

Relocation Support for Seniors (Grant Reference U2005-0225) Evaluation

FINAL REPORT (February, 2010)

RESULTS IN BRIEF

This final report examines what, if any, are the effects of relocation for elders during the reconstruction and renovation of City and County public housing in Pittsburgh. Ursuline Senior Services Inc. has provided social support to seniors over a period of six months around the relocation of these seniors. This evaluation provides an outside examination of the influence of these services.

A 43 item Resident Assessment Form was used to examine baseline characteristics of residents and relocation stress in several key areas (e.g., Activities of Daily Living (ADLs)); Mobility; Instrumental Activities of Daily Living (IADLs); Health and Functioning; and Depression. Further, an 11 item questionnaire was used to determine residents satisfaction with the program and potential areas for improvement.

The baseline data collected would suggest that residents did have an illness burden, and had the potential to suffer from relocation stress. However, the evaluation indicates that no relocation stress resulted in the form of ADLs, IADLs, or Health Functioning. Moreover, the findings show that depression was alleviated as part of the Ursuline Senior Services Relocation Support Program given to seniors.

The resident satisfaction data also shows that Ursuline Senior Services were recognized to be influential in the moves seniors made. This data also shows a very high level of satisfaction with the Ursuline Senior Services Relocation Support Program.

In conclusion, this evaluation shows: (1) the effects of relocation stress can be adequately monitored using the assessment tool for the residents included in this initiative; (2) the initiative would seem warranted as many resident measures indicated frailty; and (3) findings show no relocation stress has occurred. The Ursuline Senior Services Relocation Support Program was successful and should be replicated when other elders are moved and faced with the very real and catastrophic specter of illness/death due to relocation stress.

INTRODUCTION

Relocation of elders has been a consistent concern of practitioners for several decades. This stems from potential negative resident outcomes, which include mortality and physiological and psychological decline. This concern even resulted in a U.S. Senate debate, whereby Senator Percy stated “old people simply get sick and in some instances die when they are precipitously wrenched from one environment and thrust into a new one.” The elderly population is more prone to relocation often due to their increased need for elevated levels of care (Kampfe, 2002, pg. 1); decline in health; social interaction; loss of loved one; lifestyle and reduction in income (Choi, 1996, pg. 325, 333). The life expectancy of seniors has also increased over the years, leading seniors to age in place and sometimes relocate to retirement locations (e.g. Florida).

Understanding the effects of relocation and examining seniors who are relocated may be important in the current health care environment. The senior population is a very vulnerable population and susceptible to a number of health effects. For example, with the emergence of integrated care companies we have seen a more fluid movement of patients between providers. Long-term care providers are not immune from this trend, and the elderly are frequently transferred to and from nursing homes. Organizational reorganizations in the nursing home industry are also frequent. Facilities may relocate or merge with other providers. Closures of nursing homes are also becoming more common. Moreover, the vast majority of elders live in their own homes or apartments. The relocation of these residents is inevitable when reconstruction and renovation is required.

Senior relocation requires advanced planning. There are many elements that can interact with how seniors react to the relocation. Some items include:

- noise,
- available parking,
- lighting levels;
- safety;
- access to necessities (e.g. groceries, transportation, mail, etc.); and much more.

Seniors can suffer from detrimental actions if issues are not address, such as falls, missed meals, fires, and unpaid bills (Hayashida, 2006).

There are different types of relocation including: 1) Interinstitutional (i.e. movement from one institution to another institution); 2) Intrainstitutional (i.e. movement within an institution); 3) Residential (i.e. movement from one residence to another residence); & 4) Residential or Institutional (i.e. movement from a residence to an institution or movement from an institution to a residence) (Castle, 2001, pg. 293). Each type of relocation can have different effects on seniors. Relocations can be by choice or forced. Forced relocation can cause two times as much stress for seniors than relocation by choice (Sanders, Bowie & Bowie, 2003, pg. 24). The type of housing,

such as public housing, that seniors are forced from may also impact effects of relocation. For example, seniors who are living in public housing are typically a more vulnerable population and may be more negatively affected by relocation.

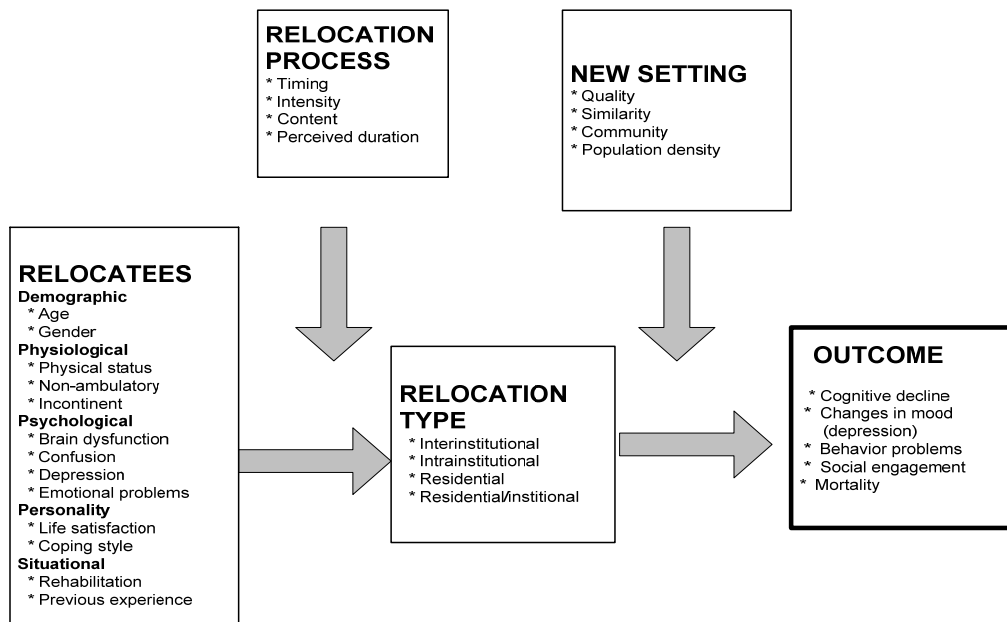
This report examines what, if any, are the effects of relocation for elders during the reconstruction and renovation of City and County public housing in Pittsburgh. Ursuline Services Inc. has provided social support to seniors over a period of six months around the relocation of these seniors. Thus, this evaluation provides an outside examination of the influence of these services.

BACKGROUND

Empirical Literature

There are a number of implications that are part of the relocation process. Senior can experience psychological decline (e.g. depression and decreased quality of life), physical decline (e.g. pain and decreased health status); mobility and mortality (Sanders, Bowie & Bowie, 2003, pg. 24) & Castle, 2001, pg. 291). Figure 1 is a model showing how different factors play a role in the relocation of seniors.

FIGURE 1: Model Showing Potentially Important Factors In the Relocation of Elders



Mortality. The literature would suggest that elevated mortality may result from elder relocation. For example, some research examined the mortality rate of 129 elderly moved from congregate

housing to an apartment building, compared to two other non-relocated groups. The mortality rate of the former was 6.2 percent and the later 9.3 percent. Appendix 1 is provided showing the empirical literature that has examined mortality associated with relocation of elders.

Physiological Decline. The literature would also suggest that elevated physiological decline may result from elder relocation. For example, some research has examined personal life satisfaction, health, and participation in activities for 68 elderly moved to a housing complex. In comparison to 69 subjects in the control group significant negative effects were found for personal life satisfaction; with a significantly lower proportion of the relocated showing lower life satisfaction than the non-relocated. Further analysis showed these effects were strongest for females. A further study, using a longitudinal control-group method examined the effects of rehousing 574 elderly. As compared to 324 community residents, they showed poor functional health, but higher perceived change for the better and satisfaction with housing. Appendix 2 is provided showing the empirical literature that has examined physiological decline associated with relocation of elders.

Psychological Decline. The literature would also suggest that elevated psychological decline may result from elder relocation. Prescription drug use, self-care dependent, belligerent/confused, anxious/depressed, bedfast/moribund, behaviorally deteriorated, paranoid/suspicious, sensorimotor impaired, withdrawn/apathetic, perceived stress scale, depression scale, self-esteem scale, and social support were measured in one study. This study included 196 residents from two nursing homes relocated to one new nursing home. The belligerent/confused measure showed significant decline in the relocated residents compared to a non-relocated control group. Appendix 3 is provided showing the empirical literature that has examined psychological decline associated with relocation of elders.

Recent Relocations in the Press

Relocation has also recently gained notoriety due to botched relocation initiatives of elders as part of hurricane evacuation procedures. For example, a bus carrying nursing home residents away from Hurricane Rita caught fire and exploded on a gridlocked highway, killing 24 people (<http://www.msnbc.msn.com/id/9449949/>).



The influence of relocation stress is also echoed in several newspaper articles. For example we see (see Appendix 4):

- * Hundreds of Senior Evacuated after S. Side Power Outage. Chicago Tribune, 8/1/2006.
- * Rockville NORC at risk seniors scramble as apartments set to go condo. Washington Jewish Week, 9/21/2005.
- * Seniors terrified as AHA plans to demolish their housing. Atlanta Progressive News, 6/23/2007.
- * Seniors at 2 CG complexes face move Rent increase won't be covered by aid; meeting scheduled. Casa Grande Valley Newspapers, 9/22/2007.
- * Senior citizens worry about eviction threat. The Register-Guard, 9/15/2007.
- * Relocation Driving Some Seniors to Drink The Salt Lake Tribune March 12, 1993
- * Forced Move Upsets Seniors Long Beach Press-Telegram (CA) May 5, 2003
- * Flood Damage Forces Seniors Out Worcester Telegram & Gazette Archives October 19, 2005
- * Patients face \$800 in fees: Bed Shortage Means Those in Long-Term Care Who Won't Relocate Will Have to Pay Toronto Star 1/13/2007

Natural disasters cause many forced relocations. One study examined the impact of forced relocation because of Hurricane Andrew on seniors (Sanders, Bowie & Bowie, 2003). It is important for those involved to plan ahead and to ensure the proper authority is trained to handle relocating seniors incase of a disaster (Sanders, Bowie & Bowie, 2003, pg. 23-24).

Preparatory Programs

The relocation literature has moved beyond merely determining whether detrimental outcomes exist. What are important are the conditions under which negative and positive outcomes manifest themselves. Preparatory programs, for example, are of interest. Several public interest lawsuits were initiated and won in several states requiring nursing home residents, for example, to undergo a preparatory program prior to relocation.

The potential negative outcomes are clear in the terms used to describe the effects of relocation: transfer trauma, relocation stress, admission stress, relocation shock, and transplantation shock. The negative outcomes are seemingly real, and university courses have been developed to address these outcomes (www.theopenpress.com/). We provide examples of negative outcomes in Appendices 1-3. However, we note that not all relocations have adverse consequences. It is also clear that relocation preparation programs can work, and the effects of relocation do not have to be catastrophic. Some “best practices” that emerge from the literature are:

- Screen for attitudes towards relocation
- Set expectations (as many times as possible)
 - Day of move
 - Time of move
 - Who will help
 - Packing
 - Family involvement
- Set expectations for new residence
 - Paying bills
 - Getting utilities turned on
 - Unpacking
 - Lifting furniture
 - Changing telephone number
 - Changing mail address
 - Inform friends of move and address (post-cards)
- Set expectations for new setting
 - Local food store
 - Local convenience store
 - Bus route(s)
 - Hospital(s)
 - Directions
- Screen for depression

This Evaluation

With this as a backdrop, Pittsburgh faces the relocation of numerous elders from several sites. Plans for these relocations are in flux, but as many as 20 different elderly high-rise apartments may experience closure or renovation (see Table 1 below). These residents will likely not be relocated in a bus (as per the example above) and may not be relocated due to a hurricane; however, even a planned relocation could have disastrous effects on the health of residents.

Despite the negative nomenclature used to describe relocation of elders and concern by the U.S. Senate, research on the detrimental effects of relocation has so far shown that relocation programs can be put in place to help elders. In short, the relocation can be stressful for elders but this stress can be mitigated by effective relocation initiatives. For example, web-seminars have been made available to elders in other areas of the country to mitigate the effects of relocation (http://findarticles.com/p/articles/mi_pwwi/is_200708/ai_n19465402). Other resources include:

- How to Manage Relocation Stress (http://www.avatar-moving.com/GH_ShowArticle.asp?HID=13).
- Coping With the Stress of Relocation (<http://www.google.com/search?hl=en&rls=com.microsoft:en-us&q=Relocation+stress&start=20&sa=N>)

Table 1: Potential Sites for Relocation

SITE (ELDERLY HI-RISE)	# Residents
KELLY	56
AUBURN	61
LOU MASON	89
DUMPLIN HALL	80
PLEASANT RIDGE	20 / 46
OHIOVIEW TOWERS	55
JOHN FRASER HALL	34
GOLDEN TOWERS	50
GENERAL BRADDOCK TOWERS	84
TRUMAN TOWER	38
WILMERDING APARTMENTS	75
CARNEGIE	15
CARVER HALL	56
BRACKENRIDGE HALL APARTMENTS	36
CARSON HALL	80
WEST MIFFLIN MANOR	98
CORBETT APARTMENTS	97
JEFFERSON MANOR	92
WEST VIEW TOWERS	98
BLAWNOX APARTMENTS	90
SPRINGDALE MANOR	90

FIGURE 1: Location of the Relocation Sites



The location of each site is given in Figure 1. In addition, a detailed overview of each site can be found at www.hacp.org/housing/facilities.jsp.

Effective programs include advice on keeping prior links: such as how to visit the current physician and where friends are located. It also includes advice on what to expect at the new residence: such as paying bills, activities in the area, and travel options. Providing help with the new environment is also useful, such as: location of shops, grocery stores, and pharmacy. Current research would suggest that these programs work most effectively when used between 3 and 6 months before the relocation is to occur and to continue between 3 and 6 months after the actual relocation. For example, clinical texts cite the greatest incidence of relocation stress typically occurs shortly before and up to 3 months after the move (e.g., Nursing Diagnosis: Application to Clinical Practice).

Thus, the Pittsburgh Foundation has contracted with Ursuline Senior Services Inc. (Ursuline) to provide relocation support for elders.

METHODS

The objectives of this evaluation were to: (1) identify if relocation stress occurred; (2) monitor resident's opinions of the relocation experience; and, (3) determine elements of the initiative that were most/least useful for elders. Objective 1 was addressed using a resident assessment form (described below). To address this first objective, a data collection protocol was developed. This protocol is described in the next section. Objectives 2 and 3 were addressed by surveying residents, this is also described below.

OBJECTIVE 1

Resident Assessment Form Development

To identify if relocation stress occurred resident assessments needed to be conducted. A Resident Assessment Form with 43 items was developed that addressed resident functioning. The Resident Assessment Form was developed by Ursuline and the evaluator prior to the initiation of the relocation initiative. The form was created in a series of face-to-face meetings consisting of the Ursuline team and the evaluator. The assessment form needed to fulfill several requirements including: easy to complete; questions need to be easily understood and reflect known resident conditions that could change as a result of relocation; and completed by Ursuline staff.

Items previously used by Ursuline staff and the evaluator fulfilled these requirements and were used as the Resident Assessment Form.

Resident Assessment Form Contents

The 43 items on the Resident Assessment Form addresses several key areas:

- Activities of Daily Living (ADLs)
 - Bathing,
 - Dressing/Undressing,
 - Grooming,
 - Eating,
 - Transferring,
 - Toileting,
 - Bladder Management, and
 - Bowel Management

- Mobility
 - Bed Bound,
 - Walk Indoors,

- Walk Outdoors,
- Climb Stairs, and
- Wheel Chair

- Instrumental Activities of Daily Living (IADLs)
 - Preparing Meals,
 - Doing House Work,
 - Doing Laundry,
 - Shopping,
 - Using Transportation,
 - Managing Money,
 - Using Telephone, and
 - Chores/Repairs

- Health and Functioning
 - Nutrition,
 - Social Participation,
 - Cognitive Functioning,
 - Emotional Status and Behavior, Informal / Formal Support,
 - Physical Environment, and
 - Financial Resources

- Depression

Data Analysis

Ursuline staff used the Resident Assessment form for each resident that was to be relocated. The form was used prior to relocation and again 6 months post-relocation. Paper versions of the Resident Assessment Form were used. The paper forms were then converted by the evaluator into an Excel data file. That is, each item on the paper form was transferred to the data file.

A random sample of 10% of Resident Assessment Forms were double entered. That is, these forms were entered into Excel a second time. This double entry procedure was used so that the data could be checked for errors. The forms entered into the data first were compared with those entered second. In this case, no errors were identified. In addition, as a further check of the data, all values for all items in the data were checked for improbable values. Again, in this case, all values of the data seemed to lie within probable and appropriate values.

Descriptive analyses are first provided using this data. For each item on the Resident Assessment Form, the percent of residents with the specific condition is provided. For example, for the ADL item addressing bathing, the percent of residents that are independent in this area is given (etc.). These descriptive results are provided for each of the relocation sites.

To determine whether any relocation stress has occurred the pre- and post-relocation data were compared. That is, the resident values for each item in the Resident Assessment Form prior to relocation were compared with those after the relocation. A considerable number of items were collected on the Resident Assessment Form and a considerable number of sites participated in the initiative. Therefore, for parsimony a scoring process was used to evaluate whether relocation stress had occurred. For example, for the ADL items a score of 1 was given if a resident was independent, 2 if uses assistive device, takes long time, or does with great difficulty, 3 if does with some help, supervision, set-up, cuing or coaxing only, 4 if does with some help, does with hands-on-help, and 5 if does with maximum help or does not do at all (helper does more than half). These scores were then compared using t-tests. A conservative p-value of 0.1 was used in making these comparisons. A significant finding would indicate that the item for the residents was significantly different (either better or worse) post-relocation, as compared to pre-relocation.

RESULTS

In the first interim evaluation (September 2007) 94 residents had been assessed using this form. These elders were from Lou Mason (N =46) and Auburn Towers (N =48). In the second interim evaluation (September 2008), an additional 52 residents had been assessed from Glen Hazel. The third interim evaluation (August 2009) report addresses residents from Mazza, Bidwell, and Northview. In this final report the findings from the pre-and post-relocation analysis (using data from all sites) are provided. This includes a total of 196 pre-evaluations and 112 post-evaluations. This includes the sites: Lou Mason (building closed), Auburn Towers (building closed), Glen Hazel (internal moves), Mazza Pavillion (temporary closure), PA Bidwell (internal moves), Morse Gardens (internal moves), Caliguri Piazza (internal moves), and Northview Heights (internal moves).

ADL Results

Table 2a shows the baseline results for ADL assessment of residents at ALL of these sites. The ADLs measured were: Bathing, Dressing/Undressing, Grooming, Eating, Transferring, Toileting, Bladder Management, and Bowel Management. Most residents were independent in these areas; although, a few residents (i.e., up to 16%) needed maximum help in these areas.

Table 2a. Baseline Results for Activities of Daily Living (ADLs)

	1. Independent	2. Uses assistive device, takes long time, or does with great difficulty	3. Does with some help, supervision, set-up, cuing or coaxing only	4. Does with some help, does with hands-on-help	5. Does with maximum help or does not do at all. Helper does more than half.
ADLs					
Bathing	72%	5%	3%	4%	16%
Dressing/Undressing	74%	6%	3%	2%	15%
Grooming	90%	2%	2%	3%	3%
Eating	71%	5%	5%	4%	15%
Transferring	89%	4%	3%	2%	2%
Toileting	84%	3%	4%	2%	7%
Bladder Management	87%	5%	1%	1%	16%
Bowel Management	92%	4%	2%	1%	1%

Table 2b shows the relocation stress analysis results for ADL assessment using all of the currently available data with ALL pre- and post-relocation resident assessments. In summary, this shows that no relocation stress for ADLs was identified.

Table 2b. Relocation Stress Analysis Results for Activities of Daily Living (ADLs)

ADLs Significant Change (P>.1)	NO CHANGE
--	-----------

Mobility Results

Table 3a shows the baseline results for mobility assessment of residents at ALL of these sites. The results for Mobility somewhat follow those for ADLs. That is, many residents are independent. Nevertheless, a fair number of residents require assistive devices to walk outside.

Table 3a. Baseline Results for Mobility

	1. Independent	2. Uses assistive device, takes long time, or does with great difficulty	3. Does with some help, supervision, set-up, cuing or coaxing only	4. Does with some help, does with hands-on-help	5. Does with maximum help or does not do at all. Helper does more than half.
MOBILITY					
Bed Bound	100%	0%	0%	0%	0%
Walk Indoors	84%	5%	3%	2%	6%
Walk Outdoors	71%	7%	4%	4%	14%
Climb Stairs	73%	7%	7%	5%	8%
Wheel Chair	82%	8%	3%	2%	5%

Table 3b shows the relocation stress analysis results for the mobility assessment using ALL of the currently available data with pre- and post-relocation resident assessments. In summary, this shows that no relocation stress for mobility was identified.

Table 3b. Relocation Stress Analysis Results for Mobility

MOBILITY Significant Change (P>.1)	NO CHANGE
--	-----------

IADL Results

Table 4a shows the baseline results for residents IADL assessment at ALL sites.

Table 4a. Baseline Results for Instrumental Activities of Daily Living (IADLs)

	1. Independent. Requires no assistance	2. Independent but with great difficulty or with mechanical help	3. With assistance of a helper	4. Unable/ helper does
IADLs				
Preparing Meals	72%	10%	9%	9%
Doing House Work	75%	10%	7%	8%
Doing Laundry	71%	10%	7%	12%
Shopping	77%	10%	6%	7%
Using Transportation	82%	7%	8%	3%
Managing Money	74%	5%	8%	13%
Using Telephone	77%	8%	5%	10%
Chores/Repairs	70%	6%	6%	18%

The IADLs measured were: Preparing Meals, Doing House Work, Doing Laundry, Shopping, Using Transportation, Managing Money, Using Telephone, and Chores/Repairs. Many residents had limitations in these areas. For example, approximately 7% of all residents at Mazza were unable to perform any of these IADLs without help.

Table 4b shows the relocation stress analysis results for the Instrumental Activities of Daily Living (IADLs) assessment using all of the currently available data with ALL pre- and post-relocation resident assessments. In summary, this shows that no relocation stress for IADLs was identified.

Table 4b. Relocation Stress Analysis Results for Instrumental Activities of Daily Living

IADLs Significant Change (P>.1)	NO CHANGE
---	-----------

Health and Functioning Results

The baseline results for seven other areas of health and functioning are shown in Table 5a. These areas included nutrition, cognitive functioning, and financial resources. Overall residents at ALL sites were self-sufficient in most areas. However, informal support and physical environment would appear to be exceptions (For example, Bidwell and Northview more than 50% of residents needed informal/formal support and physical environment support (both of which the literature would suggest are reasons for instituting relocation programs)).

Table 5a. Baseline Results for Health and Functioning

	% Self Sufficient
NUTRITION	74%
SOCIAL PARTICIPATION	97%
COGNITIVE FUNCTIONING	87%
EMOTIONAL STATUS & BEHAVIOR	88%
INFORMAL/FORMAL SUPPORT	72%
PHYSICAL ENVIRONMENT	70%
FINANCIAL RESOURCES	95%

Table 5b shows the relocation stress analysis results for the seven areas of health and functioning assessment using ALL of the currently available data with pre- and post-relocation resident assessments. In summary, this shows that no relocation stress for these areas of health and functioning was identified.

Table 5b. Relocation Stress Analysis Results for Health and Functioning

HEALTH AND FUNCTIONING Significant Change (P>.1)	NO CHANGE
--	-----------

Depression Screen Results

Table 6a shows the baseline results for the depression screen used for residents at ALL sites. No residents were identified as potentially clinically depressed (“clinical” depression cannot be diagnosed with this screen, but scores on the screen have been shown to be highly associated with clinical depression). However, several residents do have some early warning signs of potential depression (For example, at Mazza 33% of residents had experienced fatigue or low energy nearly every day for two or more consecutive weeks).

Table 6a. Baseline Results for Depression Screen

	% Yes
DEPRESSION SCREEN	
Have you experienced a sad mood nearly every day for two or more consecutive weeks?	8%
Have you lost interest or pleasure in activities that you once enjoyed?	7%
Have you experienced a significant change in appetite or weight?	2%
Have you experienced sleep difficulties for two or more consecutive weeks?	4%
Have you experienced slowing down or agitation in your physical movements nearly every day for at least two consecutive weeks?	3%
Have you experienced fatigue or low energy nearly every day for two or more consecutive weeks?	3%
Have you had feelings of worthlessness or inappropriate guilt nearly every day for two or more consecutive weeks?	6%
Have you had difficulty thinking or concentrating nearly every day for two or more consecutive weeks?	7%
Have you had recurrent thoughts of death or suicide nearly every day for two or more consecutive weeks?	0%

Table 6b shows the relocation stress analysis results for the Depression Screen assessment using ALL of the currently available data with pre- and post-relocation resident assessments. In summary, this shows that the depression screen scores improved from the pre-assessment to the post-relocation assessment. This would seem to indicate that no relocation stress for the Depression Screen was identified, and that residents functioning in this area was actually slightly better.

Table 6b. Relocation Stress Analysis Results for the Depression Screen

DEPRESSION SCREEN Significant Change (P>.1)	POSITIVE CHANGE
---	-----------------

The evaluator speculates that it would appear reasonable, based on what we know about relocation stress, that the depression scores would improve over time if an effective Relocation Program was used. That is, prior to moving residents would be stressed at the possibilities of the upcoming move – causing some depressive symptoms. With an effective Relocation Program, these depressive symptoms should be mitigated.

OBJECTIVE 2

(Monitor resident’s opinions of the relocation experience)

The resident satisfaction survey was developed by the evaluator and Ursuline. The questionnaire was conducted during January 2010, and as such represent the opinions of residents after the implementation of relocation activities. The questionnaire was developed to gauge residents’ utilization and awareness of the relocation activities; and, possible health outcomes resulting from the relocation.

Sixty-two questionnaires were returned, giving a respectable response rate of 38%. In general, a majority of respondents indicated that they were aware of the Ursuline Relocation Program and that the program had been clearly explained to them (i.e., 87%). In addition, a majority of respondents seem to have used at least some aspect of the program. 87% of residents indicated that they used the services “a lot.” Almost all residents stated they benefited from the program, and it could not have helped them more.

Table 7. Resident Satisfaction Survey

Question	Responses			
	Yes	No		
Did you receive assistance with relocation when you recently moved as part of the housing authorities renovations?	78%	22%		
Who helped you with this relocation (check all that apply)?	Family 45%	Friends 22%	Ursuline 73%	Other 11%
Was the SLEP/Relocation Assistance Program explained clearly to you?	Yes 87%	No 13%		
Did anyone ask or encourage you to participate in the SLEP/Relocation Assistance Program?	Yes, a lot 65%	Yes, somewhat 26%	No, not much 5%	No, not at all 4%
Do you think the SLEP/Relocation Assistance Program helped you?	75%	14%	5%	6%
How often did you use services with the SLEP/Relocation Assistance Program?	87%	11%	2%	0%
Do you think the SLEP/Relocation Assistance Program could have helped you more?	1%	1%	16%	82%

OBJECTIVE 3

(Determine elements of the initiative that were most/least useful for elders).

The resident satisfaction survey was developed by the evaluator and Ursuline. The questionnaire was conducted during January 2010, and as such represent the opinions of

residents after the implementation of relocation activities. Three items on the questionnaire were developed to help identify the most and least useful aspects of the program. These are provided below.

What other ways do you think the SLEP/Relocation Assistance Program could have helped you more?

Most residents answered NO to this item

Other comments were:

- Transportation help
- Moving at a better time of day
- Having help for a longer period of time

What parts of the SLEP/Relocation Assistance Program helped you most?

Most residents provided positive comments in this area.

Comments included:

- Having a “go to person”
- Reassurance that everything would be OK
- They were always available
- Provided many resources

What parts of the SLEP/Relocation Assistance Program helped you least?

No negative responses were given in this area.

However, other negative comments included:

- Keep housing authority out
- Housing authority disorganized
- Notice given before move was terrible
- They treat us like cattle
- Movers were horrible
- Insensitivity
- Poor/inconsistent communication
- Inaccurate information
- Disregard for personal property

Resident issues did seem to vary across the sites. Indeed, in some buildings the move was seen to be frustrating and highly disorganized. The moving capabilities of the housing

authority seems to have been a serious concern. However, it should be noted that this discontent was with the Housing Authority and not the SLEP/Relocation Assistance Program.

With this in mind a sensitivity analyses was conducted of the relocation outcomes identified above. That is, at each site the influence of relocation stress was examined. This was done because it may be possible that residents at sites with more disorganized relocation or faster relocation schedules may be most prone to the negative impact of relocation. No negative impact was found at any one particular site. But it should be noted that one limitation of this evaluation is that the sample sizes at each site are small – which limits the ability to detect relocation stress at any one particular site. It should also be noted that the evaluation examines respondents – some residents did not respond because they had passed-away. Clearly, this could represent very severe relocation stress for these residents. But, we have no way of identifying whether this mortality was a result of relocation (or not).

CONCLUSION

Elderly living in senior high-rises have often lost their homes and often had little choice in living in these settings. High-rises are considered appropriate senior housing due to the social interactions and safety it provides (Devlin, 1980). But, as we discuss above, moving elders again or repeatedly can have negative consequences.

The baseline results presented above would suggest that residents did have an illness burden, and were at risk of relocation stress. For example, many residents had difficulty shopping and with using transportation. From prior work we know that residents with an illness burden are prone to relocation stress. The findings for the depression screen also show how “close to the edge” some of these residents are. Many residents did not show clinical signs of potential depression, but did have early warning signs. They should be carefully monitored, because we know from previous experience that depression can often result from relocation. So, this evaluator believes that the decision to initiate a relocation support program was sound.

The sample of residents included in the initiative is adequate and captures many significant areas of health and functioning. However, it is worth noting that the data presented only capture the health outcomes for residents. Qualitative findings for some residents show some concerns. For example, some residents had the expectation that they would transition for 3 months (i.e., in efficiency apartments); but were actually relocated for 8 months. This caused significant stress for these residents.

In summary, the evaluator is able to say with confidence that the effects of relocation stress can be adequately monitored using the assessment tool for the residents included in this initiative. Based on the information collected, this initiative would seem warranted as the

residents on many health and functioning measures are frail. With the assessments available, the evaluator is able to say with confidence that no relocation stress has occurred.

Ursuline Senior Services Inc. appears to have created a cadre of relocation specialists, that were very effective in helping elders. Moreover, the activities used by Ursuline appear to have been so successful that they should be further developed/disseminated such that other agencies can use the program.

RECOMMENDATIONS

The following recommendations come from the above analyses. The recommendations range from important issues that should be addressed in subsequent implementation activities, to smaller observations that could help smooth the mechanics of similar future initiatives.

Keep

1. A relocation program for high-rises closures/moves.

Address

1. The role of the Housing Authority in the high-rise closures/moves.
 - a. Provide residents with more clarity
 - b. Provide Ursuline with more feedback / timelines

Further Suggestions

1. Synthesize the Program developed by Ursuline into a “How to help residents move 101 Guide.

Appendix 1. Summary of Studies Addressing the Mortality Rate of Relocated Elderly

Author(s)	Mortality Rate For Relocates in Period of Observation	Sample
Killian (1970)	6.33 percent in 4 months	79 geriatric psychiatric patients transferred from one state psychiatric facility to other state psychiatric facilities
Killian (1970)	13.85 percent in 4 months	65 geriatric psychiatric patients transferred from a state psychiatric facility to long-term care facilities
Lawton and Yaffe (1970)	6.2 percent in 1 year	129 elderly moved from congregate housing to an apartment building
Markus, Blenker, Bloom, and Downs (1971)	18.2 percent in 6 months 8.3 percent in 6 months 15.6 percent in 6 months 11.6 percent in 6 months ¹	373 nursing home residents from two facilities transferred to one new facility.
Ogren and Linn (1971)	20 percent in 6 months	41 male nursing home residents transferred to other nursing homes are compared with 41 male residents not transferred from the nursing home
Silverstone and Kirschner (1974)	NA	200 elderly moved following a workers strike
Bourestom and Tars (1974)	43 percent in 6 months (radical) 37 percent in 6 months (moderate)	98 nursing home patients moved to one of two other nursing homes: the first described as a radical-change and the second a moderate-change
Markson and Cumming (1974)	3.9 percent in 1 year (full sample) 9.1 percent in 11 months (elderly)	2,174 older chronic schizophrenics transferred from four state mental hospitals to other state mental hospitals. The elderly sub-group (N=494) was also examined
Markson and Cumming (1975)	3.9 percent in 1 year (full sample) 9.1 percent in 11 months (elderly)	2,174 older chronic schizophrenics transferred from four state mental hospitals to other state mental hospitals. The elderly sub-group (N=494) was also examined
Zweig and Csank (1975)	26 percent in 1 year	347 elderly male, war veterans in a hospital chronic disease unit moved to a new building
Zweig and Csank (1976)	23.3 percent in 1 year	347 elderly male, war veterans in a hospital chronic disease unit moved to a new building
Gutman and Herbert (1976)	6.2 percent in 3 months 33.33 percent in 1 year 41.2 percent in 5 years	81 male patients, 60 years of age or greater, moved from one extended care unit to another

Pino, Rosica, and Carter (1978)	24 percent in 9 months	25 residents relocated from a hospital or home to a nursing home
Grey (1978)	14 percent in one year	137 nursing home residents relocated to another building
Kowalski (1978)	3.2 percent in 3 months	157 nursing home residents: (1) moved to hospitals, nursing homes, or homes of relatives because of a fire; (2) evacuated from the building 6 weeks later, and (3) moved into a new building 3 months after the fire
Zweig and Csank (1980)	48.61 percent in 1 year	72 male, war veterans, with organic brain damage in a hospital chronic disease unit moved to a new building
Borup (1982)	7.6 percent in 18 months (moderate change) 5.7 percent in 18 months (radical change)	152 residents moved from one nursing home to another (with the same staff and administration – moderate change) and 174 residents moved from one nursing home to another (with different staff and administration – radical change)
Nirenberg (1983)	0 percent in 3 months	40 nursing home residents moved from an old facility to a new facility
Amenta, Weiner, and Amenta (1984)	11 percent in 6 months	47 residents relocated from a closed nursing home
Chanfreau et al (1990)	0% in 6 months	28 elderly psychiatric patients transferred from one psychiatric hospital to another
Grant, Skinkle, and Lipps (1992)	5.1 percent in 6 months	196 residents from two nursing homes relocated to one new nursing home
Brody, Kleban, and Moss (1974)	4 percent in 4 months	48 residents moved to different rooms within one nursing home
Watson and Buerkle (1976)	6.8 percent in 4 months 15.6 percent in 1 year	71 male geriatric Veterans Administration patients transferred from one building to another
Pablo (1977)	15 percent in 3 months 21 percent in 6 months 29 percent in 1 year 36 percent in 2 years	52 long term care and rehabilitation patients moved to three other wards within a hospital
Pino, Rosica, and Carter (1978)	24 percent in 9 months	25 residents relocated from a hospital or home to a nursing home
Borup, Gallego, and Heffernan (1980)	15.3 percent in 16 months	326 residents relocated from 30 nursing homes
Haddad (1981)	8.22 percent in 6 months	389 geriatric psychiatric patients moved from one room in a state psychiatric facility to another within the same facility
Amenta, Weiner, and Amenta (1984)	17 percent in 6 months	12 residents moved within the same facility

Shamian, Clarfield, and Maclean (1984)	3 percent in 9 weeks	20 elderly patients in a long-term care hospital unit were relocated and compared to 16 patients who were not moved
Rantz and Egan (1987)	9.8 percent in one year	91 residents moved within a nursing facility
Pruchno and Resch (1988)	13.9 percent in 1 year	207 nursing home residents who transferred rooms are compared with 353 residents who did not move
Wittels and Botwinick (1974)	3.7 percent in 1 year	462 elderly with a voluntary move to one of two buildings compared to 193 applicants to these buildings who did not move

Appendix 2. Summary of Studies Addressing the Physiological Changes of Relocated Elderly

Author(s)	Physiological Change Examined and Period of Observation	Sample
Lawton and Yaffe (1970)	Functional health in 1 year Hospital admissions in 1 year Dispensary visits in 1 year Self rated health in 1 year	129 elderly moved from congregate housing to an apartment building
Bourestom and Tars (1974)	Radical-change group: Self-perceived health in 1 month Staff/patient relationships in 1 month Activity patterns in 1 month Moderate-change group: Self-perceived health in 1 month Staff/patient relationships in 1 month Activity patterns in 1 month	98 nursing home patients moved to one of two other nursing homes.
Silverstone and Kirschner (1974)	Physical deterioration	200 elderly moved following a workers strike
Smith and Brand (1975)	Life Satisfaction Index Social contacts	75 residents, 40 relocated from their home and 35 relocated from other medical care institutions
Storandt and Wittels (1975)	Health in 1 year Activities in 1 year	89 elderly moving to a new apartment complex, compared to 34 non-movers
Grey (1978)	Locomotion Incontinence	137 nursing home residents relocated to another building
Borup, Gallego, and Heffernan (1980)	Stamina Hygiene Daily functioning	326 residents relocated from 30 nursing homes
Borup (1981)	Attitudes towards relocation Willingness to move Adequacy of information Concern about moving	326 residents relocated from 30 nursing homes
Borup (1982)	Moderate (same staff): Health status Daily functioning Life satisfaction Radical (different staff): Health status Daily functioning Life satisfaction	152 residents moved from one nursing home to another (with the same staff and administration – moderate change) and 174 residents moved from one nursing home to another (with different staff and administration – radical change)
Amenta, Weiner, and Amenta (1984)	General condition	47 residents relocated from a closed nursing home

Grant, Skinkle, and Lipps (1992)	Prescription drug use Self-care dependent Bedfast/moribund	196 residents from two nursing homes relocated to one new nursing home
Watson and Buerkle (1976)	Hospitalization in 4 months Hospitalization in 1 year	71 male geriatric Veterans Administration patients transferred from one building to another
Pino, Rosica, and Carter (1978)	ADLs	25 residents relocated from a hospital or home to a nursing home
Pino, Rosica, and Carter (1978)	Unprepared for transfer: ADLs Prepared for transfer: ADLs	25 residents relocated within a nursing home complex with some preparation and 25 residents without any preparation
Amenta, Weiner, and Amenta (1984)	General condition	12 residents moved within the same facility
Shamian, Clarfield, and Maclean (1984)	Morbidity ADLs Drug management	20 elderly patients in a long-term care hospital unit were relocated and compared to 16 patients who were not moved
Pruchno and Resch (1989)	self-care disorientation depression irritability withdrawl self-care disorientation depression irritability withdrawl	41 residents relocated within the same facility in preparation for new construction 75 residents, 38 moved to the adjacent new facility and 37 relocated within the existing facility
Brand and Smith (1974)	Personal life satisfaction ¹ Health Participation in activities	68 elderly moved to a new housing project
Lawton and Cohen (1974)	Functional health in 1 year Morale in 1 year Change for the better in 1 year Loner status in 1 year Orientation to children in 1 year Housing satisfaction in 1 year External involvement in 1 year Breadth of activity in 1 year Satisfied with status quo in 1 year	574 elderly moving into senior housing are compared with 324 community residents
Smith and Brand (1975)	Life Satisfaction Index Social contacts	75 residents, 40 relocated from their home and 35 relocated from other medical care institutions

Appendix 3. Summary of Studies Addressing Psychological Changes of Relocated Elderly

Author(s)	Psychological Change Examined and Period of Observation	Sample
Storandt and Wittels (1975)	Cognitive functioning in 1 year Personality in 1 year Health in 1 year Activities in 1 year	89 elderly moving to a new apartment complex, compared to 34 non-movers
Watson and Buerkle (1976)	Hospitalization in 4 months Hospitalization in 1 year	71 male geriatric Veterans Administration patients transferred from one building to another
Pablo (1977)		
Nirenberg (1983)	Low-functioning Mental status Location Proximity Body position Activity High-functioning Mental status Location Proximity Body position Activity	40 nursing home residents moved from an old facility to a new facility. Residents were split into 2 groups with high and low intellectual functioning
Brand and Smith (1974)	Personal life satisfaction ¹ Health Participation in activities	68 elderly moved to a new housing project
Lawton and Yaffe (1970)	Functional health in 1 year Hospital admissions in 1 year Dispensary visits in 1 year Self rated health in 1 year	129 elderly moved from congregate housing to an apartment building
Lawton and Cohen (1974)	Functional health in 1 year Morale in 1 year Change for the better in 1 year Loner status in 1 year Orientation to children in 1 year Housing satisfaction in 1 year External involvement in 1 year Breadth of activity in 1 year Satisfied with status quo in 1 year	574 elderly moving into senior housing are compared with 324 community residents

Haddad (1981)	<p>Intermediate Care: Retardation in 6 months Depression in 6 months</p> <p>Psychiatric Care: Communication in 6 months Cooperation in 6 months Paranoia in 6 months Anxiety in 6 months Retardation in 6 months Depression in 6 months</p> <p>Skilled Nursing Care: Cooperation in 6 months Paranoia in 6 months Anxiety in 6 months</p>	389 geriatric psychiatric patients moved from one room in a state psychiatric facility to another within the same facility
Patnaik, Lawton, Kleban, and Maxwell (1974)	<p>Passive behavior Instrumental behavior</p>	48 nursing home residents moved within the same facility
Bourestom and Tars (1974)	<p>Radical-change group: Self-perceived health in 1 month Psychosocial health in 1 month Staff/patient relationships in 1 month Activity patterns in 1 month Behavioral complexity in 1 month</p> <p>Moderate-change group: Self-perceived health in 1 month Psychosocial health in 1 month Staff/patient relationships in 1 month Activity patterns in 1 month Behavioral complexity in 1 month</p>	98 nursing home patients moved to one of two other nursing homes.
Pablo (1977)	<p>Self-care dependent Beligerent/confused Anxious/depressed Bedfast/moribund Behaviorally deteriorated Paranoid/suspicious Sensorimotor impaired Withdrawn/apathetic</p>	52 long term care and rehabilitation patients moved to three other wards within a hospital
Pino, Rosica, and Carter (1978)	<p>ADLs IQ Mental status Life satisfaction Personality</p>	25 residents relocated from a hospital or home to a nursing home

Pino, Rosica, and Carter (1978)	Unprepared for transfer: ADLs IQ Mental status Life satisfaction Personality Prepared for transfer: ADLs IQ Mental status Life satisfaction Personality	25 residents relocated within a nursing home complex with some preparation and 25 residents without any preparation
Roslaniec and Fitzpatrick (1979)	Level of consciousness Orientation Concentration Memory Higher cognitive function	25 elderly hospitalized for 4 days
Chanfreau et al (1990)	behavioral dependency antisocial behavior cognitive ability social interaction	28 elderly psychiatric patients transferred from one psychiatric hospital to another
Silverstone and Kirschner (1974)	Emotional problems Mental problems	200 elderly moved following a workers strike
Grant, Skinkle, and Lipps (1992)	Prescription drug use Self-care dependent Belligerent/confused Anxious/depressed Bedfast/moribund Behaviorally deteriorated Paranoid/suspicious Sensorimotor impaired Withdrawn/apathetic Perceived stress scale Depression scale Self-esteem scale Social support	196 residents from two nursing homes relocated to one new nursing home

Appendix 4: Elder High-Rise Relocation/Eviction/Evacuation Articles

Hundreds of Senior Evacuated after S. Side Power Outage. Chicago Tribune, 8/1/2006.

<http://www.globalaging.org/armedconflict/countryreports/americas/chicagoheatwave.htm>

Rockville NORC at risk seniors scramble as apartments set to go condo. Washington Jewish Week, 9/21/2005.

<http://www.washingtonjewishweek.com/main.asp?SectionID=4&SubSectionID=4&ArticleID=4111&TM=83483.67>

Seniors terrified as AHA plans to demolish their housing. Atlanta Progressive News, 6/23/2007.

<http://www.atlantaprogressivenews.com/news/0180.html>

Seniors at 2 CG complexes face move *Rent increase won't be covered by aid; meeting scheduled.* Casa Grande Valley Newspapers, 9/22/2007.

http://www.zwire.com/site/news.cfm?newsid=18844121&BRD=1817&PAG=461&dept_id=68561&rfti=6

Senior citizens worry about eviction threat. The Register-Guard, 9/15/2007.

<http://www.registerguard.com/news/2007/09/15/a1.seniorévict.0915.p1.php?section=cityregion>

Resources

- Castle, N.G. (2001). "Relocation of the Elderly." *Medical Care Research and Review*. 58(3):291-333.
- Choi, N.G. (1996). "Older Persons Who Move: Reasons and Health Consequences." *Journal of Applied Gerontology*. 15(3):325-344.
- Devlin, A.S. (1980). "Housing for the Elderly: Cognitive Considerations." *Environment and Behavior*. 12(4):451-466.
- Hayashida, C.T. (2006). "Aging in Place in Condos: Identifying High-Rise NORCs with GIS Techniques." University of Hawaii Center on Aging, Sociology, Nursing & Kapiolani Community College Assisted Living Options Hawaii. Presentation.
- Hong, S. & Chen, L. (2009). "Contribution of Residential Relocation and Lifestyle to the Structure of Health Trajectories." *Journal of Aging and Health*. 21(2):244-265.
- Kampfe, C.M. (2002). "Older Adults' Perceptions of Residential Relocation." *Journal of Humanistic Counseling, Education and Development*. 41.
- Sanders, S., Bowie, S. L. & Bowie, Y. D. (2003). "Lessons Learned on Forced Relocation of Older Adults: The Impact of Hurricane Andrew on Health, Mental Health, and Social Support of Public Housing Residents." *Journal of Gerontological Social Work*. 40(4):23-35.
- Sergent, J.F., Ekerdt, D.J. & Chapin, R. (2008). "Measurement of Late-Life Residential Relocation: Why Are Rates for Such a Manifest Event So Varied?" *Journal of Gerontology*. 63B(2):S92-S98.
- Serow, W.J., Friedrich, K. & Haas, W.H. (1996). "Residential Relocation and Regional Redistribution of the Elderly in the USA and Germany." *Journal of Cross-Cultural Gerontology*. 11:293-306.