Sage Commission NORC Workgroup Final Report

May 13, 2013

Draft Report Sage NORC Workgroup

Creating Communities that Support Aging in Place

Executive Summary

As the over age 65 population in the Finger Lakes Region increases to 21% of the total population by 2030, a growth rate roughly comparable to the national experience, the public policy agendas at the federal, state, and regional levels focus on strategies to meet seniors' health care needs effectively and efficiently, mindful of consumer preferences to age in place and committed to achieving quality outcomes.

In this context, emerging strategies emphasize re-balancing the health care system from a disproportionate reliance on institutional care, in terms of Medicare and Medicaid expenditures, to greater investment in community-based services that embrace health education, prevention, early diagnosis and treatment, and management of chronic disease within seniors' own homes as long as possible. This strategy includes an integration of the provision of social support programs such as transportation with healthcare into an overall strategy of wellness and successful aging. Key to the success of this strategy is a mechanism whereby seniors can gain knowledge of and be connected to healthcare and social support programs.

Among the programs that give strong evidence of success in supporting this goal is the Naturally Occurring Retirement Community (NORC). This report shares the experience of five NORCs in highly populated Monroe County, New York and two NORC-like models that have been adapted at the grass roots level to serve two sparsely populated rural counties in New York, Chemung and Steuben, all part of the Finger Lakes Region.

The intent in sharing this information is to highlight the successes of the NORC program in supporting aging in place, while identifying some of the challenges that hinder the program from reaching their full potential.

It is hoped that this information will influence regulatory modifications to enhance program viability, encourage other communities to implement similar programs, and illustrate the program's promise in making a valuable contribution to health care reform in New York State.

Appendices to the report provide useful considerations and guidance from established NORCs and NORC-like models to those exploring the possibility of implementing these programs in their communities.

I. The Problem:

The perfect storm is upon us. The first of the baby boomers have begun to turn 65 at the same time that the economy has been experiencing the worst turmoil since the great depression. With 8,000 baby boomers reaching 65 each day, by 2030 all the baby boomers will have reached 65 and will comprise 19% of U.S. the population.[1]

"In the Finger Lakes Region, the older adult population is expected to increase by 38 percent from 2007 to 2025 – and will then comprise 21% of the region's population."[2]

Both the federal government and New York State recognize that public costs of health care for elders and those with chronic illnesses are not sustainable and current expenditures do not result in adequate quality outcomes for the current level of spending.[3] A recent report by Milken Institute ranked Rochester 28th among 100 large Metro Areas in the U.S. for "successful aging."[4]Rochester can and should do better!

"Contrary to the common perception that elders move to retirement communities, those 65-85 are the population least likely to move.[5] According to AARP, "Nearly 90% of adults 65 and over want to age in place, and 80% believe that their current residence is where they will always live. However, for older adults to age in place, their physical and service environment must be accommodating. The AARP report concludes that "without increased consideration regarding how communities are constructed and how services are delivered, older adults may find it difficult to live in their communities and may have to consider institutional care."[6]

The data which follows will show that while the population is rapidly aging, nearly half of seniors own their own home, but have limited annual income. The majority of people report themselves in good to excellent health, even though most have some type of disability. Thirty six percent of elderly women and 18% of elderly men live alone. As people age they are at increased risk of accidents and declines in their health status. As boomers age, there will be a concurrent decline in the availability of caregivers. Nonetheless, the data will show that the rate at which people are using institutional care is declining. Taken together, these factors demonstrate the need for more robust community based services which will allow people to age at home with community support services which they can afford when informal resources are not available or sufficient.

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[1]U.S. Administration on Aging. "A Profile of Older Americans: 2011."
[2]Sage Commission's 2020 Plan for Aging Services 2011. P.6
[3]NYSDOH.A Plan to Transform the Empire State's Medicaid Program..p.1.
[4] Milken Institute. "The Best Cities for Successful Aging." July, 2012.
[5]VNS of New York Center for Home Care and Policy Research. "Best Practices: Lessons for Communities in Supporting the Health and Well Being of Older People." 2003.
[6] AARP Public Policy Institute. "In Brief: Aging in Place: A National Survey of State Livability Policies and Practices."

The information which follows will demonstrate that Naturally Occurring Retirement Communities provide cost effective models of social support that allow neighbors to support neighbors age in their own homes with minimal investment. By using minimal staff and public resources, such programs have the potential to be important partners for managed care organizations. NORCS provide access to healthcare and social support services by providing a repository of information about available community services and a means of connecting to those services. NORCS encourage seniors to remain both socially engaged as well as engaged in maintaining their health. Opportunities for volunteering, as well as health education, wellness and social activities are designed to prevent health and functional decline while preventing avoidable hospitalization and emergency department use while reducing the demand on formal health care personnel and reducing health care per capita costs.

II. Putting the Problem in Context

A. Housing & Environment

Forty-six percent of those 65 and over in the Finger Lakes Region own homes, with a median value of $110,000 and a median income of $44,000. Of those who are 85 and over, 40% own homes, but their median income is$23,300.[7] These data indicate that many elders have relatively low incomes, but value in their home.

Housing for many elderly is more than simply a residence. Many elderly have resided in their homes for most of their adult lives and their homes symbolize memories and independence. The growing number of elders means that there will be an increasing number of people choosing to age in place and therefore in need of supportive services. Lawton and Simon proposed that as individuals experience decline in their personal capacities, the role of environment becomes more important to helping them remain independent and functional[8].

American adults spend approximately an hour a day on home maintenance activities.[9]In order to remain in their homes, older people must complete routine home maintenance, the required home modifications to accommodate their changing needs. In 2011, Fausett assessed the home repair and maintenance needs of the elderly. The top three categories requiring assistance in the home according to the Fausett study were related to: mobility within the home (37%), indoor update/remodeling (32%) and home upkeep (16%) [10]To

[7]FLHSA. "Sage Commission Data Book."p. 21.
[8]M. Lawton. "Aging and Performance of Home Tasks." Human Factors. 1990, Vol32: 527.
[9] Lawton. Op.Cit.
[10]C. Fausset, A. Kelly, W. Rogers, A, Fisk. "Challenges to Aging in Place: Understanding Home Maintenance Difficulties." Journal of Housing for the Elderly. 2011, Vol. 25: 125.

complete tasks that were too challenging, Fausset found that 54% of older people reported they were likely to outsource the work.[11]

B. Safety

Housing and environment are major contributing factors to the safety of older people. Falls are among the top safety concerns for the older population. About one third of the older population falls each year, and the risk of falls increases with age. Over half of seniors age 80 and older fall annually[12].

"From 2005-2007, more than half of all falls among New Yorkers' who were hospitalized as a result of a fall, fell at home.[13] During this same period there were on average 14,800 fall related hospital discharges per year among upstate New York older adults[14] The average annual charges for fall related hospitalizations of people 65 and older in the FLHSA region from 2004-2010 was $72M. Over this period charges rose 46%.[15]

C. Isolation

While not all people who live alone are isolated, it is important to know that thirty-six percent of women over 65 in this region live alone, compared to 18% of men. [16]After retirement the rate that individuals remain involved in their community dwindles. As they venture out less, they may become more socially isolated. As people age, they are more prone to disability and less inclined to take part in leisure activities further compounding their isolation.[17].

D. Access to Services

Connecting the elderly with services and information about services often presents challenges. For many elderly the major challenges include the need for: information, transportation, and care coordination. "The National Household Survey asked people if they have a temporary or permanent condition that makes it difficult to travel outside the home.

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[11] Lawton. Op.Cit.

[12]Learn Not to Fall. How Falls Often Occur. 2012; Available at: http://www.learnnottofall.com/content/fall-facts/how-often.jsp

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[14]Excellus. "The Facts about Fall Incidence and Costs among Older Adults (age 65+) in Upstate New York." Fall, 2010.

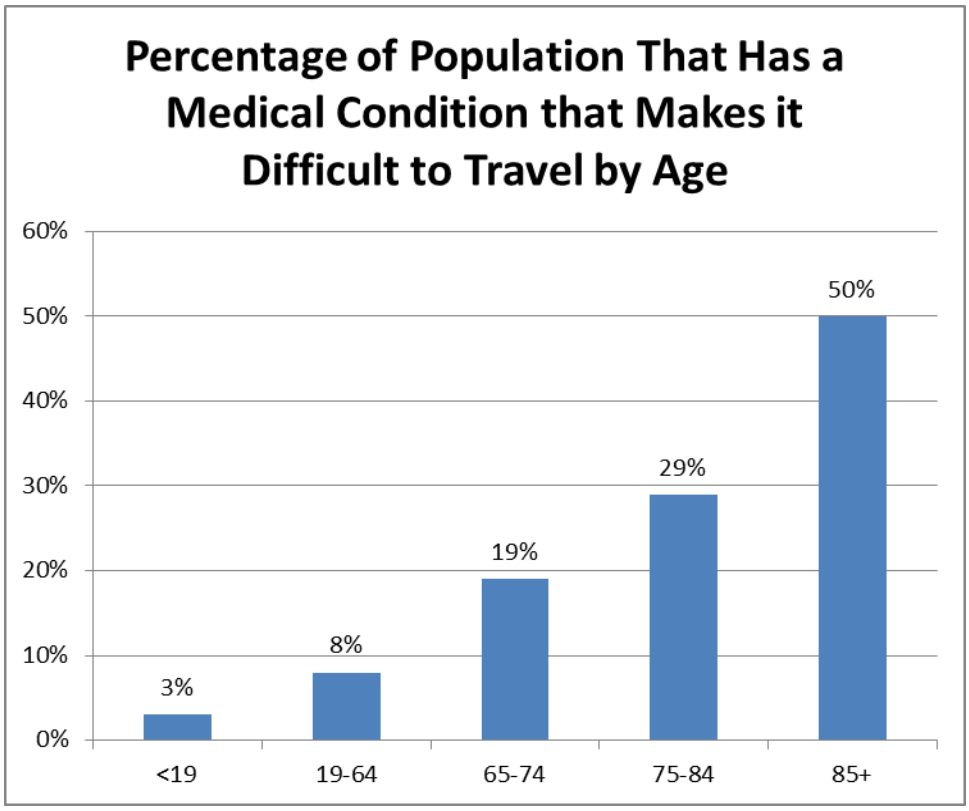
[15] SPARCS Inpatient Data Set: 2004-2010.

[16]FLHSA. "Sage Commission Data Book".

[17]New York State Department of Health. "Burden of Cardiovascular Mortality in New York State.2012; Available at: http://www/health.ny.gov/diseases/cardiovascular/heart_disease/docs/cvd_mortality.pdf.

As expected, the response is highly correlated with age. Half of those over 85 reported having a condition that makes travel difficult."[18]

Figure 1

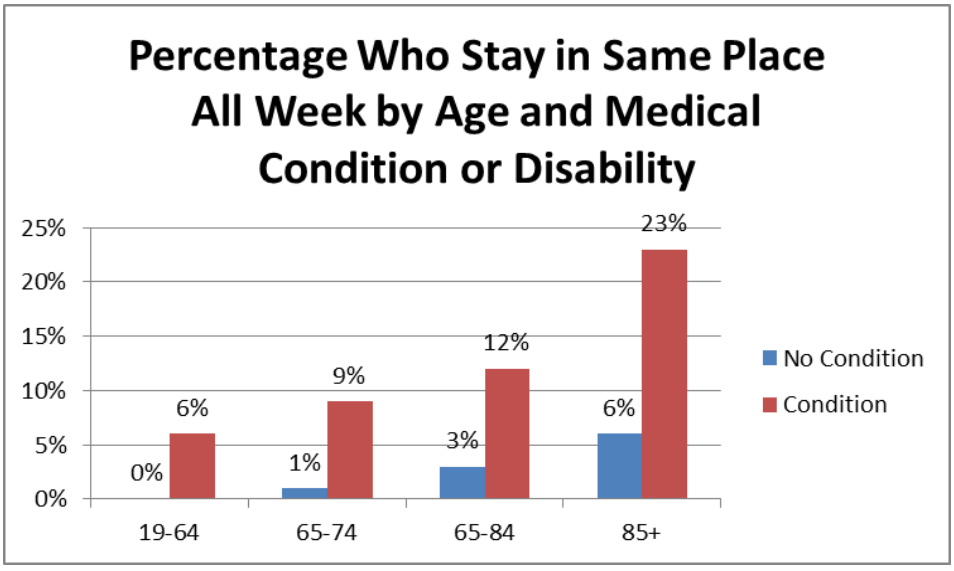


Source: National Household Travel Survey, December 2012

Not only does having a medical condition or disability make travel more difficult, the data from the same survey also finds that those with conditions which limit their travel are more likely to stay in the same place all week.[19] (See the figure below)

[18] Jeremy Mattison. "Travel Behavior and Mobility of Transportation Disadvantaged Populations: Evidence from the National Household Travel Survey." December. 2012. P.3.
[19] Ibid. p. 17.

Figure 2



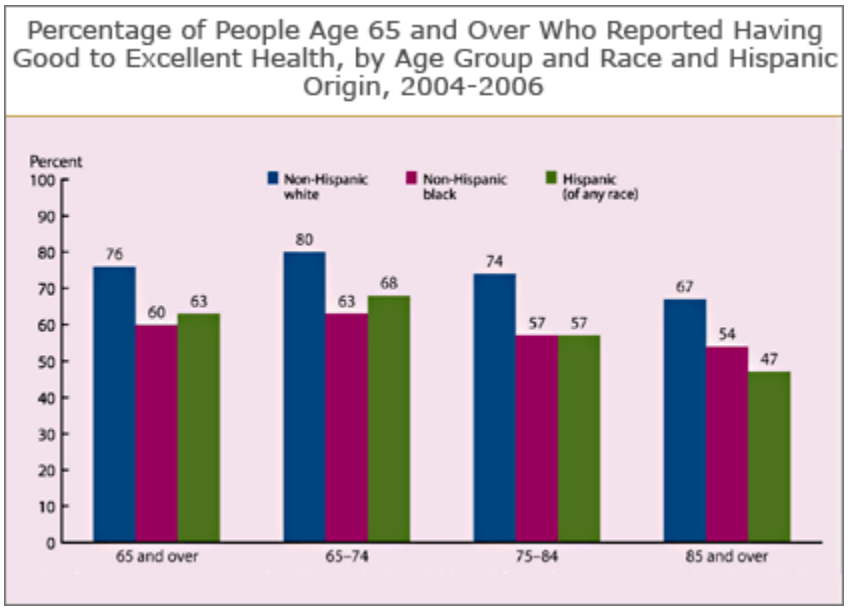
Source: National Household Travel Survey 2012

Because transportation can be the difference of people being able to get to the activities, shopping, and services they need, it is important to develop service delivery systems which can accommodate the expected decline in people's capacity to drive as they age. Such accommodations must be accessible, acceptable, and financially feasible.

E. Health and Functional Status

Self-reported health status is a reliable indicator of the population's health. [20] The chart below shows that while health status declines with age and varies across race/ethnic groups, over half of nearly all people, even those 85 and over, report themselves in good to excellent health.[21] Thus programs which support people maintain their highest level of wellness and function are important investments for a community.

Figure 3



Source: CDC National Health Interview Survey.

Regional data show that living in poverty puts an elder at higher risk of having poor health status. "Health status and health-care utilization data reveal that disproportionate burdens of chronic illnesses and premature death affect elders in the region who are poor, black or Hispanic, or who live in rural counties-- particularly in the Southern Tier. According to age-adjusted mortality rates for the region, black non-Hispanic elders have higher death rates for heart disease, stroke, diabetes, hypertension, and end-stage renal disease."[22] These data would be consistent with the variations in population health found in the National Health Interview Survey.

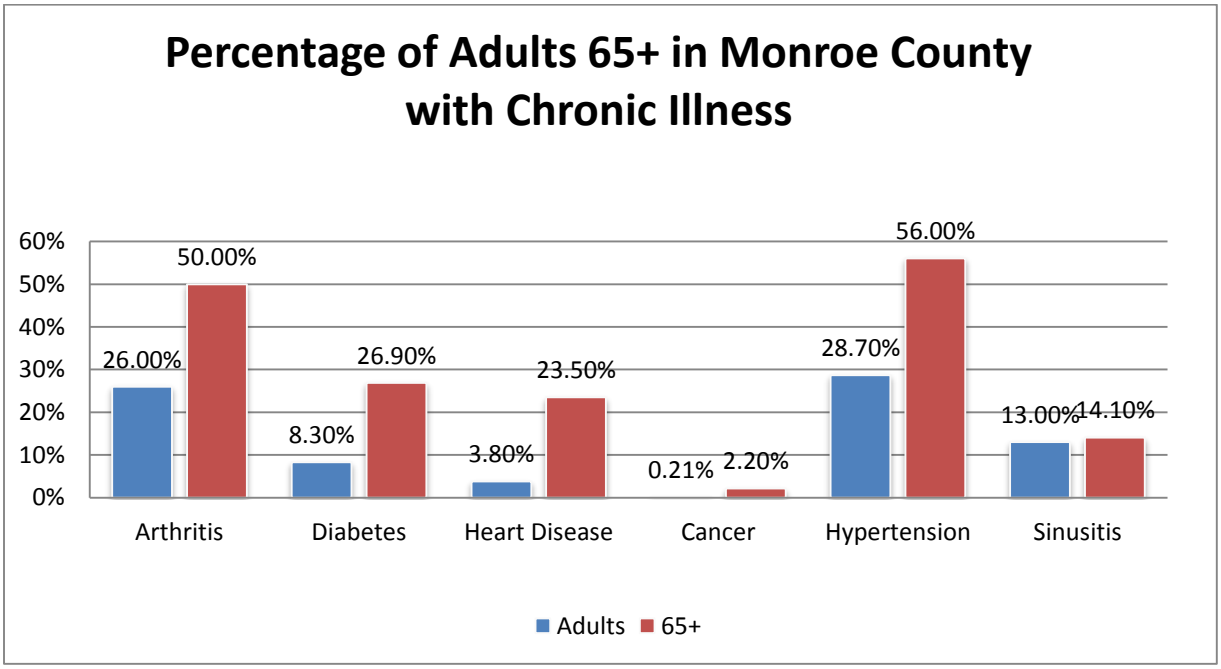
[20]J. Mossey, MPH, PhD, and E. Shapiro, MA. "Self-Rated Health: A Predictor of Mortality Among the Elderly." American Journal of Public Health." 1982. Vol. 72., No. 8, pp. 800-808.
[21]CDC. National Health Interview Survey.
[22]FLHSA .Sage Commission."2020 Plan for Aging Services." 2011. P. 7

Nearly 27% of community dwelling American older people require assistance with personal care due to physical/cognitive limitations. The number of elderly needing assistance with personal care increases as individuals' age.[23]

F. Chronic Illness

"Eighty percent of older Americans have at least one chronic condition and 50% have multiple conditions.[24] According to data from the Monroe County Adult and Older Adult Report Card, the most frequently occurring conditions are hypertension, arthritis, heart disease, cancer, diabetes and sinusitis (See Figure below).[25]

Figure 4



Source: Monroe County Adult Health Report Card. 2006.

[23]Urban Institute. B.S. Ormond. et. al "Supportive Services Programs in Naturally Occurring Retirement Communities." 2004.
[24]CDC. The State of Aging Health in America. 2007., p. 4
[25]Health Action. Adult and Older Adult Health Report Card. 2006; Available at: http://www.monroecounty.gov.ezpminer.urmc.rochester.edu/File/Health/september%2017%20version.pdf.

G. Health Care/Service Utilization and Cost

Fifteen percent of the American GDP (1.6 trillion dollars) was spent on chronic illness in 2009.[26]

In 2011, Deloitte estimated the total value for supervisory care to be $492B a year, more than three times the amount spent on nursing home care and home care($143B and $70B), with 80% of it falling on 2 person households with income less than $50,000.

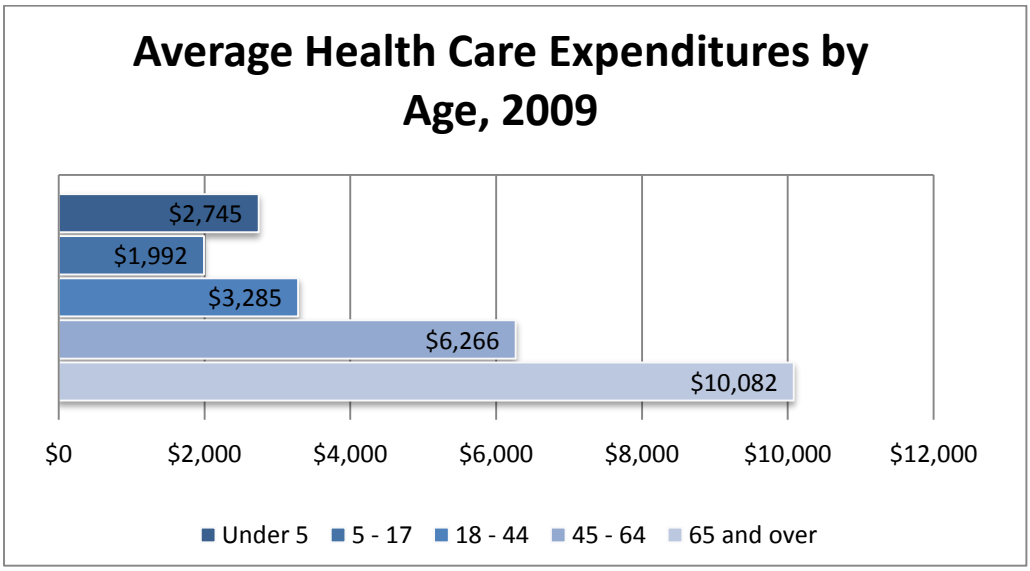
Of the total population aging in place that received long term care, only 16% (a value of $32 billion dollars) of the hours were through paid care, leaving 84% to be provided by informal caregivers. [27]

Less than 5% of long term care is provided by nursing homes. Between 2000 and 2009 nursing home bed availability for those 85 and over in the U.S. declined 27%, while nursing home occupancy rates declined 1%.[28] Thus while the nursing home bed capacity is 27% less per1000 "frail elders, overall nursing home utilization has remained virtually unchanged, illustrating the declining preference for this site of care. Of those who do use skilled nursing facilities, increasingly people are admitted for short rehabilitation stays and return home. These trends further underscore the need for robust support systems to care for people living in their homes who may have diminished capacities following a hospital or nursing home stay.

Nevertheless, the older American population does utilize health care at a significantly higher rate than the American population as a whole, and therefore incurs the highest annual health care expenditures of all groups (See Figure 5). For people 65 and older the cost of health care in 2009 averaged $10,082, with the highest expenses being incurred toward the end of life.[29]

Figure 5

[26]Monroe County. "Health Action: Adult and Older Adult Health Report Card." 2008.
[27]Deloitte and Touche. "The Hidden Costs of U.S. Health Care".2012 p. 4
[28]Nursing Home Compendium Report. 2010.
[29]Olmstead v L.C. and E.W. Supreme Court the Supreme Court affirmed the right of individuals with disabilities to live in their community. June 22, 1999.



Source:J. Pyles. Independence at Home; Reducing Medicare Expenditures with Better Health Care That Americans Want. 2008; Available at: http://webcache.googleusercontent.com/search?q=cache:P7ikWmyQ2EJ:www.ppsv.com/assets/attachments/IAH_5-Page_Sum9-

H. Decline in Available Caregivers

Between 2007 and 2025 the care-giver ratio (the ratio of women age 45-64 to people over 85) is projected to decline 15% in the FLHSA Region.[30] Minnesota has found that every 1% decline in family caregivers cost $30M in formal care services. The decreasing availability of the traditional informal care givers, as well as the unmet capacity in the formal work force that is discussed below, make it imperative that we make the most efficient and effective use of available personnel.

I. Changes in the Reimbursement System

The current way that health care is organized and delivered to older adults in New York State and the Finger Lakes Region is not financially sustainable.[3132] Historically, payment for long term care services has been biased toward institutional care, with the result that not all people who might elect to remain in their homes or the least restrictive/most integrated setting called for in the Olmstead Court Order, had the full array of community based options available to them. As New York State moves to develop and implement a plan to carry out the Olmstead decision, and as it moves to restrain the growth of publically funded health care costs with its Medicaid Redesign using managed care models for all, there will be

[30]FLHSA Sage Commission. "2020 Plan for Aging Services".p.6.
[31]FLHSA Sage Commission. "2020 Plan for Aging Services" May 2011 p.22.
[32]New York State Department of Health. Medicaid Redesign Task Force Recommendations. December, 2012. p.1.

a financial incentive to shift reimbursement to lower cost services which can substitute or delay the use of higher cost medical/health care resources.

To the extent this region can develop cost effective, neighborhood based services that will support people to remain in their own homes, with the support they need to maintain their health and functioning at their personal highest possible level, it will be possible under the newly emerging systems to achieve the goals of the Triple AIM: to improve the experience of the person, improve the health status of the community, and lower the cost of care.

J. Workforce Shortages Impacting Delivery of Community Based Services

The person that provides personal care and aide level services, whether in a person's own home, and adult care facility, or a nursing home, is probably the most important person in the provision of long term care services. These personnel are the foundation upon which the older adult, families, and formal long term care service agencies must rely for the consistent, high quality services for vulnerable people.

According to the Sage Commission's 2020 Plan for Aging Services, this region will need an additional 2852 full time equivalent aide level personnel by 2025. The need for personnel is expected to decline in the institutional sector and will increase for home and community based services. Because the roles and responsibilities are quite similar, and because personnel often are forced to seek part-time employment from multiple employers, and health systems would like to be able to have the option of having aides follow the patient across care settings, the Sage Workforce workgroup has been developing an alliance that would support the development of a dually trained (home health aide, and certified nursing assistant) workforce to expand the capacity of the future aide workforce.

IV. New York State Funded NORCS

A. Key Elements

Naturally Occurring Retirement Communities (NORCs) are apartment buildings, housing complexes or neighborhoods which were not originally built for seniors but which have evolved into enclaves of elders as people chose to age in place. There are various definitions

for NORCS based on the source of their funding. NYS funds two types of NORCS: NORC-Supportive Services Program (NORC-SSP) and Neighborhood Naturally Occurring Retirement Communities (NNORC).

To qualify for funding in NYS, NORC-SSP must meet the following criteria:[33]

- Be an apartment building or housing complex constructed with government assistance;
- Was not originally built for older people;
- Does not restrict admission to older people;
- Have 50% of the units be occupied by a person who is elderly, or have at least 2500 elderly residents;
- Have majority of the residents with low to moderate income as defined by HUD.

To qualify for funding in NYS as a Neighborhood NORC (NNORC) a program must meet these criteria:

- Have a residential dwelling or group of dwellings in a geographically-defined neighborhood;
- Have no more than 2000 people who are 60 and over reside in at least 40% of the dwellings;
- Consist of low-rise buildings six stories or less in height, or single/multi-family homes not originally build for elderly people;
- Does not restrict admission strictly to elderly people.

NORCS must be operated by not-for-profit organizations specializing in housing, health, or human services. Programs must offer supportive services such as coordination, case assistance, case management, and other services that may include: counseling, health assessment and monitoring, home delivered meals, transportation, socialization activities, and home care facilitation. NORC services are customized to meet the identified needs of the community.

The NORC model promotes healthy aging, independence, and community building through a multifaceted approach. Each NORC provides a "basket of services" based on the priorities the resident advisory board establishes.

There is a minimum of paid staff, supplemented by volunteers who are recruited, deployed and overseen by staff. As NORCs evolve they typically begin by offering social services, health care management, education, recreation and volunteer opportunities. To those core

[33]NYSOFA. NORC and NNORC Issues 3-2011.

components, some programs have added adult day care, meals, transportation, home care, legal and financial advice, home safety improvements, mental health counseling and chronic disease self-management.

All NORCS include the essential element of community partnerships, which typically include: the resident members, housing partners, home care and social services providers, local businesses and volunteers.

NORC-SSP programs are required to match state funds and 25% of the match must come from the housing development or owners. By the 5th year, NNORC programs must provide a 50% match of state funds and continue to do so in subsequent years of the contract. Waivers can be made available to programs that serve low income communities or have other hardships.

B. History

In 1986 the first NORC was developed in NYC in response to needs of large concentrations of older adults in Penn Hills South apartments. Using a mix of philanthropic funds and support from the housing complex, a new service program that integrated housing, social services and health services was developed.

In 1994 the NYS state legislature identified an increasing need for services for frail older people residing in certain apartment buildings and housing complexes. To address the need, NORC –Supportive Services legislation was enacted "to assure access to services intended to help seniors maintain their independence, improve their quality of life, and avoid unnecessary hospital and nursing home stays."[34] In its initial year, eight of the ten projects funded were in New York City. One of two Upstate projects funded was sponsored by Family Services of Rochester for Rochester Crossroads and Keeler Park Apartments. (The original Rochester NORC evolved into Andrews Terrace NORC now operated by Catholic Family Center/Elder Source)Priority was given to NORC-type programs that were already in existence and funded through private sources.

Funding for neighborhood NORCS (NNORCs) was authorized in 2005. In 2006 nine projects were funded including 2 in Monroe County- Fairport Baptist Homes' Good to Grow Old Program and the Jewish Family Services of Rochester Home Base Program. Two Catholic

[34] New York State Office on Aging. Naturally Occurring Retirement Community Supportive Services Program Report." 1995, Executive Summary.

Family Center/Elder Source programs, King's Court and NNORC at Rochester Highlands. were funded in 2007.

Today 54 NORCS operate in NYS serving moderate to low income housing developments and neighborhoods. NORCS have been started in 25 other states, and the model is being tested by the Administration on Aging's "Community Innovations for Aging in Place Demonstration Program." Another model for aging in place, referred to as the Village Model, is also expanding across the U.S. Additional information on this model, started in Boston's Beacon Hill, is found in Appendix C.

C. Monroe County Experience

Rochester has 5 NORCs (two in apartment complexes and three in neighborhood settings, technically called NNORCS – Neighborhood Naturally Occurring Retirement Communities) which serve 420 people. Chart A briefly describes the size of the population in each of the areas served, the penetration rate of the 60 and older population served, and the percentage of the housing units occupied by people over 60.

Chart A

General Information								
Program Sponsor	Program Name	Total Popula-tion	Nos. People 60+	% 60+ Popu-lation	Number and Percent Unduplicated People Served in 2011	Hous-ing Units	60+ Units	% Units 60 +
Catholic Family Center/Elder Source DOR	Andrews Terrace and Keeler	541	221	40.8%	83 37.6%	526	211	40%
Catholic Family	NORC at	852	164	19%	81 49.4%	504	140	28%

Center/Elder Source DOR	Rochester Highlands							
NNORC								
Catholic Family Center/Elder Source DOR	Kings Court	821	341	42%	5315.5%	400	187	47%
Fairport Baptist Home Community Ministries	Good to Grow Old	2520	699	28%	118 16.9%	1281	524	41%
Jewish Family Service of Rochester	Home Base at Ellison Park NNORC	500	175	35%	85 48.6%	386	125	33%
Total		5234	1600	30.6%	420 26.2%	3097	1187	38.3%

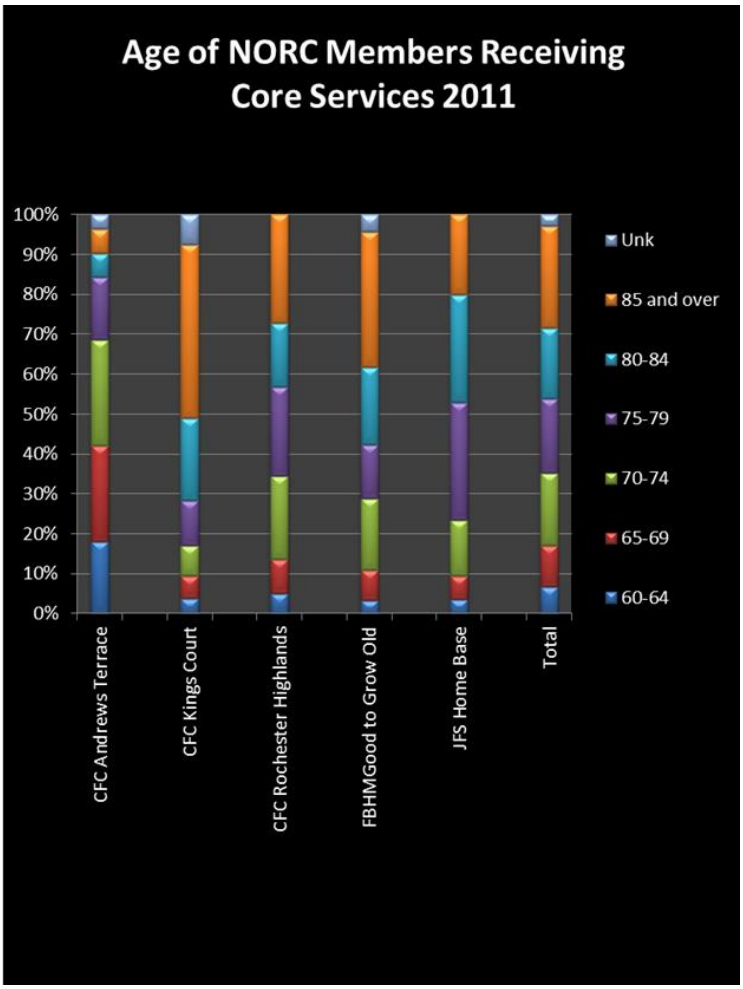
Another 400 people are supported by a NORC like program operated in Fairport. Fairport Baptist Homes' Senior Options for Independence program (SOFI) provides supports and services, to enable residents 60 and older in the town of Perinton to successfully age in place utilizing the same strategies employed by NYS funded NNORCs SOFI, is funded by the local community and does not have the geographic or age density requirements of a NYS funded NORC.

Profile of Monroe County NORC Participants:[35]

Monroe County NORC data indicates that 45%[36] of those served by NORCS in the 2010-2011 program year were 80 or older. Nonetheless, the data shows variation in the ages of the populations served across programs, with Andrews Terrace having a much younger population, and Kings Court having an older population than the other programs

Figure 6

[35] Source: Data are drawn from annual reports. Each agency submitted a copy of the 2011 Program Year Data which they had submitted to New York State Office for Aging.
[36] Percentage is based on 97% of the population for whom age was known.



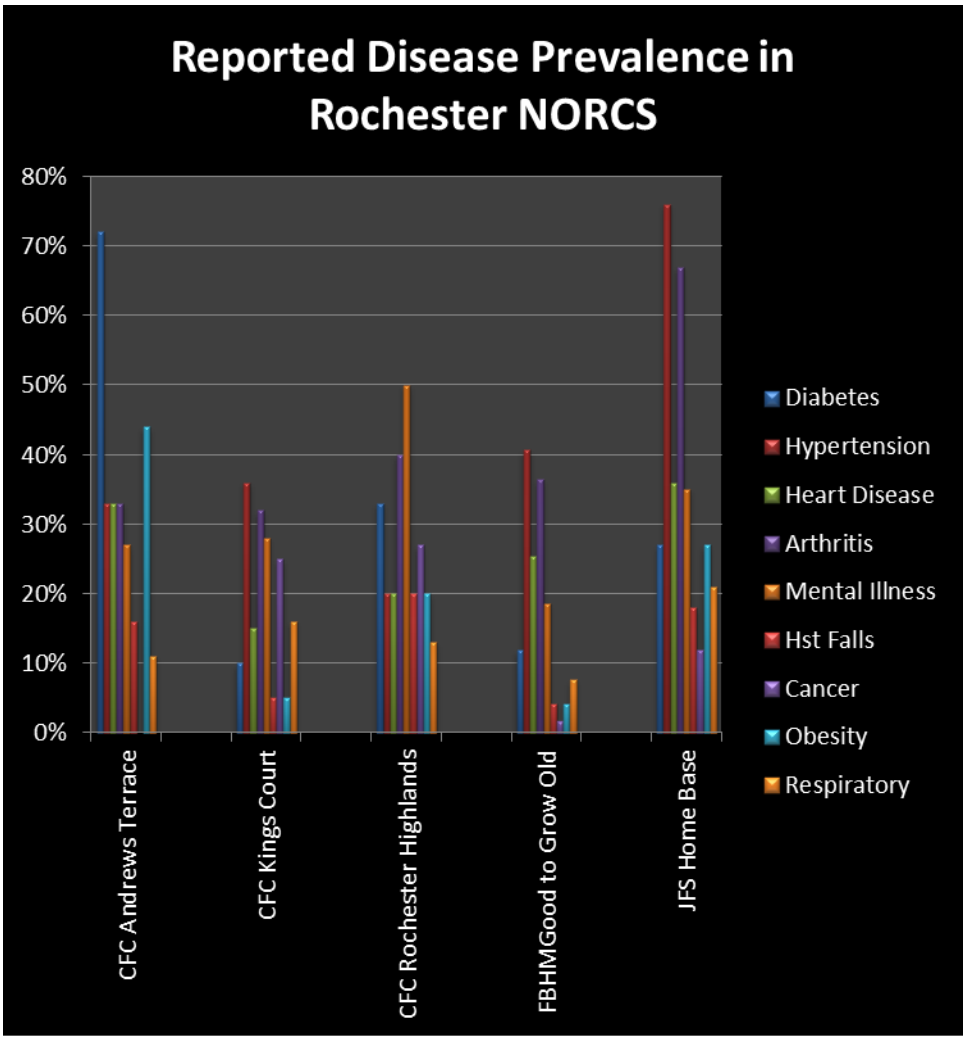
Andrews Terrace and Rochester Highlands were the only populations which were racially and culturally mixed. Andrews Terrace and Rochester Highlands serve people whose primary languages include Spanish, and American Sign Language. Jewish Family Services serves a distinctly ethnic population of Jewish Russian immigrants whose primary language is Russian.

Unfortunately, the programs don't uniformly ask the enrollees to rate their overall health status. Such a simple question might be a way to compare the populations across programs.

The data in the Figure 7 reflects the reported prevalence of problems in the Rochester NORC populations.[37] Diabetes, hypertension, heart disease, arthritis and respiratory diseases are amendable to chronic disease self-management. Obesity, falls, and mental illness are amenable to other best practice wellness programs.

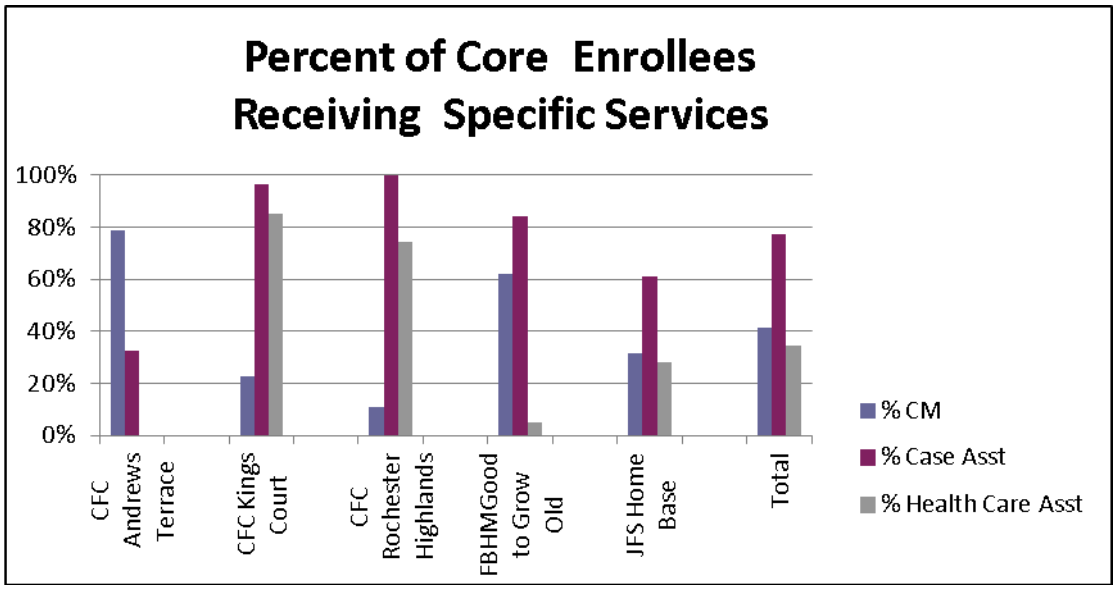
Figure 7

[37]Source: 2011 Annual NORC Reports the programs sent to NYSOFA.



Service utilization in NORC SSP's varies by program as the enrollees determine the types of services the NORC should offer. Figure 8 shows that at least 80% of core program enrollees receive some type of case management or case assistance services, which are key to assessing needs and linking individuals to available resources.

Figure 8



With growing awareness that health care alone is responsible for only a small percentage of people's health status, increased attention is being paid to the social determinants of health. If people are to realize their desires to age in their own homes, then basic needs for safe affordable, and accessible housing, adequate nutrition, personal safety, transportation, social engagement, and assistance with tasks that are essential to maintaining one's health and household are critical. The types of programs offered by NORCS are responding to this wider array of needs.

Chart B illustrates the importance of housekeeping and chore services in most programs, as well as the use of social engagement services such as companion and friendly visiting services. Door to door escort and shopping assistance are also important components for enrollees.

Chart B

Units of Major Services							
	House-keeping & Chore	Companion	Escort & Door to Door	MH and Counseling	Shopping Assistance	Info.& Referral	F. Visiting
CFC Andrews Terrace	0	857		0			166
CFC Kings Court	786			0	13	40	19
CFC Rochester Highlands	1362		188	0	18	107	38
FBHMGood to Grow Old	85		601	253	178	4	236
JFS Home Base	219			14		30	0
Total	2452	857	789	268	209	181	459
Source: All service utilization data are from organizations 2011 annual reports to NYSOFA							

Whether it is services provided by staff or services provided by volunteers, the variation in both the types and the amount of the services is distinct across each of the programs. While some of this is surely accounted for by the size of the enrolled population as well as the size of the staff, it is clear that each program responds to different types of needs. Where apartment dwellers may need more assistance with housekeeping, people living in their own home may need more assistance with yard work and home maintenance.

Chart C

Units of Major Volunteer Services								
Program and # Participants	Escort Trips	Hours	Shopping Asst	Hours	Chore/Meal	Yard/ Maintenance	Admin	Education
CFC Andrews Terrace 52	166	250	69	103	104			
CFC Kings Court 53			4	5				
CFC Rochester Highlands 81	0	0	25	63				
FBHMGood to Grow Old 118	355	710	12	24		330	392	24
JFS Home Base 85	60	120					115	196
Total	581	1080	110	195	104	330	507	220

Source: All service utilization data are from organizations 2011 annual reports to NYSOFA * # of participants cited for Andrews Terrace, King's Court & Rochester Highlands basically reflects # of people receiving Core Services. Additional people who participated in other services likely were not included.

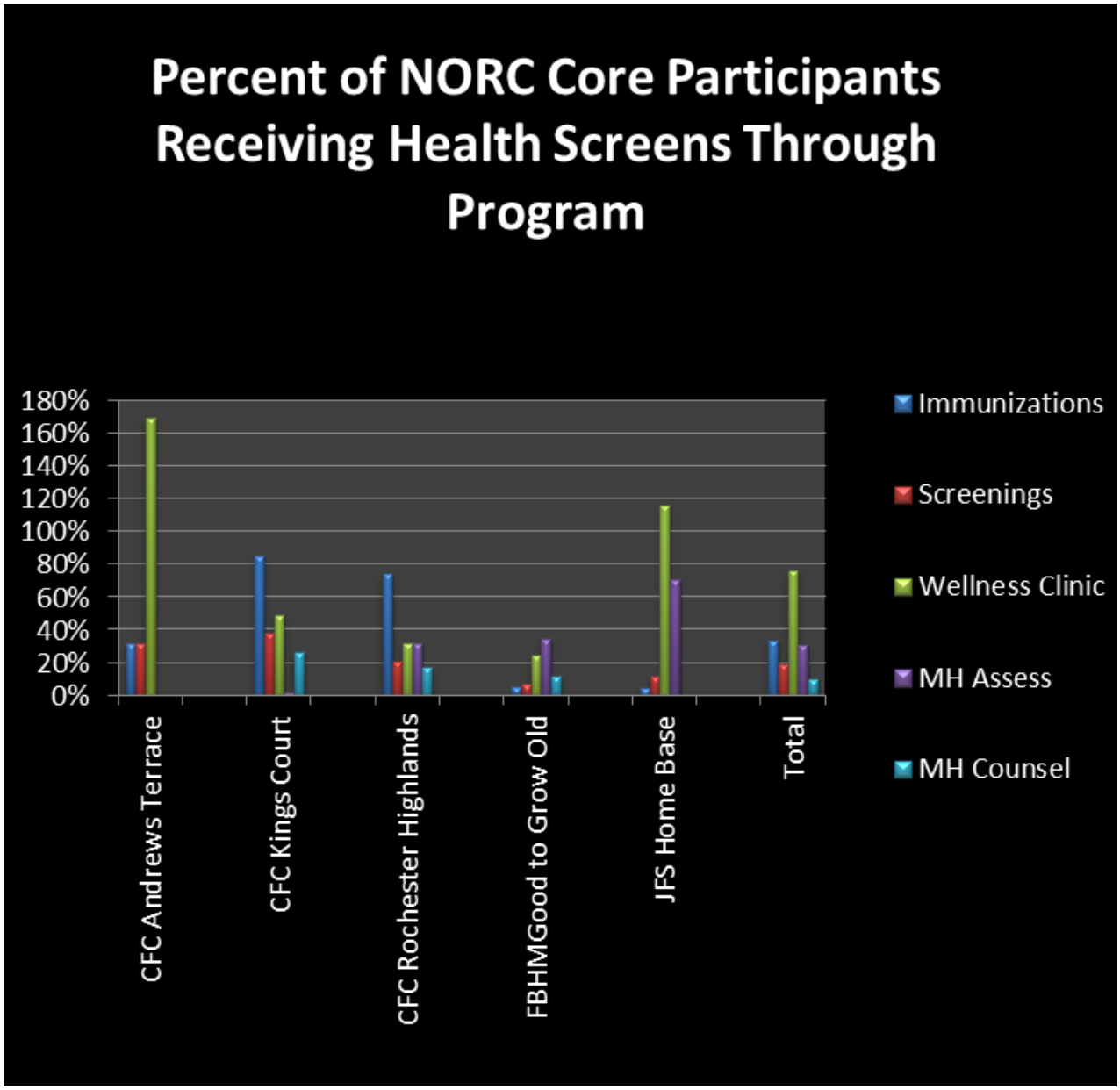
In addition to individual services, NORCS provide a number of group programs. These are for not only for their members, but are also made available to others who do not receive core services. The data in Chart D indicate that NORCS are actively engaging seniors in social, educational, and health screening and prevention activities. They are also making it possible for people to have transportation for a wide range of group activities including health related activities such as grocery shopping, nutrition and wellness programs at local community centers.

Chart D

Group Services							
	Education and Recreation		Health Promo		Health Screening		Transpor-tation
Program and # Partici-pants	Sessions	Atten-dance	Sessions	Attendance	Sessions	Total Screened	1 way trip 1 person
CFC Andrews Terrace 52	21	246	47	259	3	26	517
CFC Kings Court 81	24	248	10	93	1		62
CFC Rochester Highlands 53	98	848	8	124	2	17	152
FBHMGood to Grow Old 118	6	49	5	51	24	72	711
JFS Home Base 85	351	3684	8	99	2	89	6860
Total	500	5075	78	626	32	204	8302
Source: All service utilization data are from organizations 2011 annual reports to NYSOFA							

Figure 9 shows that nearly 80% of people served by NORCS participated in some form of wellness program. Almost 40% received immunizations, approximately 30% received mental health assessments, and 20% received health screening services.

Figure 9


Percent of NORC Core Participants Receiving Health Screens Through Program
180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
CFC Andrews Terrace
CFC Kings Court
CFC Rochester Highlands
FBHMGood to Grow Old
JFS Home Base
Total
Immunizations
Screenings
Wellness Clinic
MH Assess
MH Counsel

Funding and Support

The annual funding/per person cost for people who receive core services from NORC programs in Monroe County run between $1200- $2600 which include: case management, education and recreation, health education and health screenings, assistance with grocery shopping, friendly visiting, group transportation, volunteers to help with: rides, light housekeeping, and information and referral to partner service providers.

If costs are based on the 610 unduplicated people served in 2011, the average annual cost for NORC and NNORC participants was $893. If one includes the entire SOFI program in Fairport, and the total number of unduplicated people served (1230 individuals served in NORCS and SOFI) the annual cost of services was $663 per person. The budgets indicate that this is a low cost program, whose costs might be driven down further if there were greater flexibility in service areas.

In reviewing information provided by the NORCS to FLHSA, one of the significant differences across the programs is the sources of funding. Whereas the programs provided by Catholic Family Center/Elder Source are supported primarily by state funding with match resources coming from agency partners, the program provided by Jewish Family Services has additional resources provided by the Jewish Community. The Fairport Baptist Home programs have support from the town, the local faith communities, as well as two entrepreneurial programs set up specifically to support the work of the NORC.

One of the results from these varying levels of community engagement is seen in the staffing for the programs.

Chart E

Comparison of Staffing Across NORCS			
Program	Core Enrollees	FTE	Type
CFC Andrews Terrace	83	.6	Coordinator
CFC Kings Court	53	1.0	Care manager
CFC Rochester Highlands	81	.8	Care manager
FBHM Good to Grow Old	118	2.4	1.0 Program Administrator, .5 care manager .5 mental health coordinator .2 Transportation Coordinator .2 Driver
JFS Home Base	85	1.0	.75 Program manager
Source: Templates completed by the programs for Sage NORC workgroup report; spring 2012.			

D. Rural NORC–like Experience

1.Steuben County

There are two NORC-like programs in rural counties in this region. Steuben County has operated an aging in place model in Pulteney since 2009. Due to its population size, it does not qualify for NORC status or funding in NYS. However, it has an active community advisory group of trusted community leaders, which facilitated the development and distribution of a community survey to determine what seniors needed to age in place, has provided community education and developed services through partnerships with organizations which serve the area and local volunteers. It has developed a newsletter, "Pulteney Grapevine" as well as other strategies to market the program.

Documented accomplishments of the Pulteney project's first 2 years of operation include:

- 1200 people are reached with the program which operates on an annual budget of $12000.
- 63% of the older population indicates they are more aware of transportation options and 76% are more aware of community services available to them;
- The newsletter reaches 1100 people in the community on a quarterly basis;
- Linkages developed with the Office on Aging resulted in 161 hours of home care, 1481 home delivered meals to the population served, an increase use of the mobile food pantry, 12 referrals to NY Connects, 75 units of transportation services, and a church sponsored dinner club has opened and is operated by volunteers who serve approximately 30 seniors once a week. The volunteers are considering increasing the dinner club to twice a week, which is especially important since there is no restaurant in town. Linkages have also been developed with a mobile food pantry, and walkability studies have been conducted.
- In a town which is sufficiently isolated that it has no gas station, where the closest primary care is out of county in Penn Yan, 12 people have been provided 75 trips to medical care through the Office on Aging volunteer Project Care as a result of this collaborative effort.
- Volunteers come from: older individuals in churches, the fire department's women's auxiliary and retired people from the community. High school students help with spring cleaning and delivering fruit baskets.

Beginning in January 2012 the Pulteney model began replication in the town of Urbana.

2.Chemung Tioga Counties' Senior Information and Referral Services (SIRS)

SIRS was founded in 2006 as a member of the Tioga County Neighbors Helping Neighbors Project, funded by an Appalachian Regional Commission grant. The program has 34 trained volunteers.

The organization currently serves 36 clients, and in 2010 provided 1285 services by volunteers that gave 1304 hours and provided 8,377 miles which were reimbursed by the program. Documented accomplishments include:

- Transportation: 82 trips were provided to medical appointments and shopping trips, 204 volunteer hours were used for transportation; 2990 recorded miles round trip; an additional 1300 provided but not fully documented;
- Delivery of Meals on Wheels: 141 meals were provided; 148 hours of service was donated; 1467 miles round trip were recorded;
- Pharmacy Pick-up:
- Rides to community events;
- Home visits including chores, errands, reading 111; hours of service donated;38; miles were logged: 478;
- Nursing home/hospital visits: 13 visits made; hours spent: 13.5 hours donated; 11 people were visited;
- Phone, email, Information and referral: 546 contacts made; 138 hours donated;
- Annual income tax preparation, HIICAP counseling;
- Yard work and fall leaf raking;
- Simple home repairs: (a ramp was built, a shed roof repaired);
- Referral to local housekeepers, contractors, and appliance repair personnel;
- Bone builders exercise program;
- Support activities/Meetings:146 people engaged in activities; 234 hours donated, 757 miles recorded;
- Monthly soup and sandwich luncheon;
- Feral cat removal.

E. Evidence that NORCS Support Aging in Place

At a time when many older people have the majority of their wealth in their homes and they are unable to sell them, neighbors mobilizing to help neighbors remain in their homes make sense at many levels.

The Administration on Aging reports that 17% of those 60 and older live in neighborhoods that would qualify for the federal definition of a NORC. Illustrative of the federal government's commitment to these initiatives, in 2009 it allocated $5,213,000 for Community Innovations for Aging in Place to develop and implement innovative strategies for:

- Providing comprehensive and coordinated health and social services;
- Sustaining the quality of life for older individuals; and
- Supporting aging in place.

Research on the NORC model points to increased socialization, reduced isolation and people reporting they feel healthier and are more likely to remain in the community than they would without NORC services.

- A Brandeis Study[38] in 1996 found that NORCS provide singular opportunities to:
    - Deliver health and supportive services cost effectively,
    - Increase service availability,
    - Organize cooperative health promotion, crisis prevention , and community improvement initiatives, and
    - Develop new human, financial and neighborhood resources for the benefit of older residents.
- The 2006 United Jewish Communities NORC's National Evaluation
    - Older adults from 24 NORC-SSP communities across the US participated in a survey to assess the effectiveness of the programs. There were 10 "agree-disagree" statements about their social activities, service use, volunteer activities and health since participating in the NORC-SSP program [39].

[38]J.J.CallahanJr. and S. Lanspery . "Can We Tap the Power of NORCs?" Perspective on Aging, January–March 1997.Published by the National Council on Aging.
[39]United Hospital Fund. Aging in Place. 2012; Available at: http://www.uhfnyc.org/initiatives/aging-in-place

- There were 461 total respondents to the survey (representing a statistically significant number),
- 74% were between 70 and 89,
- 66% reported living alone,
- 72% reported that they participated in NORC activities and/or events and 44% had been involved with the NORC-SSP for 1-2 years .
- Results: Since participating in the NORC-SSP program:
    - Social Isolation
        - 88.1% of the sample agreed/strongly agreed that they talk to more people
        - 87.8% of the sample agreed/strongly agreed that they participate in more activities
        - 72% of the sample agreed/strongly agreed that they leave their homes more than they used to
    - Knowledge and Use of Community Services
        - 95.4% of the sample agreed/strongly agreed that they know more about community services than they used to
        - 92.2% of the sample agreed/strongly agreed that they know whom to ask for assistance more than they used to
        - 81.4% of the sample agreed/strongly agreed that they use community services more than they used to
    - Volunteerism
        - 48.1% of the sample agreed/strongly agreed that they volunteer more than they used to
        - Self-reported Health
        - 70.5% of the sample agreed/strongly agreed that they feel healthier than they used to
    - Likelihood of Staying in the Community
        - 88.1% of the sample agreed/strongly agreed that they believe that they are more likely to stay in the community
        - The results suggest that across the US NORC-SSP programs are having a significant effect on the quality of life of older people aging in place.

A 2009 review of the literature on NORCS by Bedney, Ph.D. found evidence that the NORC model supports the health of those they serve, with results including reductions in heart disease, falls and Alzheimer's disease; preventing post-hospitalization decline; increasing

awareness and use of community resources; promoting volunteerism; and encouraging positive self-perceptions of health, aging and community living among older adults.[40]

A study by Vladeck published in 2011[41] demonstrated how:

- the use of health indicators in a NORC population allows the program to target services to those most at risk ;
- helps seniors get the education, care and support they need for long term living with chronic conditions;
- shifts the focus from the reactive provision of units of services to a more proactive, targeted and systematic approach;
- continual measuring not only measures what they do but also the outcomes, allowing them to modify strategies based on reliable data;
- health indicators also provide a vehicle for integrating health and social services for the elderly;
- Health indicators equip aging services providers to:
    - work more effectively with the health care community,
    - educate their clients how to better manage their own health care, and
    - facilitate the client, the agency service providers and health care providers to work cooperatively to achieve the client's goals.

V. The Business Case

A. Addresses desire to age in place

Local data indicate that 47% of the people served in NORC programs were over 80 years old. National data indicate that 74% of NORC participants who responded to Vladek's survey were between 74-89 years of age.

Those responding to the survey who indicated that they participated in programs (88%), were more socially engaged than they had been prior to becoming a participant in a NORC (88%); were more engaged in volunteer activities (48%); were more aware of the community services which were available (95%); were aware of who to contact if they needed assistance (92%);

[40]Barbara Bedeny, PhD and Robert Goldberg, Esq. "Health Care Cost Containment and NORC Supportive Services Programs: An Overview and Literature Review. April 22, 2009. Available at: http://www.norcs.org/page.aspx?id=10924.

[41]United Hospital Fund. " Health Indicators". 2011; Available at: http://www.uhfnyc.org/initiatives/aging-in-place/health-indicators

were using more community services than they used to (81%); felt that they were healthier than they had been prior to their involvement (70%); and 88% reported that they were more likely to remain in the community.

The existing data indicate that NORC programs are targeted to addressing the needs of the older segments of the elderly population, supporting their continued engagement in the community, simplifying their ability to seek assistance when they need it, with the result that they are using more NORC and community services which are supporting their confidence in their ability to remain in the community.

B. Cost

In a 2011 study, Marek[42]showed that the combined Medicare and Medicaid costs of aging in place (AIP) with care coordination were $1,591.61 lower each month on average than nursing home costs for a similar patient.

The Rochester NORC data indicates that the NORC program costs for core services average $893 annually - per person served. While NORC services are not intended to substitute for skilled services, volunteer services for housekeeping, assistance with shopping, transportation, as well as personal visits and telephone calls, can reduce the need for formal services of personal care, companion, and transportation services.

Every time a NORC is able to prevent an ambulance trip to a hospital because it was able to engage a person in activities to maintain his/her health, or have a volunteer take the person to a doctor's office, $185 are saved in the transportation costs alone. If the NORC arranges transportation to a doctor's office, the round trip cost for an ambulatory person is $127 less than the Medicaid cost of an ambulance. Arranging wheel chair van service can save Medicaid $95 round trip.[43]

According to Excellus, one in every 2 people over 80 years of age falls each year. Each fall that results in a hospital visit costs over $2700 per person. While proving a negative is impossible, if

[42] KD Merek. et.al. "Aging in Place versus Nursing Home Care: Comparison of Costs to Medicare and Medicaid." Research in Gerontological Nursing. April 5, 2012. p.123.

[43] Information provided by William McDonald, Medical Motor Service. Rates are based on average reimbursements last month. These costs reflect costs for people within the city, there are additional charges of $2.50 per mile outside the city of Rochester.

programs could demonstrate that they reduce falls and prevent fractures that might have resulted from falls, costs avoided from falls can be expected to exceed the per person cost of the program cost each year.

Each day of nursing home care, avoided or delayed, saves nearly $300 dollars a day in Medicaid costs. The use of a social model with volunteers, community resources and lower cost health care services should make NORCs an attractive partner to managed care organizations.

C. Responsive to Public Policy Orientation

The Olmstead ruling indicates that people have the right to choose to remain in the most integrated, least restrictive environment. For most people, that choice is to remain in their own home. The challenge for the state and local communities is how to address the individual's right to this choice at a cost that is sustainable to the taxpayer. The low cost of NORCs makes this an appealing option.

New York State has applied to the Federal Balancing Incentives Program which seeks not only to support people remain in the community, but to do so in a manner which integrates services provided by human services agencies and health care providers who use common assessment tools, and a "no wrong door" approach with "conflict of interest free case management" services. By being a partner agency with Lifespan, the local point of entry, Rochester NORCS have aligned themselves well with these major policy initiatives.

D. Supportive Programs for the Older Population- Best Practices and Potential Savings

"As the nation grapples with the growing burden of chronic illness, especially in the elderly, both health care and aging service providers have been encouraged to strengthen their participation in preventive efforts, especially in better educating patients about reducing and managing risk factors using evidence based health promotion programs. These prevention and risk reduction efforts have largely taken place within separate silos of health and aging services. NORC programs are perfectly positioned to take on the integrative functions of bringing together the separate realms of self-care, medical care and community based support. By using health indicator tools, NORC programs can be in a position to shift practice from providing care on a first come first served basis to targeting those most at risk and helping them get the education, care and support they need for long term living with chronic conditions. Borrowing experience from the healthcare community and adapting the quality improvement process for community based aging-service providers, health indicators use data to drive what aging-

services providers do and with whom they do it. It changes the expectations of community based aging service providers, shifting focus from the reactive provision of units of services to a more proactive, targeted and systematic approach, continually measuring not only what they do, but also its effects, enabling them to modify their strategies on the basis of reliable data. Health indicator tools are a vehicle for better integrating health and social services for the elderly."[44]

Given that health care use can be expected to increase with age, NORCS can play a key role in care transitions. As a community partner with access to the person in their home, NORCS can be a valuable ally to help insure that after a hospitalization, the patient understands the discharge orders related to diet, medications, and follow up appointments for physicians. In Rochester, where high risk Medicare patients routinely are provided Coleman coaching, NORCs can be a community partner that continues to support the patient's goals after coaching services end.

Supportive programs like the NORC model are helpful in ensuring that the older population remains engaged in their communities and still socially active as they benefit from care coordination, case assistance, case management and specific health-related services. They have been linked to reducing institutionalization by almost one half. Reducing the frequency and duration of institutional care is key to bending the Medicaid cost curve and keeping publicly funded long term care costs sustainable in the future.

E. Effective use of health care personnel and volunteers

NORCS are models which mobilize the social supports of a community, including supervising cadres of volunteers to support people who are aging in place. While NORCS partner with health care organizations, their first response is that of a surrogate family member who is in touch with the older adult and responds to the needs the individual may have, which will allow her/him to remain at home (e.g. housekeeping, minor repairs, groceries, a ride to a doctor or social activities). By providing a trusting relationship and the "boots on the ground", this low cost option for contact with the person enables observation of changes and, in many cases, provision of timely, appropriate intervention with low cost services.

At a time when personal care aides and home health aides are insufficient to meet the demand, use of volunteers and congregate programming can reduce the demand on scarce health resources.

[44] Fredda Vladeck, et.al. "Health Indicators: A Proactive and Systematic Approach to Healthy Aging." Cityscape.2010 Volume 12, Nos.2. pp. 78-79.

VI. FINDINGS AND RECOMMENDATIONS

A. Urban Settings

The experience of the five NORCs/NNORCs in Monroe County proved to be positive, consistent with that documented by their previously established counterparts in various areas of the United States. Services most meaningful to program participants included gaining assistance in accessing health and health-related support services from a myriad of organizations and agencies, transportation to services not provided in their own homes, case work assistance, health education, and socialization/inter-personal connections.

Program enrollments in concentrated areas (apartment complexes or neighborhoods) met sufficient critical mass to support programming required by the New York State Office for Aging for NORC designations, within allotted resources (volunteer and financial), although the increasing matching requirements of the NYSOFA grants posed significant challenges in the advancing years of the grants.

Program participants' self-reported health status reflects the prevalence of chronic diseases that respond well to health education, prevention, and early intervention: diabetes, hypertension, arthritis, mental illness, and falls. NORC services to these community-based seniors have contributed to their remaining in their own homes, enjoying an improved or stable health status.

B. Rural Settings

The two rural NORC-like programs have made significant contributions to the health, well-being, and satisfaction of their seniors; but the sparsely populated communities have precluded their meeting the NYSOFA program requirements for NORC funding eligibility. Persistence and dedication of the programs' leadership have resulted in obtaining other time limited, ad hoc funding sources; but none represents on-going, predictable funding that would stabilize or significantly expand program offerings.

Given the demonstrated value of enabling seniors to remain at home through provision of, or connection to, relatively low cost, health, and health-related support services, creating means to overcome this financial barrier is well justified.

C. Policy Recommendations

Representatives of the five NORCs in the urban county and the two NORC-like models in the two rural counties are all satisfied with the value of the program to their respective clients and committed to advocate for ways to further strengthen the program, advance its purposes, and promote further dissemination. Working within the framework of the NORC model supported by the NYS Office for Aging, the following modifications to State policy would facilitate their efforts:

1) Ease the matching fund requirements, permitting the NORC provider to include a calculated dollar value of volunteer hours as part of the provider's match. The success of a NORC critically depends on a large number of reliable, capable volunteers. Recruiting, training, deploying, supervising, motivating, and retaining them are major NORC activities. They represent the NORC's most valuable resource.

2) Allow the Neighborhood NORC (NNORC) greater flexibility in defining its geographic service area. In many instances, local Village or Town boundaries make the most sense and justify the allocation of local governmental funds to support the program on behalf of all its eligible taxpayers. Use of easily recognizable geographic areas could also help raise awareness for medical practices that might wish to link their patients to NORC resources.

3) Include transportation as a core service, eligible for NYS Office for Aging funding, thus enabling NORCs to routinely provide same day services to physicians' offices or urgent centers as a means to reduce hospital emergency department visits and prevent hospitalizations by early treatment.*

4) NORCS can play a valuable role in new initiatives aimed at maintaining wellness and supporting people to age in place. When NORCS exist in a community, NORC staff should be part of community activities exploring ways to integrate NORCS into reform initiatives and seeking ways to financially support programs expected to reduce high cost service utilization through substitution of NORC lower cost community support services.

5) Modify current NORC regulations to entertain the possibility of NORCs in rural areas. For example, by enabling officially established NORCs to sponsor a rural satellite, extending its basic NORC infrastructure to a rural NORC-like model, the latter could offer all the required services through the affiliation.

* Note- CFC has been able to utilize their STAR system for NORC residents by providing it free of charge to NORC residents & with fewer restrictions than for the general older adult population who utilize this service. (The STAR program is actually providing these services as part of

the match (as they are using their United Way funding to cover costs for NORC residents.) All of the above are aimed at enhancing a basic, very attractive model for improving access to health care and supporting aging in place.

Appendix A.

NORC Best Practices[45]

Successful NORC programs have the following:

- A "basket" or essential set of integrated services that are focused around the needs of individuals within the community and services are adaptable as needs change;
- Appropriate human resources to facilitate programs (in the form of volunteers and paid staff);

[45]B. S. Ormand et. al. "Supportive Services Programs in Naturally Occurring Retirement Communities." Urban Institute. 2004.

- Appropriate capital in place (office and meeting space, equipment, supplies, budget, etc.);
- Buy-in of essential community collaborators,(i.e.: community organizations, churches, government entities, health care providers, etc.);
- A stable mix of public and private financial resources to support the basic elements of the program, including case management, transportation, information dissemination, education programs, volunteer programs, etc. ;
- A set of priorities identified by the community served;
- Leadership that is inclusive of the people being served (residents) and the community at large;
- The ability to plan and launch projects that address the priority needs of a problem within the population served;
- Good communication with all stakeholders;
- An evaluative tool or tools that measure progress and outcomes.

Appendix B

SWOT Analysis

The members of the Sage NORC workgroup developed the following SWOT Analysis of the NORC Model

Strengths

- The NORC model simplifies access to care for older people through a network of care coordination that also has the potential to reduce costs.

- Improved awareness and utilization of services in the community for elders and their families is major strength of the NORC model.
- Positive perceptions of aging and community living for older people is critical and the NORC model achieves this through empowering older people to live independently as well as through volunteerism and peer support.
- The collaborative nature of the model helps to build social capital within the NORC communities.
- Evidence that the NORC model supports the health of those they serve include reductions in heart disease, falls and Alzheimer's disease , preventing post-hospitalization decline, increasing awareness and use of community resources, promoting volunteerism, and encouraging positive self-perceptions of health, aging and community living among older adults.[46]
- The NORC model can be made sustainable with appropriate planning and organization.
- The model's inter-dependent nature allows for community building which adds to sustainability.
- The simplicity of the NORC model makes it very reproducible which provides opportunities for the many communities throughout the US that already have people aging in place.
- The model shifts from the paradigm where people age in their home, to a more positive model where people age as valued members of their community.
- When assessed, the change in paradigm to a NORC model has resulted in positive outcomes for the elderly.

Weaknesses

- A primary challenge of the NORC model is that it is limited to elderly participants who live in a small geographic area that was not built to be senior housing.
- While provision of programming, dissemination of information, and care coordination are easier when program participants are in dense, urban areas adapting NORC models to suit varying communities and strengthening the

[46]Bedeny, Barbara, PhD and Goldberg, Robert, Esq. "Health Care Cost Containment and NORC Supportive Services Programs: An Overview and Literature Review. April 22, 2009. Available at: http://www.norcs.org/page.aspx?id=10924.

support networks for participants in those communities are challenges worth exploring.

- There is limited funding available for NORC programs and the limited funding results in few employees who are available to dedicate the time to making the NORC model a sustainable one.

Threats

- The status quo of Medicaid and Medicare offering more generous benefits for institutionalization than home and community based services as well as the old continuum of care with institutionalization at the end of life are both threats to the NORC model. Many participants rely on home and community based services to enable them to age in place.
- Communities that are not designed for the aging population pose a threat to the NORC model. If NORC type models of community support are not developed, many older people and their families may relocate unnecessarily.
- The competitive nature of organizations that could be considered partners in NORC networks could interfere with the growth and progress of the NORC model by making it difficult to gain buy-in and cooperation.
- Evaluation processes and examination of outcomes relating to the NORC model could become threats. The early days of NORC programs were very participant focused, but over time the importance of proving program value has become critical in the battle for funding for non-profit programs. NORC programs must do a better job of evaluating their outcomes so that they may be competitive when seeking funding. That said, many evaluation models are looking for evidence that medical costs are reduced, and fail to give equal consideration to the social values associated with remaining in one's home or neighborhood.
- FLHSA staff has searched the literature and contacted staff providing technical assistance to national aging in place demonstrations, and learned that to date no one has attempted to measure the extent to which these programs delay use of institutional care, reduce hospital use or reduce emergency department use. Staff was told that these are questions for which many would like the answer, but to date researchers have not developed a design which is significantly rigorous to provide these data.
- At an intuitive level, aging in place models make sense because they:
    - engage people in activities that promote physical, social, and spiritual well-being;
    - provide a geographic locus for service delivery,
    - include the use of volunteers, and

- provide on-site observation that can monitor changes in people's status and facilitate the residents seeking timely assistance from appropriate service providers to prevent avoidable decline.

Appendix C

Villages and Similar Programs Which Support Aging in Place

Villages are similar to NORCs. They are "grassroots, membership-based non-profit organizations developed with the sole purpose of enabling people to remain in their own homes and communities as they age."[47]. Villages appeal to both the elderly and their children. "We are the boots on the ground" for children who live far away"[48]

"They are self-governing and self-supporting with a combination of membership fees (the median is $420 for individuals and $590 for households), fundraising from foundations and individual donations, event income and corporate sponsorship. Members pay dues cover staffing and operational costs. Typically villages have just one or two full-time employees who manage volunteer armies."[49] Villages offer reduced fees when fees are a barrier. .

As of Dec. 2009 there were 48 fully operational Villages in the U.S. The first was established in Beacon Hill in Boston in 2001. As of January 2013 there were 93 up and running, nearly double the number from 2009, and 125 are in development, according to Judy Willet, executive director of the Village to Village Network which was launched three years ago. Membership in villages today totals an estimated 10,000 people.

Research by Rutgers University and Berkeley's Center for the Advanced Study of Aging Services shows that the median membership for villages grew by 33% to 92 members in the first 12 months of 2012. As the movement gains momentum, it's beginning to field research to measure efficacy of the services provided. One completed study of the impact of the Concierge Club, which operates Elder Help in San Diego, "was able to demonstrate that members had a decrease in unmet needs over six months and an increase in their quality of life and a decline in the number of falls."[50]

These models are generally targeted to middle and higher income populations. Villages serve as a point of connection, a service broker and a caring community for members who can call a central phone number for whatever they need (concierge model). They are designed to support the medical, functional, emotional, social and spiritual needs of older adults. They are intentionally neighborhood-based to promote a sense of community. "Villages are recognition that for many people the traditional structures that provided services to elders—nearby family,

[47] Andrew Scharlach, PhD. "The Village Model: An Overview" Center for the Advanced Studies of Aging Services, School of Social Welfare. University of California at Berkeley. April 26,2011. Village to Village Network website.
[48] Katie McDonough, Executive Director of the Capitol Village cited in http: www.bloomberg.com/news/print/2013-01024/Village -people-community-networks.
[49]http:www.bloomberg.com.2013-01-24/village people-community networks.

[50] Andrew Scharlach quoted in ""Village People: Community Networks Help Boomers 'Age in Place'. By Carla Fried.Bloomberg, January 24, 2013 http:www.bloomberg.com.2013-01-24/village people-community networks.

churches, and fraternal organizations—don't exist."[51] Four program areas include: day-to-day practical support and assistance, social, cultural and educational activities; volunteer opportunities; and health and wellness programs. Some programs are free and some are fee-based, many with discounted fees for the members.

In 2009 the California Healthcare Foundation published a study "No Place Like Home: Models of Supportive Communities for Elders".

Element	Features
Basic Needs: safe, accessible, affordable	▪ Accessible and affordable housing and community areas; ▪ Provides information about services; ▪ Fosters safety;
Community Engagement	▪ Fosters meaningful connections; ▪ Promotes civic engagement, volunteerism, and encore career development;
Health and Well Being	▪ Facilitates access to health and social services; ▪ Promotes healthy behaviors; ▪ Supports community activities that enhance well-being;
Independence and Autonomy	▪ Mobilizes in-home supports and services; ▪ Maximizes community assets ▪ Coordinates or offers transportation; ▪ Supports Family and other caregivers.

[51] Andrew Scharlach, quoted in ""Village People: Community Networks Help Boomers 'Age in Place'. By Carla Fried Bl.oomberg, January 24, 2013 http:www.bloomberg.com.2013-01-24/village people-community networks.

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