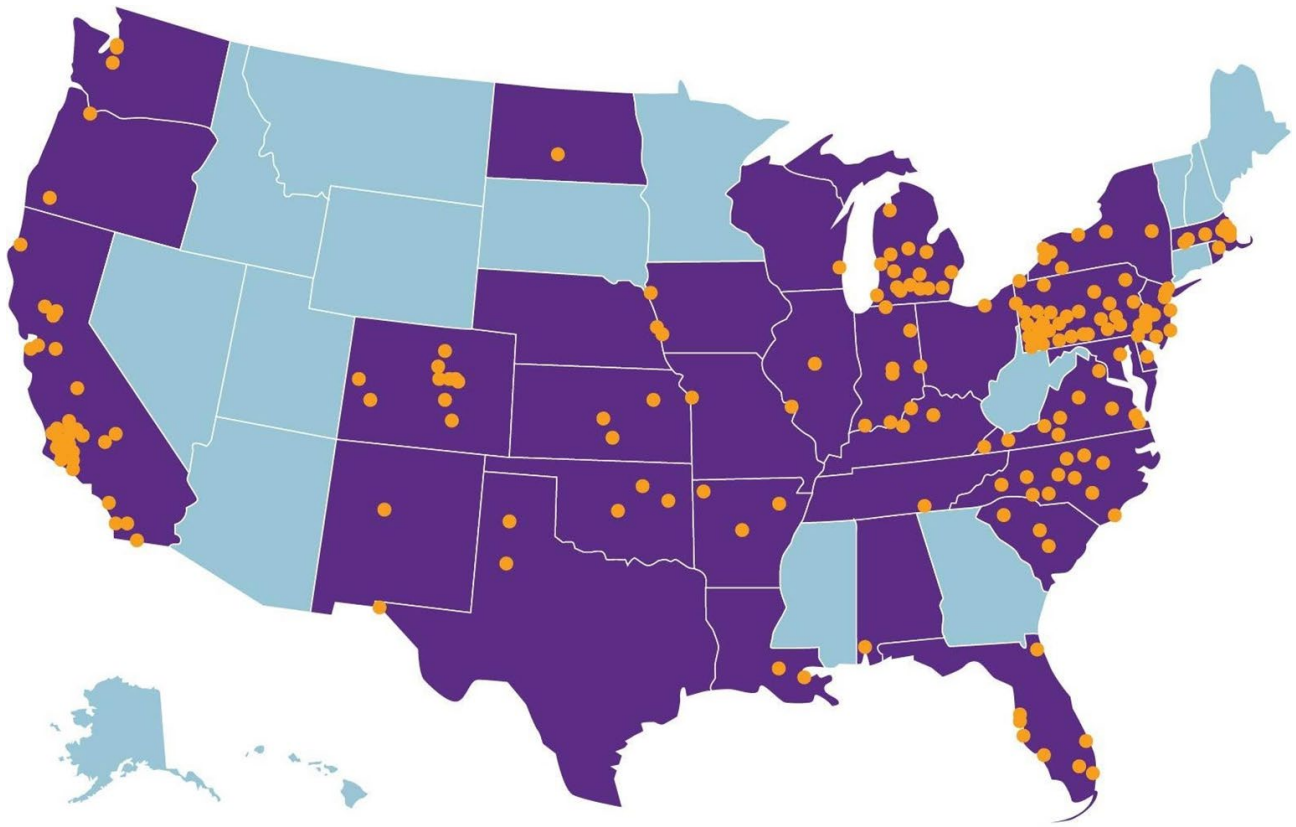
PACE Provides High-Quality Outcomes

- Reduced hospital admissions
- Decreased rehospitalizations
- Reduced ER visits
- Fewer nursing home admissions
- Better preventative care



Source: NPA PACE by the Numbers, June 2025

PACE by the Numbers



PACE Programs currently exist in 33 States and the District of Columbia.

196 PACE Organizations

376 PACE Centers

While PACE is a permanent federal program, states must choose it as an option

Over 94,000 older adults enrolled

Source: NPA PACE by the Numbers, December 2025; NPA PACE in the States September 2025 Report (internal)

Why Housing + PACE?

- Similar population demographics
- Similar eligibility and coverage
  - 90% of PACE participants are dually eligible
  - 9% of PACE participants are Medicaid-only
- Both help seniors live in the community
- Better outcomes
  - Fewer hospitalizations and E/R visits
  - Fewer unmet needs for support
  - Better and more years of Life

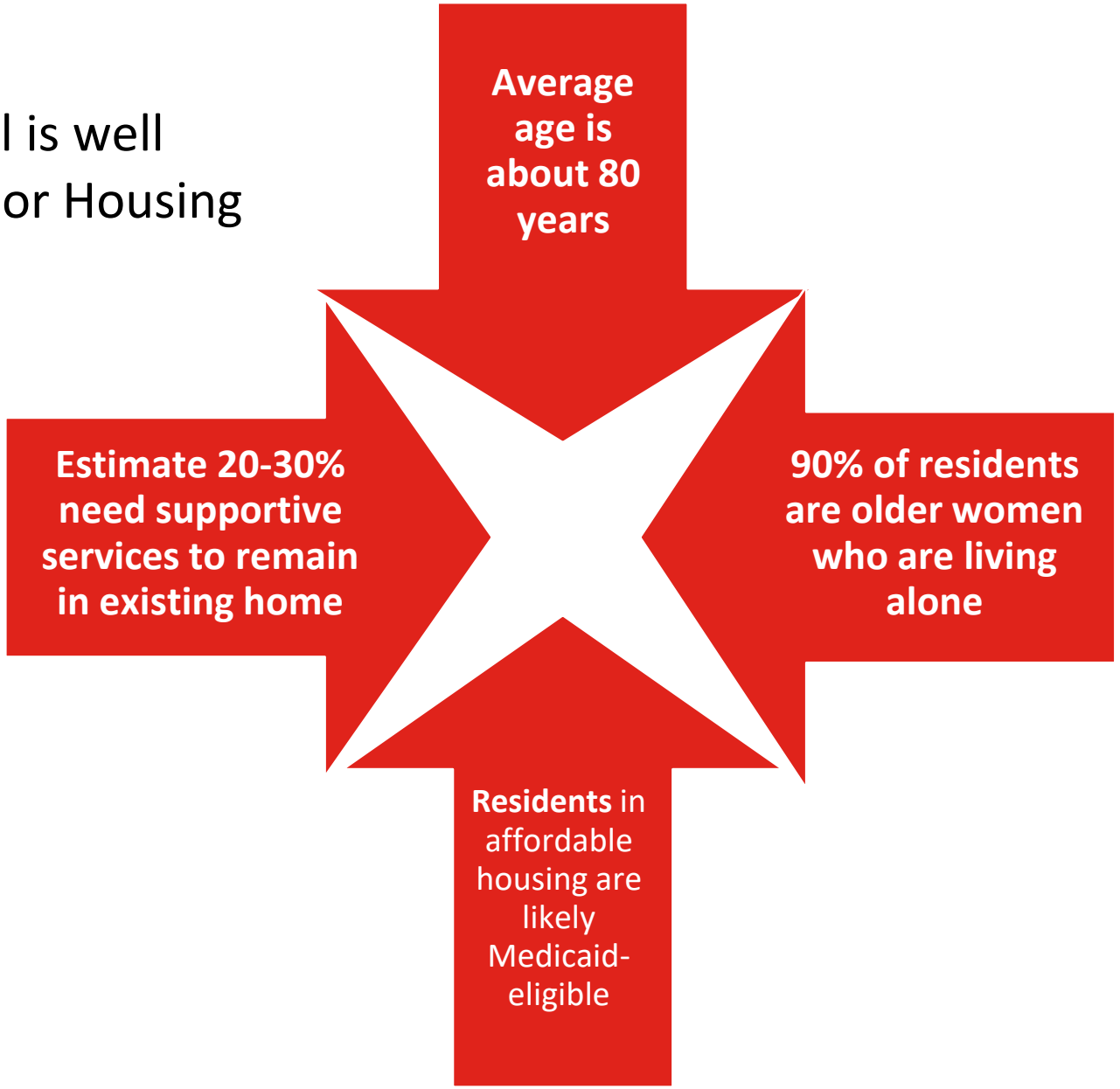
Affordable Housing + PACE: Delivery Model

- Builds on the existing infrastructure of housing and community service networks
- Generates economies of scale in organizing and delivering services
- Establishes a hub of primary care and LTSS that can be extended into surrounding neighborhoods to help even more seniors

Housing + PACE: Advancing Policy Aims

Reduce	Reduce Medicare/Medicaid costs associated with unnecessary hospital use,
Address	Address social determinants of health
Enhance	Enhance service integration and care coordination
Expand	Expand community-based long-term care options, and
Improve	Improve delivery systems for dual-eligibles
Support	Support seniors' autonomy and independence

The PACE Care Model is well designed for the Senior Housing Population



Senior Housing + PACE

- Senior housing providers connect residents to PACE
- PACE connects participants to housing
- PACE may be co-located with senior housing:
  - PACE Centers: primary care, activities, rehab, and meals
  - Alternative Care Sites: typically activities & meals

This presentation is for general informational purposes only and does not constitute business or legal advice by NPA or any of its participating members.

Co-location of PACE Services within Senior Housing

- Nearly a third of PACE organizations co-located PACE with either senior housing or assisted living
- Most co-located their PACE site with a separate housing provider
- Licensing/funding/staffing = distinct responsibility of each provider
- Part of an affordable continuum of care
- Supports broader community, in addition to residents

PACE and Housing Collaboration Arrangements: Valued Added for PACE Participants

- Expanded provision of PACE personal care services in the home
- Consumer-directed care (paid family caregivers)
- Assisted Living Facility (ALF) partnerships
- Foster Care/Group Home partnerships
- PACE facility wide supports in Public Senior Housing
- PACE operated supported housing
- PACE collaborations with senior and affordable housing providers

Other Examples of PACE/Housing Arrangements

- Co-Location of PACE Centers in housing properties
- PACE Centers Adjacent to housing
- Placement of PACE staff in housing
- Formalized collaborations between PACE and housing providers
- PACE ownership and operation of housing

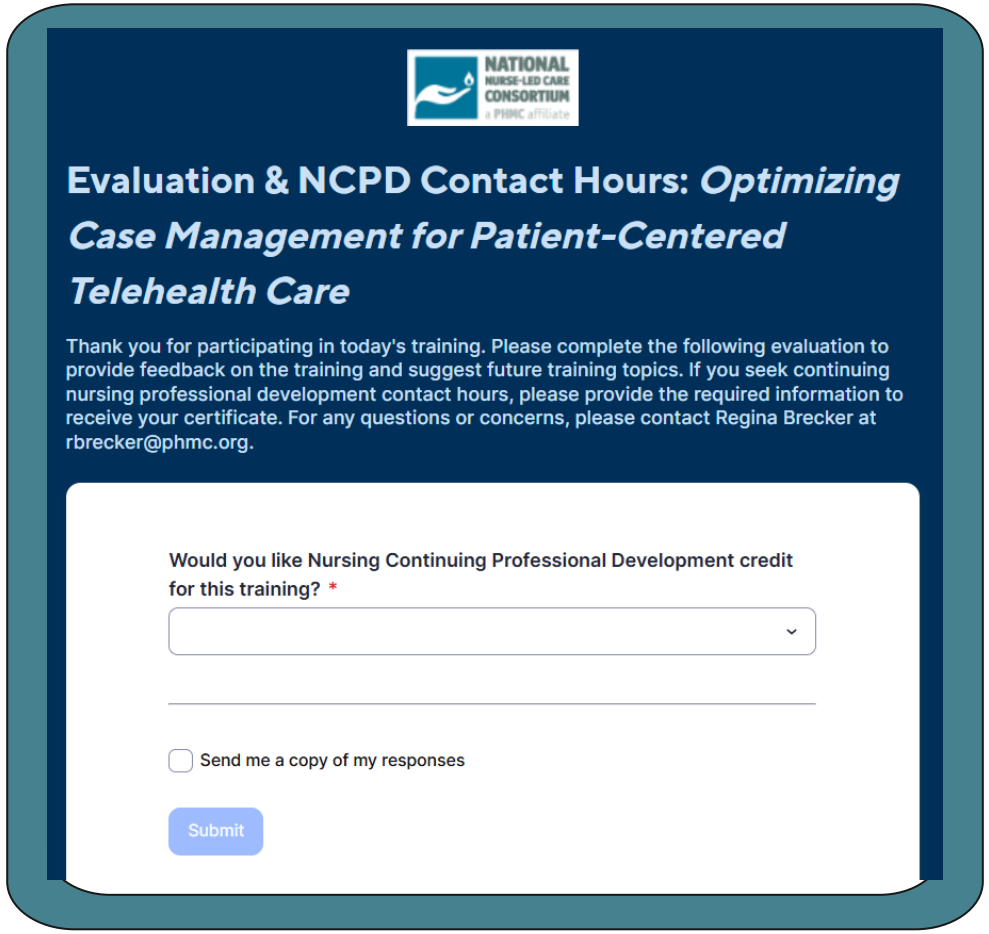
High-Level Analysis: Quality and Utilization of Services

- Decrease in the % of SNF placements of participants in housing
  - 13% to 10.6%
- Able to manage participants in community and did not have increase in ED visits compared to SNF
- Utilization is similar to participants residing in SNFs.
- Less ER utilization than participants residing in AL due to staff familiar with participants goals of care and working with PACE Program
- Participants and families satisfied with care model and support given
- Able to maintain people in supportive housing with reduced need for SNF placements

Questions?

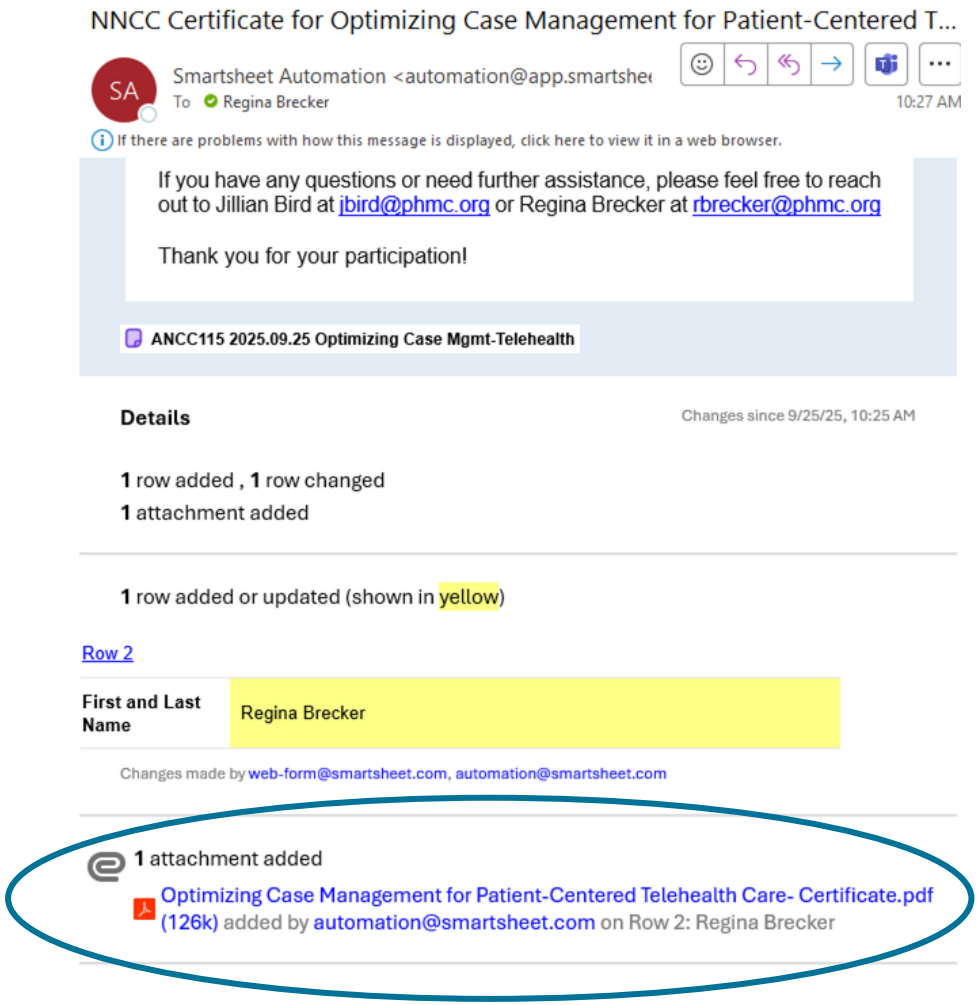
This presentation is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government.

Evaluation


NATIONAL
NURSE-LED CARE
CONSORTIUM
a PHMC affiliate
Evaluation & NCPD Contact Hours: *Optimizing Case Management for Patient-Centered Telehealth Care*
Thank you for participating in today's training. Please complete the following evaluation to provide feedback on the training and suggest future training topics. If you seek continuing nursing professional development contact hours, please provide the required information to receive your certificate. For any questions or concerns, please contact Regina Brecker at rbrecker@phmc.org.
Would you like Nursing Continuing Professional Development credit for this training? *
Send me a copy of my responses
Submit

Certificate

Once you submit the evaluation, please wait approximately **20 minutes** for your certificate to arrive. It will come from “Smartsheet Automation,” and be linked at the **very bottom of the email** (as seen below). You will not need to request access.


NNCC Certificate for Optimizing Case Management for Patient-Centered T...

SA Smartsheet Automation <automation@app.smartshee

To Regina Brecker 10:27 AM

If there are problems with how this message is displayed, click here to view it in a web browser.

If you have any questions or need further assistance, please feel free to reach out to Jillian Bird at jbird@phmc.org or Regina Brecker at rbrecker@phmc.org

Thank you for your participation!

ANCC115 2025.09.25 Optimizing Case Mgmt-Telehealth

Details Changes since 9/25/25, 10:25 AM

1 row added , **1** row changed
1 attachment added

1 row added or updated (shown in yellow)

Row 2

First and Last Name	Regina Brecker

Changes made by web-form@smartsheet.com, automation@smartsheet.com

1 attachment added

Optimizing Case Management for Patient-Centered Telehealth Care- Certificate.pdf (126k) added by automation@smartsheet.com on Row 2: Regina Brecker

Access Health Center Resources

NNCC Resource Library

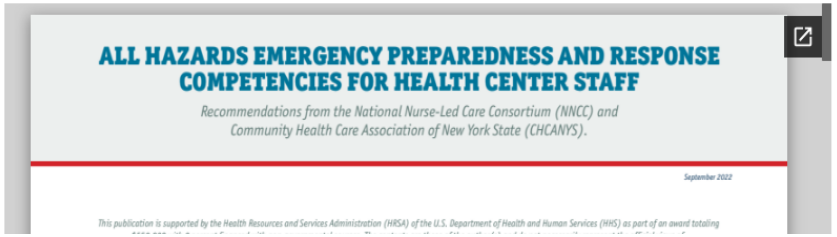
NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

Login | Join

About Programs Advocacy News & Resources Training Subscribe Search NNCC

All Hazards Emergency Preparedness and Response Competencies for Health Center Staff

To successfully perform their assigned emergency/disaster roles, health center staff must understand how their organization will respond to hazards, including the use of altered management structures and modified operations. The National Nurse-Led Care Consortium (NNCC) and the Community Health Care Association of New York State (CHCANYS) created a set of competencies to improve the emergency and disaster preparedness of all health center staff. This publication provides a comprehensive overview of those competencies and sub-competencies, as well as a description of their development process. The competencies are intended to form the foundation of health center staff education and preparedness for all-hazards emergency and disaster response and will allow health centers to direct their limited training time and resources to cover the most essential preparedness aspects.



Upcoming Trainings

February 10, 2026 – 3 pm EST

- Sessions 4: Care for Aging Residents of Public Housing: Strategies for Rural and Urban Settings
- *Registration:* *https://us02web.zoom.us/webinar/register/WN_zlaUEZ0JQ1mt5Q0ItA0v5g*

February 12, 2026 – 1 pm EST

- Radon and Respiratory Health: Addressing Hidden Housing Hazards in Health Center Communities
- *Registration:* *https://us06web.zoom.us/webinar/register/WN_CSjgwvf8SMStmx-anqMf_w*

February 19, 2026 – 3 pm EST

- Comprehensive Case Management for Prenatal Care in Health Centers: Improving Access and Outcomes
- *Registration:* *https://us02web.zoom.us/webinar/register/WN_tZvw0STTT3-ey4vVznEgmg*

Thank You!

If you have any further questions
or concerns please reach out to
Regina Brecker at rbrecker@phmc.org

Subscribe for the Latest Updates

Subscribing to our email newsletter is the best way to learn about all of NNCC's free webinars and other online learning opportunities.

SUBSCRIBE