

Policy Perspectives on Infrastructure

MIT School of Architecture and Planning
Policy recommendations convened by the MIT Norman B. Leventhal Center for Advanced Urbanism

August 2021

Building America's Care Infrastructure Through Care-Based Co-Housing

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MIT SCHOOL OF ARCHITECTURE + PLANNING

Summary

Care-based co-housing (CBCH) is a new model in which older and disabled adults along with caregivers and their families live together in the same building. All residents have independent units clustered around communal spaces in order to share care, meals, activities, and mutual support. CBCH aims to (a) ensure consistent, quality, and proactive care for older adults, enabling them to thrive (b) provide affordable housing, healthy food, and secure jobs for caregivers and share these benefits with their families. These outcomes in turn reduce the cost and strain on our nation's health and housing infrastructure.

Scope of Problem

America's Growing Care Crisis. With the greying of America, consistent access to quality care and appropriate senior housing will play critical roles in enabling older adults to thrive and in turn, ensuring their families can lead healthy, productive lives. Currently, however, severe shortcomings in both care and housing ask us to identify key obstacles. For one, the country's existing housing stock is unaffordable, insufficient, and ill-suited to meet the needs of a growing older adult population. At the same time, challenges in the care industry — from the dearth of home health aides to the high cost of long-term care — contribute to a growing care crisis. Studies show that our nation's care crisis reaches a critical point in the 2030's when the oldest Babyboomers turn 85 and face exponentially higher risks of dementia, serious physical injuries, and long-term dependency. During these "care gaps" — or periods when those who need care cannot obtain it — older adults are more likely to suffer from poor nutrition, gaps in medicine, and preventable late-stage hospital admissions. These costs are internalized by patients, their insurance companies, and taxpayers. While care at these stages is absolutely critical, few have the financial resources to pay for care in old age. America's care crisis is only growing worse: the number of Americans 65 and older will double to 98 million by 2050.

Caregiving Industry — Low Wages, High Turnover. Despite its high cost to consumers, caregiving is an industry characterized by low wages and high turnover. The majority of paid caregivers in the United States live below the poverty line. In 2021, the average salary of caregivers for older and disabled adults is \$14 per hour. Most are not employed full-time due to caregiver burnout, clients passing away or moving to nursing facilities, variable schedules, etc. The slow process of securing and onboarding into a new position costs caregivers an annual income loss of \$4,100 per caregiver as reported in the 2019 Argentum Annual Senior Living Executive Conference.

According to a 2019 report by the National Domestic Workers Alliance, half of caregivers rely on public assistance and 60 percent regularly skip meals and struggle to feed their families. Rent absorbs the majority of caregivers' income which averages \$20,000 or less a year. Lack of affordable housing also means that underpaid caregivers live further from their jobs, face long commutes as they struggle with housing costs, and struggle to spend time with their own families. Overall, caregivers face acute economic and housing precarity.

Our Solution: Care-based Co-Housing. To help address these problems, this policy paper recommends a multi-pronged approach to promoting a new model for affordable housing and care that we refer to as "care-based co-housing" (CBCH). In CBCH projects (explained more fully below), older and disabled adults share care ("congregate care") and living costs in buildings whose structure, wrap around services, and care improves the social determinants of health, and where caregivers can also live at reduced rents. A summary of our recommendations include:

1. Providing federal **capital grants** totaling \$200 million to jumpstart 20 CBCH facilities.
2. Enabling the **Low Income Housing Tax Credit (LIHTC)** to include CBCH projects. This regulatory amendment would open up significant federal funding currently prohibited due to restrictions both on supportive services charged to tenants and the provision of units to caregivers based on occupation.
3. Creating a **federal designation, accreditation, and regulatory category for CBCH** so that beneficiaries of private Long-Term Care (LTC) insurance and/or public long-term services and

supports (LTSS) can take advantage of care-based co-housing services.

4. Launching an **interdepartmental task force** across the Department of Labor (DOL), the Department of Housing and Urban Development (HUD), and the Department of Health and Human Services (HHS) dedicated to CBCH.

These policies would leverage private-public sector capital investment as well as ongoing robust funding streams to successfully sustain CBCH projects in the long run.

Care-based Co-Housing: A new model

Summary: As a new type of residential building for older adults, disabled people, along with caregivers and their families, care-based co-housing (CBCH) is a simple yet innovative concept that combines stable housing, intergenerational care, social integration, and neighborhood revitalization that can also help historically divested communities. CBCH focuses on providing care for active seniors with additional add-on care services for residents as they need it. By improving the social determinants of health and providing developmentally appropriate, well designed housing to anticipate their needs, CBCH aims to keep residents active and healthier for longer periods of time.

Governance structure and business type: CBCH projects would be built by developers partnering with a company/organization specializing in care and health management. A building manager would be responsible for the maintenance and upkeep of the building. The governance structure of CBCHs' developers and care/health management could be non-profit, for-profit, B Corp, coop, or other purpose-driven organizations and will be best determined by the partners and community stakeholders involved in each respective CBCH.

Balancing independence and community integration: In care-based co-housing, caregivers live in the same building as the older adults for whom they provide care. Each resident has their own independent unit clustered around common spaces that support shared meals, childcare, and activities such as art workshops, fitness, physical therapy, educational classes, group games/entertainment, and gardening. CBCH's design for clustered or "congregate" care makes caregiving more efficient and safer: caregivers can take turns keeping an eye on those who need close monitoring or lend a helping hand while enjoying the amenities of these communal spaces for themselves and their families. For older and disabled adults, these shared spaces offer a place to socialize and engage in mental and physical activities beyond their own individual unit. Older and disabled adults are encouraged to engage in and help facilitate activities (gardening, games, crafts, cooking, homework help for caregivers' children) in order to encourage both their cognitive health and contribute to the co-living community.

Co-living types around the world operate according to a gradient of sharing and protocols for involvement. In each CBCH, stakeholders will themselves determine their levels of privacy, sharing, integration, etc. For example, caregivers' units may all be positioned on the same floor so that they can best share childcare and resources. Alternately, caregivers may prefer to live alongside non-caregiver residents. All residents are encouraged to participate in shared meals but the frequency would be determined by CBCH stakeholders.

In exchange for their labor, caregivers receive good wages along with subsidized meals and housing for their families, childcare, and other benefits. Caregivers would coordinate care, human resources, food, activities, specialized nursing activities, medical appointments, and other aspects. Caregivers are empowered to set the tone and boundaries on how and when they integrate and maintain independence.

Sustainability: As a co-living community, CBCHs are more sustainable due to lower energy consumption as well as shared meals and housekeeping which is passed on to residents in the form of consistent, quality care and sustainable wages for caregivers. CBCH enables partners, caregivers, and community stakeholders to determine their own business type and management structure. Employee retention, training, and turnover ranks among the top challenges in the caregiving industry.

As elaborated below, high turnover among caregivers reduces the quality of health/medical care for residents, drains human resource costs, and reduces caregivers' overall income. As the CBCH model rejects a one-size fits all governance structure, CBCHs engender stronger buy-in, build leadership, and maintains long-term care relationships among older residents and caregivers' children. Enabling caregivers to self-determine what best meets their needs and their families' needs contributes to CBCHs' sustainability.

Public health: There has been growing interest in senior co-housing over the recent years as an attractive housing model for the older adult population to age together in community. Studies have pointed to the significant health benefits of co-housing that result from the social support, sense of community, and sense of security which co-housing provides. These social determinants of health are linked with higher rates of happiness, reduced stress, and improved quality of life.

What are the origins of care-based co-housing?

Care-based co-housing (CBCH) is a strategy developed in 2019 by Marisa Morán Jahn and Rafi Segal (primary authors of this paper) that emerges from and is derived from their joint building project with developer Ernst Valery entitled Carehaus, the United States' first care-based co-housing project. Located in an historically under-invested neighborhood in Baltimore, Maryland, Carehaus will open its doors in 2023 as part of the community's self-identified vision plan. Consisting of 20 units, Carehaus Baltimore's size is financially suboptimal; an optimal size begins at around 50 units. However, we are investing in Carehaus Baltimore as an important proof of concept while we discuss the prospect of future Carehauses with stakeholders in other cities.

In recognizing the social need and growth potential of a hybrid care and housing market, we are mindful about the fiscal challenges that would prohibit other developers from building this new type of hybrid housing and care — unless certain policy opportunities could be put in place. This paper draws upon multi-sector insights and proposes policy solutions to enable CBCH to scale, multiply, and prove economically sustainable.

Both CBCH and Carehaus grew out of decade-long collaborations with Caring Across Generations (CAG) and members of the National Domestic Workers Alliance (NDWA) whose members have participated in codesign sessions. We also consulted with other member-led worker organizations and advocacy groups including Fé y Justicia (Houston), We Dream in Black (an initiative of NDWA), Miami Worker Center, San Francisco Day Labor Program and Women's Collective — many of whom continue to be involved in shaping Carehaus architectural design and care services. In addition, our team has partnered with individuals from organizations involved in the care and medical spectrum including nurses, doctors, gerontologists, caregivers, domestic work advocates, people with disabilities, disability advocates, and lawyers. Key health partners who have contributed their expertise include Johns Hopkins Disability Health Research Center, Center on Innovative Care and Aging at Johns Hopkins, BrightFocus, Arosa, and CAPABLE, a program developed by Johns Hopkins School of Nursing for low-income seniors to safely age in place.

What is care-based co-housing's financial model? How exactly is Care-based co-housing paid for – today and in the future?

CBCH is a long-term rental housing model in which the rent and service charges paid by the older residents pay for caregivers' salaries and subsidize the rent for the caregiver units living in the same building. This model depends on a certain minimum number of 42 rented elder units with total units at 50 units, and based on a 1:6 ratio of caregivers to elders.

In order to establish CBCH as a desirable and successfully proven housing model, developers would need incentives (assurances/securities) to minimize investment risks associated with developing new housing models. To prove care-based co-housing and to scale it so that it can become a financially sustainable model, we propose enhancing the federal role in funding care-based co-housing through three mechanisms which are summarized here and more fully explained below.

How does care-based co-housing compare to existing senior living models?

The four most common types of senior living facilities are: independent living (ILF), assisted living (ALF), memory care, and nursing homes. Care-based co-housing (CBCH) is most similar to ILFs and ALFs but offers better care and more amenities than either.

| | Care-based co-housing | Ind. Living | Assisted Living ¹ |
|-----------------------------|---|---|--|
| Cost (average monthly rent) | \$2,500 for mixed income residents. For some low income residents, costs could be further subsidized. Supportive service charges may be partly covered by Medicare, Medicaid, private healthcare insurance, or another outside source of funding. | \$3,239 ² | \$4,977 ³ |
| Economic structure | Private, public, and mutual aid support: older/disabled adults pay for affordable housing and wrap around services. Caregivers receive subsidized housing and services. Healthier older adults assist other staff with childcare. | Residents pay for housing. Care is privately contracted if needed | Residents pay for housing and care |
| Funding sources | Individual payer, select govt programs, institutional partnerships, tax credits, public and private insurance | Individual payer | Individual payer; care for low-income residents may be covered by Medicaid |
| Caregiver Benefits | Yes; affordable housing, subsidized meals, activity programming | Not typically | No |
| Caregiver Family Benefits | Yes; care, housing, and meals for family members | Not typically | No |
| Client : Caregiver ratio | 6:1 | None | Typ 12:1 |
| Housing Type | Co-housing. Independent units (with efficiency kitchens) with communal spaces | Private house, apartment, townhouse, etc | Semi-private or private apartment |
| Assistance w/ ADLs | Some | No | Yes |
| Meals | Communal meals once a day + 24/7 stocked kitchen | Varies from no meals to all meals provided | All meals provided |
| Medical care | Telehealth, minimal health services | None to minimal | Medication administration; Health services |
| Staff On Site | 24/7 | None to 24/7 | 24/7 |
| Caregiver qualifications | Ongoing annual required caregiver training. One Certified Nursing Assistant (CNA) on site at all times. | N/A | Varies - minimal training to Registered Nurse (RN) |
| Events/Classes | Integrated approach to wellness: art, yoga, exercise, weekly outings to cultural offerings and community events, gardening led by residents with staff support | Various events, activities, and classes | Various events, activities, and classes |

¹ National Caregivers Library, [The Basics of Assisted Living](#)

² U.S. average monthly rent from [NIC MAP@ Data Service](#)

³ Ibid

What are the economic benefits of care-based co-housing? What are its public health advantages? How does care-based co-housing save individuals and taxpayers money?

Several recent studies demonstrate that integrated health care services within older and disabled adult housing facilities contribute to better health outcomes and decreased health care expenditures. A study by Center for Outcomes Research & Education revealed that housing facilities with health staff and services (such as doctors, nurses or other health professionals) saw significant reductions in emergency room visits and total health care expenditures compared to facilities without these services.

Additional benefits:

- In CBCH, seniors pay less on average than at senior living facilities offering care.
- Caregivers receive a living wage, obviating government subsidies and creating taxpayer savings in Medicaid, SNAP, and other social programs.
- Caregivers are offered affordable rents that are lower than market rents in most areas. Additional benefits and services include utilities, shared meals, a stocked kitchen, fitness facilities, access to physical training, social programs, and cultural activities.
- Caregivers save in commuting costs and childcare
- CBCH architecturally integrates recent science on how to mitigate the spread of pandemics — outdoor spaces for socializing, the elimination of narrow passageways in favor of broader corridors, HEPA filtration ventilation systems, virtual visitation and videoconferencing rooms — and other measures to provide safe housing for the community's most vulnerable.

Numerous other state and federal programs find reduced costs and improved outcomes from integrated health care and housing, such as Vermont's Supports and Services at Home (SASH) program. HUD's IWISH program built on this SASH model enables low-income seniors to age in place and is currently in the early stage of being evaluated by HUD as to whether it reduces unplanned hospitalizations, use of acute care, increased stay in housing and delayed transitions to long-term care facilities.

The services provided in care-based co-housing would help residents remain healthier, and the savings in health care costs would make this model financially sensible.

How is congregate or clustered care safer for live-in caregivers or caregivers who work in individuals' private homes? What do caregivers think about CBCH?

CBCH derives from the concerns voiced by 100+ caregivers and advocates that Jahn interviewed from 2010-2021 and the 11 caregivers directly involved in Carehaus codesign workshops from 2019-2021.

Conclusions and outcomes from these interviews and codesign workshops:

- All caregivers saw an advantage of CBCH over live-in care where only one caregiver was living with their employer.
- 80% of caregivers saw advantages in a congregate care situation where they live next door to a fellow caregiver and can support each other while providing care.
- Half of caregivers saw advantages of living in the same building as those for whom they cared for.

Many of the pecuniary benefits for caregivers in CBCH buildings are listed above. Among the health and safety challenges these caregivers faced, muscular-skeletal disorders and burnout ranked among the highest. Ergonomic pain points within a caregivers' daily workflow occur at the point bending over to lift clients from their beds or baths — as well as repetitive stress injuries from cleaning tasks associated with keeping their clients' homes sanitary and tidy. So too, the mental toll of caregiving contributes to emotional burnout and exhaustion. Being able to rely upon a fellow caregiver to lend a helping hand or take turns on tasks makes congregate care safer.

CBCH buildings are designed to anticipate the needs of older and disabled adults and reduce the physical challenges of caregivers. For instance, bathrooms with grab bars and walk-in showers, as well as private rooms with bed lifts, significantly minimize the physical work of caregivers and reduce risk of injury and physical exhaustion.

In addition, unlike traditional live-in care models, caregivers' units in CBCH buildings are designed to maximize the privacy of caregivers whose units are clustered together with a physical separation from older/disabled residents. Common rooms and communal meals enable them to opt-in to shared meals. Clearly delineated work shifts also ensure caretakers receive proper rest and stable routines.

What are the health and community benefits of social integration — a key tenet within care-based co-housing? How is social integration a particularly helpful benefit for historically underserved communities?

In the United States, one-fourth of adults aged 65 and older are considered to be socially isolated due to the loss of family or friends, chronic illness, and hearing loss. Numerous studies, including one by Andrew Steptoe et. al., have proven that social isolation and loneliness have adverse health effects on older adults by increasing risk of cardiovascular disease and mortality. Multiple studies have also indicated that social isolation among older adults is more prevalent among those of lower income. CBCH seeks to reduce social isolation in order to improve quality of life and reduce mortality risks. Thus, there is a clear benefit to providing co-living with social integration programming for older adults.

What are the benefits of intergenerational and mutual care?

Many studies have pointed to the increased sense of isolation in older adults due to our generationally-stratified society. To reverse this, the CBCH model promotes integration across generations through caregiver/care recipient co-living. Older adults live in community with their caregivers and caregivers' families; the potential of interaction with youth, as cited by various sources, can increase older adults' sense of belonging, self-esteem, and well-being.

The co-living model also promotes mutual care between older and disabled CBCH residents. Both mutual care and intergenerational care contributes to an increased sense of purpose, cognitive activation, motor skills, and general wellbeing.

What are the community-wide benefits of care-based co-housing?

In many places, CBCH projects will help revitalize the low-income neighborhoods in which they are built. The presence of older adult populations have a positive impact on the economy of a neighborhood. Older adults are drivers of consumer spending, they fuel a need for local service jobs, provide volunteering and educational services, provide assistance to working parents through child caregiving, and help fuel local civic and cultural programs and services. CBCH also embodies place-based development practices by seeking not only to provide low-income housing in the neighborhoods in which it is built, but also be integrated with the community by providing open spaces, community assets, safe streets, connected corridors, and diversity of retail and housing options serve both local residents and visitors.

Key Policy Obstacles

Limitations: LIHTC

The Low-Income Housing Tax Credit (LIHTC) program is the country's largest subsidy source for affordable rental housing production. Unfortunately a few barriers to accessing LIHTC funds pose challenges for CBCH projects as envisioned in this paper.

First, according to existing LIHTC regulations, buildings eligible to receive LIHTC tax credits require monthly rent for low-income tenants to be below a certain Area Median Income (AMI) for the metropolitan area, usually 60% AMI. In the case of Carehaus Baltimore 2023, the maximum rent for LIHTC units would be \$1,182 per month. While LIHTC equity would help cover the initial building development costs, the LIHTC rents would not cover the cost of care and supportive services that are included in CBCH. As wrap-around care and supportive services are key elements of CBCH, additional sources of operating subsidy such as those suggested below would be necessary beyond rent paid by low-income tenants. As a long-term solution, a legislative amendment could allow LIHTC buildings that operate according to a CBCH model to charge a mandatory fee.

Second, under current existing LIHTC regulations, units set aside for caregivers could not be counted towards LIHTC. The obstacle here is that caregivers' units are not residential units available to the general public for use, and caregivers are not an explicit group targeted by other rental subsidy programs, as exist for artists. Therefore any CBCH project would need to find alternative sources of capital to develop caregiver units — a challenge which disincentivizes private developers unless this policy obstacle is addressed.

Limitations: Medicare and Medicaid

Currently, Medicare covers select necessary medical services for adults over 65 but does not cover living expenses in most senior care facilities — and would not cover care in a CBCH building.

Medicaid coverage, which is jointly funded by the federal and state governments, is managed by the individual states. As a result, coverage varies by state. In Maryland for example, there are programs that support low-income adults earning up to 300% of Supplemental Security income (@\$28,000), who require assistance with at least 2 activities/assistance for daily living (ADL) and have assets (excluding housing) of less than \$2,500. To qualify for Medicaid coverage, seniors are required to spend down their savings and liquidate assets — essentially impoverishing them and their family. Texas requires a higher level of care needed (nursing home level of care) for its participants to receive Medicaid but has similar financial requirements.

Medicaid benefits vary in terms of the amount and kinds of care they cover: some state Medicaid programs do not cover in-home care, while some of those that do cap the number of people who can get it. Medicaid payments to congregate care varies by state. One precedent in Maryland, titled the Maryland Congregate Housing Services Program, is funded by the MD State Dept of Aging. Congregate care facilities need to be certified by the state and seniors need to have some disability — but this poses a limitation for CBCH which optimally keeps older adults healthier for longer periods of time, thereby mitigating the domino effect of an initial injury and reducing amount of care needed over the long term.

Policy Recommendations

Care-based co-housing would be economically sustainable in the long-run through the following recommendations which leverage public and private sector capital investments alongside robust, ongoing funding streams.

1. Allocate Capital Grants to Jumpstart CBCH as Pilot Projects Incentivize care-based co-housing through a capital matching grants totaling \$200 million to jumpstart 20 CBCH building projects.

The federal government should create a capital matching grant to incentivize the creation of 20 care-based co-housing buildings across the country. The program would provide a 1:1 match of funds towards the creation of a CBCH project, with a per project cap of \$12.5 million in grant funds.⁴ By reducing initial capital construction costs, this matching grant program would provide sufficient incentive for the construction of CBCH projects, especially in areas of the country that are expensive to develop housing.

As a new model with the prospect to scale nationally, care-based co-housing needs assistance from the government to implement its first projects and prove the viability of the concept accompanied by rigorous evaluation.

These pilot projects would be rigorously evaluated through longitudinal studies measuring the effectiveness of CBCH strategies in terms of overall health, reduced emergency room visits, hospitalization, medical expenses, economic stability, and total health care savings to individuals and state and federal government.

⁴ In high cost metro regions, residential projects can cost up to \$500,000 per unit to develop. Therefore a 50 unit project would require up to \$12.5 million in CBCH grant funds to be developed.

2. Amend LIHTC regulation to include CBCH

As explained above in “Key Policy Obstacles,” current limitations in the LIHTC program preclude the use of LIHTC equity toward the construction of a CBCH project. The primary limitation is the prohibition on the monthly cost of supportive services charged to tenants that are necessary for a CBCH project but would make it ineligible for LIHTC. A legislative fix would allow for these mandatory supportive services charges above the computed affordable LIHTC rent based on Area Median Income. An amendment in LIHTC enabling CBCH projects to charge a fee for supportive services would prove significant for private developers.

Additionally, current LIHTC rules preclude a developer from selecting tenants for a given unit based solely on their occupation as a caregiver, even if the caregivers’ income levels qualify them for the LIHTC program. Therefore, as caregivers are central to CBCH’s success, we recommend a change in the LIHTC statute in §42(g)(9), allowing units in a CBCH project set aside specifically for on-site caregivers to qualify for LIHTC, similar to the existing carve out for artists.

These two amendments would make LIHTC, the current largest source of Federal capital subsidy for affordable residential projects, viable for a majority of the units in a CBCH project.⁵

3. Create a federal designation and accreditation for CBCH

Enable beneficiaries of private Long-Term Care (LTC) insurance and/or public long-term services and supports (LTSS) to take advantage of CBCH services.

Long Term Care (LTC) insurance is a privately-funded, voluntary insurance policy which provides funding for services such as assistance with activities of daily living (ADLs) which are not typically covered by regular health insurance. LTC insurance is purchased by individuals with a median income of almost \$90,000 (which is the top 20th percentile of US earners) and is largely out of reach for most older adults. To meet the needs of middle and low income families, advocates such as Caring Across Generations, AARP, and governmental task forces such as The California Aging and Disability Alliance are currently advocating for public, government-supported long-term service and supports (LTSS), examples which include:

- The 2019 amendment to The New York Health Act which provides universal long-term care for every resident.
- In California, a pilot program called Whole Person Care was launched in 2020 to provide coordinated health and social services to people with complex needs in underserved communities. Through a waiver program, the State funds programs in 25 counties and cities across California to invest in infrastructure linking Medicaid with social service providers including long term care.
- Washington’s long term care program is funded in a way similar to Medicare and Medicaid wherein all residents will pay 58 cents on every \$100 of income into the state’s trust. After state residents have paid into the fund for three years, they can tap \$100 a day up to a lifetime cap of \$36,500 when they need help with daily activities such as eating, bathing, or dressing.
- The Community Living Assistance Services and Supports Act (CLASS), a federal law enacted as Title VIII of the Patient Protection and Affordable Care Act which was repealed in 2013, would have provided an elective public long-term care insurance option financed through voluntary payroll deductions. The program would have benefited eligible individuals with functional limitations to cover the costs of community living assistance services and supports — ultimately enabling them to continue to work and/or remain in their communities.

Currently, CBCH buildings and services are not recognized as accredited care facilities by either private LTC insurance companies or growing number of publicly-funded LTSS programs. A federal

⁵ The size of the LIHTC subsidy for the upfront capital costs depends on the qualified low income tenants occupying the building; if the building is occupied by less than 100% low income tenants, developers would receive less than 100% of the LIHTC equity they would otherwise be eligible for. In terms of the percentage of Total Development Costs (TDC) the LIHTC equity would cover, that depends on a number of factors with the percentage of low income tenants as a key determining factor. As originally designed, the 9% LIHTC intends to cover roughly 70% of TDC and that may still be the case in low-cost areas of the country. However, this percentage decreases to 50-60% in coastal metro areas with the remainder of the TDC covered by a First Mortgage and various other state and local subsidies.

designation and accreditation of CBCH projects and regulatory inclusion would enable beneficiaries of either private or public programs to receive CBCH housing, care, and wrap-around services.

Ultimately, we recommend the adoption of a federal long-term care insurance which recognizes CBCH as one resource-efficient and cost-effective strategy to keep older and disabled adults healthier through leveraging the social determinants of health.

4. Launch Inter-Departmental Task Force

As seen in the recommendations above, CBCH is a new housing model that crosses jurisdictions and thus provides the opportunity to explore innovative cross-agency funding mechanisms at the intersection of the Department of Labor (DOL), Department of Housing and Urban Development (HUD), and Department of Health and Human Services (HHS).

One example for a meeting between housing and other infrastructure agencies can be seen in the collaboration between housing and energy, whereby homes (from single to multi-family) that harvest solar energy feed back the grid. Another successful collaboration of housing needs and infrastructure can be seen in the Transit Oriented Development (TOD) Zoning adopted by several US cities. In TOD, housing developed in proximity to public transportation is maximized to promote public transport ridership, walkability, and sustainable urban growth. Housing developed in relation to transportation infrastructure has yielded new residential building types that better serve their location, the livelihood of their residents, and the city as a whole.

Conclusion

The United States' state-by-state patchwork care system leaves millions of older adults without a safety net — and the problem is only growing worse. From 2018 to 2030, the number of Americans 65 and older will increase by more than 60 percent requiring new solutions to our nation's care infrastructure that redress our nation's growing care gap. This paper has focused on the multiple benefits of care-based co-housing and policy opportunities to enable its economic sustainability. A summary of our recommendations are as follows:

Short-term:

- Create interdepartmental task force
- Allocate \$200 million towards a pilot program of capital matching grants to jumpstart 20 CBCH across the U.S.
- Designate and accredit CBCH as a new hybrid housing and care model to be supported by private-sector and public long term care insurance.
- Amend LIHTC regulations to include CBCH

Long-term:

- Create federal Long Term Care (LTC) insurance that covers CBCH

Additional Links

Jahn, Marisa Morán and Segal, Rafi. "[Architecture Plays Key Role in Re-imagining Care Solutions.](#)" Op Ed, Boston Globe. April 26, 2021

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About policy perspectives on infrastructure

Policy perspectives present responses from faculty in MIT's School of Architecture and Planning to the American Jobs Plan. The effort was convened by the MIT Norman B. Leventhal Center for Advanced Urbanism.

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