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Multifamily Subsidized Housing Seniors' Awareness of Aging and Disability Resource Center Services

Katrina Polk
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Katrina Polk

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Review Committee
Dr. David Milen, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Gary Kelsey, Committee Member,
Public Policy and Administration Faculty

Dr. Tanya Settles, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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MPA, Southeastern University, 2005

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Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Public Policy and Administration
Health Service Specialization

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Abstract

Over 75% of adults 60 years of age or older who live in Washington, D.C. are unaware of access to Aging and Disability Resource Centers' (ADRC) community-based services. Approximately 25% of these individuals are low-income and reside in multifamily subsidized housing. With a theoretical basis in Penchansky and Thomas' construct of access, this phenomenological study explored whether increased awareness of access to ADRC service delivery may potentially better meet the needs of this socioeconomically marginalized population. Data were collected through semi-structured interviews with 20 senior citizens in Washington, D.C. who received some programmatic assistance, such as housing or meal delivery, but not necessarily through an ADRC. Interview data were inductively coded and analyzed using Braun and Clarke's thematic analysis method. Findings indicate that while there is an apparent need for community-based services, many participants who were not aware of ARDC services wanted more information about how to access the service delivery system to age in place, avoid burdening children, retain housing vouchers, and prevent nursing home placement. In contrast, seniors who accessed ADRC, based on the construct of access, found services acceptable, accessible, affordable, available, accommodating, and helpful in allowing them to remain independent and at home. The results of this study contribute to positive social change by recommending that program administrators focus on outreach to the program's target population, thereby improving access to resources so they can be self-reliant and prolong residential longevity for aging-in-place demands.

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Dedication

This dissertation is dedicated to the memory of my father, Eulance Nathanial Polk, Sr., and Lula Brown, my great-great grandmother, who never ceased trying to prepare me for my destiny. Thanks to their persistence, I have succeeded in championing one of many "big" accomplishments to come, as I continue to walk on my path of greatness.

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Finally, I must thank my chair, Dr. David Milen, for his continuous support and constant reminder to "cooperate and graduate." Also, my gratitude for guidance and recommendations to Dr. Gary Kelsey and Dr. Tanya Settles. Everyone assured me that I would arrive at the light at the end of the tunnel—*I am here*. Thank you.

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Chapter 1: Introduction to the Study

> *The science of gerontology has the practical purpose, as we often say, of "adding life to the years" of the latter part of the human life span. The phrase "adding life to the years" implies helping people to enjoy life, and to get satisfaction from it (Havighurst, 1961, p. 8).*

Introduction

In 2003, the Administration on Aging (AoA), an independent federal agency under the U.S. Department of Health and Human Services (HHS), partnered with the Centers for Medicaid and Medicare (CMS) to develop the infrastructure for the Aging and Disability Resource Center (ADRC) service delivery system. These entities established ADRC as a system with a single point of entry for long-term supportive services, inclusive of community-based services, that streamlined the benefits and assistance process for adults 60 years of age and older, for persons ages 18-59 years living with disabilities, and for caregivers in every state in the United States (Civic Impulse, 2015). Since 2003, the scope of the partnership has expanded to include the Veterans Health Administration, and HHS has created a new agency, the Administration for Community Living (ACL), which is responsible for the ADRC program's continued implementation. The federal government realigned the AoA, the Administration on Intellectual and Developmental Disabilities, the Center for Disability and Aging Policy, and the Center for Management and Budget under the ACL. Simultaneously, the Center for Aging Policy and the Center for Disability Policy joined to form the Center for

Integrated Programs. At the federal level, the Center for Integrated Programs oversees ADRC.

In Washington, D.C., the Office on Aging directs and coordinates community-based services that assist adults 60 years of age and older who are aging in place through ADRC's senior service network. In the network, eight ward-based community service organizations called *lead agencies*, funded by grants from the District of Columbia Office on Aging and various local funds, provide services supported by the Older Americans Act, Title III. These supportive services include case management, homemaking, congregate meals, community services, and adult day services (Department of Health and Human Services [HHS], 1988). Services available under the Older Americans Act target persons 60 years of age or older who are in the greatest social and economic need, with an emphasis on low-income minority populations.

The District of Columbia Office on Aging coordinates local services that include resource and referral assistance, light housekeeping, transportation, and community meal programs through the senior services network and other community-based providers. Local providers, such as the Capital Area Food Bank, So Others Might Eat, Covenant House, A Wider Circle, and Catholic Charities rely upon funding streams that are distinct and apart from funding that flows through Older Americans Act programs. None of those four services have eligibility requirements beyond age (60 years or older) and place of residence (Washington, D.C.). Regardless of their respective funding sources or eligibility requirements, all of these services are accessible through registering with ADRC.

Adults 60 years of age or older residing in Washington, D.C. who are interested in learning about or accessing various community-based services that might be useful to them must register with their local ADRC. The ADRC serves as a single resource that provides resources, makes referrals, and facilitates connections to long-term support and service options and community-based services that are designed to help adults 60 years of age or older age in place. All eight quadrants of the city have an ADRC office that reflects the community and is responsible for community outreach efforts to the seniors. Residents of Washington, D.C. who are persons with disabilities between the ages of 18 to 59 years old, are 60 years and older, and their caregivers are all eligible for ADRC services. There are no eligibility requirements to access ADRC resources beyond age or disability, yet these services are used by fewer than 33% of Washington, D.C.'s older adults (District of Columbia Office on Aging, 2012).

Although all Washington, D.C. residents 60 years of age or older are eligible to register with their closest ADRC to learn about community-based service options, very few have done so. A 2012 *Senior Needs Assessment* (District of Columbia Office on Aging, 2012) found that 77.4% of adults 60 years of age or older "had no knowledge or understanding of any services the ADRC provides" (District of Columbia Office on Aging, 2012, p.144). Approximately 25% of these individuals are low-income and reside in multifamily subsidized housing. Manjarrez, Popkin, and Guernsey (2007) found that residents of low-income housing are at greater risk of having multiple chronic diseases than those living in other types of housing. Given these facts, it seems likely that increased awareness of ADRC could potentially better meet the needs of seniors living in multifamily subsidized housing who want to age in place.

Low awareness of the ADRC suggests that there may be an access problem. According to Penchansky and Thomas' (1981) construct of access, there are five domains of access: Affordability, availability, acceptability, accessibility, and accommodation; all five are influential in determining whether a service is actually accessible to those seeking entry into a service system. According to this concept, a consumer's awareness of a service is linked to availability of a service. Availability is, in turn, closely linked to affordability, acceptability, accessibility, and whether or not recipients perceive the service or service system as accommodating. Studies of awareness and access to community-based services by seniors living in multifamily subsidized housing are rare. This problem is significant because the literature shows that unawareness of access to community-based services can impede seniors' ability to lengthen tenure of independent community living and forestall or prevent nursing home placement.

Researchers have established the connection between poverty and poor health. Researchers have shown that residents of subsidized housing are more likely to experience chronic medical conditions, see Chapter 2. Perl (2010) found that structural factors stymied their access to community-based services. The U.S. Department of Housing and Urban Development's efforts to remove barriers to access privileged 202 properties, which are restricted to people 62 years of age and older, over multifamily dwellings. Today, 202 properties have service coordinators on site to provide information about resources and help residents gain access to community-based services but multifamily dwellings do not.

African Americans and people living in poverty are underrepresented in the more specialized literature on aging in place, see Chapter 2 for specifics. In addition, methods used in those studies were not conducive to collecting all pertinent information from respondents. Researchers noted that telephone surveys with close-ended questions led to conflated results on occasion. Miscommunication between surveyors and respondents plagued the data. Errors stemmed not only from confusion over proper names used to identify services and providers, but also from affirmation bias. Chapter 2 discusses these findings in more detail. Finally, the most significant gap in the literature was the lack of voice afforded study participants and their own statements about services. The perspective of people with lived experience was absent from the literature reviewed. For all of these reasons, multifamily subsidized housing seniors' awareness of and experiences with ADRC warrants study.

Background of Problem

In 1975, the City Council of Washington, D.C. established the District of Columbia Office on Aging as the State and Area Agency on Aging (AAA). The City Council commissioned the District of Columbia Office on Aging to build a system that advocates, educates, promotes, and provides adults 60 years of age or older with opportunities to engage in services and programs that focus on health and wellness, employment and supportive services (District of Columbia Act on Aging, 1975). In the last 10 years, the District of Columbia Office on Aging gained oversight over

Washington, D.C.'s ADRC. The District of Columbia Office on Aging is responsible for efficiently and effectively planning, developing, coordinating, and implementing local ADRC community-based services that ensure access to a continuum of services. The ADRC also serves as a clearinghouse for obtainable senior service resources, identifies gaps in services, and provides linkages to coordinators of long-term services and supports.

Additionally, in an effort to increase access to available community-based service resources, the District of Columbia Office on Aging established a strategic planning committee that developed, published and implemented a *New Community Living Strategic Plan for 2013-2017* (District of Columbia Office on Aging, 2013). One major goal of the plan was to expand older adults' access to services provided in the home and community through ADRC. The purpose of that goal was to remove barriers that prevented individuals from accessing resources that are currently available to support aging in place by residents of all neighborhoods of Washington, D.C. According to the *New Community Living Strategic Plan for 2013-2017,* expanding access to services could provide adults 60 years of age or older "appropriate quality resources" for aging in place (District of Columbia Office on Aging, 2013, p. 3).

Global, national, and local trends show that older adults are living longer and their preference to age in place continues to show exponential growth. According to Plouffe and Kalache (2010), "The number of people age 60 years and older as a proportion of the global population will double from 11% in 2006 to 22% by 2050, at which time there will be more older people than children ages 0 to 14 in the population for the first time in human history" (p.733). How and where they will live is of increasing concern.

McFadden and Lucio (2014) found that many aging adults have increasing levels of physical, mental, and cognitive impairments, and that the prevalence of impairing conditions will continue to grow. Older adults who are in their 70s and 80s and are members of racial and ethnic minority groups will experience declines in physical and mental functioning and require supportive services (Beard & Carnahan, 2011). When these aging individuals become homebound as a result of increasing functional deficits, they are at-risk for insufficient care as they continue to age in place (Beck, Arizmendi, Purnell, Fultz, & Callahan, 2009).

A 2010 AARP survey revealed that 88% of people residing in the United States aged 65 years and over desired to age in place as long as possible (Keenan, 2010). In 2010, approximately 80% of adults 60 years of age or older living in the United States owned their homes and 21% lived in rental properties (Adminstration on Aging [AoA], Administration of Community Living [ACL], & U.S. Department of Health and Human Services [HHS], 2012). In contrast, in 2010 in Washington, D.C., 59.9% of seniors owned their homes; 40.1% rented their place of residence (U.S. Census Bureau, 2011). Many of these renters have low incomes and reside in subsidized housing communities.

Subsidized housing programs are affordable housing options the government sponsors for low-income people who need assistance with housing costs (Landis & McClure, 2010). In the United States, the three main programs are public subsidized housing, Housing Choice Voucher Program, and multifamily subsidized housing. In public housing, the government is the landlord and the properties operate under the governance of the local housing authority; however, housing choice vouchers and multifamily subsidized housing program offers the opportunity to lease from the private sector. The Housing Choice Voucher Program provides rental assistance to qualified families or individuals, based on income and family size, who locate housing that meets federal Housing Quality Standards. The voucher stays with the person, moving with them if they relocate to a different residence that meets the Housing Quality Standards. Subsidies, in contrast, remain with the properties.

In the United States, 1.3 million older adult renters live in publicly-subsidized housing (Enterprise Community Partners & LeadingAge, 2011). Many of these individuals are not in good health and will need help if they are to continue to live at home. They are more likely to experience chronic medical conditions and they need supportive services but have not always been able to gain access to them. Nearly fifteen years ago, the U.S. Department of Housing and Urban Development recognized that nationwide, many subsidized housing residents had poor access to senior services. Subsequently, the department scrutinized poor access to services by seniors living in subsidized housing. It attributed this to ineffective coordination efforts among public agencies (such as housing authorities and social service agencies), local service providers, and housing providers (Cohen, 2011; Levine & Robinson-Jones, 2008).

Like seniors nationwide who live in subsidized housing, those in Washington, D.C. are likely to have physical, mental, and cognitive impairments, and are at higher risk of having multiple chronic diseases. Low-income older adults are especially vulnerable to depression and anxiety (Robison et al., 2009). According to Ruel, Oakley, Wilson, and

Maddox (2010), individuals living in subsidized housing suffer from physical, mental, and cognitive impairments. They are at greater risk of experiencing chronic illness and disability. Fewer social connections, poor integration into the community, and community detachment are likely to increase the risk of cognitive decline among these individuals living independently in the community (Charles & Carstensen, 2010). Most do not use services beyond those covered by medical insurance and do not access a broader system (Castle & Resnick, 2014). It is likely that the older adults living in multifamily subsidized housing have health problems and lack awareness of access to services.

Improved access to community-based services through an ADRC demonstrably helps older adults remain in their homes and communities (Baretto et al., 2014). It is especially important to improve awareness of access of older adults living in all subsidized communities so that they can remain independent, meet the additional requirements imposed upon tenants of subsidized housing, and defer nursing home placement.

In 2014, the District of Columbia Housing Authority reported that at least 12.4%, but fewer than 33.8%, of subsidized housing residents (excluding the U.S. Department of Housing and Urban Development's Section 202 properties) were 60 years of age or older. This group includes people who were recognized as having a disability earlier in life but now are over 60 and aging in place in properties overseen by the District of Columbia Housing Authority. The proportion of subsidized housing residents over 60 years of age in need of community-based services is unknown. Numbers can be extrapolated from those that are known, but the extrapolations yield ranges rather than precise numbers.

In 2012, the population of Washington, D.C. was approximately 650,000 of whom 16%, or 105,000 were adults 60 years of age or older (District of Columbia Office on Aging, 2010). The proportion of Washington, D.C. residents, 12.4%, who lived in subsidized housing, yields the number 54,000 (The District of Columbia Housing Authority, 2014). As above, between 12.4% and 33.8% of the number of residents of subsidized housing are 60 years of age or older, which means that between 6,480 and 17,820 residents of subsidized housing are over 60. The precise number, how many of that number may need services, and what services would help them age in place are all unknowns.

Problem Statement

Most adults 60 years of age or older residing in Washington, D.C. are unaware of access to services through ADRC. The District of Columbia Office on Aging's *Senior Needs Assessment* (2012) showed that 77.4% of adults 60 years of age or older had "no knowledge or understanding of any services provided by ADRC" (District of Columbia Office on Aging, 2012, p.144). Access to services for individuals aging in their homes has become an increasingly significant issue in health services for the aging (Luppa et al., 2010). Blumberg, Berger, Cook, and Ruby (2013) found that aging with independence is becoming a more pressing issue as the size and age of the older adult population increases. In Washington, D.C., as elsewhere, this population is likely to require some in home assistance and, or community services and supports. The subgroup of the aging population that resides in subsidized housing is known to experience physical, mental, and cognitive impairments (McFadden & Lucio, 2014). Public administrators need a better understanding of the level of awareness of and access to services by older adults living in subsidized housing, particularly their awareness of and access to transportation, home delivered meals and light housekeeping services.

Transportation Services

Transportation represents an essential element of healthy independent aging for adults 60 years of age or older who are living in the community. This population depends upon public and private transportation for freedom, independence, and options. Research has shown that due to insufficient personal and public transportation choices, many older adults had "no access to shopping, physical activity, or social outlets" (Hunter et al., 2011). According to the District of Columbia Office on Aging's 2012 *Senior Needs Assessment*, the main reasons older adults have difficulties accessing transportation include "having to rely on others (37.1%), affordability of transportation (17.7%), needing assistance to get around (11.5%) and having restricted mobility due to disability or other health-related reasons" (p. 105). Certain transportation services not tied to the Older Americans Act are available through ADRC. Those transportation services are available at no cost to all adults 60 years of age or older, but they are underused. In Washington, D.C. older adults are challenged in the area of transportation; more precisely, they have little or no knowledge of or experience with access to transportation options for travel to and from medical appointments, pharmacies, human service agencies, grocery stores, and social events.

Light Housekeeping Services

Many older adults are likely to experience health decline and functional impairments as they age. As their conditions worsen and activities of daily living (ADL) and instrumental activities of daily living (IADL) decline, their environment and physical abilities for self-care become incompatible and assistance is warranted (Seplaki et al., 2014). Approximately 80% of older adults 65 years or older have at least one chronic condition, and 62% have two or more (Lee, Fischer, & Johnson, 2010). Unmet housekeeping needs adversely affect the health and wellness of these individuals who in the community (Allen, Piette, & Mor, 2014). In Washington, D.C., the ADRC promotes independence through community providers that provides adults 60 years of age or older with the supports they need to age in place. ADRC homemaker services, such as light housekeeping and companionship services, which are not funded under the Older Americans Act, are free of charge all adults 60 years of age or older; however, they do not access homemaker services. According to the District of Columbia Office on Aging's *Senior Needs Assessment* (2012), "56% of respondents had no opinion" regarding homemaker services. Mostly likely they are unaware that this supportive service is available" (p. 90).

Community Meals Programs

Home delivered meal programs are provided in all 50 states through the Older Americans Act (2006) (Civic Impulse, 2015). These meals improve nutrition and health status for many community dwelling older adults and improve food security. They also reduce hospital admissions by decreasing the prevalence of chronic diseases, helping individuals manage chronic disease, and by supporting convalescent efforts to help lower rates of hospital readmission. The United States continues to experience exponential growth in its aging population; this segment of the population will grow to four times its current size (Houser, Fox-Grage, & Ujvari, 2012). Based on the projected population growth and economic trends, the number of older adults without the means to acquire a consistent supply of food is likely to increase (Katz Policy Institute of Benjamin Rose Foundation, 2009).

As Washington, D.C.'s population ages, a better understanding of senior household food insecurity and older adult poverty is crucial for government agencies, nonprofit organizations, and the community groups that attempt to serve this expanding population. According to D.C. Hunger Solutions (2012), approximately 14.5% of adults 60 years of age or older live below the federal poverty line. Food insecurity has been linked to malnutrition, poorer health status, limitations in daily activities, and lower quality of life (Food Research and Action Center, 2013). ADRC offers community dining and referrals for home-delivered meals and brown bags provided at no cost by community organizations, but cording to the District of Columbia Office on Aging's *Senior Needs Assessment* (2012), nearly 80% of the aging population does not participate in meal programs because of "lack of information about how to get congregate and home-delivered meals" (p. 98).

Understanding the problem of awareness of or access to services the ADRC provides required learning more about the factors that influence an older adult's awareness of access to services. Gaining knowledge about this phenomenon involved studying the lived experiences of adults 60 years of age or older in multifamily subsidized housing using a qualitative research method. This phenomenological study using a narrative inquiry approach could generate information useful to stakeholders about how to improve knowledge and understanding of access to ADRC's community-based service options. Ultimately, perhaps, increased awareness could better meet this population's needs.

Purpose of the Study

The purpose of this phenomenological study was to capture the awareness of and experiences with ADRC by adults 60 years of age or older who live in multifamily subsidized housing communities. This study also allows the voices of this socioeconomically disadvantaged group to be heard. The findings could inform service providers, policymakers, and advocates about issues that impact access to needed community-based services. Stakeholders could use this information to create strategies to improve or increase awareness and access to services and to promote service use.

Theoretical Framework for the Study

Access as a construct and its practical application have been hypothesized as the appropriate fit between an expectation of a consumer and characteristics of a servicing system (Penchansky & Thomas, 1981). Penchansky and Thomas (1981) refined this theoretical framework by breaking the concept of access into five domains: affordability, availability, acceptability, accessibility, and accommodation. Their typology of access is examined later, in Chapter 2. In addition, Jacobs, Ir, Bigdeli, Annear, & Van Damme, (2012) presented a similar conceptual model of access that helped explain barriers to access in low-income Asian countries. Their concept of access was also useful for the present study. The model included geographic accessibility, affordability, availability, and acceptability. Both of these models emphasized some parallel aspects of access. However, the present study examined access more broadly. Jacobs et al. (2012) applied the dimensions of access in a manner that is useful to the present study. Accessibility includes geographical considerations, such as location of services, other community resources and the location of the residences of service users (Jacobs et al., 2012). Transportation, therefore, is an important aspect of accessibility (Jacobs et al., 2012). Acceptability encompasses such concepts as personal skill sets of the service providers, rapport, cultural competencies, stigma, and trust (Jacobs et al., 2012). Findings in the literature informed the role of the researcher. The research question and interview protocol were designed to elicit narratives that touched upon many of these dimensions of access.

Research Question

What awareness or experiences do adults 60 years of age or older in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC services?

Nature of the Study

Narrative inquiry was the appropriate design for this phenomenological study. According to Spector-Mersel (2010), narrative inquiry is useful in creating an understandable viewpoint of society and understanding how individuals psychologically maneuver and perform within it. More specifically, narrative inquiry is both a phenomenon and method; it investigates how people experience society (Connelly &

Clandinin, 1990). A narrative inquiry yields more than a narrative that can be coded and analyzed. Using narrative inquiry as a method can elicit a story in which some listeners can find value and solace (Duff & Bell, 2002).

Narratives based on lived experiences, told by adults 60 years of age or older who reside in multifamily subsidized housing communities, regarding their awareness of access to services ADRC offers could shed light on the complexity of aging in place in that environment. Stories told by adults 60 years of age or older who are seeking help to remain in their homes and live independently may benefit not only the narrators, but other similarly situated individuals, by helping them create and lend "meaning to what can seem a meaningless situation" (Gilbert, 2002, p. 224).

Selecting a narrative approach for this study allowed the narrative of the researcher's lived experience to be included. In a phenomenological inquiry, the researcher's experiences are excluded from the study for the purpose of understanding a specific phenomenon through the lived experiences of the participants only (Sorrell & Redmond, 1995). In this study, the goal of the narrative approach was to gain understanding of lived experience among adults 60 years of age or older regarding their awareness of and experiences with access to ADRC.

Definitions

Activities of daily living: The term activities of daily living (ADL) is the functional ability to complete one's personal activities (e.g., bathing, eating, dressing, walking) (Lowry, Vallejo, & Studenski, 2012).

Aging and disability resource centers: The federal government designed Aging and Disability Resource Centers (ADRC) to be a single point of entry for comprehensive information regarding long-term supportive services in every state for seniors and disabled populations (Reinhard, Kassner, & Houser, 2014).

Aging-in-place: The term aging-in-place is a concept of seniors living in their homes and communities where the quality of life is enhanced by familiar surroundings and supports (Whitfield, Daniels, Flesaker, & Simmons, 2012).

Aging with independence: The term aging with independence, for the purpose of this study, pertains to any initiatives that consist of community-based providers assisting seniors with aging services to support continued independent living in their homes (Rantz et al., 2011).

Area aging on agency: In this study, Area Agency on Aging (AAA) developed and coordinated the network of services that addressed seniors' demands through aging network providers in local geographical areas (Judd & Moore, 2011).

Home and community based services: Home and Community-Based Services (HCBS) are supportive services that adults 60 years of age or older can receive in the home and, or community, such as adult daycare, personal chore and care services, and family caregiver supports; some of these services may have eligibility guidelines (Ferris, Glicksman, & Kleban, 2014).

Housing choice voucher program: The Housing Choice Voucher Program is a federal housing program the U.S. Department of Housing and Urban Development sponsors; it replaced the Section 8 Housing Program. The program provides low-income people the opportunity to rent in privately the sector of the housing market by applying for a housing subsidy to assist with rental payment (Gonyea, Mills-Dick, & Bachman, 2010).

Instrumental activities of daily living: The term instrumental activities of daily living (IADL) refers to self-care tasks, such as housekeeping, cooking, and medication administration. IADLs are an important element of independence for seniors; they are known to decrease in connection with neurodegenerative diseases (Suchy, Williams, Kraybill, Franchow, & Butner, 2010).

Older adult: In Washington, D.C., age 60 years and older is considered an older adult or senior citizen as per the District of Columbia Office on Aging's eligibility criteria for programs and services (District of Columbia Act on Aging, 1975).

Older Americans Act of 1965: President Johnson signed the Older Americans Act in 1965. The Act is administered at the federal level of government. The Act's primary purpose is to promote health and wellness for Americans 60 years of age and older, and their caregivers, through entitlement services and programs (e.g., nutrition, supportive services, health promotion, caregiver assistance) to support independent living (Moone & Cagle, 2009).

Single point of entry: For the purpose of this study, single point of entry is a central point of information and referrals to community-based services for persons with disabilities, seniors, caregivers, families, or senior-focused organizations (Richardson, Simning, He, & Conwell, 2011).

Subsidized housing: In this study, subsidized housing is a rental subsidy provided by the U.S. Department of Housing and Urban Development in which the resident's share of the rent is calculated based upon the resident's income (Gibler, 2003).

Supportive services: In this study, supportive services are services provided to seniors who require assistance with various personal care requirements, meals, or need multiple units of care in different residential settings (Freedman & Spillman, 2014).

Vulnerable: For the purpose of this study, vulnerable populations include the elderly; lacking supportive resources, they are considered vulnerable due to evaluated risk of negative physical conditions (Flaskerud & Winslow, 1998). Vulnerability is the result of unmet socioeconomic and health requirements that increase exposure to adverse outcomes within a particular population.

Assumptions

Among the assumptions underlying this study was the presumption that volunteers were willing participants and responded to the questions asked based upon their lived experience. Throughout the process of data collection, the researcher tested the assumption that participants were able to comprehend interview questions fully and responded to those questions to the best of their knowledge. That assumption appeared to be sound. Participants were assured of anonymity and confidentiality; and, through volunteer self-reporting, any nonvulnerable statuses were acknowledged. The researcher reasonably assumed that the data provided information about the participants' experiences and those experiences were relevant and significant to the subject being examined (Charmaz, 2014). Based on prior studies of lived experience that used a narrative inquiry, the researcher assumed that 20 interviews would generate sufficient data for themes to emerge. Further, this research rests upon the assumption that the instrument used to conduct this study was adequate, appropriate, and accurate in securing the necessary information.

Scope and Delimitations

This study was restricted to adults 60 years of age or older residing in multifamily subsidized housing communities and receiving housing choice vouchers. The scope of inquiry was limited to inquiries about personal, social, and other contextual factors or influences pertinent to access to services the ADRC offers (i.e. transportation, light housekeeping services, and community meal programs). I conducted all interviews and examined the narratives for emergent themes and recurrent issues. The study used a nonrandom maximum variation sampling strategy; therefore, the sample represented a range of experiences related to the study and may be heterogeneous in the general population. Additionally, the study was completed in Ward Eight, Washington Highland, Washington, D.C.'s poorest neighborhood (D.C. Hunger Solutions, 2012); consequently, the results might not be applicable to other geographical areas.

Limitations

Limitations may have decreased the generalizability of results to other populations (Burns & Grove, 2010). Potential limitations of this study were:

1. This study relied on volunteer self-reporting.
2. Participants' ages ranged from 60 to 100 years.

3. Recruitment efforts for this study were limited to older adult residents receiving housing choice vouchers and living in a multifamily subsidized housing community within the poorest community in Washington, D.C. (D.C. Hunger Solutions, 2012)— the Southern Ridge Apartments and The Overlook at Oxon Run Apartments in Washington Highlands.
4. At least 85% of the participants were low-income African American women.
5. All of the participants were receiving subsidizing housing through the Housing Choice Voucher Program.
6. At least 50% of the participants did not have a high school diploma.
7. Due to the sensitivity of the subject matter, participants might not have been completely forthcoming with information.
8. The study focused only on one of the District of Columbia Office on Aging's programs—ADRC.

Significance of Study

There is little literature on awareness of and access to community-based services among adults 60 years of age or older living in multifamily subsidized housing communities. None, save for the IMPAQ report (Baretto et al. 2014), examined awareness of or access to services and program options available through ADRC. Furthermore, studies of access are typically conducted using surveys that ask closed questions to collect data. A search of the literature found no studies of access that relied upon a narrative approach. This research is significant because stories and ideas produced through a narrative inquiry present a broader picture of access to services from the perspective of an older adult who is aging in the community. New information could provide a better understanding of their experiences vis a vis awareness of and access to community-based services. New information and a better understanding could spur service providers and other stakeholders to develop or refine initiatives that promote outreach, create stronger collaborations and partnerships, establish better community connections that could ultimately improve access to services available through ADRC.

Implications for Social Change

The results of this study could contribute to positive social change by serving as a basis for developing recommendations for action. Actionable themes emerged from the narratives of older adults with lived experience regarding their awareness of and access to community-based services. The findings of this study are highly likely to be informative to stakeholders. Stakeholders in Washington, D.C. need a better understanding of why services that are available, affordable, acceptable, accessible and accommodating are used by such a small proportion of older adult residents.

Stakeholders need to know that even the most disadvantaged seniors, i.e., those who participate in the Housing Choice Voucher Program and are residing in multifamily subsidized housing, are unaware of access to services and resources that are readily available through ADRC. The themes that emerged from the findings of this study could serve as an impetus for stakeholders to create strategies for improving awareness and increasing access to available services. One obvious recommendation, for example, is that if a program is designed to assist people aged 60 years or older remain self-reliant and age in place, outreach should focus on improving their awareness of and access to available community resources. Stakeholders could take actions that contribute to residential longevity in subsidized housing, thereby reducing the frequency of nursing home placement within this population.

Finally, there are social implications for the participants in this study as well as for the population they represent. Hearing the stories of similarly situated individuals could help seniors make meaning of their own circumstances and experiences. Second, this study can serve as a platform for seniors to *give voice* to their experience. Seniors living in multifamily subsidized housing in Washington, D.C. may use their voice to express their knowledge, opinions and wishes to one another, to stakeholders and to decision makers. Giving voice could empower some to seek changes that they believe would benefit themselves and others.

Summary

Chapter 1 introduces the question of what knowledge and understanding adults 60 years of age or older living in Washington, D.C., have, especially those residing in subsidized housing communities, regarding access to available resources from ADRC. This chapter includes background information on the problem and a problem statement, research question, a conceptual framework, and the significance and scope of this study. Chapter 1 also documents possible implications for social change at the community level.

In Chapter 2, the literature on social and health factors that affect aging in place is reviewed and summarized. The chapter also documents the literature search and summarizes the pertinent literature on access, focusing on access to nonmedical supportive services provided in the community. Literature on access and obstacles to access faced by older adults, members of ethnic minority groups, low-income individuals, and residents of subsidized housing is reviewed. Chapter 2 also reviews community-based supportive services and models that help older adults remain independent and live a high quality of life in their homes and communities. Chapter 2 summarizes the current literature associated with themes and issues that influence older adults' knowledge and understanding of access ADRC's available service resources in the community. In addition, literature review takes note of research related to access among these vulnerable individuals and compares theories of subject-matter experts.

In Chapter 3, I present the qualitative methodology and research design employed in this study. The design and methodology were chosen because they are well suited to capturing the richness of lived experience and have the advantage of minimizing the likelihood of miscommunication between researcher and respondent. I collected narrative data from 20 participants during face-to-face interviews using a structured protocol and open-ended questions.

Chapter 4 documents the research findings based on analyses of the narratives about their awareness and experience, told by adults 60 years of age or older, who live in Washington, D.C.'s multifamily subsidized housing communities under the Housing Choice Voucher Program, regarding access to ADRC and associated services. This chapter also presents interpretations of findings and explanations of applied processes.

Chapter 5 integrates, synthesizes, and evaluates the results of the study and offers recommendations for future research. This chapter also examines the study's implications for social change.

Chapter 2: Literature Review

Access is an important concept in health policy and health services research, yet it is one which has not been defined or employed precisely. To some authors 'access' refers to entry into or the use of the system, while to others it characterizes factors [availability, accessibility, accommodations, affordability, and acceptability] influencing entry or use (Penchansky & Thomas, 1981, p. 127).

Introduction

In this chapter I present the related literature for the purpose of establishing the need to explore the meaning of access to community-based supportive services among adults 60 years of age or older living in Washington, D.C.'s multifamily subsidized housing communities. These supportive services include, but are not limited to, care management information and referral assistance, transportation, homecare services and adult day services. As the U.S. population lives longer, the preference to age in the community shows exponential growth. Consequently, the demand for access to supportive service resources increases. The Older Americans Act Reauthorization (2006) sought to improve access to self-directed community-based supportive services by establishing the ADRC to help meet the demand for community services driven by aging in place (Civic Impulse, 2015). However, older adults, in particular those living in Washington, D.C.'s multifamily subsidized housing, are not accessing those services.

The ADRC is designed as a single point of entry to link older adults with a supportive service system more effectively and efficiently to address burgeoning senior needs (Civic Impulse, 2015). The District of Columbia's Office on Aging has administrative and fiduciary responsibilities for the operation of the ADRC. In Washington, D.C., 77% of older adults did not access community-based supportive services (District of Columbia Office on Aging, 2012). A possible cause of this problem could be contextual factors that influence access (Jacobs et al., 2012).

The purpose of this phenomenological study was to explore whether increased awareness of access to ADRC is likely to better meet the needs of senior citizens living in the District of Columbia's multifamily subsidized dwellings. The study also examined factors that influence individuals' efforts to access community-based services. Themes emerged from the narratives told by older adults about their experiences related to accessing the resources they needed to age in place. Stakeholders could use these themes to improve access to services that are available, thereby lengthening residential longevity in multifamily subsidized housing and lessening the prevalence of nursing home placement within this socioeconomically marginalized population.

This chapter presents literature related to the social and health factors that affect aging in place for adults 60 years of age or older, especially those living in multifamily subsidized housing. It also reviews community-based supportive services and models that help older adults remain independent and live a high quality of life in their homes and communities. In addition, this chapter reviews the typology of access. Access encompasses influential contextual factors, such as accessibility, availability, acceptability, affordability, and accommodation as they relate to the fit between service systems and service users. The last segment of the literature review provides a summary that transitions to Chapter 3, the methodology section.

Literature Search Strategies

A literature review was conducted using the terms: access to services, access to health care, access to medical care, access to service barriers, access to supportive services, aged, affordable housing, aging and disability, aging and disability resource centers, aging in community, aging in place, aging in public housing, aging in subsidized housing, aging network, aging policies, aging with independence, community aging, community-based aging program, community-based supportive services, chronic disease, disability, elderly, elderly tenants, gerontology, homebound older adults, home and community-based supportive services, long-term services and supportive, low-income tax housing credit, public health, public housing, older adults, resource availability, older adults, subsidized housing, successful aging, supportive services, and vulnerable populations in the Walden Thoreau database. Databases used to find related literature included Academic Search Complete, CINAHL, ProQuest, PubMed, PsycINFO, ScienceDirect, SocIndex, and Sage Premier. Only peer reviewed articles written in English were selected. The literature search was conducted on materials dating from 1927 through 2016. Associated articles found to be the latest research and added validity to the literature review.

Theoretical Framework

Since Penchansky and Thomas' (1981) seminal contribution to the literature on access, access to healthcare has become a topic of even greater interest in the public health arena. Access is connected to the development and reorganization of health services delivery systems, the fields of utilization management and outcome evaluation, and is integral to comparisons of models, providers and programs. Access is a multifaceted concept that is of central concern in the study, financing, delivery and evaluation of healthcare services (Ricketts & Goldsmith, 2005). By necessity, policy makers, program developers and systems evaluators, and empirical researchers crafted different definitions of access to fit the goals of a given program, the characteristics of a certain system, or the purpose of empirical investigations. A number of theoretical frameworks of access have been developed to support empirical research. One limitation of the voluminous body of literature that has accumulated over the past three decades is that the vast majority of it addresses access to healthcare.

Relatively little systematic study has been done on access to home based and community support services. Underuse of such services has emerged as a consistent theme in the literature that has developed to date. Typically, the underuse of supportive services is deplored and stakeholders ask *WHY*? See, for example, Freiman and Harris' (2013) report to HHS, authored by experts at the Urban Institute at HHS's request. The investigators examined the experiences of a group of former subsidized housing residents in Memphis, TN who relocated to non-congregated housing located in so-called better neighborhoods as part of HOPE VI. HHS requested this study to assist them in developing a list of best practices for stakeholders that serve high-needs populations. One goal of the relocation of HOPE VI tenants was to encourage financial independence; employment preparation and training were among the supportive services provided but under used. Investigators asked two focus groups, which included adults aged 24 years and over, about their use of a variety of supportive services, including employment preparation and training.

A second type of study focuses on meaning, identity, and the social and emotional environment of low-income older adults. Those studies seek to illuminate the differences between aging-in-place experiences and expectations associated with class, income, and ethnicity in the lives of older adults. Researchers warn against overgeneralization of findings from studies of more affluent white populations to people of color living in poverty. See, for instance, Kohon and Carder's (2014) study of aging and identity in a low-income context. The researchers interviewed 47 older adults whose incomes qualified them for subsidized housing, asking about family, health, money, independence, and aging in place. Most of the participants, 35 (74%), were White/Caucasian. The researchers concluded that planners should consider that "subsidized housing residents represent a range of identities that both reflect and contradict standard images of public housing occupants as entirely needy, sick, or disabled" (p. 54). The open-ended interview questions used in the present study were designed to elicit rich personal information from one segment of subsidized housing residents.

Because only a small fraction of the literature on access addresses non-medical supportive services, that literature contains few empirical findings that bear directly on the research question of the present study. The most frequent finding is that underuse of community-based support services is associated with lack of awareness that the services are available (Bacsu et al., 2012; Guo & Castillo, 2012; Hughes, Harold, & Boyer, 2011; McFadden & Lucio, 2014). See, for example, Crawford Shearer (2009), which found that older adults' lack of knowledge of available services contributed to worsening health. Lack of awareness of supportive services is a robust finding across the United States, as well as in other nations that provide such services (Chan, 2014; Denton et al., 2009; Whitfield et al., 2012).

Concept of Access

Penchansky and Thomas (1981), noting the variety of ways access was used in the healthcare literature, derived five dimensions of access from then current usage and wrote operational definitions for each. Their goal was to define access more precisely so that researchers and policy makers could focus better on the myriad factors that affect use of healthcare services. Penchansky and Thomas subjected their taxonomy of access to tests of construct validity and discriminant validity to demonstrate its validity and utility. While the measurements of validity they supplied to bolster their taxonomy fall outside the boundaries of this review, the five dimensions they defined are relevant to the present study. Penchansky and Thomas proposed the following five domains of access:

- Availability: The relationship of the volume and type of existing services (and resources) to the clients' volume and types of needs. It refers to the adequacy of the supply of physicians, dentists and other providers; of facilities such as clinics and hospitals; and of specialized programs and services such as mental health and emergency care.
- Accessibility: The relationship between the location of services and the location of clients, taking account of clients' transportation resources, travel time, distance and cost.

- Accommodation: The relationship between the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate to these factors and the clients' perception of their appropriateness.
- Affordability: The relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance. Client perception of worth relative to total cost is a concern here, as is clients' knowledge of prices, total cost and possible credit arrangements.
- Acceptability: The relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristic of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients. In the literature, the term appears to be used most often to refer to specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, neighborhood of facility, or religious affiliation of facility or provider. In turn, providers have attitude about the preferred attributes of clients or their financing mechanisms. Providers either may be unwilling to serve certain types of clients (e.g., welfare patients) or, through accommodation, make themselves more or less available (pp. 128-129).

In the present study, availability of services was presumed, since the impetus for the research was lack of awareness of services that are available. Affordability was not an obstacle to access because all participants in the study had incomes that qualified them for subsidized housing and were insured by Medicaid, Medicare or both; therefore, they would not be charged a fee for supportive services the ADRC provides.

The World Health Organization, a world leader in public health and a staunch advocate of universal health care coverage, recognizes that availability of services is only half the battle; barriers to access must be identified and knocked down. Thirty years after Penchansky and Thomas' (1981) division of access into five measureable components, Jacobs et al. (2012), investigated why certain interventions designed to overcome barriers failed and proposed "an analytical framework for selecting appropriate interventions in low-income Asian countries" (p. 288). They used four dimensions of access, omitting only accommodation. They used definitions of the dimensions that were very similar to those proposed by Penchansky and Thomas (1981). Departing from the alliterative effect of calling all the dimensions of access by a name beginning with the letter 'A,' Jacobs et al. (2012) renamed accessibility geographical access. One of their most significant findings was that contextual factors are of great importance in understanding and overcoming barriers to access. That finding is highly relevant to the present study.

Empirical Findings

Only those studies most directly relevant to the present study were included in this review of the literature. Studies that addressed access to home-based community services that were guided by very similar research questions, or that employed a similar method, or used a population that had important characteristics in common with the population of the present study, are reviewed here. To date, two of the main findings regarding use of and access to home and community-based services mirror those in the larger literature on supportive services connected to healthcare. First, non-medical supportive services available in the home and in the community are underused. Second, the most frequent reason for underuse is lack of awareness.

Flaws that have resulted in gaps in the scholarly literature include: (a) acquiescence bias in responses as an artifact of method of inquiry, (b) overgeneralization of conclusions derived from research on older adults of middle class or higher SES to older adults living in poverty, and (c) residents of subsidized housing have rarely been included in the samples. The present study is designed to contribute to the underdeveloped part of the literature by using open-ended interview questions to elicit the narratives of older adults living in multifamily subsidized housing.

Older adult awareness of community support services is much lower than previously thought because findings were marred by over claiming bias or acquiescence due to the methods researchers employed (Denton et al., 2009). Furthermore, some studies covered both home health and supportive services; researchers noted that respondents seemed at times to be referring to home health services rather than to supportive services. The present study avoided those pitfalls by posing open-ended questions, allowing ample time to probe, and eliciting all pertinent information from respondents.

Using Penchansky and Thomas' (1981) five dimensions of access as a basis for categorizing nonfinancial barriers to access, Kullgren, McLaugglin, Mitra and Armstrong (2012) analyzed the reasons given by 15,197 patients who sought medical care but whose care was delayed or whose need went unmet. Although the research questions were limited to medical care and individuals of all ages were included in the sample, because of the large sample size and broad scope, the conclusions were germane to the present study. Kullgren et al. (2012) found that adults in younger age groups more often experienced nonfinancial barriers to access than did other age groups. Adults in fair or poor health were less often barred by affordability but had more nonfinancial barriers (Kullgren et al., 2012). Adults with a minimum of one chronic medical problem had a higher incidence of nonfinancial barriers to access than did adults with no chronic condition (Kullgren et al., 2012). Because their study was the first large scale attempt in the U.S. to analyze patient response data to examine the extent to which nonfinancial barriers to access to medical care might affect the success of new programs designed to make medical care more widely available (Kullgren et al., 2012), the importance of their overall conclusion for policy makers cannot be overstated. They found that among adults in the U.S., nonfinancial obstacles were more likely the reasons for unsatisfied need or delayed medical care than was lack of affordability. Many adults who faced affordability barriers also faced nonfinancial barriers to access (Kullgren et al., 2012).

As in Washington, D.C., older adults living in Canada have low rates of using community support services designed to lower the rate of institutionalization (Strain & Blandford, 2002 as cited in Denton et al., 2008). As in the U.S., in Canada, typical supportive services, include but are not limited to, food delivery, transportation, caregiver support, and day programs (Denton et al., 2008). The similarities between the positions of older Canadians and older adults living in Washington, D.C. do not end there. The barriers to access are also similar. According to Denton et al. (2008), among the reasons that community support services are not accessed by older Canadians are: "lack of awareness, the multiplicity of small agencies providing community support, and the lack of a central access point. Furthermore, as the health care system becomes more complex, navigating the system becomes more difficult for older people, their families, and health care professionals" (p. 360).

Denton et al.'s (2008) research questions, reasons for conducting the study, and method have some parallels to the present study. Furthermore, the structure of the service delivery systems and the types of services offered in Hamilton, Ontario, CA and Washington, D.C. are similar enough to warrant comparison. Local service providers who requested the Hamilton, Ontario study were dissatisfied with low rates of use. They wanted to know the level of public awareness of available services and requested recommendations about how to communicate with prospective service recipients more effectively.

Respondents to Denton et al.'s (2008) telephone survey differed demographically from the participants in the present study in that they spanned a wider age range (just 61% were over age 60) and most had incomes that would render them ineligible for subsidized housing. They were, however, all urban dwelling residents of a city of 500,000. Hamilton, Ontario is roughly the same size as Washington, D.C. As in

Washington, D.C., in Hamilton, Ontario support services are driven and partially funded by federal mandate, administered locally, and provided by an array of organizations, departments and agencies. Both cities created a single point of entry designed to make access as easy and streamlined as possible for people seeking services.

Denton et al. (2008) found that awareness of community support services varied by offered service. Respondents were most likely to be aware of transportation services, dementia care assistance, and in-home care. Respondents seeking information about support services were most likely to look to informal sources first, such as the yellow pages of a telephone book, then turn to newspapers, libraries, and information and referral centers. Third, they asked formal sources, specifically physicians and doctors' offices, for information. Friends, neighbors, and family members were fourth. Only 10% of the respondents said they would contact the Community Care Access Center, Hamilton's single point of entry, for information about community support services. They recommended that the CCAC list itself and all service providers in the yellow pages of telephone books, provide doctors' offices with information about available services, and exploit informal sources of information (Denton et al., 2008).

Casado, van Vulpen and Davis (2011) did a secondary analysis of data obtained from a sample of 1,021 caregivers interviewed for the 1999 National Long Term Care Survey who provided care to frail older adults. Although restricted to caregivers, the purpose of the study, the research questions, and the age and poverty of the respondents make the findings germane to the present study. The mean age of the caregiving respondents was 63 years; the mean age of the care recipients was 81.3 years. As no income levels were reported, public assistance was used as a proxy for income level. All care recipients used Medicare. Roughly 20% of the households had a member who received some form of welfare. Roughly one third of the respondents were White, one third were Hispanic, and one third were Black. Respondents were asked to provide their reasons for not using seven services that fall under the umbrella of Home and Community-Based Services (HCBS). Among the questions asked were why respondents did not use housework services, home delivered meals and transportation services (Casado et al. (2011).

Because the present study included only adults 60 years of age or older who qualified for subsidized housing, used Medicare or Medicare, and were African American, and because the purpose of the study was to learn about their knowledge of available supportive services, selected findings by Casado et al. (2011), particularly those that reveal the reasons that needs for HCBS went unmet, are pertinent. Findings regarding three of the seven types of HCBS included in their secondary analysis, housework services, home delivered meals, and transportation services, were most germane to the present study. Three of the ten of reasons why needs for HCBS went unmet were categorized as *Not Aware of the Service, No Special Reason/Never Thought of It,* and *Other Reasons* (Casado et al., 2011). Not being aware that services were available, i.e. *Not Aware of the Service*, was at the top of the list of the ten reasons service needs were not met.

Looking at housework services, 26.5% of respondents were *Not Aware of the Service*, 7.1% had *No Special Reason/Never Thought of It*, and 11.8% had *Other Reasons* for not using it. Unfortunately, the interviewers insufficiently probed the category *Other Reasons* during the interviews, so no further information was available about the responses in that category. This gap in the literature regarding reasons for going without needed services remains. It cries out for more research (Casado et al., 2011). Looking across the three reasons that this need went unmet shows that over a third, 35.4%, of the caregiver respondents with a need for help with housework did not access that service either because they were unaware it was available, had never thought of it/for no special reason, or due to other, unknown reasons.

Casado et al.'s (2011) findings regarding home delivered meals and transportation services were similar. When asked about home delivered meals, 21.5% of respondents indicated they were *Not Aware of the Service*, 15.6% had *No Special Reason/Never Thought of It*, and 19.3% had *Other Reasons* for not accessing home delivered meals services. Collapsing the subtotals of these three reasons shows that 56.4% of the caregiver respondents who needed home delivered meals did not access that service either because they were unaware it was available, had never thought of it/for no special reason, or due to other, unknown reasons. Regarding transportation services, 31.7% of respondents were *Not Aware of the Service*, 8.1% had *No Special Reason/Never Thought of It*, and 23.6% had *Other Reasons* for not asking for assistance with transportation. A whopping 63.4% of caregiver respondents who needed help with transportation did not access that service either because they were unaware it was available, had never thought of it/for no special reason, or due to other, unknown reasons.

As compared to Hispanic and White respondents, Black respondents more often reported that they had no need of such a service and were unaware that the service was available (Casado et al., 2011). Casado et al.'s findings regarding the reasons that Black respondents did not access HCBS services, most especially the perception that they did not need supportive services, underlines the need for the present study.

Aging in Place

In a speech given by the President of the United States, Barack Obama, at the 2015 White House Conference on Aging, he stated, "Each and every day almost 10,000 of those babies [Baby Boomers] turn 65 years old. So, more than 250,000 Americans turn 65 every month. They're living longer and they're living healthier" (Obama, 2015). According to the 2014 "Profile of Older Americans," in 2013 one in every seven persons was 65 years of age or older, and by 2040, this will increase to one in every four persons; additionally, in 2014, approximately 7 million of this population lived 125%-300% below the poverty level (AoA, ACL, & HHS, 2015). Many of these older adults live in their homes and communities, not an institutional setting. Where older adults will continue to live as they age in place is a burgeoning concern.

Throughout history, older adults have desired to live independently in their homes (Pynoos & Liebig, 1995). Today, adults 65 years of age and older still prefer to age in place in their homes and communities. Aging in place has become the key term to describe this population's desire to remain independent as they age. Aging in place is "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (Centers for Disease Control and

Prevention [CDCP], 2010). According to a 2010 AARP survey, 80% of individuals 65 years of age and older agreed with the statement "What I'd really like to do is stay in my current residence for as long as possible" (Keenan, 2010, p. 4). Access to appropriate supports is essential for older adults to successfully age independently in their homes and communities.

Legislators, supportive service providers and various stakeholders who have acknowledged the importance that maintaining independence and aging in place has for older adults, now place great emphasis on aging in place versus nursing home placement (Vasunilashorn, Steinman, Liebig, & Pynoos, 2012). The benefits of aging in place for older adults are attachment to and familiarity with home and community. Currently, local aging-in-place provisions are being supported by numerous federal policies that the ACL governs, which HHS established in 2013 to provide support for aging- in-community efforts (Black & Dobbs, 2015). As the emphasis on aging in place increases, so does the priority to ensure that older adults have access to community-based supportive services for home and personal care and chronic disease management.

Many older adults residing in their homes have chronic conditions. Those conditions frequently cause cognitive and physical decline and increasing dependence upon supportive services. Chronic diseases affect people's ability to live independently at home and perform essential daily activities. When an individual is incapable of self care due to a chronic illness, often they lose their independence and are placed in an institution. According to the Centers for Disease Control and Prevention (CDCP) (2013), 80% of older adults (65 years and over) have at least one chronic medical condition;

those conditions are the leading causes of their death. Aging-in place-standards require community-based supportive service delivery components that help older adults manage and maintain their independence. Participants in the present study were impoverished, 60 years of age or older, and African American. It is likely that some of them suffered from one or more chronic conditions and, were, therefore, prime candidates to receive supportive services.

During the past 10 years, many organizations, among them the AARP, the CDCP, and the World Health Organization, developed guidelines to create aging-in-place standards to improve the quality of life for the aging population. AARP's guidelines addressed health care, the physical environment, and the planning needed to foster aging in place. AARP's strategies included assisting public agencies and organizations develop policies in the areas of choice of healthcare and housing options, flexibility of supportive services, entrepreneurship for affordable service delivery, maintaining mixed generations in the community, and designing communities that are more accessible and livable for all persons (Ball, 2012). In contrast, the CDCP's approach focused on health care, specifically, the stabilization of the health of the aging population, in order to improve the population's ability to age in place. The CDCP's approach was based upon five key facts: (1) the population is growing; (2) the population is diverse; (3) health care costs are rising; (4) chronic diseases are the main reasons for increasing health care costs; and (5) disability and physical and cognitive decline do not have to be the expected result of aging (CDCP, 2013). The CDCP emphasized the significance of healthy aging, preventive services, and lifestyle changes to manage older adults' independence and the needs associated with aging in place.

Researchers have proposed a variety of useful concepts and frameworks for the study of aging in place and community aging (Black, 2008; Black & Dobbs, 2015; Bookman, 2008). Black, Dobbs, and Young (2015), for example, proposed six core elements, or concepts, that they believe can be fruitfully used in the study of older adults managing independence while aging in the community, "Meaningful involvement, aging in place, respect/inclusion, communication/information, transportation/mobility, and health/well-being" (p. 219). In the context of studying of service delivery systems, Bookman (2008) identified three common models of aging in the community, Aging in Place, Naturally Occurring Retirement Communities (NORCs), and Villages.

The aging-in-place model is also a strategy to keep older adult in their homes and communities for as long as possible (Rantz et al., 2011). A NORC is a naturally occurring retirement community, with subsidized and/or market rate dwellings, that developed into an unplanned older adult community and offers supportive services onsite (Guo & Castillo, 2012). The Village model offers products and assisted living services to fee-paying members as a group, as opposed to paying individually, for older adults living in the community (McDonough & Davitt, 2011). The major difference between these models is that the traditional aging-in-place model employs the typical service recipient/service provider relationship, while the other two models allow older adults to help organize and volunteer to provide the services and programs delivered.

In prior research, Pynoos (1990) examined the social and physical framework of aging in place as a "fit" between people and their homes and the ability to manage both through policies and programs. Physical and social contexts include residential settings, neighborhoods characteristics, and access to service. In addition, Lawton and Nahemow (1973) examined the ecological aging model that portrays the aging-in-place process as a continuous adjustment in the physical environment and health capabilities during the life cycle. At this time, however, the extent to which older adults can gain access to those services that could help them manage the physical environment and health challenges that threaten their independence remains unclear. The present study began at the limits of the literature; the purpose was to assess older adults' knowledge and understanding of access to supportive services they need to age independently while living in multifamily subsidized housing.

Aging in Subsidized Housing

Subsidized housing programs are affordable housing options the government sponsors for low-income people who need assistance with housing costs (Landis & McClure, 2010). In the U.S., the three main kinds of assistance are public subsidized housing, housing choice vouchers, and multifamily subsidized housing. In public housing, the government is the landlord and the properties operate under the governance of the local housing authority; however, the housing choice voucher and multifamily housing programs offer the opportunity to lease from the private owners. The voucher stays with the person, while the subsidies remain with the properties.

In 2010, approximately 80% of adults 60 years of age or older living in the United States owned their homes and 21% lived in rental properties (AoA, ACL, & HHS, 2012). Approximately 31% of low-income older adult renters resided in subsidized housing communities (McFadden & Lucio, 2014). People who live in subsidized housing want to age in place no matter where in the world they live, whether in Hong Kong or New York City, but they need supportive services in order to age in the community. Like, their counterparts in the United States, Hong Kong's older adults who live in subsidized housing want to remain living independently in their communities and need supportive services to avoid institutionalization (Bedney, Goldberg, & Josephson, 2010; Chan, 2014).

Approximately 1.3 million older adult renters live in publicly subsidized housing in the United States, according to an announcement made at a 2010 summit on Aging in Place in Public Housing (Enterprise Community Partners & LeadingAge, 2011). Individuals living in subsidized housing have higher rates of physical, mental, and cognitive impairments (Ruel et al., 2010). It is likely that older adults living in subsidized housing have health problems. A HOPE VI study found that residents of low-income housing are at greater risk of having multiple chronic diseases (Manjarrez et al., 2007). Digenis-Bury, Brooks, Chen, Ostream and Horsburgh (2008) conducted a comparable study that revealed the same elevated levels of chronic conditions in a Boston low-income housing community. Older adults living in subsidized communities suffer from mental health problems. They are especially vulnerable to depression and anxiety and are at greater risk of experiencing chronic illness and disability (Robison et al., 2009; Simning, Conwell, Fisher, Richardson, & van Wijngaarden, 2012). The socio-environmental context of many subsidized housing dwellings may be a factor in the physical and mental health of residents. A few studies have shown that a strong sense of community and social attachment are beneficial to residents of subsidized housing communities (McFadden & Lucio, 2014; Wiles, Leibing, Guberman, Reeve, & Allen, 2012).

Gibler (2003) found that older adult renters living in subsidized housing were physically and mentally worse off than non-subsidized housing renters. They required help with daily personal and household tasks (Gibler, 2003; Heumann, 1988). The absence of supportive services increases the vulnerability of older adults living in subsidized housing and the likelihood of nursing home placement. Researchers have found that property management offices located onsite at multifamily subsidized housing dwellings typically do nothing to forestall nursing home placement of older adult residents. Onsite property management offers limited or no supportive service resources; nor do they have contingency plans for older adults whose health status has deteriorated in the community (Bernstein, 1982; Gibler, 2003; Sheehan, 1986). In the present study, the researcher was aware of the fact that onsite property managers make no efforts, formal or informal, to connect older adult residents with community resources or supportive services. The research question and participants' answers to it were expected to shed light on whether increased awareness of access to ADRC services could potentially help with meeting the needs of this population.

More recent studies reached the same conclusions regarding the health, vulnerability and needs of older adults living in subsidized housing. Older adults who are aging in place in multifamily subsidized housing communities are more vulnerable than their counterparts who are aging in unsubsidized housing. While older adults are living healthier and longer, it is still the case that a significant proportion of older adults aging in multifamily subsidized housing have more chronic diseases and mental health needs. Consequently, they require assistance with activities of daily living (ADL) and instrumental activities of daily living (IADLS) *but* they reside in properties that have limited to no access to supportive services (Castle & Resnick, 2014; Flores & Newcomer, 2014; McFadden & Lucio, 2014). Typically, these individuals are in their 70s and 80s, are members of racial and ethnic minority groups, experience declines in physical and mental functioning, and require supportive services (Beard & Carnahan, 2011). As the needs of the older adult population grow, so does the demand for access to the supportive service delivery system that provides community-based services.

Aging Disability Resource Center Service Delivery System

In 1965, Congress passed the Older Americans Act. The Act created a federal agency—AoA, and state agencies—AAA, to address the growing needs of the aging population. Congress charged these agencies specifically with the management of aging-in-place efforts that afford opportunities to "maximize independence" with "comprehensive and coordinated services" and to promote a "continuum of care" for vulnerable adults 60 years of age or older in the community (C.V.O'Shaughnessy, 2011). Currently, public policy initiatives are striving to keep pace with aging-in-place requirements through the promotion of community-based supportive services in order to lessen institutionalization. However, access to these formal services is difficult for older adults, especially those living in subsidized housing, resulting in many individuals experiencing unmet needs, social isolation, or nursing home placement (Castle &

Resnick, 2014; Cohen, 2011; Golant & LaGreca, 1994; Theodos, Popkin, Parilla, & Getsinger, 2012).

The federal government acknowledged unmet supportive service demands of the aging population and responded by providing concrete support to promote aging in place. For example, in 2003, AoA and the Centers for Medicaid and Medicare jointly awarded 12 grants to selected states to develop infrastructure for ADRCs as a means of strengthening aging-in-place efforts by improving the access of older adults and disabled individuals to a continuum of long-term care supportive services (O'Shaughnessy, 2010; Putnam, 2014). Later, in 2006, the reauthorization of the Older Americans Act (2006) required AoA to create an ADRC in all states to serve as a single point of entry for adults 60 years of age or older. The purpose of the ADRCs was to better connect older adults to services, such as information and referrals to other agencies and service providers, option counseling, quick and easy eligibility determination for public services, and to transitional care for persons returning home from hospitals and nursing homes (Civic Impulse, 2015; Napili & Colello, 2013). In many states, AAA serves as the lead agency and collaborates with other organizations to perform these ADRC functions.

In 2012, HHS established the ACL the purpose of improving access to supportive services in homes and communities of the aging population (Black & Dobbs, 2015; Putnam, 2011). The ACL administers and funds the ADRC, which is housed in the Center for Integrated Programs. Programming is managed at the state and local levels of government. Simultaneously, the federal government brought the Administration on Intellectual and Developmental Disabilities, Center for Disability and Aging Policy, AoA, and Center for Management and Budget under the governance of ACL.

In the past, older adults seeking access to supportive services were confronted by a myriad of fragmented supportive service systems with numerous authority levels within federal, state, and local agencies. Access was stymied by lack of coordination between service providers and duplication of application processes. The consequence of independent operations by multiple agencies was that older adults made unfavorable decisions due to incomplete and inaccurate information based on presented service and program choices (C. V. O'Shaughnessy, 2011). Today, access to these service systems is centralized. Access for older adults seeking supports was simplified by the change to a single agency focused delivery model with a stand-alone entity that helps coordinate services (C.V. O'Shaughnessy, 2011).

Since it was first implemented, the ADRC supportive service delivery model has been modified to streamline access and the scope of federal collaboration broadened. The 2006 reauthorization of the Older Americans Act expanded the federal partnership to include the Veterans Health Administration. The current ADRC model includes centralized, decentralized, and mixed-model operating approaches. Centralized units have one operating organization, decentralized units have more than one operating organization, and mixed-model units have a mix of centralized and decentralized operating organizations (Napili & Colello, 2013; O'Shaughnessy, 2010). The ADRC is designed for service seekers to experience streamlined access via *one-stop shop* services based upon the concept *no wrong door* (Greenfield, 2012). Service seekers should be able to enter the ADRC network through any agency's entry point and be referred to appropriate services.

The ADRC model is roughly 12 years old; there are approximately 525 ADRC sites across the United States and its territories. Although the model in is widespread use, very little is known about its effect upon access to services. The ACL compiles data about certain aspects of ADRC operations and performance semi-annually, but until 2014, no national studies or reports on the effectiveness of the system had been completed. Nor had quality assurance evaluations of services and programs been provided to consumers (Baretto et al., 2014). In 2013, the ACL commissioned the first national evaluation of ADRC. Under contract to HHS, researchers affiliated with IMPAQ International studied state and local ADRC performance, capacity, contextual factors that influence supportive service outcomes, and consumers' experiences (Baretto et al., 2014). All states were invited to participate in the study. Nearly all participated; 472 ADRC sites and 48 states responded by completing an online survey. Data were collected from April through mid-September 2013.

According to the IMPAQ report, although the ADRC model has shown great improvement in reaching its program goals and objectives over the past decade, access to services and supports is still an obstacle for many people (Baretto et al., 2014). However, consumers that gained access to ADRC reported a high level of satisfaction with their outcomes. The present study is aligned with the most current findings regarding ADRC sponsored community-based services—access remains the key obstacle for most people.

Community-based Services

The Older Americans Act is implemented through state and local AAA, local offices on aging, and ADRC to make community-based supportive services available to those who need them. As shown by the literature reviewed in this chapter, supportive services are of great importance to older adults who require assistance to age in place. These services, which are provided in people's homes or in the community, are designed to ameliorate the effects of functional declines and enable recipients to maintain the highest quality of life possible. Under Title III of the Older Americans Act, service options include care information and referrals for long-term services and supports, care management, and transportation (Civic Impulse, 2015). HCBS, such as chore services, personal care, and home health aides, are also included in supportive services (Tang & Lee, 2010). Services and programs are funded by Title II of the Older Americans Act; under Title II, the ADRC uses the no wrong door model to make information about access to supportive services (O'Shaughnessy, 2011) more easily accessible. All adults 60 years of age or older are eligible for these supportive services. The target population, however, is individuals with the greatest financial and, or social need for supportive services.

Despite efforts to make access easy, older adults are experiencing difficulties with access to supportive services. According to a report issued in 2014 by the National Association of Area Agencies on Aging (2014), an association of agencies located in the Washington, D.C. metro area, transportation and home and community-based services were rated the most desired and most difficult to obtain. The importance of connecting older adults and home and community-based services cannot be overstated. Conversely, the consequences of failing to connect available services with those who need them are dire. HCBS use among older adults increases the length of time they can continue to reside in their homes and in the community, delays nursing home placement, and subsequent to an inpatient admission, provides them with the option to return home from an institutional setting (Chen & Berkowitz, 2012).

As shown by the literature reviewed above, the older adult population is plagued by chronic illness and deterioration in physical and cognitive functioning. One frequent cost of living with a chronic condition is quality of life. Many older adults living in subsidized housing have disabilities and chronic diseases that interfere with their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Beard & Carnahan, 2011; Casado et al., 2011). The inability to carry out ADLs and IADLs poses a threat to their ability to age in place. ADLs include toileting, bathing, dressing, and transferring to bed and, or chairs (Lowry, Vallejo, & Studenski, 2012). IADLs consist of cooking, housing keeping, medical administration and shopping (Suchy, Williams, Kraybill, Franchow, & Butner, 2010). Results of a national survey by the American Association of Homes and Services for the Aging (2010) revealed that approximately 36% of older adult residents needed assistance with at least two or more ADLs, and 63% required help with two or more IADLs. Due to ethnicity of the participants, impaired ADLs and IADLs, and functional limitations, some individuals are at greater risk for nursing home placement. Given these findings and the demographics of the participants in the present study, I expected that their responses to the open-ended research question would raise the possibility of nursing home placement in the future.

A few researchers have found that in addition to care needs, race and ethnicity are factors associated with need for supportive services. Poor urban African American women in their 70's and 80's living in subsidized housing are adversely affected by failing ADLs and IADLs more frequently than their white counterparts (Beard & Carnahan, 2011). These women typically live in poverty, are at higher risk of having chronic conditions and suffering from depression, and lack formal support, but they are less likely to move out of subsidized housing (Casado, et al. 2011). Casado, et al also reported that important predictors of unmet demands for community-based programs included "[b]lack ethnicity, higher numbers of ADL and IADL limitations, and behavioral problems increased the odds of having unmet needs for community-based [support service] programs, whereas having substitute help available and family support reduced the odds for unmet needs for this type of service" (p. 543).

There are myriad benefits for older adults who use supportive services. Chen and Thompson (2010) found that older adults who accessed supportive service for IADLs experienced good outcomes relating to their ability to remain in the home and community. They also reported that older adults who are knowledgeable about their IADL deficiencies were more likely to access IADL supportive services, with concomitant increases in the likelihood that they would age in place (Chen & Thompson, 2010). Jansen et al. (2009) found that older adults who obtained HCBS during the earlier stages of declining health benefitted more from subsequent treatment. Muramatsu, Yin and Hederek (2010) found that older adults who received HCBS had lower rates of depression than those who had informal supports. The research shows that an effective and efficient community-based supportive service delivery model is necessary to facilitate more positive results for older adults who want to age in place but need assistance with ADLs and IADLs.

Need for Future Research

Research findings on the benefits of community-based services that are unrelated to medical care are compelling, but the literature on older adults' awareness and access to those services is sparse. The problems of low awareness and poor access to services that are needed and available must be solved if older adults are to fulfill their desire to age in place in the community. In light of the increasing number of older adults and the burgeoning need for community-based services, this gap in the literature warrants the attention of researchers. More specifically, there is little literature on awareness and access to home and community-based supportive services for older adults, and none about awareness and access from the perspective of older adults living in multifamily subsidized housing who want to age in place. The literature regarding access to home and community-based supportive services by older adults is marred by methodological problems. For example, the level of awareness that such services are available may have been overestimated. In one study, researchers inquired about both home health services and non-medical supportive services, which may have led to confusion on the part of respondents (Denton et al., 2008).

Summary

There is a voluminous amount of scholarly work devoted to aging in place and factors that influence whether older adults continue to live independently in their homes and communities or transition to institutional living. The literature on access to health care and health-related supportive services is also vast. Researchers agree that community-based services are essential to maximize independence and support aging in place. Factors that militate against aging in place, such as isolation, poor health, and depression, are well documented. The body of literature on non-medical supportive services provided in the home and community is relatively small. Although access to community-based services is known to be problematic, there has been very little systematic inquiry that delves into obstacles to access by using a typology of access as a conceptual framework.

There are also gaps in the literature stemming from limitations on sampling. People living in poverty and African Americans are both underrepresented in the literature, which could compromise the generalizability of findings. Researchers caution against presumption that results based upon surveys of white, middle class respondents apply to people living in poverty or to African Americans. Despite the voluminous literature on the concept of aging in place and the value of home and community-based services to vulnerable individuals, very few researchers sampled adults 60 years of age or older living in multifamily subsidized housing communities. This study built upon previous findings and addressed gaps in the literature by examining access to non-medical community-based supportive services. This study also contributed to the literature by improving upon methods used to collect data. Prior methods resulted in acquiescence bias and miscommunication between surveyors and respondents; this study avoided those errors. The methodology, sample and analyzes used for this study are presented in Chapter 3.

Chapter 3: Research Method

> *A social institution can be fully understood only if we do not limit ourselves to the abstract study of its formal organization, but analyze the way in which it appears in the personal experience of various members of the group and follow the influences which it has upon their lives (Thomas & Znaniecki, 1927, p. 1833).*

Introduction

In the Washington, D.C.'s multifamily subsidized housing, adults 60 years of age or older lack awareness of access to ADRC community-based services that could assist them with aging-in-place efforts. Services include but are not limited to care management, resource and referral assistance, transportation, light housekeeping services, and community meal programs. If residents were aware of access to ADRC's service delivery system, they could learn how to access resources that might help them maintain independence and remain in their homes and communities longer.

The purpose of this phenomenological study was to explore whether increased awareness of access to ADRC is likely to better meet the needs of senior citizens living in Washington, D.C.'s multifamily subsidized dwellings. Those who participate in the Housing Choice Voucher Program provided stories based on lived experiences regarding their knowledge of and experience with access to services ADRC offers and the contextual factors that influenced them.

In this chapter, the justification for conducting a qualitative study using a phenomenological research design is provided first. Characteristics of the participants and the data collection procedures are described next. The chapter concludes with discussions of the method used to analyze the data and the ethical considerations and guidelines I followed during this study.

Research Question

What awareness or experience do adults 60 years of age or older of Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC services?

Research Design and Rationale

Qualitative research is an approach in which the researcher chooses to study a social phenomenon in its natural context as it happens. The phenomenon chosen for this study was the awareness of access to a service delivery system for community-based resources among low-income adults 60 years of age or older who reside in multifamily subsidized housing. One aspect of this research is to give low-income adults 60 years of age or older who reside in multifamily subsidized housing a platform from which to give voice to their knowledge of access to services that are acceptable, accessible, affordable, accommodating, and available through their local ADRC offices. Analyses of the narratives of their lived experience could shed light on the effect that this phenomenon, i.e., their awareness of access to services via ADRC, has upon their lives.

Their experiences will serve not only as the basis for studying the phenomenon, they may also help stakeholders gauge the fit between the expectations of aging consumers and the characteristics of a service delivery system that offers resources to individuals aging in the community. Researchers have rarely provided public administrators working in the area of aging with first-hand reports of the lived experiences of this population. I selected phenomenology as the research method to capture the lived experiences of these individuals and their interactions with the ADRC service delivery system.

Phenomenological Inquiry

The purpose of phenomenological inquiry is to fully describe a lived experience. In this type of research, researchers rely upon data patterns to extract the intrinsic nature and characteristics of a participant's perspective or meanings (Flood, 2010). The researcher seeks to combine ideas and the essences of a phenomenon, the reality according to the participant's experience, and the phenomenon. Only those who have experienced the phenomena can describe and explain them to other individuals (Mapp, 2008). In a phenomenological study, the researcher analyzes the how and what of the lived experience to better understand and align the participant's responses as derived from a narrative inquiry with open-end interview questions.

Narrative inquiry was selected for this study because of its origins and its fit with the purpose and participants of the study. Early in the 20th century, the University of Chicago's Department of Sociology, the *Chicago School,* was one of the first and most significant schools of sociology to embrace qualitative research and using various narrative inquiry research designs. During the 1920s and 1930s, the Chicago School dominated the field of qualitative sociology by merging qualitative theory with the practical application of collecting life histories and personal documentation in research efforts (Johnson, 2001). Leading scholars applauded the use of this narrative approach, which originated from research done by William Isaac Thomas and Florian Znaniecki on the life history of a Polish immigrant. By utilizing this methodology, Thomas and

Znaniecki (1927) completed and published *The Polish Peasant in Europe and America*, a study that captured the lived experiences of immigrants from Poland who settled in the United States of America.

Narrative inquiry is a method by which an individual can tell a true story about something he or she experienced. A narrative can be spoken and/or written as the result observation, an interview, or a naturally occurring conversation; it also can come from personal documentation. Chase (2007), explains that narratives can arise out of many situations:

> …A narrative may be (a) a short topical story about a particular event and specific characters such as an encounter with a friend, boss, or doctor; (b) an extended story about a significant aspect of one's life such as schooling, work, marriage, divorce, childbirth, an illness, a trauma, or participation in a war or social movement; or (c) a narrative of one's entire life, from birth to present. (p. 653)

This qualitative study used a narrative inquiry research design. A narrative inquiry is a phenomenon and a method that investigates how people experience society (Connelly & Chandinin, 1990). The researcher studies the life stories of individuals by asking one or more persons to provide personal narratives about a particular aspect of their lives and linking those perspectives with the experiences of researcher in a combined narrative. According to Spector-Mersel (2010), using qualitative research with a narrative inquiry as a methodology makes it possible to create an understandable viewpoint of society and to see how individuals psychologically maneuver and perform within it.

A narrative approach was chosen for this study because as a method it results in more than a collection of stories; it yields personal accounts of lived experience. Analytical studies have found that self-reflecting individuals find refuge and value in other people's accounts (Duff & Bell, 2002). Second, a narrative approach was chosen because other approaches impose an important limitation on the process of data collection. The researcher's experiences are excluded from the study for the purpose of understanding a specific phenomenon though the lived experiences of the participants only (Sorrell & Redmond, 1995). The researcher in this study has a related story. The researcher's lived experience is, therefore, an important part of this study and was included by design. The researcher's experiences can be brought to bear upon the question of how the phenomenon under study affects the lives of the participants.

The Role of the Researcher

I was raised by my maternal great-great grandmother. I lived with my great-great grandmother for 27 years. We co-housed with my maternal grandmother and grandfather in a low-income community in Philadelphia's Germantown section, surrounded by subsidized housing. In my childhood and early adulthood, I served in the role of senior supportive service aide and advocate not only for my grandparents, but for their aging friends as well. I remember running errands, helping organize medication, communicating to outside parties via oral and written correspondence to address problems and issues, and doing light housework. There were other children in our home part-time but I was the only one required to assist with the aforementioned tasks. My great-great grandmother chose me because I lived in our home full-time and I was trustworthy. After my great-great grandmother and her friends died, I continued to help aging grandparents, family members, friends, and other older adults in my community by providing supportive services.

When I was fifteen, I observed so many low-income, urban older adults coping with adversity that their struggles touched me to the core. Whether on public transportation struggling with bags, or shut in their homes and in despair, these older adults were in need of help. Most lacked money to pay rising medication costs. Witnessing their struggles, I felt obligated to work for change in my community. I sought out opportunities to provide supportive services in faith-based organizations and educated myself about the issues associated this population.

As I entered adulthood and continued to provide care for my grandparents, I remained fascinated by older adults and their needs. I decided to pursue a part-time career in aging services in senior communities. I established a nonprofit organization in Philadelphia that helped community dwelling older adults age with independence. Most of people I assisted lived in subsidized housing and were in need of some type of personal care and/or homecare due to failing health and limited supportive resources.

Today, I am employed by a developer of senior housing as a Senior Supportive Service Network Manager and am preparing to complete a doctoral program. I often reflect on the time when I was first exposed to low income older adults' challenges, witnessed their unmet needs for supportive services, and served as a caregiver, advocate, and service coordinator. Early on, I realized the importance of researching this topic in more detail and the use of narratives to gain a better understanding what the older adults experienced regarding their access to services. Now, as a supportive service network manager for older adults living in subsidized communities, I believe that the combination of my personal experiences as a caregiver and my professional experiences from fieldwork are a good complement to the role and responsibilities of a researcher studying this population. I believe my experience, skills and understanding enhanced my awareness and sensitivity to the topic of this study and helped me work more effectively with the participants.

I developed a rigorous methodology to address gaps in the literature on multifamily subsidized housing dwelling seniors' experiences with access to community-based services, and to avoid the response bias that marred previous studies. In addition, one of my obligations as a researcher conducting this study was to ensure that personal assessments, assumptions, and preconceived notions were recognized and addressed during the beginning phase of the research. Although I made every effort to be objective, my personal biases could conceivably have influenced the way I collected, viewed, and/or understood the data. I was, however, well informed and knew that service providers are not always at fault for consumers' lack of access. I also understood that some older adults do not access services for various personal reasons. To manage my preconceived notions and minimize their effect on this study, I focused intensively on previous studies and the validation strategies used. Furthermore, I remained open to the thoughts and opinions of other professionals in the field.

Methodological Process for Narrative Inquiry

Participants

This study used a criterion-based sampling strategy to include multiple perspectives of what adults 60 years of age or older, participating in the housing choice voucher program and living in multifamily subsidized housing communities in Washington, D.C. know and have experienced regarding access to information and service options available through ADRC. To achieve this, 20 older adult volunteers, who were solicited through distribution of invitational fliers for research study participation and who lived in subsidized housing communities in Washington, D.C., were interviewed. Volunteers were selected on a first-come, first-served basis. Prior to the data collection interview, participants were advised of their rights and asked to sign an informed consent form.

Sample

Purposeful sampling is used in qualitative studies. This methodology recognizes the richness of data and the central phenomenon in the study (Palinkas et al., 2015). There are approximately 16 different types of purposeful sampling (Patton, 1990). This study used purposeful sampling in the recruitment of participants and choice of location. Sampling also was criterion-based; participants' age, residence, and willingness to participate were the criteria that informed the research question that guided the study. Using a criterion-based methodology in the selection of the sampling assures quality control (Pirkle, Dumont, & Zunzunegui, 2011).

Data Collection

In this study, I used face-to-face interviews to collect data. Invitational fliers were posted in multifamily subsidized housing communities throughout Washington, D.C., soliciting adults 60 years of age or older to volunteer to participate in the study. Per the flier, volunteers were asked to contact the researcher to have their names added to a prospective participant list. Once the list was completed, I contacted 20 volunteers by telephone to make an appointment for an in-person initial meeting. Each volunteer chose the location of the initial meeting. There was a waiting list of 10 additional volunteers in case of attrition, but none of the volunteers on the waiting list were needed, as there was no attrition.

During the initial meeting, I collected volunteers' demographic data, including their place of residence, to determine whether they met the selection criteria. In addition, the initial meeting was a way to establish rapport as well as to explain the purpose of the study and the procedures used to collect data (i.e. interview, audio taping). I explained the meaning and process of giving informed consent, discussing it in a manner that allowed me to gauge volunteers' level of comprehension of the particulars. Subsequently, the data collection interview was scheduled. I gave each volunteer a hard copy of the informed consent form to take home.

Based on my experience, prospective participants were given a minimum of 3-5 days to process the information given at the initial interview, review the consent form, and discuss their participation with trusted others. Volunteers then received a follow-up telephone call concerning their participation in the study. I assured each volunteer that there were no consequences for deciding against participating and that they could change their mind at any time. All 20 volunteers with whom I had an initial meeting agreed to participate in the study. In the event that any prospective participants had decided not to go forward with the study, they would have been assured that there would be no consequences for declining to participate in the study. The next volunteer on the waiting list would have been contacted as a possible replacement.

Once the sample was selected, I completed narrative inquiries during face-to-face interviews using a structured protocol with open-ended interview questions. The interviews were audio taped and I made observation notes of particularly salient points. I allowed participants to control the pace of the interview though a non-directive style of inquiry. Had there been a need to clarify anything that was said during a data collection interview, procedures called for me to schedule a follow-up meeting with the participant and make queries using the same style of questioning to prompt the participant to elaborate on their previous response. No follow-up meetings were needed for clarification. A sample of interview questions is attached as Appendix A.

Data Analysis

After the data were collected, I analyzed them using a thematic analysis methodology. Thematic analysis is commonly used in qualitative research. It focuses on describing a social phenomenon through themes and patterns that are specifically related to the research question (Braun & Clarke, 2006). I had confidence in this approach and relied on Braun and Clarke's guidelines (2006, p. 14-23). The guidelines include the following steps:

1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes

I listened to each recorded interview as many times as needed and transcribed data into electronic word processing files. All documents were saved with password protection on my laptop computer. Only the researcher has access to the computer and data files. The transcribed data consisted of statements participants made about their lived experience in response to questions about their knowledge of services and programs the ADRC offers. I used these statements to formulate meanings to analyze while describing and coding the context of participants' experiences. From these meanings, themes for analysis emerged. I reviewed the emergent themes, then defined and finalized them. I used NVivo 11 qualitative software to organize, manage, and analyze the data.

Validating Strategies

Researchers conducting qualitative studies use various validating strategies to assure credibility of findings. These strategies include "member checking, triangulation, thick description, peer reviews, and external audits" (Creswell & Miller, 2000, p. 124). Member checking, triangulation, and peer review assured the credibility and validity of this study's results. In accordance with Walden University's doctoral dissertation requirements, the dissertation committee and its chair, the program director, and the university research reviewer reviewed and validated the results of the data analysis. In addition, an independent subject matter expert in the ADRC system and Washington, D.C.'s services for the aging reviewed the data, transcripts and emergent themes.

I also relied on Tong, Sainsbury, and Craig's (2007) guided questions and description from "Domain 3 analysis and findings" checklist (p. 352), for a sustained focus to assure the study's credibility and reliability. I showed each participant a transcript of their interview and asked whether it accurately reflected their intended meaning. Themes emerged from the data. I identified major and minor themes, reported these as findings, and interpreted them.

Ethical Considerations

Participants in this study were treated in accordance with the ethical guidelines of Walden University's Institutional Review Board and the "Code of Ethics and Professional Conduct for Psychologists" of the American Psychological Association (American Psychological Association, 2002, 2010). Beginning with the initial telephone conversation, I developed a rapport with the participants, protected their interests, and made every effort to ensure that they understood that they did not have to participate, could decline to answer any question I asked, and knew that there was no tangible reward in exchange for their participation. Participants were advised of their rights many times, both orally and in writing, and queried to be certain that they understood their rights and believed that they could exercise the freedom to withdraw from the study at any time. Every precaution was taken to ensure that all participants felt safe and comfortable during the data collection process and after the study's conclusion. They were offered breaks during interviews and asked how they were feeling. I contacted participants who asked for more information after the conclusion of the study, giving them the information they requested, and asking them how they felt now about their participation in the study.

To protect the participants' rights, the following safety precautions were taken and provided to participants in writing:

- Documentation of the voluntary nature of their participant in the study; and, their ability to withdraw from the study or decline to reply to any interview question without being penalized;
- A written informed consent;
- Explanation of data collection methods;
- Access to transcriptions, interpretations, and final report of data;

Although no identifiable risks were found for participants in this study, the researcher considered the following sensitive factors in dealing with older adult volunteers and participants:

- Their ability to cognitively evaluate the risks and benefits and make a decision;
- Their ability to comprehend the information;
- Their ability to reschedule the interview due to fatigue, illness or unforeseen events; and,
- Their understanding that the researcher had no position of authority nor should she exhibit any signs of coercion.

In addition, the researcher offered the following assurances to participants:

- The researcher would maintain confidentiality and protect their identity by coding information and providing factitious names in any narratives quoted in the final report;

- Their participation or nonparticipation would not affect services in the future; and,
- All data were secured in the computer and stored in a locked file cabinet of the researcher.

Summary

This phenomenological study used a narrative inquiry design to analyze the lived experiences of adults 60 years of age or older, who received a housing choice voucher and lived in multifamily subsidized housing communities in Washington, D.C., regarding their knowledge of or experience with the ADRC's services and programs. The goal was to understand whether increased awareness of access to ADRC is likely to better meet the needs of these individuals. A sample of 20 volunteers participated in face-to-face interviews that followed a structured protocol with open-ended interview questions. The interview data were analyzed using a thematic analysis methodology. The researcher adhered to research resource tools, guidelines, and recommendations of specialists in the field to constrain the effect of biases and preconceived notions. In addition, the researcher was guided by ethical considerations especially pertinent to older adult participants, built in several layers of security to protect the interests and confidentiality of the participants, and adhered to the ethics codes of Walden University and the American Psychological Association.

Chapter 4: Results

The findings from a qualitative study are not thought of as facts that are applicable to the population at large, but rather as descriptions, notions, or theories applicable within a specified setting (Malterud, 2001, p.486).

Introduction

The purpose of this phenomenological study was to explore whether increased awareness of access to ADRC service delivery system could potentially better meet the needs of low-income adults 60 years of age or older who reside in Washington, D.C. in multifamily subsidized housing communities. This chapter presents the findings from a narrative inquiry conducted by interviewing 20 senior citizens who lived in multifamily subsidized housing through the Housing Choice Voucher Program about their awareness of access to ADRC. The expectation was that the narratives of their lived experiences would serve as a basis for deciding whether increased knowledge regarding access to services could potentially support this population's efforts to age in place.

The research question that guided this study was "What awareness or experience do adults 60 years of age or older who live in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC services?" The study findings show the direct linkages between themes and participants' experiences and perceptions of what contributed to their familiarity with access to local ADRC services. Study findings emerged from an analysis of the audiotaped interview transcripts and observation notes.

Themes that emerged from interviewee narratives included:

- Need for community-based services;

- Lack of knowledge of or experience with ADRC;
- Seek to retain housing voucher in order to age at home and in the community;
- Remain independent to avoid burdening children and prevent nursing home placement;
- Request increased awareness and knowledge about ADRC and its services;
- Unhappy with ADRC outreach and want community liaisons to do person to person outreach at their place of residence to inform them about ADRC services.
- Vigilantly guard privacy rights regarding disclosure of personal or demographic information; and,
- Receive limited amount of information about community-based services from community liaisons (e.g. onsite property management personnel, senior daycare staff, and community center staff).

In response to queries, three participants reported that their limited knowledge about access to ADRC services was learned in the context of employment, or as a caregiver for a family member. The participants who had accessed services reported that they found them acceptable, accessible, affordable, and, accommodating, and said that the services helped them with one or two unmet service needs, and increased their ability to remain in their communities.

Researcher Bias

I was aware that my personal assessments, assumptions, and preconceived notions about seniors who live in multifamily subsidized housing and their use of community-based services could influence this study. I am well informed about the complexities of coordinating providers, managing networks, and funding streams. I know that service providers are not necessarily at fault for, nor can they always make an impact upon, consumers' lack of awareness, inability to access services, or choices consumers make about whether or not to use available services. I understand that some older adults do not obtain community-based services for various personal reasons. I have worked in the field of gerontology for 27 years, and my knowledge and experiences led to the desire to undertake this study. I made a conscious effort to manage my perceptions and influence by focusing on previous studies conducted on the topic, validating strategies, and being open to the thoughts and opinions of other professionals in the field.

Research Question

What awareness or experience do adults 60 years of age or older who live in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC services?

Applied Methodological Process for Narrative Inquiry

Description of Study Sample

This study used purposeful sampling in the recruitment of participants and choice of locations. Additionally, I used a criterion-based selection process. Criteria for participation included age, location and type of residence, and willingness to participate. These participant characteristics informed the questions that guided the study. The overall population of this study was adults 60 years of age or older who live in multifamily subsidized housing and receive a housing choice voucher in Washington, D.C. Property managers of selected District of Columbia Housing Authority's subsidized housing communities, one in each of seven wards, posted invitational fliers that solicited participation in the study. There are eight wards in Washington, D.C.; however, this study focused on multifamily subsidized housing residents only, which excluded a single ward, Ward 3. Ward 3 does not have any subsidized housing. *Table 1* lists the names and locations, by ward, of the subsidized housing communities where invitational fliers regarding participation in this study were posted.

Table 1

Washington D.C. Ward & Subsidized Housing Community Data

Ward	Multifamily subsidized housing communities	Respondents
1	Wardman Court Apartments	0
2	1330 7th Street Apartments	0
3	No Subsidized Housing	0
4	Fort Steven Hills Apartments	0
5	Edgewood Terrace	0
6	Tyler House Apartments	0
7	Mayfair Apartments	0
8	Overlook Apartments	20

Demographics

This study included 20 participants residing in Ward Eight, located in the southeast quadrant of Washington, D.C. The sample had 17 women and three men; their ages ranged from 60 to 91. All participants were low-income African Americans living independently in multifamily subsidized housing. All were recipients of a Housing Choice Voucher that the U.S. Department of Housing and Urban Development sponsors. All individuals in the sample were receiving at least one community-based service. *Table 2* shows participants' demographics, services, and ward.

Table 2

Participants' Demographics

Demographics	Number of participants
Gender	
Men	3
Women	17
Age range in years	
60-70	3
70-80	15
80-90	2
Receiving free community-based services	
Transportation (Medical Appointments Only)	9
Monthly Supplemental Food	20
Ethnicity	
African American	20
Caucasian	0
Hispanic	0
Asian	0
Other	0

(Table continues)

Demographics	Number of participants
Marital Status	
Single	7
Married	0
Divorced/Separated	0
Widow/Widower	6
Undisclosed	7
Living Arrangement	
Live Alone	20
Live with someone	0

Data Collection

Before data collection began for this phenomenological study, Walden University's Institutional Review Board granted me approval (01-04-16-0111541) to begin work on the study. I collected data were collected through face-to-face interviews. When collecting the data, I used the methodology described in Chapter 3, which included recruiting volunteers (potential participants) by posting flyers in multifamily subsidized buildings, selecting participants who met the sampling criteria, making audio recordings of data received from participants, and reviewing the data with participants to check accuracy of interpretation.

More specifically, the steps that the researcher followed during this study's data collection process were:

1. Provided invitational fliers to the property managers of one multifamily subsidized housing community in seven wards throughout Washington, D.C. There are eight wards in Washington, D.C.; however, this study focuses on subsidized housing which excluded one ward, Ward 3, as that ward does not have affordable housing units. The fliers solicited residents 60 years of age or older willing to participate in the study.
2. Extended an invitation to potential participants to contact the researcher via telephone for more information about the study. The first 20 respondents agreed to participate.
3. Scheduled appointments for an initial in-person meeting in the participant's home, private space/room in their building, or a private meeting room in a community center.
4. Conducted first meeting with each respondent, during which the researcher provided information about the study, discussed details about informed consent, and confirmed a date, time, and location for each interview.
5. Met with each participant for a 30-45-minute audio recorded interview and collected their signed informed consent. A protocol of interview questions (Appendix A) was used to guide each interview.
6. Reviewed participants' audio recorded responses with them to ensure the accuracy of interpretation of content.
7. Prepared and disseminated a written copy in the third-person narrative giving voice to each participant based on their respective personal experiences and

perceptions of what contributed to their knowledge of access to local ADRC services for transportation, light housekeeping, and community meal programs.

I also analyzed the narratives and identified those ideas expressed by all, or nearly all, of the participants. Only a few unique thoughts emerged from the narratives. I used open coding when analyzing the data. In the process, I found consistent themes among the participants' responses, which indicated that this study achieved data saturation.

Data Analysis

In this phenomenological study, the data were analyzed and coded using a thematic analysis methodology. I reduced data into themes through a coding process that focused on describing social phenomena related to the research question. I trusted this approach and relied on Braun and Clarke's strategies (2006, p. 14-23) to guide the process. This method included the following:

1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes

The data analysis and collection processes happened concurrently, as described below. After completion of the interviews, I transcribed and reviewed the data for themes. The process of reviewing the data led to open coding; identifiable themes emerged through conducting inquiries using NVivo 11 software. I used queries seeking word frequency, text search, and coding for frequently used keywords.

For the purpose of thematic analysis, the participants' responses to interview questions were analyzed for similarities and differences through the process of coding. Patterns and themes aligned under groupings of information throughout the process. I took emerging topics and organized and transcribed the data into categories relating to main ideas. Upon completion of the transcripts, I gave the documents to the participants to review and edit. Once each participant indicated that they were satisfied with the transcription, I began analyzing the data for themes.

Thematic Analysis

Emergent Themes

As indicated in Chapters 1 and 2, the following topics relating to adults 60 years of age or older receiving a housing choice voucher and residing in multifamily subsidized housing and their awareness of access to community-based service options the ADRC provides could emerge as themes: (a) The need to access community-based services, (b) Lack of knowledge of or experience with the ADRC, and (c) Received limited amount of community-based services information from community liaisons (i.e. residential property personnel, senior daycare staff, and community center staff). The narrative inquiry revealed several surprising themes: (a) Retain housing voucher to aging in home and community, and (b) Remain independent to avoid burdening children and nursing home placement. A small fraction of the participants, 15% (3 of 20), had received limited information regarding ADRC from personal or professional experiences. Appendix A shows the research question and all sub-questions that elicited the themes that emerged. Table 3 shows how study questions aligned with participants' narratives.

Table 3

Study Questions Alignment With Participants' Narratives

Study questions	Participants' narratives
Preinterview questions How old are you? What is your home address? Are your married? Is your family nearby? Level of education? Income? Source of income?	All participants gave their age range in lieu of their actual age and disclosed their marital status. They were all over 60 and receiving a Housing Choice Voucher, and living in a multifamily subsidized housing community in Washington, D.C. They did not disclose whether they had family nearby, their level of education or income.
Research question	
What awareness or experience do adults 60 years of age or older who live in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC Services?	Eighty-five percent of participants (17 of the 20) said they had no awareness and, or experience with an ADRC.

(Table continues)

Study questions	Participants' narratives
Subquestions	
What is your knowledge of or experience with access to supportive services from the ADRC?	One hundred percent of participants (20 of the 20) said they had no awareness and, or experience with supportive services.
What is your knowledge of or experience with access to transportation services from the ADRC?	Eighty-five percent of participants (17 of the 20) said they had no awareness and, or experience with transportation services.
What is your knowledge of or experience with access to light housekeeping or homemaker services from the ADRC?	One hundred percent of participants (20 of the 20) said they had no awareness and, or experience with light housekeeping or homemaker services.
What is your knowledge of or experience with access to community dining or home delivered meals from the ADRC?	Eighty-five percent of participants (17 of the 20) said they had no awareness and, or experience with community dining or home delivered meals.

(Table continues)

Study questions	Participants' narratives
Subquestions	
What information and, or resources have you received from your local ADRC regarding access to community-based services? And, how was it obtained?	One hundred percent of participants (20 of the 20) said they received some information about community-based services from non-ADRC staff.
Do you have any else to say or questions you would like to ask me before we stop?	Ninety-five percent of participants (19 of the 20) identified with all themes listed below. Identified a need to receive community-based services. Requested information about ADRC and what services it provides. Seeking to retain housing voucher to aging in home and community Seeking to avoid burdening children for support. Seeking to stay independent to avoid nursing home placement.

(Table continues)

Study questions	Participants' narratives
	Displeased with ADRC outreach Suggested that system provide community liaisons to do onsite outreach regarding programs and services.

Study Findings

Interview Data

What awareness or experience do adults 60 years of age or older who live in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC Services?

The experiences of 20 participants in the narrative inquiry were congruent. More precisely, 85% of the participants (17 of 20) had no knowledge of or experience with the ADRC, and 15% (3 of 20) had received limited information regarding ADRC from personal or professional experiences. None of the three participants represented in the discrepant findings had knowledge of three or more resources that could be accessed through the ADRC. Not surprisingly, the two participants who knew of services learned of them in the context of serving as caretakers. *Table 4* illustrates an emergent themes alignment with participants' interview results.

Table 4

Aligned Themes With Participants' Interview Results

Emergent themes	Participants' interview results
Need to access to community-based services	Twenty (20) participants only accessed one or two community-based services at the time of interview.
Lack of knowledge or experience with the ADRC community-based services	Seventeen (17) participants had no knowledge of or experience with the ADRC community-based services. Twenty (20) participants had no knowledge of or experience with supportive services through ADRC. Seventeen (17) participants had no knowledge of or experience with the transportation services through ADRC. Twenty (20) participants had no knowledge of or experience with light housekeeping through ADRC. Seventeen (17) participants had no knowledge of or experience with community dining or home delivered meals through ADRC.

(Table continues)

Emergent themes	Participants' interview results
Request for increased awareness of ADRC services	Nineteen (19) participants inquired about more information on ADRC services after the interview.
Right to preserve privacy regarding sharing detailed demographic information	None of the twenty (20) participants were willing to reveal demographic information or personal data (current age, informal supports, income, education).
Receive limited amount of community-based services information from community liaisons (i.e. residential property personal, senior daycare, community center staff)	Twenty (20) participants identified one or more community liaisons as the source of their information regarding access to community-based services.
Seeking services to stay independent to avoid burdening children and nursing home placement	Nineteen (19) participants requested ADRC information seeking for assistance to help them with staying independent to avoiding burdening children and nursing home placement.

(Tables continues)

Emergent themes	Participants' interview results
Unhappy with ADRC outreach so want a community liaisons to do onsite outreach regarding programs and services	Nineteen (19) participants were displeased with ADRC outreach and suggested they have a community liaisons to do onsite outreach regarding programs and services.

Discrepant Data

Three study participants reported that personal or professional experiences were the sources of their knowledge and, or experience with, access to ADRC service options. At the time of the study, they received supplemental food, and/or were provided with limited transportation services. The transportation provided was inadequate to meet their needs because it was restricted to medical appointments only. Of the three respondents with knowledge of ADRC service options, one man, a retired nursing home cook, had learned about food and transportation and related services in the context of his former employment. Two women had accessed homemaker, transportation, and/or delivered home meals programs for aging family members. None of these three participants had knowledge of three or more services that the ADRC offered. Therefore, these data were not in conflict with the emerged themes.

Summary of Narratives

The narratives related to the lived experiences of adults 60 years of age or older receiving housing choice vouchers and living in Washington, D.C.'s multifamily subsidized housing communities and their knowledge of access to community-based services the

ADRC offers were consistent. When answering the question, "What awareness or experience do adults 60 years of age or older who live in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC services?", most participants (85%) indicated they had "no knowledge of or experience with the ADRC." After recording was halted, they asked questions. Most participants followed up with two questions "Who are they?" and, "Where are they located?" The same individuals requested "more information about the ADRC." Some participants seemed to be surprised and indignant. GW's response was representative: "I've been advocating for seniors and services for over 40 years and now that I am a senior, I can't find services for me!"

Ninety-five percent of participants said they didn't want to burden their children by asking them for help. One such response was that of MW, who said, "My daughter is taking care of her grandchildren and I hate to be a burden to her and ask her to help me clean up my apartment for the housing inspector. But if I don't they will fail me again and I might lose my voucher." Loss of a housing voucher was seen as tantamount to losing the ability to continue living independently in the community. Fear of losing the voucher was voiced by 95% of participants. FD's response explains the connection: "I need help with my recertification for my apartment. I don't have anyone to help me get my documents in order. The manager for the building said it was not her responsibility. If I don't get the right paperwork to them, I will lose my apartment. I love my place."

In contrast, of the persons who had some awareness and, or experience with the ADRC, one male participant stated, "I know who they are, I retired from the nursing home down the street and representatives would come out and talk about services." He also noted, “I don’t need their services right now. I let the people who need it get it.” When asked to identify what services he was familiar with, he could name only two services (transportation and home-delivered meals) out of approximately 20 ADRC community-based services available in his community. The other two participants who had some knowledge of and/or experience with the ADRC had exposure to a few offered services due to previous family caregiving experiences. One of the two participants stated, “I need more information about their services and any other services,” and the other said, “I am about to retire and want to know more about their services.” *Table 5* is a composite of answers by the 20 participants in response to the questions the study posed.

Table 5

Narrative Study Data For Participants

Participant ID	Knowledge of or experience with ADRC	Familiarity with ADRC services /consumer satisfaction	Source(s) of information for ADRC	Community-based services received	Source(s) of information for community-based services*	Participant request for additional information
CN	Yes	Meals Transportation /Yes	Work	Yes Supplemental Food	CCS	None
GLW	None	None/No	None	Yes Transportation Supplemental Food Day Program	CCS	ADRC Information
IM	None	None/No	Family	Yes Supplemental Food	CCS	ADRC Information
JB	Yes	Meals Transportation /No	Family	Yes Transportation Supplemental Food Day Program	SD/CCS	ADRC Information
BG	Yes	Meals Transportation /No	None	Yes Supplemental Food	CCS	ADRC Information
VM	None	None/No	None	Yes Transportation Supplemental Food	CCS/RRP	ADRC Information
CB	None	None/No	None	Yes/Supplemental Food	CCS	ADRC Information
WH	None	None/No	None	Yes Supplemental Food	CCS/RRP	ADRC Information
CJ	None	None/No	None	Yes Supplemental Food	CCS	ADRC Information
AS	None	None/No	None	Yes Supplemental Food	CCS	ADRC Information
MJ	None	None/No	None	Yes Supplemental Food	CCS	ADRC Information

(Table continues)

Participant name	Knowledge of or experience with ADRC	Familiarity with ADRC services /consumer satisfaction	Source(s) of information for ADRC	Community-based services received	Source(s) of information for community-based services*	Participant request for additional information
MW	None	None/No	None	Yes Supplemental Food	CCS/RRP	ADRC Information
FJ	None	None/No	None	Yes Supplemental Food	SD/CCS	ADRC Information
JR	None	None/No	None	Yes Transportation Supplemental Food	SD/CCS	ADRC Information
LP	None	None/No	None	Yes Transportation Supplemental Food	CCS/RRP	ADRC Information
RH	None	None/No	None	Yes Transportation Supplemental Food	CCS	ADRC Information
EC	None	None/No	None	Yes Supplemental Food	CCS/RRP	ADRC Information
MWH	None	None/No	None	Yes Transportation Supplemental Food	CCS/RPP	ADRC Information
GW	None	None/No	None	Yes Transportation Supplemental Food	CCS/RRP	ADRC Information

**Residential Property Personal (RPP), Senior Daycare, (SD), Community Center Staff (CCS)*

Evidence of Quality

Evidence of quality influenced this research and the writing of this dissertation. After I had obtained approval from the Institutional Review Board to conduct the study, I maintained the highest quality standards throughout the process by using the strategies previously referred to in Chapter 3. During the data collection process, after participants agreed to participate in the study, I provided the consent form (Appendix B) to them via hand delivery, and the interview was scheduled. After collecting the signed consent form from participants, I researcher conducted the interview. For an added measure of participant protection, each participant received an oral overview of the terms and the meaning of giving informed consent, more information about confidentiality, as well as a reminder that participation was strictly voluntary, with heavy emphasis on their freedom to withdraw from the study at any time. After conducting the interviews, I transcribed the audio recorded interviews and delivered them to participants to check accuracy and for verification of interpretation.

I ensured the participants were heard by transcribing audio recorded interviews, member checking, and peer review. I used an exploratory interview format with a semi-structured protocol. To maximize the privacy and comfort of participants, I conducted interviews in participants' homes or local community centers, depending upon each participant's selection. Member checking and peer review were complementary to guiding the study. I completed the process of member checking by reviewing the audio recording and transcribed data with each participant. Also, a local geriatric social worker who understands adults 60 years of age or older living in subsidized housing needing access to services peer reviewed the research study. The social worker ensured the integrity of the process by listening to the recorded interviews and reading the transcripts. In addition, I audio recorded and wrote in my observation notes the details, dates, and times of interviews for the coding process. NVivo 11 was used to code, extract themes, and align data directly with the research question.

I stored all paper documentation in a secure padlocked metal stationary file cabinet located in my home office (1885 Tubman Road SE, Washington, D.C. 20020). I saved electronic data with password protection on my laptop computer. Also, I backed up electronic files on an external hard drive safeguarded by password protection. The drive was stored in a secure padlocked metal stationary file cabinet in my home office. These items are available to the university's Office of Research Integrity and Compliance immediately upon request.

Summary

Chapter 4 documented the data analysis and significant research findings of the study. Based on the research question, eight themes emerged. These themes included:

- Need to access community-based services;
- Lack of knowledge of or experience with the ADRC;
- Request for information about ADRC and its services;
- Right to preserve privacy regarding sharing detailed demographic information;

- Received limited amount of community-based services information from community liaisons (i.e. residential property personnel, senior daycare staff, community center staff);
- Seeking services to retain housing voucher to aging in place;
- Seeking services to remain independent and avoid burdening children and nursing home placement; and
- Unhappy with ADRC outreach and want a community liaison to do onsite outreach regarding programs and services.

A small fraction of the participants (15% or 3/20) had obtained limited information regarding ADRC through their personal or professional experiences. Their experiences were consistent with findings in the literature regarding individuals who deny needing assistance and decline services and those who learn about services while serving as caretakers. Chapter 4 features a detailed outline of this study's findings and data processing components, including data collection, data analysis, verification, quality, and storage. Chapter 5 contains a discussion of the study, its implications for social change, and recommendations for further research.

Chapter 5: Discussion, Recommendations and Conclusion

Moreover, as we look to the future and realize the challenges to our geriatric, social and medical service systems resulting from the explosive growth of the senior population, it is likely that the NORC-SSP [Natural Occurring Retirement Communities—Supportive Service Program] model, which mobilizes and organizes the human, professional, and financial resources of a community to sustain and support individuals in their own homes, will make a significant contribution in helping our society address those needs (Altman, 2006, p. 200).

Introduction

This research study captured the lived experiences of adults 60 years of age or older, who reside in Washington, D.C.'s multifamily subsidized housing communities and participate in the Housing Choice Voucher Program, by assessing their knowledge as it relates to access to community-based services the ADRC offers. The study's results suggested non-medical transportation, light housekeeping, and community meal programs are available, affordable, accessible, acceptable, and accommodating through the ADRC; however, few seniors have accessed them. Based on this study's findings, there could be a problem with older adults' awareness of access to ADRC services.

According to the literature, improved awareness of access to community-based services helps older adults age in place. Knowledge and awareness regarding access is especially important to older adults living in multifamily subsidized housing. This study indicated that some older adults living in multifamily subsidized housing will need help in order to continue to meet periodic renewal and yearly inspections, as well as to meet eligibility requirements associated with housing voucher programs and to comply with standing leasing obligations. Chapter 5 documents the outcomes and limitations of this study and provides an interpretation of its findings and conclusions. Chapter 5 also offers recommendations for action and future research based on study findings. Implications for social change flow from themes that emerged from new data and findings, which decision makers could use to increase the awareness of access to services by adults 60 years of age or older living in multifamily subsidized housing communities.

Overview of the Study

Awareness of access to community-based services for individuals aging in their homes is a significant issue for older individuals, their families, policy makers, and community-based service providers. Adults 60 years of age or older residing in Washington, D.C.'s multifamily subsidized housing communities may have a problem with knowledge of access to community-based services the ADRC offers. Increased awareness of access to ADRC service delivery system could potentially better meet this population's aging-in-place needs. According to the literature, the two highest community-based service priorities for older adults in the United States are transportation and in-home and community-based long-term care. In Washington, D.C., these services are currently offered. The ADRC service delivery model is designed for individuals to gain awareness of service options and experience streamlined access to community-based services. Over the past decade, the ADRC model has shown great improvement in reaching its goal, which is to connect consumers to services; however, older adults' awareness of access to resources is still an obstacle.

Access and its practical application has been hypothesized as the appropriate "fit" between an expectation of a consumer and characteristics of a servicing system (Penchansky & Thomas, 1981). Access was selected as a conceptual framework for this study based on demonstrated linkages between awareness and access across five dimensions: affordability, availability, acceptability, accessibility, and accommodation. This multidimensional concept of access (Penchansky & Thomas, 1981) provided a theoretical framework for examining what influences awareness and access to ADRC resources for adults 60 years of age or older who live in multifamily subsidized housing in Washington, D.C.

A review of the literature showed that only a small fraction of the studies on awareness and access addressed non-medical community-based services. Most of these studies offered few empirical findings. The most frequent finding noted in the literature indicated that underuse of community-based support services was associated with lack of awareness that the services were available (Bacsu et al., 2012; Guo & Castillo, 2012; Hughes et al., 2011; McFadden & Lucio, 2014). Lack of awareness of community-based services is a compelling finding across the United States, as well as in other nations that provide such services (Chan, 2014; Denton et al., 2009; Whitfield et al., 2012).

In an effort to better understand what adults 60 years of age or older living in multifamily subsidized housing know or have experienced regarding access to services, I chose a qualitative research design using a narrative inquiry. One research question guided this study: What awareness or experience do adults 60 years of age or older who are living in Washington, D.C.'s multifamily subsidized housing have regarding access to ADRC services? I conducted face-to-face interviews using a structured protocol with open-ended interview questions. The interviews were audio recorded. This approach afforded 20 participants aged 60 years of age or older who live in multifamily subsidized housing and have housing choice vouchers, an opportunity to voice their experiences and offer their views, in their own words, about their awareness of access to ADRC services (transportation, light housekeeping, and community meal programs). The participants were selected via purposeful sampling, which guided volunteer recruitment and choice of locations. A criterion-based selection process for participation included age, location and type of residence, and need for services.

Study findings included the identification of emergent themes in the data analysis process using a thematic analysis methodology. Themes that emerged from participants' narratives included their need for community-based services, no knowledge of or experience with ADRC, requests for information about ADRC and its services, and an emphasis on the right to preserve privacy regarding sharing personal demographic information. A small fraction of participants had received a limited amount of community-based service option resources from community liaisons (i.e. residential property personnel, senior daycare staff, or staff of a community center). In response to queries, three participants reported that their personal or professional experiences as caregivers were the source of their limited knowledge of access to ADRC resources, which had in the past assisted them with one or two unmet needs for service.

Interpretation of Findings

The context of this research, three years after the 2013 IMPAQ study of consumer awareness of and access to ADRC service options was delivered to the ACL, is an important consideration when interpreting the findings of the present study. In the IMPAQ report, researchers identified problems with awareness and access. The researchers made three recommendations that ARDC could follow to improve the awareness and access of intended service recipients, “Expanding geographic service areas, increasing diversity in ADRC clientele, and strengthening key partnerships” (Baretto et al., 2014, p.287). Although these findings and recommendations were known to ACL, and ACL disseminated them to all ADRCs in 2013, the present study, conducted in 2016, found that barriers to access—stemming first and foremost a widespread lack of awareness that services were available to be accessed—remained in place, continuing to stymie the delivery of services to people over age of 60 who reported that they are in need of community-based services.

IMPAQ’s findings that ADRCs were showing improvement in meeting program goals and objectives notwithstanding, in early 2016, 17 of 20 study participants were unaware that transportation, homemaker, and home delivered meal services could be accessed through ADRC. However, as indicated in Chapter 4’s finding, Theme 5: All participants in this study received a limited amount of information regarding these types of community-based services, which were not ADRC services, from community liaisons (e.g. onsite property management personnel, senior daycare staff, and staff of a community center). The only three participants who had any awareness that ADRC services were available obtained their information from personal or professional experiences as caregivers. Those participants only had knowledge of transportation, home delivered meals and/or homemaker services.

The ADRC is not alone. The literature is replete with findings that implicate lack of awareness as a major factor in poor access to community-based services. In Chapter 4, Theme 2: Lack of knowledge and experience with the ADRC, 17 of 20 participants had no knowledge of or experience with ADRC. As shown in Chapter 2, the lack of knowledge of supportive community resources is linked to deteriorating health conditions among aging individuals (Crawford Shearer, 2009). In the United States, as well as other nations that provide such services, the lack of awareness of community services is a key finding (Chan, 2014; Denton et al., 2009; Whitfield et al., 2012). Public policy initiatives are striving to keep pace with older adults' needs and to make services more accessible. Despite those efforts, e.g., "no wrong door" and "one stop shopping" initiatives, plus age-friendly communities and village-to-village networks that were launched in the early 2000s, federal agencies are still striving to improve awareness of access to community-based services. As indicated in the literature review, the U.S. Department of Health and Human Services commissioned the Urban Institute to help develop a list of best practices for stakeholders serving high-risk populations, such as older adults (Freiman et al., 2013).

Two study findings—Theme 1: Need to access community-based services, that at the time of the study, all participants were receiving only one or two community-based services; and Theme 3: Request for increased awareness of ADRC and its services, that 19 of 20 participants wanted more information about ADRC services—were consistent with the literature reviewed in Chapter 2. Several studies found that individuals in their 70s and 80s who are members of racial and ethnic minority groups and live in poverty require supportive services (Beard & Carnahan, 2011; Castle and Resnick, 2014; Flores & Newcomer, 2014; McFadden & Lucio, 2014). Nearly all participants (19 of 20) said that one of the reasons they volunteered for this study was because they hoped that the researcher would provide information that would help them obtain community-based services.

An important finding of this study is one that stands in contrast to the literature indicating that African Americans are less receptive to community-based services and/or less likely to view themselves as in need of services (Beard & Carnahan, 2011; Casado et al., 2011). In their secondary analyses of caregivers who were interviewed for the 1999 NLTCS, Casado et al. (2011) delved into the reasons why these caregivers, who cared for frail older adults, did not use home-based community services. Casado et al. (2011) found that Black respondents (as compared to Hispanic and White respondents) more often reported that they had no need of services. The findings of this study were markedly different. Nearly every participant, all of whom were African American, was eager to know how and where to access community-based services.

The care with which participants in this study safeguarded their privacy emerged as perhaps the most surprising theme. In theme 4: Right to preserve privacy regarding sharing detailed demographic information, as reported in Chapter 4, all participants in the study were volunteers but all refused to answer certain questions that are routinely asked to collect basic demographic data; 100% of participants declined to specify their current age. They were, however, willing to specify a decade bracket, e.g. 60-70, 70 to 80, when asked their age. None were willing to divulge their level of formal education, the composition of their household, level of income, whether or not family members lived nearby, or the nature of any informal support they received from family, friends, or others. Consistent with this theme, and contrary to my expectation that most participants would prefer the convenience of being interviewed in their homes, only two participants chose to be interviewed at home.

One plausible interpretation of participants' protective stance regarding personal information is that this age cohort is old enough to remember the era when the receipt of some publicly funded services was contingent upon compliance with such requirements as remaining unmarried, living in a residence that did not include a second parent, counting the income of all residents of a household against eligibility requirements, and so forth. Although many such conditions have been revoked or revised, it is still the case that today that eligibility and/or receipt of certain publicly funded services is affected by personal arrangements.

In the case of residents of subsidized housing, in one pertinent example, some forms of housing assistance prohibit a second person from residing in the dwelling leased by the subsidy recipient. In a second salient example, one that directly affects the participants of this study, leases for apartments located in multifamily subsidized buildings contain a requirement that the apartment be maintained in a state of cleanliness. Residents of subsidized housing units are subject to eviction for not keeping their apartment clean enough. Although I found the high level of privacy the participants maintained regarding their personal demographic information a surprise, in retrospect it seems less surprising and more likely to be an adaptive response to precarious circumstances.

Another plausible interpretation of the vigilance with which they guarded their privacy is that participants did not take my assurances of confidentiality that use would be made of the data not only for the study, but also in the future, at face value. Therefore, they withheld information that they considered sensitive. It is conceivable that research methodologies led to findings that African Americans are less receptive to community-based services than are Hispanics and Whites. Perhaps these methodologies obscured African-Americans' qualitative responses about why they didn't use services by sorting all responses into categories that the researchers defined. Most studies asked yes or no questions or used a multiple choice or forced choice format. Responses were then sorted into categories, such as "unaware of services," "unreceptive," or "not in need of services," to facilitate quantitative analyses.

Based upon my professional experiences with the population, Theme 6: Seeking services to retain housing voucher to age in place, the concerns that participants had regarding completion of renewal paperwork was unsurprising. Nineteen of 20 participants said they needed help with the biennial renewal process, which was consistent with my prior experience. The primacy of their concern about being able to keep their apartments clean enough to pass inspections and retain their voucher was a surprise. Twelve out of 20 seniors voiced concern about losing their voucher and emphasized that concern most heavily. When I have acted in the role of manager of senior supportive services, older adults have not requested my help with housekeeping, decluttering, or discarding excess possessions. It is conceivable that because the data collection interviews were held in participants' homes, they were more forthcoming with their requests for help with housekeeping and decluttering.

Another finding in this study, Theme 7: seeking service to stay independent to avoid burdening children and nursing home placement, all participants stated the desire to avoid removal to a nursing home, which was not a surprise. The fact that all participants wanted to avoid burdening their children by asking for concrete assistance, such as housekeeping, preparing correspondence, and assisting with shopping, was a surprise. After that theme emerged, and acting in my role as a manager for senior supportive services, I began to notice behavior related to the theme. For instance, I observed an interaction between a senior and a family member that transpired while all three were present in the senior's home. As soon as the family member departed, the senior raised for the first time a major unmet need. I observed evidence seniors' unwillingness to burden children through their lengthy recitations about why it would be inappropriate to let their children know of an unmet need, or worse, to ask them to help out. For example, several seniors with health problems that stem from poor behavioral health decisions made in earlier years, such as drinking alcohol, poor diet, or smoking, have been steadfast in their resistance to telling their children how sick they really are and asking them for help with household chores or other concrete services.

For the last study finding, Theme 8: Unhappy with ADRC outreach so want a community liaison to do onsite outreach regarding programs and services, although I was unsurprised that none of the participants were aware of the ADRC located within blocks of their place of residence, I had been unaware until I happened upon the ADRC that that 19/20 seniors requested a person come to their building to provide information regarding access to ADRC. This was unexpected, but several possible explanations came to mind. First, I have noticed that seniors often ask for help understanding written materials. Perhaps they do not want to try to interpret written information regarding access to services. Second, seniors have often told me that they are more inclined to have confidence in information obtained during face-to-face contact. Telephone communications seem to inspire less confidence; seniors have voiced skepticism about whether the person to whom they are talking is interested, sincere, and well informed enough about the purpose of the call to provide helpful information. Furthermore, a reliance on face-to-face information was more typical when seniors were young or middle-aged adults. Insurance salesmen made a point of selling their product to relatives, friends, and of going door to door to make new personal contacts. Many other professions also relied upon face-to-face contact. Face-to-face communication and demonstration of sincerity, such as a handshake, seem to give seniors a basis for feeling more confident that what was communicated is accurate and of lasting value. Based upon my professional experiences, if a community liaison were to come to seniors' place of residence, one-to-one meetings would not be necessary. Seniors are likely to attend a group meeting held in their building.

In conclusion, this research study represents an improvement over most methods researchers typically employ on this topic. It also addresses critical gaps in the literature by sampling an impoverished group of adults 60 years of age or older residing in multifamily subsidized housing and focusing on their experiences and awareness of access to community-based services. I used a data collection process that gathered data in person rather than via telephone or written survey, asked open-ended questions, and allowed participants to select a location for data collection that was convenient and comfortable for them. This protocol permitted study participants to respond to questions more accurately and enabled them to give voice to their stories based on their experiences related to awareness of and access to ADRC services. This study also contributes to filling a gap in the literature because it included African-American participants.

This study also represents the need to acknowledge and understand contextual factors that influence awareness among adults 60 years of age or older about access to ADRC service options. As mentioned in the literature review, five dimensions of access propounded by Penchansky and Thomas (1981) are relevant to this study. These dimensions are acceptability, availability, accessibility, affordability, and accommodating. This study revealed that an ADRC was located less than .1 mile away (approximately 3-5 blocks) from the buildings where all participants lived, yet 17 of 20 participants had no knowledge of or experience with this agency. Regarding the dimension of acceptability, the three participants who had limited knowledge and awareness of ADRC services reported that they deemed those services to be acceptable, accessible, and accommodating. Their opinions were consistent with IMPAQ's 2014 report, which found that consumers who received ADRC services reported a high level of satisfaction (Baretto et al., 2014). Therefore, based on the study findings, improved awareness of access to services is likely to benefit aging individuals who live independently in multifamily subsidized housing, so that they can continue to age in place.

Implications for Social Change

This research study's results indicate that adults 60 years of age or older receiving housing choice vouchers and living in Washington, D.C.'s multifamily subsidized housing communities have a problem with awareness of access to ADRC resources, which are available, affordable, acceptable, accessible, and accommodating. A potential contribution of this study is that it will add to existing knowledge about awareness of access to services for aging adults who are living in poverty and/or reside in multifamily subsidized housing. It is therefore important to disseminate the findings and recommendations to participants in the study, the District of Columbia Office on Aging and its senior service network, the D.C. Commission on Aging, the Community Preservation Development Corporation, and to members of the American Society on Aging. More widely, the data will be shared with interested residents of all types of subsidized housing communities in Washington, D.C., with providers of senior services to older adults, and with other subsidized housing affiliates.

As indicated in Chapters 1 and 2, the narratives of aging adults residing in multifamily subsidized housing and their knowledge and, or experience with, community-based services accessible through ADRC produced emergent actionable themes such as: (a) The need to access community-based services, and, (b) No knowledge of or experience with ADRC. As reported in Chapter 4, the narratives conclusively revealed that only a small fraction of the participants, 15% (3 of 20), possessed limited information regarding ADRC, information that they gained from personal or professional experiences.

By identifying these themes, this study could improve overall effectiveness and functioning of ADRC and its Senior Supportive Service Network by making a persuasive argument that older adults living in multifamily housing are unaware of ADRC, have unmet needs for services, and want information about community-based services. In addition, these themes could serve as an impetus for stakeholders, such as study participants, adults 60 years of age and older, the District of Columbia Office on Aging, the Commission on Aging, as well as developers of multifamily subsidized housing to create strategies for improving awareness of access to community-based services, thereby lengthening residential longevity in multifamily subsidized housing and lessening the burden of nursing home placement within this population.

A more thorough understanding of older adults living in multifamily subsidized housing on the part of the offices, departments, and agencies dedicated to serving older adults could lead to enhanced initiatives that promote outreach, create stronger collaborations and partnerships, establish better community connections, and ultimately improve awareness of access to services. The researcher recommends that enhanced initiatives are disseminated in the form of a document, which might be entitled *ADRC Community-based Services Outreach Plan*. Any such initiative or outreach plan should address each quadrant of Washington, D.C. individually, and contain the following elements:

- Analyze results of seniors' service needs assessment
- Develop shared situation statement
- Define goals
- Identify stakeholders and positioning
- Develop messaging
- Create a more effective outreach approach
- Establish an evaluation tool and an evaluation process with timeline
- Create an overall timeline
- Develop protocols for public relations
- Create and implement training modules for ADRC staff and stakeholders

Study Limitations

Limitations of this research were the number of ethnic groups represented in the sample, the predominance of one gender, and the limited geographical range. All responding volunteers were African-Americans residing in the same ward, Ward 8, which is located in the SE quadrant of Washington, D.C. All lived in the same community, Washington Highlands. This homogeneity could be perceived to be a weakness in the study, as it raises the question of how generalizable the findings are to multifamily subsidized housing residents living in other wards of the city and to other ethnic groups. These limitations also raise questions regarding the possible existence of additional factors that could influence awareness of access to services. For instance, there could conceivably be factors that are strongly related to geographic location, i.e. which quadrant or ward one lives in, or factors associated with cultural norms and mores, e.g.

Whites and Hispanics might gather information differently than African-Americans do, perceptions of need for community-based services might differ between ethnic groups, or there could be ethnic differences in willingness to ask for services. Each of these limitations could be addressed by further study.

The small sample size of this study could be viewed as a limitation. The selection of a small sample was intentional. In a phenomenological study using a narrative inquiry approach, the researcher studies the rich life stories of individuals, which provides an abundance of information on a topic (Duff and Bell, 2002). The convergence of themes that emerged from the narratives indicates that data saturation was achieved and the findings are valid.

A final limitation in this study is that the results may not be generalizable to men. Just five out of 20 participants were men; the results might contain a gender basis. Another limitation may be the questions asked of the participants. The questions could have been improved to elicit better in-depth responses about participants' connections to other services inclusive of informal supports. This potential enhancement could have provided more insight into the connectivity that adults 60 years of age or older have to a senior service network that includes both formal and informal services.

Recommendations for Action Introduction

Given the finding of this research study, the results may add to existing literature on awareness of access to community-based services. My view of the problem of the study population's knowledge of and experience with awareness of access to ADRC has changed from that of an individual issue to that of a systemic failure of community outreach. As indicated in the findings of the IMPAQ report, although over the past decade the ADRC model has greatly improved in progressing toward its program goals and objectives, awareness of access to services and supports is still an obstacle for prospective service users (Baretto et al., 2014). Accordingly, an enhanced community outreach initiative is necessary to establish stronger collaborations and partnerships and develop stronger community connections to increase awareness of access to services.

Therefore, I offer several recommendations to gain knowledge and improve the experiences of adults 60 years of age or older who need access to the community-based services their local ADRC provides:

- Conduct focus groups with community dwelling seniors and providers of community aging services
- Establish aging councils in each community
- Organize community aging service provider meetings
- Implement synergistic opportunities between providers and consumers through grassroots campaigns
- Establish positions for Community Liaisons in each quadrant of the city
- Cultivate community social engagement through person centered activities within senior populations
- Host town hall meetings and issue reports and updates on new developments
- Expand communications efforts through technology
- Work with all stakeholders to create an effective communication and marketing outreach plan

Upon completion of Walden University's dissertation process, this study will be presented to participants, stakeholders, the District of Columbia Office on Aging and its senior service network, the Commission on Aging, and subsidized housing owners, developers, and management companies. The findings will be discussed and recommendations offered on how to improve the ADRC's community outreach.

Recommendations for Further Study

Future research studies could include:

- Interview questions that elicit narrative responses and instructions that prompt interviewers to explore respondents' concerns regarding personal privacy.
- In-depth interview questions that address other aspects of awareness of access to services, such as uses of informal and formal supports, connections to caregivers, and how needs are met currently.
- Interview questions that enable researchers to collect some data while allowing respondents who do not want to answer every question to be included in the sample.
- Explorative study of how the lack of awareness of and access to services impacts the ability of adults 60 years of age or older to live alone.
- Explorative study of the obstacles that impede adults 60 years of age or older from qualifying for or connecting with public service assistance.
- Case studies of what adults 60 years of age or older are experiencing when seeking out supportive services for their unmet needs would be informative.
- Additional research using the same method in more geographical locations to address limitations of this study.

- A mixed methods study could be conducted to determine the efficacy of ADRC's community outreach plan to improve awareness of access to services among adults 60 years of age or older.

Researcher's Experiences

Narrative of the Researcher

Being a four-year-old was odd for me. I was in "get-set" which is now call "head-start," and I was leading an extraordinary life. That is when I began a life of public service. Once a week for many years, I would miss school because I had to help support the ill seniors from our church. My great-great grandmother volunteered for an auxiliary at her church that focused on providing supportive services to aging folks in need. Granny was 80 years old and most of the individuals she served were younger. She organized this service because back in those times, there was little to no assistance for seniors.

At four years of age, I was alongside of my Granny organizing medication, providing light housekeeping, teaching new words, and helping prepare a week's worth of meals for those convalescing at home. Low-income seniors could not afford short-term rehabilitation and/or a home health aide to provide those services back then. Nor did they know how to access any services that might have been available and affordable for them. Supportive services were not available, acceptable, accessible, affordable, or accommodating for the seniors I knew during that time.

Today, I am a Senior Supportive Service Network Manager working on a doctoral study in Public Policy with a specialization in Health Service. Shockingly, aging folks and I are still wrestling with access to senior services. There remains a breach in service delivery. Access to senior services is an enigma to many frustrated seniors and their caregivers, families, and community liaisons. Despite my years of education, experience, and professional training, when seeking services for the aging, on many occasions I have found myself confused. My previous experience seeking access to information and senior services that are available through ADRC were similar to those of the individuals I interviewed for this study. I did not know that ADRC existed until one day I stumbled upon it. And, just like my interviewees, I wanted to know more!

Study Reflections

After decades of my career have passed, it is only now that life's purpose is clear. As the doctoral study process came together and the findings emerged, it all made sense. I belong in the field of gerontology. Completion of this scholarly endeavor has also been a self-defining moment of truth. I always wondered how and why my life's path had always backed-tracked to senior services for older adults and their unmet needs. In hindsight, it was not a remedial stagnation because of a lesson that I had not learned, but destiny and passion intertwined.

As I interviewed the older adults who participated in this study, I came to the conclusion that the senior service needs of the impoverished seniors from the late 60s and early 70s are ever so true and prevalent today. It makes me wonder if society has lost its way, forgotten from whence it came, or simply does not care about the aging population. Most older adults have served the people and systems that now deny them dignity, their respect, and enough support to allow them to grow old in the community of their choice.

At the end of this study, I found it egregious that older adults living Ward 8, in the Washington Highlands Community, have an ADRC fewer than 5 blocks from their home, and yet they are unaware of available senior services and resources. Services that could help them age independently and successfully in their environment are available but unknown to them. My knowledge, skills, and abilities, plus the findings of this study, will afford me a platform from which I can push for public policy initiatives with renewed compassion and vigor. I plan to advocate forcefully on the behalf of low-income seniors and their need for services that are available, acceptable, accessible, affordable, and accommodating.

Conclusion

Barack Obama, President of the United States stated, "Each and every day almost 10,000 of those babies [baby boomers] turn 65 years old. So more than 250,000 Americans turn 65 every month" (Obama, 2015). According to the U.S. 2014 Profile of Older Americans, in 2013 one in every seven persons was age 65 or over, and by 2040, this will increase to one in every four persons. In 2014, approximately 7 million of this population lived 125%-300% below the poverty level (Administration on Aging et al., 2015). How and where older adults will continue to live as they age in place is a growing concern. Supportive services in multifamily subsidized housing, inclusive of awareness of access to community-based services for individuals aging in their homes and communities, is a significant issue.

As noted earlier, the ADRC service delivery model is designed for older individuals (60 years of age or older) and disabled persons (18-59) to gain knowledge of service options and experience streamlined access to community-based services to sustain community living. Over the past decade, the ADRC model has shown great improvement in reaching its mission and goals; however, awareness of access to services is still an obstacle for older adults. This narrative inquiry gave voice to 20 African American adults 60 years of age or older receiving housing choice vouchers and living in Washington, D.C.'s multifamily subsidized housing. They were seeking to increase their knowledge an/ or experience with access to ADRC's service system to better meet aging-in-place needs.

As mentioned previously in Chapter 4, the stories shared in this study gave rise to several emergent themes of older adults' experiences that included their lack of understanding of access, lack of knowledge of local ADRC resources, and request for increased awareness of ADRC to enhance their ability to age independently. With this study, I hope to narrow the gap in the literature on awareness of access to community-based services among adults 60 years of age or older who live in multifamily subsidized housing. In addition, this study may provide stakeholders with an improved understanding that might lead them to develop enhanced initiatives that promote outreach, create stronger collaborations and partnerships, establish better community connections, and increase knowledge of access to services.

This research study will be shared with stakeholders, such as study participants, adults 60 years of age or older, the District of Columbia Office on Aging, Commission on Aging, Community Preservation Development Corporation, and the American Society on Aging. These findings are intended as a basis for discussions about strategies for improving seniors’ awareness of access to services, empowering them to age in place by lengthening residential longevity in subsidized housing, lessening burdens on their children, and avoiding nursing home placement.

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Appendix A: ADRC Seniors Supportive Services Interview Questions

Research Question:

What knowledge of or experience do adults 60 years of age or older, who live in Washington, D.C.'s multifamily subsidized housing, have regarding access to Aging and Disability Resource Center (ADRC) Services?

Questions:

1. What is your knowledge and, or experience with access to supportive services from the ADRC?
2. What is your knowledge and, or experience with access to transportation services from the ADRC?
3. What is your knowledge and, or experience with access to light housekeeping and homemaker services from the ADRC?s

4. What is your knowledge and, or experience with access to community dining and home-delivered meals from the ADRC?
5. What information and, or resources have you received from your local ADRC regarding access to community-based services? And, how was it obtained?