Connected to the Community: Current Aging-in-Place Choices

by Susan Poor

As we age, our needs and interests evolve and change, so our choices of housing should be wide ranging, as should be the spectrum of activities and services.[1]

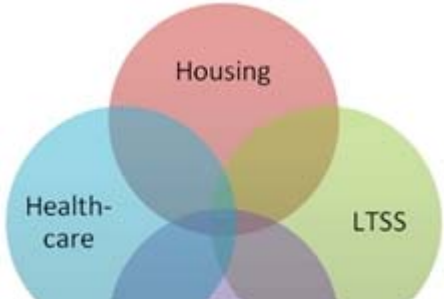
Most older adults wish to remain in their homes and communities as they age. Today, just 10% of older adults live in supported environments of some kind, with the remaining 90% living in "traditional" housing with no external assistance.[2] By choice and perhaps economic necessity, the large majority of older adults will continue to live as independently as they can for as long as they are able — and will need a range of services and supports to achieve this.

Successful aging in place requires coordination — and ideally integration — at the intersection of housing, health care, non-medical long term services and supports (LTSS), and technology. LTSS components are the services and practical supports that, when absent, may limit peoples' ability to live independently or encourage them to neglect their medical plan of care, which can lead to poorer health. The supports include such things as caregiving assistance, transportation, grocery shopping, home modification, prepared meals, connection to the larger community, and social capital. This article profiles a number of options that are allowing older adults to age in place, connected to their communities.

Aging — The Big Picture

The American population is aging and living longer. Baby boomers — the oldest of whom began turning 65 in 2011 — can expect to live into their 80s and 90s, giving them a 20-30-year period of phased retirement, encore careers, volunteer activity, and perhaps roles in raising grandchildren, supporting their children, or being caregivers to family members and friends.

As they age, nearly all will have at least one chronic condition, and many will have several. If their health declines, it will likely occur gradually over time, with intermittent periods of inpatient care and more intense medical needs. Some conditions, such as high blood pressure and arthritis, which occur in half the



population, will be readily managed in home settings. Advanced stages of other diseases (e.g., dementia, cardiopulmonary disease, stroke, cancer, diabetes, obesity-related conditions) will require intensive care management and a range of medical and non-medical services to support patients and their caregivers. These realities notwithstanding, 85 percent of Medicare beneficiaries with three or more activity limitations still live in traditional housing.[3]

The majority of boomers, like their parents, own their own homes. Some will live with other people; some (primarily women) will live alone or become widowed or divorced during these years. Yet for many, homes have lost value, and retirement savings have diminished due to the 2009 real estate and economic crisis.

Homes may also need basic maintenance as well as modifications in response to owners' physical needs. While estimates vary, the Employee Benefits Research Institute reports that in 2012, 64 percent of retired Americans had less than $50,000 in their retirement accounts.[4]

Other data indicate that nearly half of middle-income workers will be poor or near poor in retirement.[5] Some may benefit from reverse mortgages, annuities, and other vehicles for increasing their economic security. But poverty will disproportionately impact the heath care, housing, and economic security of low-income and minority individuals and their families.

While nearly all will be covered by Medicare, many will be shocked to learn that Medicare does not cover either residential or community-based long term services and supports (LTSS) and that their access to nursing homes or community-based alternatives means spending down to become Medicaid eligible. They will need, on average, three years of assistance, including one year in a nursing home (currently about $87,000/year) and two years of paid care at home (currently about $36,000/year).[6] As is true today, family and other informal caregivers (e.g., friends and neighbors) are likely to provide the majority of the care older adults will receive.

Aging in Place Considerations

Aging in place has generally meant aging independently while living in the place of one's choosing for as long as possible. What the overview above makes clear is that aging in place, in the community, is not only the preferred choice of older adults; it may be the *only* affordable and available option for many seniors. While publicly funded systems and services exist for those with low incomes, the same supports do not exist for the middle class. Even if older adults wish to move, most will not qualify for subsidized housing and will find other options, such as Continuing Care Retirement Communities (CCRCs) and assisted living, costly. The challenge of the future is therefore to enable *affordable* independent living in peoples' own homes, as the need for services increases

and at a time when it is clear that the federal and state governments are not going to lead these efforts for middle-income seniors.

Increasingly, aging in place incorporates the idea of "aging in community" and the necessity of "housing with services." Aging in community expands the concept of aging in place by including active engagement of older adults in planning and implementing services and supports, maintaining meaningful connections to the surrounding community, and having control over housing and other choices. We must weave together housing with health care, LTSS, and technology so that people have both a place to live and healthcare coverage and the non-medical services and supports that buttress independent living and enhance the success and efficacy of medical interventions.

The role of technology cannot be underestimated in achieving these goals. Advancements in technology for social connections, communication with medical personnel and family, brain fitness, arranging in-home services, diagnosis, medication management, health monitoring, receiving medical services at home, etc., will be groundbreaking in upcoming years. Finding balance in the "hi-tech/hi-touch" equation will play out over a long period of time.

A New Vision of the "Continuum of Care"

Today's seniors — including baby boomers who have experienced the aging of their parents — are searching for and creating alternatives to the traditional forms of long-term care (skilled nursing facilities, assisted living, or continuing care retirement communities). These settings are increasingly seen as institutional and out of sync with consumers' preference to age in their own homes and stay meaningfully connected to their communities. That said, there is a "culture change" movement afoot that is impacting institutional long-term care facilities and encouraging a shift in focus from the needs and ease of the institution to those of the resident and family. Key to this transformational shift is emphasis on "person-centered care" or "resident-directed care."

> Person-Centered or Resident-Directed Care is an ongoing, interactive process between residents, caregivers, and others that honors the residents' dignity and choices in directing their daily life. This is accomplished through shared communication, education, and collaboration. Relationships developed as part of this process benefit all involved, creating a community that affirms the dignity and value of each individual who lives and works in the nursing home.[7]

The current and ever-expanding spectrum of choices for places and support services for aging — ranging from the medical model of skilled nursing facilities to emerging models of programs that support aging in place in one's own home — is almost mind-numbing. Following the conclusion of this article, you will find a descriptive compendium that

includes examples of transformational change occurring within the more traditional models of long-term care settings as well as within the community.

Thinking About the Future

No sector of the U.S. economy will be untouched by the doubling of the age 65+ population over the next 30 years to 20 percent of the population — 80 million people, one in five of us. Twenty-two percent of the older population (19 million people) will be age 85+, half of whom will have dementia. Is the near universal desire of older adults to age in their homes and communities a pipe dream or the only affordable option we have as a society?

It is more affordable if we "operationalize" the value of non-medical LTSS. Vermont's Blueprint for Health recognizes the difference between evidence-based *medicine* and evidence-based *health*. Leaders there discovered that evidence-based *medicine* doesn't work, because physicians have limited, if any, knowledge about obstacles patients live with at home and in their communities that keep them from doing what physicians recommend. In an evidence-based *health* model, community health teams that include physicians, nurses, social workers, and behavioral health counselors help tie medical care together with real-life issues such as transportation, insurance problems, housing, and unemployment. Based on its evidence-based health approach, Vermont has seen reductions in hospital admissions, emergency department visits, and lower monthly costs per person.[8]

Isolation is another factor that, when left unchecked, can have a severe impact on health status and therefore costs. Data show that social connections — friends, family, neighbors, or colleagues — improve our odds of survival by 50 percent. Low social interaction is equivalent to smoking 15 cigarettes a day, equivalent to being an alcoholic, more harmful than not exercising, and twice as harmful as obesity.[9] Further, receiving social, non-medical supports decreases morbidity and mortality rates and increases life expectancy, self-efficacy, adherence to medication regimes, and self-reported health status.[10]

To extend the resources available to upcoming generations of older adults, it is critical that housing, health care, and LTSS models be linked (and enhanced by technology) to take advantage of low-cost "aging in place, connected to community" models such as Villages, NORC SSPs (Naturally Occurring Retirement Community Supportive Services Programs), TimeBanks, grassroots caregiving models, neighborhood associations, block captain approaches, and church and other faith-based networks. All of these models have strong civic engagement, volunteers, and mutual assistance cultures that can strengthen communities while supporting the individuals who live in them.

We will need many innovative housing and LTSS choices for the burgeoning older adult population. We cannot ignore the need for consumer direction, safe dwellings, and

holistic, humane settings for those needing skilled or custodial care in group environments. But we can greatly expand the range of non-medical LTSS by shining a brighter light on the wealth of social capital that exists in most communities and inspiring the creation of innovative ideas and solutions.

A Compendium of Options

Skilled nursing facilities, formerly called nursing homes, are nursing and healthcare facilities licensed by the state which provide a residence for elders who need skilled nursing and assistance with LTSS. Many provide additional services such as dental care, mental health care, dementia care, pain management, and palliative care. Medicare covers short-term rehabilitation stays but does not pay for elders who have longer-term needs. For those with long-term acute or chronic healthcare needs, they will have to pay out of pocket until they "spend down" their assets to become eligible for Medicaid, which covers costs for those who are low-income. Long-term care insurance can also be a vehicle for covering costs for a time period specified in the contract. In 2011, the average annual cost of a private room in a nursing home was $87,235.

Assisted living facilities provide a residence to elders who need some support with such activities as dressing, bathing, or cooking, or who want a more supportive environment (e.g., dining room meals, planned social activities, transportation), but who do not require skilled nursing care. Smaller settings for up to six people may be called adult foster care, adult family homes, supportive care homes, and board and care homes. Most assisted living facilities only accept private pay or long-term care insurance. A few states offer fee-waiver programs for low-income elders. Assisted living costs in 2011 were about $3,500/month or $42,000/year.[11]

Congregate care facilities combine private living apartments with centralized dining services, shared common spaces, and some LTSS, including meal preparation, housework, and outside

Index

Skilled nursing facilities
Assisted living facilities
Congregate care facilities
Continuing Care Retirement Communities (CCRCs)
Green Houses®
Alternative Assisted Living Facilities
Section 202 Supportive Housing for the Elderly
CCRCs Without Walls
Villages
Age-restricted communities
Naturally Occurring Retirement Communities (NORCs)
Accessory Dwelling Units (ADUs)
Shared Housing
Cohousing or Cluster Housing
Senior Cooperative Housing
Community-Based Services
PACE
Hospice
Senior Centers
Adult Day Centers
Innovative Community Models
Mather Lifeways Café Plus
Episcopal Senior Communities
The Living At Home Network
Innovative Grassroots Support and Caregiving Models
Share the Care
Lotsa Helping Hands
TimeBanks
Tyze Networks
The Transition Network Caring Collaborative

the facility shopping and healthcare appointments. Some contract for healthcare services, but congregate facilities are not licensed to provide care services such as bathing, dressing, and toileting. Congregate care is an industry segment between independent living and the health-related services of the assisted living facility. Costs are slightly less than those of assisted living.

Continuing Care Retirement Communities (CCRCs) provide a continuum of care as a resident's health changes, from independent living apartments, to assisted living, to skilled nursing care, although not all residents move through the continuum. Most CCRCs require a one-time entrance fee ranging from $250,000 to upwards of $700,000 and monthly service fees of $2,000-$4,000 or more. CCRCs typically offer at least one of three contract types: 1) life care (Type A) where the entrance fee is nonrefundable (or refundable on a declining balance approach) while monthly fees are fixed regardless of the level of care the resident requires; 2) modified life care (Type B) where the entrance fee is usually refundable in part and the resident is entitled to some period of free care (e.g., 60 days) or at a reduced cost when the resident moves to a higher level of care; and 3) fee for service (Type C) where the entrance fee is almost always refundable but the resident pays market rate if a higher level of care is needed. Many CCRCs accept Medicare in the skilled nursing section of the community, and some are beginning to address residents with long-term-care insurance, but otherwise no third party reimbursement is available to cover the fees associated with CCRCs. INDEX

Green Houses®[12] are small, home-like, skilled nursing facilities for six to ten people that focus on a holistic approach to care and services. They are designed to provide an alternative to institutional long-term care, with an emphasis on honoring seniors' dignity, privacy, and autonomy by providing meaningful activity and relationships, independence, and improved quality of care. Green House architectural hallmarks are an open kitchen, a hearth, a single dining room table, and lots of natural light, creating a home-like atmosphere rather than the often more sterile environment of a large nursing facility. The organization and philosophy of care of these homes are transformative, with an emphasis on creating a small, intentional community and an emphasis on person-centered care. The costs are comparable to those of nursing homes; currently about half of Green House residences are covered by Medicaid. INDEX

Alternative Assisted Living Facilities are a small but growing number of assisted living facilities that are embracing a more holistic care model in response to consumer demand for person-directed care. For example, in Oregon, Elite Care's Extended Family Residences provide resident-directed assisted living in a home-like environment. Embedded in their philosophy is a culture of mutual reciprocity, family involvement, and engagement of residents who might otherwise need to be in a skilled nursing facility due to high physical care needs or dementia.

Section 202 Supportive Housing for the Elderly is the only federally funded housing

program specifically for low-income seniors, although other subsidized housing programs do include older adults. Section 202 Housing provides secure, barrier-free, and supportive housing that can accommodate residents as they become more frail. Services commonly available include transportation, assistance with housekeeping and meals, and some social and health services, usually provided in partnership with other community providers. INDEX

CCRCs Without Walls — also called Continuing Care at Home (CCAH) models — are less expensive alternatives to "brick and mortar" Continuing Care Retirement Communities. Sometimes managed by staff affiliated with existing CCRCs, these home-based programs offer the continuum of care concept to community residents who do not wish to live in a CCRC or can't afford to, but who want access to services such as home health aides, visiting nurses, and transportation that could delay or even prevent the need to move away for care. Care Coordination is a key aspect of these community-based plans. Like CCRCs, there are both "Type A" and "Type B" continuing-care-at-home plans. Type A plans typically offer unlimited lifetime coverage and require up-front entrance fees ranging from $20,000 to $70,000, and monthly fees from approximately $250 to $800 per month. In Type B plans, the subscriber shares some portion of the financial responsibility for care and, as a result, fees are significantly lower. The entrance fee, which can be paid over time, is typically equivalent to the total fees for a full year and ranges from $3,000 to $7,000 depending on age at enrollment. Type B plans are especially appealing because subscribers don't feel as though they are paying for something that they may never use. Like the Village model, most CCRCs Without Walls seek to promote a sense of community through organized events, from exercise classes and book clubs to theater nights and museum tours. There are currently CCAH plans operating in ten states, including the District of Columbia. INDEX

Villages are consumer-driven, grassroots, membership-based organizations that empower older adults to remain active and engaged in their communities as they age. Villages offer members a network of resources, services, programs, and activities that revolve around community building; daily living needs; social, cultural, and educational activities; ongoing health and wellness; and member-to-member volunteer support. Ninety Villages are now in operation across the country. Villages average 150 members with annual membership fees ranging from $100-$1,200. INDEX

Age-restricted communities, also called senior retirement or active adult communities, provide market rate housing to healthy, active seniors, generally age 55 and older, who wish to live among their peers rather than in mixed-age communities. Supportive services are not provided, and residents may need to move should their health conditions change requiring more care.

Naturally Occurring Retirement Communities (NORCs) is a demographic term used to describe typical communities or neighborhoods where a large number of residents have

lived for a long time and have aged in place. AARP estimates that about 5,000 NORCs exist across the country; these concentrations of older adults can facilitate the organization of supportive communities. In some NORC communities, non-profit organizations have partnered with other agencies to create Supportive Services Programs (SSPs) that include social services, healthcare services, and socialization, recreation, and volunteer opportunities for residents. NORC SSPs are designed to be responsive to individual and community needs, and they depend on resident involvement and community partnerships to maximize success. INDEX

Accessory Dwelling Units (ADUs) are a type of housing created or added to a single family home or built separately on a lot. In-law units, "granny flats," and restored out-buildings are examples of ADUs. Consumers can lease and purchase ADUs (if their local zoning laws permit them) through such companies as MedCottages™,13 which provide prefabricated 12-by-24-foot bedroom-bathroom-kitchenette units that can be set up as a free-standing structure in a back yard and include state-of-the-art technology features.

Shared Housing is an arrangement in which a homeowner provides space for a tenant and, in return, receives income and/or needed assistance. It also includes individuals jointly sharing the housing expenses. Shared housing allows older adults to stay in their homes while benefitting from companionship, assistance, and mutual support. INDEX

Cohousing or Cluster Housing models create intentional neighborhoods by designing residential developments around shared and jointly owned common areas. Cohousing supports independence but promotes interconnectedness, mutual assistance, community interaction, and a degree of community management. Elder Cohousing communities are built by midlife to older adults and focus on the unique needs of this population.

Senior Cooperative Housing is a housing model popular in rural communities that provides apartments and townhomes that residents own and run cooperatively, although some hire a management company to assist in managing the property. Commonly owned amenities include a community room, kitchen, gardens, workshops, laundry facilities, and exercise room. There are usually a number of resident-directed social programs such as book club and gardening clubs, pot lucks, and games and activities in the common room. Like elder cohousing, because of density they make a good location for community partnerships that serve older adults, such as a congregate meal site or health clinics such as a flu vaccine site. INDEX

Community-Based Services are an integral part of the network providing critical services to older adults and invaluable support and respite for family caregivers.

- **PACE** (the Program of All-Inclusive Care for the Elderly) fully integrates Medicare and Medicaid financing as well as medical and social supports, with services delivered through Adult Day Health Centers and home care. About 20,000 people

in 29 states are served by PACE programs.

- **Hospice** is an integrated, end-of-life medical/social model that supports families with a full range of skilled home health care and supportive services when a person is diagnosed with a terminal illness and has a life expectancy of six months or less. Hospice benefits are usually covered under Medicare, Medicaid in most states, insurance plans, as well as private pay, depending on individual circumstances. INDEX
- **Senior Centers** provide a wide array of services, including socialization/civic engagement opportunities, information and assistance, meals and nutrition counseling, transportation, options counseling, wellness programs, etc., often at very low cost or even free for qualified seniors. Over 60 percent are delivery sites for Older Americans Act programs and services. Many senior centers are reinventing themselves to appeal to a broader range of community residents. The country's 11,000 senior centers serve 1 million older adults every day.
- **Adult Day Centers** provide a range of services for older adults. Social centers provide meals, recreation, and some health-related services. Medical/health centers provide social activities as well as more intensive health and therapeutic services. Specialized centers provide services to specific care recipients, such as those with diagnosed dementias or developmental disabilities. Adult Day Centers also serve as sites for Chronic Disease Self-Management Programs. About 4,600 adult day centers across the country serve over 260,000 people. INDEX

Innovative Community Models

- **Mather Lifeways Café Plus** model serves up fun and educational, wellness-related programs and activities in pleasant café surroundings. The Café Plus model has been appealing to senior centers looking at new ways to attract older adults.
- **Episcopal Senior Communities Senior Center Without Walls** program is a nondenominational free telephone program connecting California elders through activities, friendship, and community. From the comfort of their homes, participants can access an assortment of classes and support groups, when going to a community senior center is difficult. INDEX
- **The Living At Home Network** in Minnesota coordinates local volunteers, health professionals, and a wealth of other resources to help older residents stay in their own homes and connected to their communities.

Innovative Grassroots Support and Caregiving Models represent an innovative wave of services and programs to support seniors living in their homes and their caregivers. These models harness the social capital within the community and utilize the individual assets of people willing to volunteer their assistance to provide care.

- **Share the Care** brings together friends and family in an organized network to provide supports and services for people who are chronically ill, terminally ill, or

disabled.

- **Lotsa Helping Hands** provides a free, Web-based service that develops communities for organizing circles of community during times of need. INDEX
- **TimeBanks** represents "pay it forward" models that allow members to perform a service for another member, in the process earning a "time dollar" that can be redeemed for an hour of time volunteered by another member.
- **Tyze Networks** provides private online communities centered around one person needing friendship, support, and connection.
- **The Transition Network's Caring Collaborative** provides member-to-member volunteer support for health-related needs. INDEX

Susan Poor, M.P.H., is the Director of Innovation and Business Development at On Lok in San Francisco. She is a specialist in community approaches to aging, the Village model, long term services and supports (LTSS) for older adults, end-of-life care, family caregiving, health care reform, and managed care. Prior to joining On Lok, Susan worked with the Village-to-Village Network to replicate Villages nationwide. As Owner/Principal of Susan Poor Consulting, she worked with local governments and nonprofit providers on a wide range of aging and health-related projects. Susan is a Founder and Board Member of San Francisco Village, Co-Chair of the San Francisco Long Term Care Coordinating Council, and West Coast Director of Outreach for Share The Care. In her work with On Lok and the Village movement, Susan is a leader in focusing attention on the LTSS needs of middle-income seniors. Susan can be reached at susan@susanpoor.com or spoor@onlok.org.

Second Journey, Inc.
4 Wellesley Place, Chapel Hill, NC 27517
(919) 403-0432
Second Journey [at] frontier [dot] com

Second Journey, Inc. is a tax-exempt nonprofit corporation.

Resources ~ Newsletter ~ Mission ~ Books ~ Contribute ~ Join Us

Notes

1 See "The Roseto effect: a 50-year comparison of mortality rates" at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1695733/.

1 Henry Cisneros, Margaret Dyer-Chamberlain, and Jane Hickie, eds., *Independent for Life: Homes and Neighborhoods for an Aging America* (Austin, TX: University of Texas Press, 2012).

2 *Independent for Life*.

3 *Independent for Life*.

4 Helman, R., et.al., "The 2012 Retirement Confidence Survey," Employee Benefit Research Institute, March 2012. (accessed August 31, 2012).

[5] Teresa Ghilarducci, "Our ridiculous approach to retirement," *New York Times*, July 21, 2012.(accessed August 31, 2012).

[6] MetLife Mature Market Institute, "Market survey of long-term care costs" (New York: Metropolitan Life Insurance Company, October 2011). (accessed August 31, 2012).

[7] Wisconsin Coalition for Person Directed Care. www.wisconsinpdc.org.

[8] Pauline Chen, "When doctor's advice is ignored at home," *New York Times*, March 10, 2011. (accessed August 31, 2012).

[9] Julianne Holt-Lunstad, Timothy B. Smith, and J. Bradley Layton, "Social relationships and mortality risk: A meta-analytic review," *PLoS Medicine*, July 10, 2010. (accessed August 31, 2012).

[10] Michele Heisler, "Building peer support programs to manage chronic disease: Seven models for success" (California HealthCare Foundation, December, 2006).

[11] MetLife Mature Market Institute.

[12] See thegreenhouseproject.org.

[13] See medcottage.com/index.php.