California HealthCare Foundation

There's No Place Like Home:
Models of Supportive Communities for Elders

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Prepared for
California HealthCare Foundation

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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

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I. Introduction

California's older adults, like seniors across the country, want to remain in their homes and communities as long as possible.[1–3] More than 89 percent of those over age 50 want to remain in their own homes as they age, according to AARP, as do 95 percent of those over 80.[4]

Those who do "age in community"—also referred to as "aging in place"—can benefit in terms of their health and longevity. Seniors who maintain active social relationships and connections in the community may decrease their risk of institutionalization by almost one-half, according to one study.[5] A 2006 study showed that having close friends and staying in contact with family members offers a "protective effect against the damaging effects of Alzheimer's Disease."[6] Other research indicated that community approaches to aging delay institutionalization and the need for residential care such as assisted living.

These findings are crucial to California's long term care system as demographic projections point to rapid growth of the 65 and older population between 2010 and 2050. This age group will grow from the current rate of nearly 12 percent to almost 20 percent of the total population by 2050.[7] By 2049, all of the baby boomers—individuals born between 1946 and 1964—will be 85 or older.[8]

This report examines the trends impacting the California's seniors and the long term care system and identifies innovative models that provide access to the components needed to support community living. Successful aging within the community requires economic security, adequate and affordable housing, and access to health care. Critical components include:

- Medical services;
- Preventive care;
- Emotional support;
- Health insurance or funds to cover personal assistance;
- Long term supports and services (LTSS);
- Caregiving support;
- Transportation;
- Social capital (support from and connections with trusted family, friends, and community organizations that provide practical assistance); and
- Opportunities for engagement as a result of meaningful activities.

II. Trends Affecting Seniors

It can be difficult and costly to integrate the critical components within the often fragmented service delivery system. While changing demographics are behind the push for community-level innovation, many other trends frame the experience of aging that the baby boom generation faces.

Population Shifts

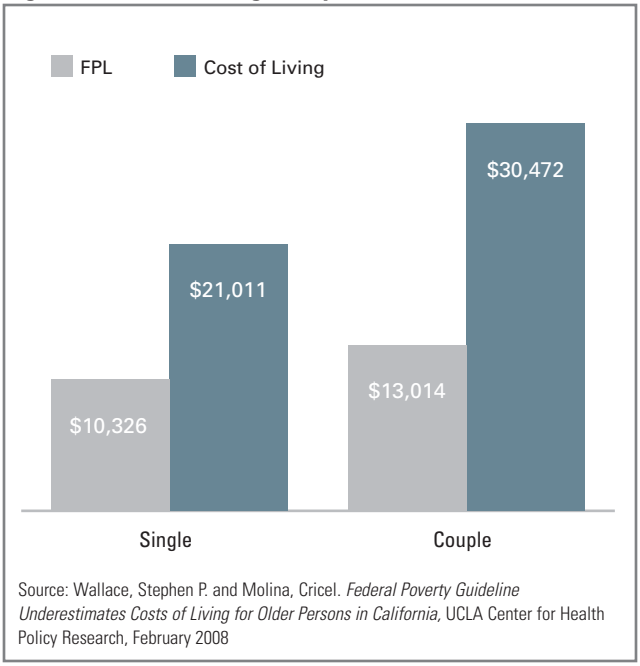
The fastest growing age group both nationally and in California are those 85 and older, the group most likely to need extended care at home or in skilled nursing facilities.[9,10] Due to changes in ethnic and cultural diversity, by 2040 over half of the state's 65 and older population may be foreign born or immigrant.[11] This trend will require careful attention to cultural competence and sensitivity in the delivery of long term services and supports.

Economic Security

Seniors as a group are not financially secure in the current economy. There are 6.6 million Americans age 65 and older in the workforce today, but the nearly half a million who choose to re-enter the workforce are having difficulty finding jobs. This is more than five times the level earlier this decade, and is this group's highest unemployment level since the Great Depression. Many have lost their jobs, incurred high debt, obtained second mortgages, and seen their pensions and 401(k)s decline in value. The age to obtain full Social Security benefits has increased from 65 to 66 for those born after 1942.[12]

The level of poverty for the 65 and older age group has increased because of the downturn in the economy. In the United States, the 2008 median annual income was about $20,000 to $25,503 for males and $14,559 for females.[13] Over 8 percent of Californians age 65 and older have incomes below the 2008 federal poverty level (FPL) of $10,326 for a single person and $13,014 for two people.[14] An additional 677,000 California seniors living alone or with a partner struggle to survive on incomes above the FPL but below a higher, more realistic measure of economic security, the Elder Economic Security Index (EESI).[15] These are individuals who do not qualify for Food Stamps, Medi-Cal, Medicare, or subsidy programs because eligibility is based on the FPL.[16] Using the EESI, the basic annual cost of living for a retired older adult or couple with good health in rental housing in California averages at least twice the FPL—$21,011 for an individual and $30,472 for a couple.[17]

Figure 1. Cost of Living Compared to FPL, 2008



Source: Wallace, Stephen P. and Molina, Cricel. *Federal Poverty Guideline Underestimates Costs of Living for Older Persons in California,* UCLA Center for Health Policy Research, February 2008

The Institute on Assets and Social Policy maintains that more than half (54 percent) of all senior households do not have the financial resources needed to meet median projected expenses. This estimate is based on current financial net worth, projected Social Security, and pension incomes.[18] Homeownership is the most common source of privately held assets, but with the current market decline borrowing equity may not be an option.

Table 1. Annual Income of Seniors Age 55 and Older as Percent of Total Population, 1999

ANNUAL INCOME	PERCENTAGE OF TOTAL POPULATION
Under $15,000	19%
$15,000 to $49,000	40%
$50,000 to $99,000	26%
$100,000 and above	15%

Source: California Department of Aging. *California State Plan on Aging.*

Programs with low-income eligibility based on the FPL ignore the majority of elders living above the FPL but below what they need to make ends meet. Of the 25 most populous California counties, 20 have EESIs that are 200 percent of the FPL or greater, and the average of all county EESIs for the state is 222 percent of the FPL ($22,709). Low-income single seniors with incomes between 130 percent of the FPL ($13,500) and 155 percent of the FPL ($16,000) are the most vulnerable, even if they receive housing assistance. Without housing assistance, these older adults are unlikely to meet more than 70 percent of their economic needs.[19]

Further, when combined with food and rent, long term care costs exceed median income in all 58 of California counties. In 38 counties, the cost of long term care combined with basic living expenses for elderly single women living alone is twice the median income for this group.[20]

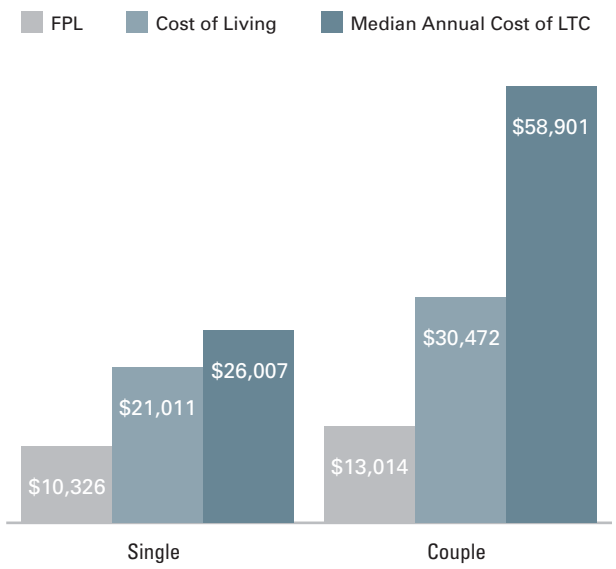
Housing

Stable, adequate, and affordable housing is a critical element to aging, but is often overlooked in discussions of long term services and supports. Three-quarters of Californians age 65 and older are homeowners. Of this group, 26 percent live alone and 42 percent have a disability. Nearly 10 percent are living below poverty levels and 31 percent are women living alone.[21] Older adults age 75 and older are more likely to be female, to live alone, and to be renters. Of all Californians living alone, nearly three-quarters (72 percent) are older women.[22]

While many seniors own their own homes, they may not be able to afford LTSS and cover the costs of maintaining a home (i.e., property taxes, utilities, and basic maintenance). These individuals must often choose between their home and securing funding for LTSS because they typically cannot afford both. The most common scenarios are either spending-down to Medicaid or using home equity to cover LTSS costs. For very low-income populations, housing is rapidly becoming an unaffordable option without significant assistance. Depending on the level of care required, the UCLA Center for Health Policy Research estimates that the median cost of community-based long term care in California, coupled with the Elder Economic Security Index, ranges from $26,007 to $58,901 per year.[23]

Nationally, senior housing assistance programs available through the federal Department of Housing and Urban Development (HUD) serve just 10 percent of the low-income elderly population with a housing burden (paying more than half of annual income on housing costs). HUD's Section 202 Supportive Housing for the Elderly rates highly among participants for the quality of the housing, the presence of Service Coordinators in many properties, the availability of congregate dining and communal spaces for social and recreational

Figure 2. Cost of Home- and Community-Based Long Term Care, 2008



Source: *Home- and Community-Based Long Term Care Package Costs, California, 2007.* UCLA Center for Health Policy Research.

activities, and the relationships with other providers to provide assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).[24] Individuals eligible for Section 202 must have incomes up to 50 percent of the area median family income, which is adjusted for household size. Research indicates that residents in HUD 202 projects are primarily elderly women living alone with annual incomes between $5,000 and $15,000. Currently demand exceeds supply; average waiting lists are up to two years. Research shows that for every low-income elderly household assisted by HUD programs, five others are unassisted because HUD has not been funded to keep up with the demand for its housing units.[25] In addition to Section 202 support, low-income seniors may quality for Housing Choice Vouchers (Section 8), public housing, or Low-Income Housing Tax Credits.

There are several housing options for older adults who wish to move out of their homes to live in a supportive setting; they are listed below from most to least independent.[26] Because Medicaid does not cover room and board charges for residential facilities, these options require adequate income to cover buy-in as well as rental and/or monthly fees.

- **Senior age-restricted apartments** are usually for those healthy and active seniors age 55 and older or 62 and older and follow HUD regulations allowing for such "age discrimination." If the restriction is 55 and older, at least one person in the apartment must be at least 55 and the apartment community must have no more than 20 percent of all residents under the age of 55. If the restriction is 62 and older, all residents must be at least 62. Residents buy their homes and belong to community associations that handle property maintenance and other operational issues. They do not provide support services or health care.
- **Continuing care retirement communities (CCRCs)** provide an independent lifestyle with a continuum of care as a resident's health changes. The community offers access to coordinated social activities and dining services. Most CCRCs require a one-time entrance fee and monthly service fees. There are 79 operational CCRCs in California with about 20,000 residents.[27]
- **Residential care facilities** are also called community living, board and care, assisted living, congregate housing, independent living facilities, or residential care for the elderly (RCFEs). They help people who do not need skilled nursing and are able to live independently with limited assistance. There are about 7,900 board and care facilities in California with approximately 90,000 licensed spaces and an overall occupancy rate

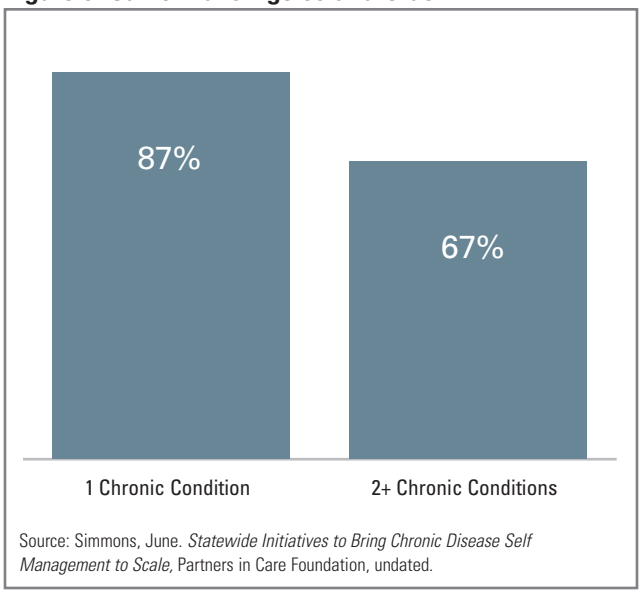
of about 80 percent.[28] The economic downturn has negatively impacted occupancy, making it difficult for potential residents to sell their homes to obtain the financial resources needed to move into residential settings.

- **Nursing homes or skilled nursing facilities** house about 115,000 Californians on any given day, with 316,532 total admissions in 2005, down 4 percent from 2000. The majority of nursing home patients are 75 and older, female, and white. More than half the care received in California nursing homes is paid for by Medi-Cal. Payments by individuals account for less than 20 percent of revenue.[29]

Health Status

Today's senior population has less disability but more chronic disease than previously, research shows.[30] With improved health and longer lifespans, older adults will tend to experience chronic progressive conditions rather than episodes of injury and sudden death. Eighty-seven percent of persons 65 and older have at least one chronic condition, and 67 percent have two or more.[31] Older adults are disproportionately affected by chronic diseases, which account for 70 percent of all deaths and 75 percent of all health care expenditures.[32] Forty percent of deaths in the U.S. are due to modifiable risk factors, primarily smoking, obesity, and lack of physical exercise.[33]

Figure 3. Californians Age 65 and Older



Source: Simmons, June. *Statewide Initiatives to Bring Chronic Disease Self Management to Scale,* Partners in Care Foundation, undated.

Long Term Supports and Services

The aging of the baby boomers will more than double the number of people 65 and older with disabilities, many of whom will require long term care.[34,35] If nursing facility use rates remain at 2004 levels there will be more than triple as many nursing facility users in 2050.[36]

From 1998 to 2004, nursing home occupancy rates in California declined by 3.5 percent even as the size of the older population increased. This corresponds to increased use of residential care and home-and-community-based services.[37] While most Americans age 65 and older are covered by Medicare, only 10 percent have long term care insurance to cover nursing home or home care.[38] Others are paying for needed services themselves, covering these services through Medigap insurance, and/or using informal caregiving arrangements with family and friends. Of the 1.5 million Californians who received Medicaid long term care services in 2005, only 5 percent benefitted from home-and-community-based waivers. Twenty-two percent benefitted from personal care services through the California's In-Home Supportive Services Program.[39] Currently, 1.1 million Californians are eligible for both Medicare and Medicaid.[40] Medicare is their primary insurance, with Medicaid covering the services Medicare does not, such as nursing home stays and home- and community-based alternatives.

Demand for long term supports and services will increase, both for skilled nursing facility care and for

home- and community-based services. Finding the right balance between institutional and community-based care will be important, as will ensuring that seniors have the financial means to purchase what they need and that services are available and affordable. An estimated 20 percent of nursing home residents could live in the community if appropriate supports were available.[41]

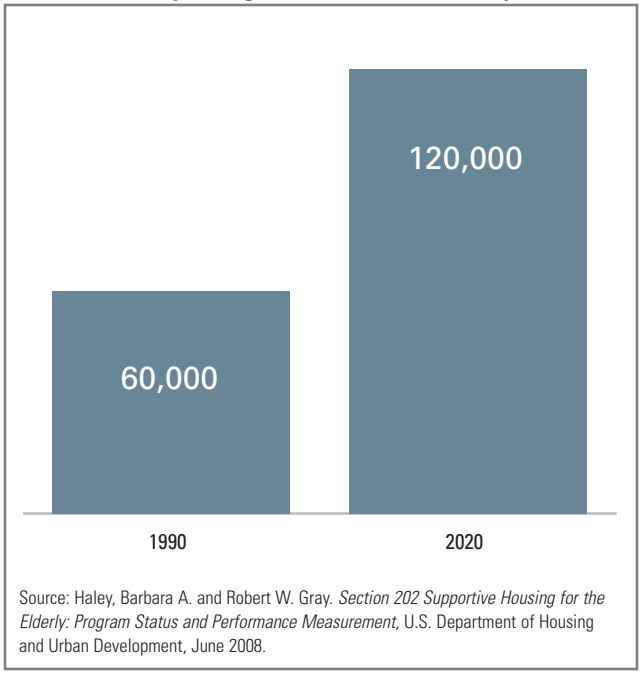
Family and Informal Caregiving

About 44 million Americans provide 37 billion hours of unpaid, "informal" care each year care for adult family members and friends with chronic illnesses or conditions. This care includes such activities as bathing, managing medications, preparing meals, and other activities of daily living. Family caregivers, particularly women, provide over three-quarters of the caregiving support in the U.S. Seventy-eight percent of adults receiving long-term care at home rely exclusively on family and friends to provide assistance. In 2007, the estimated economic value of family caregivers' unpaid contributions was at least $375 billion, which is what it would cost to replace that care with paid services.[42]

Research predicts decreases in informal long term care capacity because of fewer children, higher labor force participation among women, and greater longevity of aging parents. In addition, when grown children are divorced, widowed, or remarried, they have less ability to provide assistance with aged parents.[43] When families turn to paid professional support, the costs are staggering. In FY 2005, the national average cost of one year of private pay nursing home care was $70,000. The vast majority of Americans are not prepared for such costs.

Twenty percent of the population over 65 is childless. By 2020, the number of older adults living alone in the community without living children or siblings will reach 1.2 million, doubling the number reported in 1990. Nearly half of those who reach the age of 85 and live in the community will have some disability that requires assistance. By 2030, an estimated 25 percent of adults age 70 to 85 will lack the availability of informal family caregivers. Because spouses and grown children are the typical sources of informal care, help will be needed from a broader range of family members if available.

Figure 4. Californians Age 65 and Older without a Family Caregiver, 1990 vs. 2020 Projection



Source: Haley, Barbara A. and Robert W. Gray. *Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement,* U.S. Department of Housing and Urban Development, June 2008.

III. Programs and Waivers for Services

Like many states, California has a number of programs and waivers through which it provides alternatives to nursing homes for beneficiaries who qualify based on income or functional status.

- **PACE, the Program of All-Inclusive Care for the Elderly,** is an integrated, interdisciplinary program for individuals 55 and older who are eligible for Medicare, Medicaid, or both. PACE serves individuals who are certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Services include all medical and supportive services, adult day health care, home health and personal care, prescription drugs, social services, respite care, and hospital and nursing home care when necessary. Five California programs operate 17 sites in the state and serve about 2,500 clients.[44]
- **The In Home Supportive Services (IHSS) Program** is part of California's Medicaid state plan and serves about 400,000 adults per year. It is a consumer-directed program that provides assistance with Activities of Daily Living and Instrumental Activities of Daily Living and is not limited to people who are eligible for nursing home services. About 60 percent of clients are over age 60.[45]
- **The Multipurpose Senior Services Program (MSSP)** provides case management to adults 65 and older who would otherwise need to reside in a nursing home due to functional limitations. MSSP serves about 13,000 clients throughout the state.[46]
- **Adult Day Health Care (ADHC)** serves individuals age 18 and older who have one or more chronic or post-acute conditions, have limitations in two or more ADLs, or lack adequate family or caregiver support. ADHCs have both medical and social components and serve 40,000 to 50,000 beneficiaries per year.[47]
- **The Assisted Living Waiver** was approved in 2005 and renewed in 2009 for another five years. Targeting adults age 21 and over, the waiver has to date served approximately 200 people transitioning from skilled nursing to residential settings.[48]
- **The AIDS Waiver** annually serves about 2,500 persons with limitations in two or more ADLs.[49]
- **The In-Home Operations Waiver and Nursing Facility Acute Hospital Waiver** provide case management and other services to beneficiaries requiring a nursing level of care.

Together, the IHSS program, PACE, and the waiver programs serve about 475,000 people a year. By design and to control costs, the waiver programs are limited in the numbers of people they can serve. IHSS was cut significantly during budget negotiations in 2009, but the cuts are being legally challenged by several consumer advocacy groups. Efforts are underway to have ADHC become a permanent Medicaid benefit.[50]

IV. Models for Aging in Community

At the heart of aging in community is a focus on seniors as "drivers of their own destiny" rather than simply being recipients of services. In a community approach, seniors are active participants in the planning and implementation of services and activities. As consumer preference continues its shift toward person-centered care and individual choice, the creation of models that support people in their own homes will become a critical aspect of state and local planning.

Several aging-in-community models are briefly described below. These approaches share some elements, but also have unique aspects that set them apart as innovative strategies to community approaches to aging.

Naturally Occurring Retirement Communities (NORCs)

In their simplest form, NORCs are communities or neighborhoods where residents have lived for a long time and have aged in place. Typically, a community is defined as a NORC when at least half of the residents are 60 years old, but there is variation in this definition nationwide. NORCs can be found in urban, suburban, and rural communities. Vertical NORCs may exist in apartment or condominium buildings, while streets, blocks, or neighborhoods of single-family homes can make up a horizontal NORC. Regardless of the location, community members have sought to organize social, recreational, and wellness activities. While not created as part of an intentional community for seniors, NORCs have evolved as home to older residents who by preference or necessity are aging in place.

Taking the NORC concept further, federally funded NORC Supportive Services Programs (NORC-SSPs) were created to provide access to and coordination of a range of necessary services and supports that allow seniors to age-in-place. A NORC-SSP is essentially a partnership between key community service stakeholders: government, residents, service providers, and philanthropy organizations. It is a program that operates as part of a larger nonprofit organization that incorporates guidance from a Consumer Advisory Board or similar resident advisory group. The model promotes healthy aging, independence, and community-building through a multifaceted approach. The key elements are: case management and social work services; health care management and prevention programs; education, socialization, and recreational activities; and volunteer opportunities for program participants and the community.[51]

The first NORC program began in 1986 in New York City.[52] Today, United Hospital Fund (UHF) hosts the NORC Blueprint Project, an online resource that fosters connections to on-the-ground experience from experts and facilitates dissemination of information on best practices and models for planners, funders, policymakers, and others as they work to create NORCs. According to the UHF there are about 80 NORC-SSPs across the United States, including 27 programs in New York City (local government programs), 14 programs funded by New York State, and 44 programs that are federally funded through Administration on Aging funds and the U.S. Department of Housing and Urban Development (HUD).[53]

Through the United Jewish Communities federally funded Aging in Place Initiative, California NORC-SSPs have been established in Sacramento, San Diego, Alpine, and Los Angeles counties.[54]

Research on the NORC model pointed to increased socialization and reduced social isolation among older adults. Participants tended to feel healthier and were more likely to stay in the community.[55]

Living At Home/Block Nurse Programs

The Living At Home/Block Nurse Program (LAH/BNP) was started in 1981 by six women of the St. Anthony Park neighborhood in St. Paul, Minnesota. Today the nation has more than 40 of these neighborhood associations, most located in Minnesota. Under the leadership of one of the six original founders, Marjorie Jamieson, R.N., the LAH/BNP, Inc. was established in 1987 as a nonprofit organization in Minnesota. The Elderberry Institute, created in 1997, functions as the outreach and education arm of the LAH/BNP. It is currently building LAH/BNP communities in Texas, North Dakota, Wisconsin, and Ohio. Other states are considering the model as well.

The purpose of the LAH/BNP is to enable seniors to remain secure in their own homes. Located in both urban and rural neighborhoods, the LAH/BNP uses a nonprofit organizational structure to coordinate neighbors and customize services in small geographic areas. A volunteer network maximizes the strengths of the community members.

The process of being involved in these endeavors is itself a benefit, reducing social isolation with its increased risk for morbidity, mortality, cardiovascular disease, dementia, and Alzheimer's disease.[56] Volunteering has been associated with higher levels of well-being and improved mortality rates among older adults and poor self-rated health is a risk factor for hospital admission and nursing home placement among older adults.[57]

LAH/BNPs are self-governing nonprofit organizations that are managed for and by residents within each program's geographic boundaries and overseen by a community board. Rather than duplicating existing services, LAH/BNPs use all available volunteer services to the greatest extent possible, supplementing them with outside resources when necessary. In 2007–2008 the price per individual in the LAH/BNP in Minnesota was $46 per month.[58]

Volunteer services include social visits, telephone check-ins, small home repairs/maintenance, lawn/garden maintenance, transportation, paperwork assistance, social outings, and coordinated social activities. Services coordinated with outside organizations include Meals on Wheels, housekeeping, adult day care and senior center activities, respite support, legal and financial assistance, health assessments and basic preventive care through a Medicare-certified nursing agency, and public health education workshops. A program nurse works with elders to identify health issues, determine whether health services are necessary, consult with other providers such as physicians and social workers, and provide referrals and evaluate health issues. If it becomes necessary, the program partners with a nursing agency or other community provider to transition a member to home health aide support, a skilled nursing home, or hospice care.[59]

Villages

Villages are grassroots, membership-based, nonprofit organizations that provide support and community to residents who wish remain in their own homes or apartments as they age. They are self-governing and self-supporting, and are built by those who will lead and use them. Generally at least half of Villages' board of directors are also members.

Villages are financed by a combination of membership fees, fundraising dollars (from foundation grants, individual donations, event income, corporate sponsorships), and in-kind support. Members pay monthly or annual dues, which cover staffing and operational costs. Villages also offer reduced fee memberships to those for whom the regular fee is a barrier to membership. To date, no Village has been able to cover its full operating budget with membership fees alone.

Currently there are 48 fully operational Villages in the country and over 100 communities developing the Village model. The first Village in the U.S. was established in 2001 by the Beacon Hill Village in Boston.

There are several Villages in California and many more in development:

- Operating Villages in Northern California include Avenidas Village in Palo Alto, Avalon Village in Alameda, and San Francisco Village covering the City and County of San Francisco.
- Those in development include Marin Village, Pt. Richmond Village, Ashby Village, North Oakland Village, and the Northeast Exchange Team in San Francisco's Telegraph Hill community.
- Operating Villages in San Diego include Tierrasanta Village and the Concierge Club of ElderHelp of San Diego.
- Developing Villages in Los Angeles include WISE & Healthy Aging/City of Santa Monica Village, Westchester-La Playa Village, and Mar Vista Village.

Villages serve as a point of connection, a service broker/consolidator, and a caring community for members, who can call a central phone number for whatever they may need (the concierge concept). The model is designed to support the medical, functional, emotional, social, and spiritual needs of older adults. Village goals include the promotion of healthy aging and engagement with people of all ages. Villages are intentionally neighborhood-based to promote a sense of community. Four program/service areas include day-to-day practical support and assistance; social, cultural, and educational activities; volunteer opportunities; and health and wellness programs. Some programs and services are free with membership and some are fee-based, many with discounted fees for Village members. Services and programs are provided by partner organizations, small businesses, vendors/providers recommended to and screened by the Village, and member-to-member volunteer assistance. In addition to offering their own services and programs, Villages help their members access existing programs.

With a grant to NCB Capital Impact, The SCAN Foundation in Long Beach is continuing to support the development of the Village model in California. NCB Capital Impact will undertake the following tasks:

- Pilot six Villages — two each in San Francisco, San Diego, and Los Angeles — and provide technical assistance for Village start up and growth;
- Expand knowledge throughout the state on the viability of the Village model for replication;

- Develop information technology and software technical assistance tools to help Villages effectively manage sustainable organizations; and
- Create a data-collection tool to inform future research and evaluation of the Village model's impact on the lives of older adults, public policy issues, economic development, and community building.

Senior Cohousing

Begun in Denmark during the 1970s, cohousing moved to the U.S. in the early 1990s after being made prominently visible by U.S. architects Kathryn McCamant and Charles Durrett. While not exceptionally popular in America, cohousing has a growing base of interest. Several senior cohousing communities are in the planning stages in California.

The underlying components of cohousing include community engagement, communal design features, resident management, common facilities, private multifamily units, lessened impact on infrastructure, and lower energy costs. Senior cohousing takes the existing co-housing model and reshapes it for an older audience. Families, younger individuals, and seniors live in cohousing that facilitates community and services to seniors and families. Cohousing is generally more affordable than conventional housing due to the multifamily nature of the units, but also because a core focus of cohousing is to control costs. Cohousing units tend to be studio, one-bedroom, and two-bedroom accommodations. Buildings are clustered, and therefore use less land. Shared water or gas mains and laundry facilities use less energy.

As cohousing is resident-led, volunteer groups may be established to provide aid to seniors, and some services may be contracted out to service providers. Senior cohousing communities may include optional studio residences in or near the common house to provide living quarters for service provides/home health aides, allowing for partial or full 24-hour services provision. Most senior cohousing is designed for ease of access for all levels of physical ability.

Senior Cooperative Housing

In this model, housing is cooperatively owned by seniors, typically in multifamily living arrangements and controlled by the residents. Similar to cohousing, senior housing cooperatives include substantial community spaces for gathering and community engagement. Some cooperatives may even include light housekeeping and meal service as amenities.

Residents decide which support services are necessary for their cooperative community. They may elect to use a volunteer service coordinator within the cooperative, or employ an onsite residential services manager. Another option is to have services provided by a community partner, like a local services organization. Typically, basic support services include social activities, housekeeping and maintenance of common areas, pot-luck and delivered meals, transportation (most co-ops have vans driven by staff or a qualified resident), and shopping. Personal and home care are arranged, at a cost, with outside providers.[60]

There are several senior cooperative housing communities in California, particularly in the Yolo County area, some with housing for lower-income adults.

V. National and State Policy

MANY OF OUR NATIONAL AND STATE SYSTEMS are not ready for the changes that will be affecting the senior population. The following areas are worthy of policy attention.

Economic Security and the FPL

Economic simulations point to a growing "underclass" of baby boomers that may increase the demand for publicly subsidized services. By 2030, 4 percent of those age 65 and older will have incomes at 150 percent of the federal poverty level ($15,489 in today's dollars), but will not qualify for programs in which eligibility is based on the federal poverty level. The use of FPL as the guideline for Medicaid eligibility is widely acknowledged as outdated. It is based on a 1950s estimate that families spend about one-third of their income on food. Its value is increased by the Consumer Price Index—which does not accurately reflect the spending patterns of older adults—and it does not vary geographically.

Nationally, as well as in California, other states, and in local communities, the Elder Economic Security Standard Index (EESI) is being explored as a more accurate measure of income adequacy and economic security for determining eligibility for publicly subsidized service programs. The EESI benchmarks basic costs of living for elder households, taking into account geographic variability, household size, and expenses for mortgage/rent, transportation, food, and health care—without public or private assistance.

Legislative efforts are underway to replace the FPL with the EESI in mandated state and local needs assessments and in determining eligibility for needs-based programs. The Elder Economic Dignity Act of 2009 (AB 324) included this requirement. It was vetoed by Governor Schwarzenegger on October 11, 2009.

Limitations of Home- and Community-Based Services

Currently, seniors who qualify for Medicaid Home and Community Based Services (HCBS) must meet Medicaid's income and frailty eligibility criteria. The state of California uses the Medicaid HCBS category to define waivered services that provide assistance with activities of daily living (ADLs) to individuals in home settings, outside of institutions.

Seniors who don't qualify for these services include those with incomes ranging from just above Medicaid eligibility to upper middle-income levels ("tweeners") and those who have deteriorating chronic conditions but are not yet classified as frail (having impairments in at least two activities of daily living).

With only about 10 percent of seniors having long term care insurance, individuals' ability to pay for long term supports will vary.[61] Some will be unable to afford long term supports, some will be able to pay for a portion of what they need, and a few very wealthy people will be able to pay in full. Without some support, seniors have little choice but to "spend down" their assets to qualify for Medicaid, creating additional costs to the state. Spending down entitles individuals to medical care and, if frail enough, nursing home placement or participation in Medicaid HCBS. However, several HCBS programs (IHSS, ADHC, Linkages, Caregiver Resource Centers, California Department of Aging programs) have been drastically reduced due to California's

budget crisis. The average private-pay cost of a nursing home stay in California is $6,600 a month or $79,200 a year.[62]

Federal Support for Expanded Home- and Community-Based Services

There are a number of national movements that are seeking solutions to expand home- and community-based services to address the fragmentation of human services.

One of these is Project 2020 — Building on the Promise of Home- and Community-Based Services Act of 2009 (S. 1257/H.R. 2852). Project 2020 is intended to take to scale evidence-based initiatives underway in California and other states in three critical areas:

- **Single point-of-entry (SPE) systems.** SPE systems are based on the Aging and Disability Resource Center model that has been tested in California and 48 other states and territories. The goal is to reduce the fragmented information systems that seniors confront when trying to learn about programs and services available to them.
- **Evidence-based health promotion and disease prevention programs.** These have been piloted by the Administration on Aging in California and 23 other states, and have resulted in fewer outpatient and emergency department visits and fewer hospitalizations. They have also reduced lengths of stay, and made more appropriate use of health care resources.
- **Nursing home diversion programs.** The goal of these initiatives is to help consumers most at risk of spending down to Medicaid. They provide a consumer-directed option allowing consumers to purchase services and supports to remain independent as long as possible.

Project 2020 is funded through federal dollars and state matching funds. An independent analysis of Project 2020 by the Lewin Group estimates that California would be able to serve more than 1.6 million residents over five years through Project 2020 and would accrue over $105 million in net savings to the state budget over the same time period, while reducing federal Medicaid and Medicare costs by approximately $2.8 billion. At least one of the health reform proposals under consideration by Congress includes Project 2020's three components.

The CLASS Act

The Community Living Assistance Services and Support (CLASS) Act of 2009 creates a national, voluntary insurance program for purchasing community-living supports and services. The program allows for voluntary pre-financing of long term care through payroll deductions, and then provides a cash benefit to purchase services. CLASS Act benefits may be accessed by individuals 18 and older unable to perform two or more activities of daily living. Covered supports include non-medical expenses, such as housing modifications, assistive technologies, transportation, and personal assistance services. Individuals do not need to be Medicaid-eligible to participate in CLASS coverage. Two of the three health reform proposals under consideration by Congress include the CLASS Act.

Policy Considerations

Innovative healthy aging policy reform could identify ways that "spend down" can be avoided and ensure older adults can be supported before they become frail; this requires cost-effective, community-based interventions that focus on housing, home safety, transportation, health and wellness, chronic disease management, physical activity, nutrition, and social supports. Most of the emerging aging-in-community

models are consumer-driven, grass roots initiatives with no public funding. They are committed to making aging a shared community responsibility. While these initiatives are launching with relatively healthy participants/members and with support from membership fees, donations, foundation grants, and corporate sponsorships, it is unclear what will be required to sustain them over time as members' health declines.

Possible policy directions could include the following:

- Support development of a "safety net" for non-Medicaid-eligible seniors, building on public-sector initiatives already underway. Such an approach would leverage resources in the public and private sectors and use Villages, Block Nurse Programs, and other models to enhance information and referral services, promote evidenced-based chronic disease self-management programs, and help delay Medicaid spend-down.
- Explore potential linkages between emerging aging-in-community models and publicly funded programs and services such as affordable and supportive housing, Community Development Block Grant funding, Medicaid, Older Americans Act programs, Aging and Disability Resource Centers, local AAA's, and state units on aging, community health centers, and other initiatives.
- Explore potential linkages between emerging aging-in-community models and for-profit and nonprofit private-sector initiatives that could focus on health care advocacy, care management, transportation, and other needs.

VI. Conclusion

The quickly growing population of seniors faces tough issues as retirement income from investments and 401(k)s dwindle, along with home equity. The challenges related to traditional financing, organizing, and delivering of long-term supports and services provide a framework to discuss innovative solutions.

The aging-in-community models described in this report offer seniors, communities, and state and local governments plausible solutions. With a growing consumer preference to remain within one's own home and neighborhood, the likelihood of more seniors seeking innovative solutions will increase. At the core of the aging-in-community models are the benefits of choice, independence, a strong sense of community, and greater physical well-being. The needs, interests, and preferences of seniors are given priority because the initiatives are led by and for seniors themselves.

State governments faced with budgetary pressures and affordable housing challenges may find that these innovative aging-in-community programs offer an opportunity to leverage local long term care social capital networks to provide long term care and decrease reliance on costly institutional settings.

Appendix: Community Approaches to Aging, Organization/Program Profiles

PROGRAM	SERVICE AREA	GOVERNANCE/ STRUCTURE	START DATE	MODEL/ ANNUAL FEES	ENTRY AGE	TARGET POPULATION	NO. OF MEMBERS	STAFF	DIRECT SERVICE VOLUNTEERS	FUNDING
Free-Standing Nonprofit Villages										
Avalon Village	Alameda Island	• Independent nonprofit • 7-member BOD • 12-member Advisory Committee	2009	Membership Model • $250/person • $450/household • $150/person reduced fee	55+	Independent/ moderately independent seniors/adults	21	• FT Executive Director • PT Volunteer and Service Coordinators (10 hrs/wk each)	25	• Organizational fundraising • Corporate donations • Member fees
San Francisco Village	City and County of San Francisco	• Independent nonprofit • 11-member BOD • 14-member Advisory Council	2009	Membership Model • $600/person • $750/household • $100/$150 reduced fee	No age limit	Independent/ moderately independent seniors/adults	110	• FT Member Services Coordinator	35	• Foundation support • Member fees • Organizational fundraising • In-kind support
Westchester Village Network	Cities of Westchester and Playa Del Rey, Los Angeles County	• Independent nonprofit (not yet operational) • 8-member BOD (currently)	2010	Membership Model • Anticipate $500/person and $750/household • $100 reduced fee	55+	Independent/ moderately independent seniors/adults	None	None	None	• Foundation support • Anticipate member fees and organizational fundraising
Village Variation										
Concierge Club	San Diego County	• Program of ElderHelp of San Diego, a 36 year-old nonprofit organization providing services and information to seniors. No separate governance structure. • Volunteer Advisory Board • Council of Caregivers	2008	Volunteer-based, Fee-for-Service Model. • Members purchase up to 7 services/month for set fees ranging from $55 to $285/month ($660 to $3,420/yr). • Services are free for members with annual incomes below $2,000/month ($24,000/yr).	65+	Middle and higher income populations ElderHelp has traditionally served lower-income members focusing on those with compromised health, little support, and some with higher levels of disability.	130 5,000 served by all ElderHelp programs	• FT Executive Director • Associate Executive Director • Member Services Manager • Business Manager • Volunteer Services Manager • 4 Care Managers • 2 HomeShare Coordinators	350 Serve all ElderHelp programs	• Foundation support • Federal, state, and local government support • Member fees • Organizational fundraising

PROGRAM	SERVICE AREA	GOVERNANCE/ STRUCTURE	START DATE	MODEL/ ANNUAL FEES	ENTRY AGE	TARGET POPULATION	NO. OF MEMBERS	STAFF	DIRECT SERVICE VOLUNTEERS	FUNDING
Villages that are Programs of Larger Organizations										
Avenidas Village	Primarily Palo Alto and nine adjacent towns in San Mateo and Santa Clara Counties	• Program of Avenidas, a 40 year-old, nonprofit, multiservice senior organization. • 20-member Advisory Board with link to Avenidas Board of Directors	2007	Membership Model • $825/person • $1,050/household	55+	Independent/ moderately independent seniors/adults; some frail adults, who also receive services from Avenidas	300	• FT Village Director • FT Member Services Manager	400 Serve for all Avenidas programs	• Avenidas Foundation support • State and local government support • Member fees • Organizational fundraising Initial support from Avenidas Capital Venture Fund. By 2010, member fees will cover costs
WISE & Healthy Aging City of Santa Monica Village	City of Santa Monica	• Will be part of WISE & Healthy Aging (WISE), a large nonprofit multiservice organization serving L.A. County. • WISE BOD has a Programs and Strategic Planning Committee and the Village will have a Steering Council.	2010	Membership Model (not yet operational) • Fees/structure to be determined	50+	Middle and higher income populations WISE has traditionally served lower-income clients who range from healthy, active and well-supported to those who are less healthy and more isolated.	None (at time of publication) WISE serves more than 50,000 people/year through all of its programs.	Anticipate one FT Village Manager/ Coordinator	300 Serve all WISE programs	• Federal, state, and local government support • Membership fees
NORC										
Living Independently in a Friendly Environment (LIFE) Program	Park La Brea, Los Angeles	• Program of Jewish Family Services of Los Angeles (JFSLA), a 155 year-old, multiservice nonprofit serving L.A. County • 25- to 50-member Steering Committee of providers chaired by a JFSLA BOD member • 8-member Advisory Council with a representative on the Steering Committee	2004	Membership Model • $25/person All residents are able to participate in programs regardless of ability to pay. Scholarships available for very low income participants.	60+ per NORC federal funding guidelines	All residents age 60+ who reside in the gated Park La Brea community	450 Total; $150 dues-paying members	FT Program Manager and Social Worker	30	• Foundation support • Federal government support • Member fees • Organizational fundraising • In-kind support

PROGRAM	SERVICE AREA	GOVERNANCE/ STRUCTURE	START DATE	MODEL/ ANNUAL FEES	ENTRY AGE	TARGET POPULATION	NO. OF MEMBERS	STAFF	DIRECT SERVICE VOLUNTEERS	FUNDING
Cohousing Movement										
East Bay Cohousing Group	Berkeley, CA	10-year-old group formed as an umbrella group to help people build sustainable communities and cohousing. Managed by two group leaders.	1999	Volunteer-based Social Action Initiative • $100 fee for sustaining members (Free to those who can't afford it.)	35+ age not tracked	Independently active seniors/ adults; relatively healthy but with a minimal support network	15 400 active participants	No paid positions at present	24 assist with meetings/events	• Member fees • Organizational fundraising • In-kind support • Event fees
Community or System Change Initiatives										
Contra Costa for Every Generation (CCEG)	Contra Costa County, CA	Independent nonprofit advancing a countywide effort to make Contra Costa communities aging-friendly. • 7- to 10-member BOD • Four volunteer initiative groups: housing, transportation, health care/wellness, neighborhoods and communities	2007	Volunteer-based Social Action Initiative • No membership fees	55+	Independent/ moderately independent seniors/ adults; all health status categories	NA	FT Executive Director	50 active, 100 semi-active	• Foundation support • Organizational fundraising • In-kind support
San Francisco Partnership for Community-based Care and Support (SFP)	San Francisco, CA	Cooperative/ collaborative effort among organizations to improve the provision of long term care and supportive services for adults. SFP was staffed by Project Director with Steering Committee. Project Director now staff member of City's Department of Aging and Adult Services.	2004	Community Planning Initiative • No membership fees	18+	Independent/ moderately independent seniors/ adults; young disabled; low-income (home care initiative); all health status categories	70 member organizations	FT Project Director/ Manager	None Not a volunteer model	2004–2008: RWJ Community Partnerships for Older Adults Initiative After 2008: • Foundation support • Local government support • Organizational fundraising • In-kind support

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