



SHELTERFORCE

Health & Community Development

Addressing the Social Determinants of Health

What Happens When a CDC Pivots to a Health-First Focus?

By Amanda Abrams

IN SEPTEMBER, OLD BROOKLYN CDC officially released a community health needs assessment for the 6-square-mile Cleveland neighborhood the organization covers. The rigorous health survey was the result of almost two years of strategizing, shoe-leather canvassing, and number crunching. But it also represented a

time, however, it struggles against doubts on the part of those who are comfortable with the way things have always been done.

But the real challenge comes now. Survey results in hand, Old Brooklyn CDC must figure

Old Brooklyn CDC in Cleveland finds that being an early adopter has its advantages.

radical transition for the 44-year-old group: the decision to reframe its work from that of a standard community development organization to one that views its goals and successes through the lens of residents' health.

Around the country, community development groups are increasingly using the social determinants of health as a proxy for residents' well-being, and many are forming new partnerships with health institutions. But Old Brooklyn is one of the first to wholly shift its focus and make positive health outcomes its priority. Its leaders have been remarkably savvy in navigating this new terrain, and the organization has benefited from being an early adopter and leader. At the same

time, however, it struggles against doubts on the part of those who are comfortable with the way things have always been done.

Thinking Big and Shifting the Lens

In 2015, Jeff Verespej—Old Brooklyn CDC's executive director—decided to take a critical look at the organization's mission and its work in the community. The group had started as a coalition of residents, business owners, and religious leaders back in the mid-1970s

ALSO INSIDE

Medicaid Dollars for Housing?

by Amanda Abrams

Keeping Seniors in Their Homes,

by Amanda Abrams

How Teeth Affect Housing Stability,

by Stacie Birchett

Locals participate in Old Brooklyn's Smorgasbord Street Fest.

and largely focused on business support and housing development. But Cleveland's largest neighborhood was changing. African American and Latinx populations were growing and the poverty rate was rising, but the community was also stratifying, with the proportion of household incomes over \$100,000 increasing.

"We felt we needed a change to reflect those evolving times," says Verespej, who had been hired a couple of years earlier. "So we took a critical look at the status quo: was it acceptable, or did we need to change?" The organization was open to thinking big.

After almost nine months of conversations with community members, stakeholders, and staff, it was the facilitator hired to help with the strategic planning process who introduced the idea of focusing on health to Verespej. "The consultant sat me down in the conference room one day and said, 'I think you'll be investing in community health. You're already doing it: you're in housing and economic opportunity, you've just never tied it together to be health,'" recalls Verespej.

He quickly saw the consultant's point and jumped on the idea with enthusiasm. "What it's about is quality of life," says Verespej. Issues such as the safety of neighborhood streets and the distance of grocery stores selling healthy food mattered to local residents, and they fell under the organization's existing mission: to improve the neighborhood by uniting residents and businesses. The bottom line was the same; only the health terminology would be different. "We've never framed it that way, that's the shift.

"As a neighborhood that's in between strength and instability, investing in community health as a quality-of-life strategy is critical. We don't want to go off the edge either way

and we believe that this [focus] will help as it uses data, partners, and root causes," says Verespej.

Katie Grace Deane, associate director of research, evaluation, and field development at the Center for Community Investment, which focuses on the nexus of community development and health, says Old Brooklyn CDC may well be a leader in the community development field. "I haven't heard of anyone refocusing the entirety of their work on health," she says. And as long as the organization's actions truly reflect the needs and desires of the community, she adds, it could wind up being very successful.

While unsure of what it meant for them, senior staff liked the idea; some of their titles changed, but no one left. Board members, too, were largely supportive. Still, says Verespej, "It was a multiyear process to get them to adopt the [new] strategic plan. They asked all the critical questions along the way."

Lawyer Sean McGrane was perhaps the most skeptical board member. "When you define health very broadly, as we have, I have a concern that it'll subsume the traditional functions of a CDC," says McGrane. For example, Old Brooklyn CDC had long been engaged in housing rehabilitation in the area. "Is the physical infrastructure part of health?" McGrane asks rhetorically. "We had a staff member focused on education, helping with schools—is that part of health?" (The organization's education and rehab programs have both continued.)

And there was grumbling when the organization lost funding for its code enforcement manager while simultaneously raising money for the health-oriented initiative. But by and large, board members were willing to take a "wait and see" position.

Thirty-Eight Questions

Verespej has consistently been described by colleagues and funders as ambitious, persistent, and far-sighted. Once he'd been converted to a health focus, he moved very deliberately, careful to build partnerships and alliances every step of the way. After the organization's new strategic plan was adopted in 2016, he contacted people all over the region who were even tangentially related to the field of community health to hear their thoughts.

It was through those conversations that he and board members came up with their next steps: hiring a health fellow who would form an advisory committee and conduct a community health needs assessment (CHNA); that way, the organization could get a data-driven sense of the area's problems before designing any programs.

To support the initiative, Verespej returned to several local funders who had provided money for the original strategic planning process to ask them to back the fruits of that process. He was largely successful. Colleen Gilson, vice president of CDC advancement for Cleveland Neighborhood Progress, an umbrella agency for the city's CDCs, was immediately intrigued with Old Brooklyn CDC's new ideas.

The Old Brooklyn Farmers Market.





Community artmaking at Cleveland's Summer Cinema at Old Brooklyn's Loew Park.

"It was unique, different, and something we thought we could certainly learn from," says Gilson. There was risk involved, certainly, but she was impressed with Verespej's leadership, vision, and big plans, and felt that the city's CDCs would benefit from observing his group's efforts to shift to a health focus—characteristics that other funders noted as well.

Her organization wound up naming Old Brooklyn CDC as one of its strategic investment grantees and awarded it a total of \$300,000 of unrestricted operating dollars over three years. Two other local groups, the Cleveland Foundation and Enterprise Community Partners, committed to providing roughly \$50,000 each over two years.

Funding in hand, Old Brooklyn CDC conducted a national job search for its health fellow and in May 2017, the organization hired Jennifer King, who had recently earned a doctorate in public health. Her job description was clear: "Convening a community health advisory committee, conducting a community health needs assessment, and really figuring out how to empower the residents of the neighborhood to understand what health is and how to take an active role in improving it," says King.

Many of the stakeholders Verespej had originally spoken with became members of the advisory committee. In particular, the MetroHealth System, Cleveland's safety net hospital that has a branch within Old Brooklyn, was engaged from very early on. Others included representatives of the city and county health departments, as well as the Better Health Partnership—a group of stakeholders focused on improving health outcomes—and the Cleveland Clinic, a local medical center with an international reputation.

After initial discussions with neighborhood residents to gain a sense of their priorities and concerns, advisory group members hammered out a set of questions for the survey. Dave Margolius, a MetroHealth doctor, Old Brooklyn CDC board member, and advisory committee member, remembers one meeting when Merle Gordon—Cleveland's director of public health and a fellow advisory committee member—was particularly insightful.

"She came up with a great idea of asking, 'Where do people go grocery shopping?'" he says. Answers to that question would allow the

organization to pinpoint exactly how far residents have to go for groceries, and could even open the door to eventually lobbying specific stores to stock healthier items, for example.

In the end, the CHNA had 38 questions on topics like safety, green space, food accessibility, housing, child health, and substance abuse. Calling it a CHNA—the same name used by health care institutions for the audits the IRS requires, and by local and state health departments—was intentional, says Verespej: the survey was the same kind of tool used by big hospitals, simply tailored to a much smaller area. And that's unusual. "As far as I know, this is the only one that's been done by community-based organization for its neighborhood," says Verespej. He and his staff hope hospitals will learn from the organization's community-driven, bottom-up approach.

Before releasing it to the community, Old Brooklyn CDC took the extra step of getting the survey approved by the Institutional Review Board (IRB) at nearby Baldwin Wallace University. IRB approval is standard for academic research; it gives the assessment the stamp of scholarly legitimacy and enables its outcome to potentially be published in an academic journal.

Finally, in early 2018, the organization posted the survey on its social media channels, and staff members hit the streets, using whatever opportunities they could think of to reach a range of neighborhood populations. "That included going to the public library, the neighborhood recreation center, barber-shops, parent-teacher night at local schools," says King. She and other staff members quickly realized they were oversampling older white women, so they redoubled their efforts to connect with other demographics. In the end, over the course of three months, 412 people responded to the survey.

In the summer of 2018, when staff finally examined the survey's results, there were surprises. Almost 20 percent of respondents worry about running out of food, with the same percentage reporting that they frequently have to choose between food and housing; over one-third said they spend more than 30 percent of their income on housing. Ten percent said they abuse prescription drugs, and virtually none have plans to quit doing so.

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Those results show the benefits of having conducted a statistically sound survey. “It allows others who don’t necessarily have a public health background or are really involved in this work to see that [these issues] are very real,” says King.

Developing Interventions and Finding Funding

Old Brooklyn CDC held a two-day summit in September to publicly release the survey’s results and convene community developers for a conversation about health programming prompted by the survey. The event had another objective as well: to help the organization identify potential new allies. After all, “the starter’s

gun has just gone off,” as Verespej puts it. With the assessment complete, it was now time to get to work identifying possible interventions to address the neighborhood’s needs.

To assist with that process, the CDC hired a community health coordinator to develop a residents’ advisory group, in order to ensure that whatever comes next is truly grassroots-driven.

Jennifer King left her job for academia; the next person who fills the health fellow role will have to be action-oriented. And the organization was recently granted \$80,000 by the CareSource Foundation to begin developing community health interventions.

What those interventions will look like is still murky, though. There are some ideas floating around: MetroHealth has an office of opioid safety and recently bought a drug recovery facility in the neighborhood, for example, so the organization could find a way to work with the health care group. Or Old Brooklyn CDC might work with the Greater Cleveland Food Bank to deliver food to the community’s many seniors.

Or it could partner with the local farmers’ market to hold fitness events and healthy-cooking demonstrations.

But first, staff will have to figure out the organization’s identity in these activities. The strategic plan dictates that Old Brooklyn CDC act as a community backbone, but what that means is context-dependent and not always obvious. “One of the things I’ve challenged Jeff and the

organization with is, ‘Let’s understand the role we play: are we a facilitator? Coordinator? Starting new services?’” says Dave Martin, the organization’s board chair. “Let’s not try to do it all. Let’s pick the next few things we think we can do effectively and gain some momentum that way.”

Indeed, Old Brooklyn CDC is already part of one new initiative. Together with MetroHealth, the organization purchased the last non-institutionally owned property near the MetroHealth branch in the neighborhood, and the two groups won a \$65,000 study grant from the regional transportation agency. The plan is to turn the property into a green space—something the survey illustrated was lacking in the center of the neighborhood—and enhance its attractiveness to pedestrians.


Unsurprisingly, partnering with MetroHealth in this way is a smart and strategic decision on Old Brooklyn CDC’s part. It’s a low-cost, feel-good project, and MetroHealth is perhaps the organization’s most obvious ally. As a public hospital, its mission closely aligns with that of the CDC, but because it’s a large institution, many of the public health activities it supports can be done more nimbly and with more community support by an organization like Old Brooklyn CDC.

“Obviously, Old Brooklyn [CDC] understands way better than we can the housing market for Old Brooklyn,” says Greg Zucca, MetroHealth’s director of economic and community transformation, “or where there is lead contamination, or gaps in transportation to get people to work. Working with CDCs creates that lens.”

MetroHealth isn’t rolling in funds, though. “We’re a public health hospital; we don’t have a ton of money to be investing in a lot of things,” says Zucca. That’s largely true for other local hospitals as well, even the Cleveland Clinic; though it co-sponsored the summit in September, the nonprofit hospital posted a decline in operating revenues for the first half of 2018.

There have been challenges with other funding, too. Being an unconventional CDC isn’t always a benefit, Verespej has found. Recently he met with the community development manager of a large regional bank to talk about what Old Brooklyn CDC was doing. “We were flatly told, ‘This doesn’t fit into a community development portfolio. We love this work, but we need to see it proven before we can invest in it,’” Verespej remembers. That wasn’t the first time: not surprisingly, big institutional lenders aren’t always comfortable taking risks on new ideas.

Nor are other community development corporations fully comfortable working with Old Brooklyn CDC. Few showed up at the September summit, probably because not many have staff members explicitly tasked with community health.

Clearly, there’s a lot of work ahead for Old Brooklyn CDC. But Verespej excels at forming partnerships, and the organization—like most community development nonprofits—has become adept at leveraging funding in order to get more funding. With the CHNA as a map for its future, Old Brooklyn CDC may well find a way to greatly improve the neighborhood’s health and improve the lives of its residents. 

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AMANDA ABRAMS, Shelterforce’s health fellow, is a freelance journalist living in Durham, North Carolina.

As a neighborhood that’s in between strength and instability, investing in community health as a quality-of-life strategy is critical.

RESOURCES

“Setting Aside Housing for Frequent Health Care Users,” by Amanda Abrams, *Shelterforce*, July 30, 2018 bit.ly/SF191Abrams

“Greening Vacant Lots: Low Cost, Big Effect in Philly,” by Maggie Loesch, *Shelterforce*, Nov. 13, 2018 bit.ly/SF192Loesch

Medicaid Dollars for Housing?

By Amanda Abrams

LATE LAST YEAR, ALEX Azar, the secretary of the U.S. Department of Health and Human Services (HHS), shocked people in the health, housing, and social services fields by strongly hinting that Medicaid funds could be used for housing costs in the future. “What if we provided solutions for the whole person, including addressing housing, nutrition, and other social needs? What if we gave organizations more flexibility so they could pay a beneficiary’s rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food? If that sounds like an exciting idea . . . I want you to stay tuned to what CMMI [the Center for Medicare and Medicaid Innovation] is up to,” Azar said in a November 2018 speech to the Hatch Foundation.

Later that day, he gave a speech to the Commonwealth Fund with a similarly intriguing message. “We are actively exploring how we

a network of human service organizations. The funding can be applied to housing-related services, as well as for some housing modifications, like the removal of moldy carpets, which can trigger asthma attacks. But the waiver also declares that Medicaid funds in the pilot areas can be used for one-time payments for security deposits and first month’s rent, as well as for post-hospitalization housing for up to six months. “That’s something of a breakthrough,” said Jeffrey Levi, a professor of health policy and management at George Washington University. “It’s clear the administration is doing this to see how far they can

The U.S. Department Health and Human Services is exploring ways to pay for non-health services with Medicaid, but it’s unclear whether that would, or could, actually happen.

could experiment with actually paying for non-health services, like housing and nutrition—an integrated, individually driven approach to health and human services on a scale that has never before been tried in the United States,” he said.

Over the past few years, the Centers for Medicare & Medicaid Services (CMS) has embraced the concept that upstream factors like housing and food—the social determinants of health—deeply affect individuals’ health. That may seem revolutionary for a federal agency in the Trump administration, but it’s part of a general trend across the health care industry. “I think it’s consistent with a move towards value-based payment”—paying for health outcomes rather than direct services—“that incentivizes value, not volume,” said Diana Crumley, a program officer at the Center for Health Care Strategies.

In 2015, CMS began granting waivers to states to allow them to use Medicaid funding for various preventive measures, including housing-related services that help individuals find and stay in housing. This option was considered groundbreaking, and several states have applied for and received those waivers, including Illinois, California, and New York. California’s Whole Person Care pilot program, for example, allows hospitals and social service organizations to collaboratively treat high-cost homeless patients; Medicaid funds can be used for housing services, and local and state money can be applied directly to housing payments, helping to get needy individuals into homes. However, using Medicaid funds to pay directly for housing, as opposed to housing services, is prohibited by the Social Security Act—which is why Azar’s comments came as such a surprise. And few observers know exactly what he has in mind.

But some analysts point to a Medicaid waiver for North Carolina that CMS approved in October 2018 as a possible roadmap. With the waiver, North Carolina will launch two to four pilot projects over the next five years; each will be implemented in collaboration with

go to address health under the social determinants.” Levi thinks that those types of housing payments still fall under the health-related services category, at least according to CMS’s general counsel, and therefore allowed by law.

This isn’t charity, points out Lisa Dubay, a senior fellow in the Health Policy Center at the Urban Institute. Maybe there will be some additional funding later, she adds, but the bottom line is a waiver “has to save money.”

For populations with substance abuse problems or severe mental illness, paying for housing is indeed cost effective, because it keeps them out of hospitals and other institutions. And for low-income families facing a financial emergency who might need just \$100 to stay in their apartment at the end of the month, assistance could allow them to avoid a raft of serious short- and long-term health problems that follow the stress and disruption of eviction and homelessness.

But ultimately, those are efforts at the margins. For CMS to allow Medicaid funding to be used in a much bigger way—to build enough housing to address the housing crisis, for example—would be an almost inconceivable stretch. “I think it’s potentially an important change in policy,” said Dubay of Azar’s comments. “But in the end, we’re going to have to build affordable housing; the health care system can’t do that.” 🏠

To comment on this article, go to bit.ly/SF193Medicaid or write to letters@shelterforce.org.

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Keeping Seniors

MOST SENIOR CITIZENS WANT to stay in their homes as they age, but health considerations often make that impossible. Almost a decade ago, Vermont's Cathedral Square Corporation, which has been building affordable senior housing for 40 years, questioned the seeming inevitability of that pattern. Could its staff design a slate of health interventions that would address older residents' physical and emotional needs and also allow them to grow old at home?

application of concepts many organizations only give lip service to: partnership, collaboration, and connecting people. Those elements were integral from the start, and remain key to its success.

Cathedral Square developed the concept of SASH in 2009. Working with about 60 older adult residents at one of the organization's housing sites in Burlington, Cathedral Square's staff designed the program by querying experts: the people themselves.

"That was very intentional: we knew that they were probably the ones with the answers about how to build a system," says Molly Dugan, the director of SASH. "We really worked with them; we had weekly meetings with residents and their families or guardians where we'd choose a particular topic"—say, issues around coming home from

Vermont's SASH program, which connects elderly residents with community-based services, is saving money in urban areas by reducing emergency room and specialist visits.

The result is Support and Services at Home (SASH), a hands-on program that does just that. Operating across the state of Vermont, SASH promotes the coordination of health care by connecting elderly residents with community-based services and a traveling wellness nurse. The program allows residents to continue living as independently as possible, and—as a team of researchers recently wrote in HUD's *Cityscape* journal—it makes a significant dent in health care costs, as well.

But it's only possible because of the real

a hospital visit—"and we heard a lot about what was working well, what wasn't." Existing community partners who work with seniors, such as home health agencies and departments of aging, were also part of the discussions.

Starting in 2009, Cathedral Square piloted the program for a year. In 2010, SASH joined the state's health care reform initiative—Vermont Blueprint for Health—in an application to the Centers for Medicare and Medicaid Services for one of its innovative payment reform demonstration programs. Funding through that program was secured in 2011 and allowed for Medicare funds to be used differently and provide payments for primary prevention efforts, including those prioritized by the SASH program.

Today, the program is all of Vermont's 14 counties and helps roughly 5,000 older residents, most of whom live in low-income housing developments. SASH has divided the Vermont map into six geographic areas, and they're all administered by affordable housing providers, including Cathedral Square. That's crucial, says Dugan: "Those organizations have the connections with their people and communities," which means they're better able to identify residents' particular needs and habits.

A full-time care coordinator and a part-time nurse visit the residents regularly, but a big part of their roles is to connect the residents with services that can help them. Those service providers—from

At right: Two residents of Wright House, an affordable housing community Vermont, participate in SASH July 4th activities. Below: Ellen Gagne leads a group activity on creating winter bird feeders.



in Their Homes

By Amanda Abrams

senior transportation agencies to grief support groups to healthy eating specialists—sign an agreement to collaborate with SASH staff and regularly attend meetings. “We’ve got to get services to where people live, and this simplifies it a whole lot,” said Dugan. “The existing organizations have years of experience, and they’re key.”

The wellness nurse, meanwhile, is in close communication with primary care providers. “[The nurses] are seeing their patients and have a lot of interesting information—for instance, ‘Here’s what’s really in the medicine cabinets of your patients,’ or ‘They’re really not using their walker like you told them to,’” explains Dugan.

The upshot is that the participating seniors are happy. Dugan says she sees it every day, in the grateful letters she gets from residents’ family members and the small ways SASH staff are able to improve the seniors’ health and lessen their social isolation. “Our staff are charged with building trusting relationships,” says Dugan. “That is, ‘what makes this participant tick? What do they need to stay happy and healthy? I know we’re making a difference.’”

And it’s a difference that’s quantifiable, as recently demonstrated by researchers from RTI, LeadingAge, and other organizations, who wrote about SASH in *Cityscape*’s November issue.

Their findings initially look disappointing; the study found that SASH has no significant impact on total Medicare expenditures. But the finer print is heartening. In fact, the programs administered by Cathedral Square, and other programs that specifically focused on urban areas, did show statistically significant savings, particularly in emergency room and specialist visits, two high-cost areas. In total, the programs administered by Cathedral Square saved \$91 per beneficiary per month in Medicare dollars, while the urban programs saved \$122.

Those numbers aren’t too surprising: Cathedral Square had run its SASH program for a longer time than the others, and utilized a team leader who was able to take over some administrative tasks and free up other staff members. And the urban programs allowed staff members to spend less time in transit and concentrate more closely on residents.

And that’s very meaningful, says Amy Kandilov, a senior research economist with RTI and the study’s lead researcher. “A lot of programs get tried and don’t show any effect at all. This is the glass half full: it has favorable results and we can see characteristics that will help move it forward.”

Robyn Stone, another member of the research team, and senior vice president of research at LeadingAge, the national association of aging-related nonprofits, agreed. “I think it was a fairly strong finding for urban areas, and the applicability is to most housing across the country, so it’s quite valuable. Also, it’s a consistent finding



over multiple years,” she says, adding that those elements add real legitimacy to the program.

In fact, organizations in several other states have shown interest, and some are already implementing SASH look-alikes. Cathedral Square is working with a housing group in Minnesota to replicate SASH at five housing communities there. And the model is already being used in Rhode Island, in a high rise for low-income seniors in downtown Providence. Those residents are mostly Spanish speaking, and Dugan says, “It’s so cool to see such a different context and see the SASH model flourish there.” 📍

To comment on this article, go to bit.ly/SF193SASH or write to letters@shelterforce.org.

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Shelterforce is a national publication for the housing and community development field. We've long recognized the connection between health, affordable housing, and community development, and are now exploring it more deeply in this regular health and community development supplement. For more on this topic, or on affordable housing and community development in general, visit us at shelterforce.org. You can also sign up for our weekly email summary of new stories at bit.ly/SFWeeklySignUp.

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How Teeth Affect Housing Stability

By Stacie Birchett

DENISE LECLAIR WAS RESIGNED to never eating her favorite fruits and vegetables. The 77-year-old retiree had last seen a dentist 18 years ago when she had dental insurance. But in the years since, she's been unable to afford even a routine cleaning and her teeth began to decline. At one point, she consulted a dentist. "They told me it would take about \$20,000 to fix everything." With no savings and on a fixed income, this was out of the question. So she resorted to eating mostly soft, processed foods.

In addition to her physical discomfort, LeClair became self-conscious of her appearance, and began to withdraw socially. As anyone who works with older adults can tell you, lack of good nutrition and social isolation are two preventable factors that, over time, can contribute to a decline in overall physical and mental health. Left unaddressed, the decline escalates in most cases, and can lead to institutionalization or premature death.

LeClair's story is not unique. Forty-nine percent of seniors who have not seen a dentist in a 12-month period cite cost as the No. 1 reason for not visiting the dentist more frequently. That number skyrockets to 69 percent of low-income seniors. A study by the Pew Research Center finds that 61 percent of Americans 65 and older said they want to "age in place," or stay in their own homes as long as possible. Maintaining good health—including good oral health—as long as possible, then, is a critical component of aging in place.

The Role Community Development Organizations Play

In a recent survey, NeighborWorks—a membership and support network for more than 245 community development organizations nationwide—found that 89 percent of its members offered some sort of health and wellness program to residents of their rental communities. LeClair is lucky to have found one: the Better Housing Coalition's (BHC) senior rental communities. Headquartered in Richmond, BHC owns and manages 16 affordable rental communities, eight of which are for lower-income seniors.

With average annual incomes of only \$14,000, most of BHC's senior residents can't afford dental insurance. Observing a growing unmet need for oral health care services among its senior residents, BHC partnered with the Lucy Corr Dental Clinic in Chesterfield, Virginia, which specializes in dental services for adults 65 and older, and provides its services free of charge. To date, more than 50 residents from five of BHC's senior communities have become regular Lucy Corr patients. During a wellness checkup, BHC's on-staff senior specialist identified LeClair as a good candidate for services, and connected her with the clinic. 🏠

*This article has been excerpted.
Read the full story at bit.ly/SF193Birchett.*

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