**Maryland Communities for a Lifetime**

**Policy Brief**

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**Introduction and Purpose**

Policymakers, public health professionals, and others – in Maryland and nationwide – have become familiar with a compelling story about the burgeoning elderly population and daunting predicted costs to care for these elders. By 2030, one in five Americans will be age 65 or older (U.S. Census Bureau, 2008), and their care will cost an estimated $760 billion if impairment levels remain the same. (Congressional Budget Office, 2004). Despite these demographic and economic imperatives, as well as strong consumer demand for flexible services that meet individual preferences, there are not enough independence-enhancing options for people as they age and/or develop disabilities. People rarely ask to live in a nursing home (Eckert, Morgan, & Swarmy, 2004), and we have significant evidence that people want to receive services in their homes and communities as they age (AARP, 2010, Carlson, Dale, Foster, & Brown, 2007). Yet, families across this nation are struggling to help their aging parents obtain the services they need while staying in their homes. Caregiving is likely to be even more challenging for middle class and low income Americans, and especially for those without relatives who live close by. It is also well established that many caregivers experience high levels of stress (Feinberg, et al, 2011; CDC, 2008).

There have been significant national efforts in recent years to expand publically-funded community services, including the now “suspended” Community Living Assistance Services and Supports (CLASS) Act that would have provided long-term services insurance benefits through the 2010 Patient Protection and Affordable Care Act (ACA) (Lindberg, 2011). However, the majority of public funding for long-term services and supports (LTSS) is spent on nursing facilities (Kassner, et al, 2008). Maryland lags behind most other states in efforts to shift the emphasis on LTSS spending from nursing homes to home and community-based options (HCBS). In fiscal year 2008 over 84% of publically-funded Maryland elderly/disabled long-term care was provided in nursing homes, compared to just under16% in community settings (State of Maryland, 2011). The national average for LTSS spending on HCBS for elders and adults with physical disabilities in 2009 was 33.8% (Milligan & Woodcock, 2011).

To address the need for more community-based LTSS options, and shift away from an emphasis on nursing home care, Maryland legislators passed the 2011 Maryland Communities for a Lifetime Act (Maryland SB 822). This legislation, based on recommendations from the 2009 Maryland Communities for a Lifetime Report (Statewide Empowerment Zone for Seniors Commission), proposes a “comprehensive, strategic state plan to address the aging-in-place preference of current and future seniors and to promote a state “communities for a lifetime” program that overcomes barriers in housing, transportation, health care, employment, and social and civic engagement.” The interest indicated by this bill (despite the lack of funding to implement the legislation), along with ACA financial incentives to states to lower their institutional LTSS spending, and the significant need for expanded community-based options to help Marylanders age in their communities, create a timely opportunity to address this important issue. This effort supports the President’s Year of Community Living (whitehouse.gov, 2009) and a call to make rapid expansion of community services “a national priority today so that tomorrow’s much larger cohorts of older people can look forward to aging with dignity and independence.” (AARP, 2010).

This policy brief will build on the 2009 Maryland Communities for a Lifetime report that led to passage of SB 822, Maryland Communities for a Lifetime, and provide an overview of aging community initiatives on a national and state level. After reviewing demographic and economic forces establishing the need for age-friendly communities, the paper will summarize key federal initiatives expanding community-based LTSS – an essential building block of communities for a lifetime. Next, the policy brief will describe national initiatives to develop “age friendly” cities. It will then discuss Maryland’s participation in these national programs, which may serve as a launching point for Maryland’s Communities for a Lifetime Initiative. The policy brief will conclude with recommendations for next steps in implementing this important, yet unfunded, legislation.

**Who Can Benefit from Communities for a Lifetime? Meet the Green, Jimenez, and Abbott Families**

*Mrs. Green is an 87 year-old widow who lives alone. Despite chronic conditions and three falls, she led an active life until she lost her vision last year. She needs help with many daily living activities such as shopping, cleaning, and transportation. Her daughter lives out of town, works full-time, and has a young child. Mrs. Green is slowly regaining some sight, and is determined to remain in her home. Medicare does not pay for personal care services and caregiver costs are depleting her small savings. Isolation and vision loss are depressing.*

*Mr. Jimenez, an 80 year-old immigrant, is recovering from a broken hip and lives with his 78 year-old wife in a two-story house. Their daughter lives close by, works full-time, and has three small children. Mr. and Mrs. Jimenez have very limited finances and receive minimal Social Security benefits. English is not their first language. They want to stay in their home.*

*Mrs. Abbott is 75 years old, has an early stage of dementia, and lives with her daughter, son-in-law, and two teenage grandchildren. Her daughter works full-time, and worries about her mother being home alone. She worries about the future as her mother’s dementia progresses, Mrs. Abbott’s son lives across town, has young children, and visits weekly. Both children want their mother to remain at home.*

“Communities for a Lifetime” have the potential to address specific needs for the Green, Jimenez, and Abbott families. Incorporating a continuum of multi-disciplinary approaches spanning simple technology; complex, computer-based assistive devices; and everything in between; the following ideas can address the many challenges that these families face. Aging and urban planning experts can develop communities that offer LTSS for these families, including age-friendly housing and services to help elders with disabilities maintain active lives. These services may include transportation, social activities, health care, and help with daily living activities (e.g. bathing, using the toilet, dressing, cooking, eating, shopping, cleaning, home maintenance, bill paying, etc.). “Smart home” technology may help Mrs. Green’s low vision and monitor Mrs. Abbott as her dementia progresses. Innovations involving architecture and engineering could help Mr. Jimenez manage the stairs in his two-story home. Experts in fall prevention can help Mrs. Green avoid future falls. A multi-disciplinary community approach could develop innovative solutions to address each family’s unique needs – a far cry from the all-too-common assumption that an older person with limitations needs to live in an institutional setting.

**Demographics, Consumer Preferences, and Economics Drive Demand for HCBS**

America has a growing percentage of elders, and aging baby boomers expect services that provide independence and choice. A strong preference for consumer-driven services and economic need will continue to increase the demand for community-based services. The following information illustrates this picture:

* By the year 2050, there will be approximately 89 million Americans age 65 and older, largely due to the aging baby boomer cohort (U.S. Census Bureau, 2011). Maryland’s population age 65 and older is expected to grow by 104 percent between 2005-2030 (Maryland Department of Planning, 2007).
* As Americans age, they often have one or more chronic disease (e.g. heart disease or diabetes) or physical deficit (e.g. reduced vision or cognitive impairment) that limits their ability to perform daily living activities such as dressing, bathing, cooking, taking medicines, and paying bills (U.S. Census Bureau, 2005). For example, there are over 5.4 million Americans living with Alzheimer’s disease, including over 86,000 in Maryland (Alzheimer’s Association, 2011).
* Even with complex health issues, most elders want to remain in their homes and communities with family, friends, and neighbors (MetLife 2010, Reinhard, 2010). More than 14 million elders with a physical or cognitive disability live at home, and over 10 million elders live alone (U.S. Census Bureau, 2011).
* Unpaid family and friends provide the vast majority of long-term services. Approximately 90% of elders receive unpaid assistance (i.e. informal care), and an estimated 42.1 million family caregivers provide unpaid care to family members each year, worth approximately $450 billion in 2009 (Feinberg, et al, 2011; Mollica et al, 2009)
* In 2009, there were over 42 million informal caregivers in the U.S. caring for an adult needing help with daily living activities, and 80% cared for someone over the age of 50. About 65% of caregivers are female (Feinberg et al, 2011). Even though about two-thirds of informal caregivers have other jobs, 17% provide caregiving services 40 hours per week or more (Foster & Kleinman, 2011). Not surprisingly, caregiving can take a toll on the caregiver. They are more likely than non-caregivers to be anxious or depressed and to have chronic health conditions (US DHHS Office on Women’s’ Health (2008).
* With a larger elderly population, it is likely that an increasing number of elders will rely on public services to remain in their communities.
* States have been increasingly turning toward community services in hopes of cutting costs (Walls et al, 2011, Doty, 2010). However, policymakers are now targeting increased Medicaid HCBS expenditures for budget cutting because they are optional Medicaid services. (Nursing home services, a more expensive option, are a required Medicaid service.) While this approach may address an immediate budget need, there is evidence indicating that cost savings from HCBS accrue over time. Cutting HCBS programs may be shortsighted as states that invest in HCBS have slower Medicaid expenditure growth than states with low HCBS spending (Mollica et al, 2009).

**Federal Initiatives to Expand Home and Community-Based Services (HCBS)**

Given the significant public policy concerns regarding the cost of LTSS for older Americans (Institute of Medicine, 2008; Knickman & Snell, 2002), during the past decade federal initiatives have focused on expanding community-based services that offer flexibility and choice. These efforts aim to “rebalance” LTSS spending to reverse an emphasis on institutional care. While communities for a lifetime address a broader array of services than those met by HCBS programs, LTSS are an essential building block of any initiative enabling elders with disabilities to maintain active lives in a community setting. When addressing the future of LTSS, Kane and Kane (2012) emphasize that all those needing these critical services have “the desire for control, social integration, and a lifestyle of one’s choosing.” Clearly, the goals of communities for a lifetime begin with these desires. The following section describes key federal initiatives designed to expand HCBS services to a diverse population of people needing these services.

* The Cash and Counseling Demonstration and Evaluation (CCDE), funded by the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services in 1995, was a national test of one participant-directed (PD) model of LTSS in which volunteers -- including elders -- were randomized to receive either traditional agency services or PD services. The traditional model of home and community-based services emphasizes professional decision-making and agency oversight, and imposes rules and restrictions regarding the timing, duration, amount, and scope of services. In contrast, participant-direction (PD), also called consumer-direction (CD) and self-direction (SD) is a service model that offers people of all ages with disabilities more control over their services. Cash & Counseling (C&C), one of the most flexible models of PD, allows participants the authority to manage a personal care budget, hire, supervise, and fire their own personal care workers (including relatives), and purchase other personal assistance goods and services. More than 6,500 Medicaid consumers in Arkansas, Florida and New Jersey participated in the social experiment that was directed by the University of Maryland Center on Aging. CCDE evaluators addressed the issue of quality of care and concluded that *“The control and flexibility offered by the program greatly increased consumers' satisfaction with the help they received and with their overall quality of life. Consumers under Cash and Counseling appeared to receive care at least as good as that provided by agencies, in that they had the same or an even lower incidence of care-related health problems.”* (Carlson et al., 2007). Based on these findings, the funders supported a twelve-state replication project, which was successfully completed in 2009 (O’Keefe, 2009). The number of PD programs of all types, including the C&C model, has grown in the last decade. A 2011 national inventory of PD programs indicates that there are 298 PD programs in the U.S. with 810,000 participants, an increase from an estimated 450,000 ten years ago (Doty, et.al, 2012).
* The Alzheimer’s Disease Supportive Services Program (ADSSP) was created by Congress in 1992 to expand the availability of diagnostic and support services for persons with Alzheimer’s Disease and Related Dementias (ADRD), their families, and their caregivers, as well as to make the HCBS system more “dementia-friendly.” Between 2008 and 2011, the Administration on Aging funded 80 ADSSP projects across the nation (Administration on Aging, 2012).
* In 2001, President George W. Bush announced the New Freedom Initiative, which was designed to implement the Supreme Court *Olmstead* (1999) decision. It called for a shift in emphasis on institutional care to promote full integration of people with disabilities into all aspects of society – a far reaching goal including access to education, assistive technology, jobs, and other areas of community living. Building on the C&C program, the Centers for Medicare and Medicaid Services (CMS) developed the Independence Plus Initiative, a consumer-directed state Medicaid program that gave consumers the option to direct an individual budget (Crowley, 2003). In 2003, CMS awarded $5.4 million in Independence Plus grants to 12 states (Milne, 2012). In 2001, Congress funded the Real Choice Systems Change for Community Living (RCSC) program to help states transform their LTSS systems and move away from reliance on institutional care, expand their HCBS options, and develop infrastructure to promote full community participation. CMS awarded 352 grants totaling over $288 million between FY 2001-10 (Milne, 2012). In January, 2012, Maryland received a RCSC grant, jointly funded by CMS and the U.S. Department of Housing and Urban Development, to provide affordable housing for people with disabilities (State of Maryland, 2012).
* In 2003, CMS expanded the RCSC grants to include Money Follows the Person (MFP) that helped Medicaid consumers in nursing homes return to the community (Reinhard, 2012). The 2005 Deficit Reduction Act (DRA) established a national MFP Demonstration program and authorized CMS to spend $1.75 billion over five years for MFP grants. As of 2011, 44 states, including Maryland, and the District of Columbia had received these transition grants. Since MFP began in 2001, it has helped divert more than 20,300 persons away from nursing homes (Reinhard, 2012). The DRA also allowed states to add HCBS as an optional benefit to their Medicaid state plan, and eliminated the need for a cumbersome waiver application (Doty, Mahoney, & Sciegaj, 2010). Expanding beyond these Medicaid-funded HCBS programs, the Administration on Aging (AoA) has had a growing presence in pro*viding H*CBS programs in recent years (Doty, 2010). In 2003, AoA and CMS jointly funded Aging and Disability Resource Centers (ADRCs) to better integrate aging and disability services and help consumers locate LTSS public and private programs. Since then, 54 states and territories, including Maryland, have received ADRC grants (Alecxih & Blakeway, 2012).
* The Nursing Home Diversion Program, later renamed the Community Living Program (CLP), began in 2007 to encourage Aging Network services to transform their services into flexible, consumer-directed programs. In an effort to re-balance the LTSS system and complement the Money Follows the Person (MFP) grant, the Community Living Program targets people at risk of nursing home placement and spend-down to Medicaid eligibility and helps them stay in the community. Between 2007-2009, 42 states, including Maryland, received CLP grants, totaling $25 million in the first two years (AoA, 2011). In 2008, the Veteran’s Administration partnered with AoA in developing the Veteran-Directed HCBS program. These programs, based at VA Medical Centers and informed by the experience with Medicaid and AoA-funded consumer-directed services, bring this philosophy to veterans of all ages (NRCPDS, 2012). There are currently 35 VD HCBS programs in VA Medical Centers (Kayala, 2012).
* The Maryland Department of Aging (2012, p. 51) identifies the Aging and Disability Resource Center (ADRC)/Maryland Access Point (MAP) model as Maryland’s centerpiece of a broader delivery system reform effort that includes Money Follows the Person (MFP), Community Living Program, Person-Centered Hospital Discharge, Evidence-Based Care Transitions, Options Counseling, and the VD HCBS services. These initiatives demonstrate the growing collaboration among different state and local agencies, and aim to rebalance Maryland’s LTSS system toward consumer-directed, community-based services. The ADRC/MAP model provides a visible place from which people of all ages and incomes may seek information and services for long-term services and supports.

HCBS program experience from the previous decade informed development of the LTSS acts within the ACA, including the now “suspended” CLASS Act. This Act intended to create a voluntary national long-term care insurance program that provided a cash benefit to adults unable to perform two or more daily living activities, allowing more elders with disabilities to remain in a community setting. The CLASS Act was suspended in 2011 because policymakers had doubts about its financial sustainability (Lindberg, 2011). To encourage further “rebalancing” of public funding from nursing homes to community-based LTSS, the ACA’s Community First Choice Option and Balancing Incentive Payment Program (BIPP) increase the federal share of Medicaid costs to states’ person-centered, community-based LTSS (Lamphere, 2010). Maryland received a 2012 BIPP grant for $106 million (State of Maryland). In addition, the ACA includes funding for Aging and Disability Resource Centers for five years and extends the MFP program through 2016 (The Henry J. Kaiser Family Foundation, 2011).

**Aging-Friendly Communities Initiatives**

While the previously discussed HCBS programs are at the heart of aging-friendly communities, they are a necessary, but not sufficient component of the services that elders with disabilities need to stay in a community setting. National and international guidelines for age-friendly cities include other important services. This section describes key programs that address a broad array of services needed for elders with disabilities to maintain healthy, active, lives.

Administration on Aging Community Innovations for Aging in Place (CIAIP)

* The CIAIP, which was included in the 2006 Older Americans Act reauthorization, was designed to assist communities create services to help elders with disabilities maintain their independence in their homes and communities (AoA, 2010). Applicants needed to develop innovative approaches for linking elders to services such as care management, housing assistance, health and personal care, transportation, evidenced-based disease prevention and health promotion. Indicating extensive need and interest, the program received over 200 applications in 2009 for awards to diverse communities in 14 states. The Visiting Nurse Association of New York City received a grant to provide training and technical assistance to the 14 grantees. Projects varied greatly, and included innovations such as: delivery and coordination of health and social services to Native American, rural, and urban communities in New Mexico; capacity building to develop Lifelong Communities in the Atlanta region; and establishment of a partnership between an experienced case management organization and an Aging and Disability Resource Center to help elders in Howard County, Maryland maintain their independence in their own homes. The CIAIP outcomes will be available shortly.
* On April 16, 2012, AoA merged with the Administration on Developmental Disabilities and the Office of Disability to become the new Administration on Community Living (ACL). This new agency aims to increase access to community supports and full community participation for people of all ages with disabilities (ACL, 2012).

World Health Organization (WHO) Guidelines for Age-Friendly Cities

* The WHO conducted a large, international community-based participatory research project in 33 cities to identify elements of age-friendly cities (WHO, 2007). Portland, Oregon participated in this global effort, and New York City joined later. Based on the principle that elders know best about their needs and preferences, researchers conducted 158 focus groups with people aged 60 years and older to learn about their experiences navigating their urban areas. In addition, the project included focus groups with 250 caregivers who could represent elders who may not be able to participate in the groups due to physical or cognitive disabilities. Finally, service providers from a variety of public, voluntary, and private organizations provided their views in focus groups.
* The focus groups addressed eight broad areas needed in age-friendly cities: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, as well as community support and health services. This project has resulted in a variety of products, including a guidebook informing policymakers, city planners, and others about the extensive information gleaned from the focus groups (WHO, 2007a), checklists defining the eight components of age-friendly cities (WHO, 2007b), and a network of cities interested in developing their own age-friendly cities. Portland, OR was the first U.S. city to be named a WHO age-friendly city, and New York City was the second. Des Moines, IA and Philadelphia, PA have joined the WHO Network.

AARP Network to Foster Age-Friendly Communities

* On April 12, 2012, AARP announced a new initiative to promote age-friendly cities, and funded seven states and the District of Columbia to create their own initiatives. This initiative, affiliated with the WHO guidelines for age-friendly cities, will help government, business, and community leaders expand their efforts to prepare neighborhoods for a growing elderly population. Each pilot state will identify communities that want to improve the social and physical environment for their older citizens so they can remain safe and engaged in local activities. The pilot states include Georgia, Iowa, Kansas, Michigan, New York, Oregon, and Pennsylvania. The project’s WHO affiliation will give these states access to global resources and age-friendly city best practices (AARP, 2012a).

The Village Movement

* The village model is a consumer-directed approach to aging in a community setting that began with the Beacon Hill Village in Boston in 2002 (Scharlach, Graham, & Lehning, 2012). The model focuses on the social and practical supports that elders need to live independent, healthy lives in their communities. As villages build on and coordinate existing services, the model can complement other community approaches to aging such as Aging Network programs and other state and local services. The Village Movement has grown quickly -- primarily in white, middle class communities-- and there are 80 operating villages nationwide with at least another 120 in the planning stage. The D.C. metropolitan area has 28 villages operating or in development (Poor, Baldwin & Willet, 2012; Village to Village Network, 2012).
* Villages are a focal point, where members can call to receive information and guidance about the confusing array of LTSS that exist in most cities. Staffed by a combination of members, volunteers, and paid staff, member services generally include the following: 1) one phone number for information and assistance; 2) member-to-member volunteer supports, 3) help with daily living activities such as transportation, grocery shopping, light home maintenance, check-in calls, and medication reminders; 4) health-related supports such as help negotiating the medical system and assistance with hospital-to-home transitions; 5) social, educational, and wellness programs to help members stay active; 6) help arranging home care and other services provided by vetted and possibly discounted providers; and 7) early case management to prevent crises (Poor, Baldwin & Willet, 2012).
* While villages vary greatly to serve individual neighborhood needs, they share the following common hallmarks: 1) they are self-governing and self-supporting membership-based organization (half of funding comes from members); 2) their organizational structure and services are designed to serve each village’s members’ needs; 3) they have volunteers who provide services to members; 4) they are consumer-driven and holistic in approach; and 5) they promote volunteerism (Poor, Baldwin & Willet, 2012). Villages are developed without public funding, and largely outside the aging services network; however, states and counties have shown interest in working with villages. For example, the state offices on aging in Michigan, Ohio, and Pennsylvania are exploring ways to support the development of villages to meet the LTSS needs of elders. In the District of Columbia, the Mayor has directed the Office on Aging to bring villages to every neighborhood. Montgomery County, Maryland has a detailed blueprint to help communities develop villages (Marks, L., 2010) and has funded village founders’ memberships to a national membership, peer-to-peer network named The Village-to-Village Network (Poor, Baldwin & Willet, 2012).
* While the Village Movement has grown quickly on a national level, there is much to learn about the model. Research and evaluation is a high priority for the Village-to-Village Network to better understand organizational structures, member characteristics, services provided, and the impact of services on members. Scharlach, Graham, & Lehning (2011) completed two surveys of 30 operational villages to learn about organizational structures and member services. The authors recommended further study of the model’s adaptability for communities with racial, ethnic, and economic diversity as most villages are in white, middle-upper middle class areas. They identified challenges with sustainability, and suggested that villages may need to be tied to public policies for long-term sustainability. Villages might be included in Older Americans Act programs such as Community Initiatives for Aging in Place, as well as federal and state HCBS policies that prioritize consumer-directed services such as the Cash & Counseling model. States offering C&C programs might consider allowing consumers to use their allowance for village dues and services.
* Current research is comparing the characteristics of villages and Naturally Occurring Retirement Communities Supportive Service Programs (NORC-SSP). A NORC is a geographic area with a large proportion of older people, and the community may comprise apartment buildings or single family homes. The NORC-SSP model adds a service component to community (Ormond, Black, Tilly, & Thomas, 2004). Villages are similar to the NORC-SSP model and other HCBS programs as they help elders obtain health and social services to maintain their independence in the community. However, villages differ from the NORC-SSP and other HCBS models as they are generally grass roots, consumer-directed, self-supporting organizations vs. provider-directed (Scharlach, Graham, & Lehning, 2011). Maryland has two NORCs, one operated by the Jewish Federation of Greater Washington in Rockville, and another operated by the Jewish Federation in Baltimore.(Maryland Statewide Empowerment Zones for Seniors Commission. 2009).

Challenges to Aging in a Community Setting

Despite these global, federal, and state initiatives to emphasize community-based services, there are challenges to aging in a community setting. Among others, key challenges include: a nursing home bias in LTSS, limited coordination of the many services needed to remain in a community setting, and a caregiver shortage.

* As previously explained, the vast majority of Maryland’s Medicaid expenditures for LTSS are for nursing homes and clearly reflect a bias toward nursing home care (State of Maryland, 2011). However, passage of SB 822, “Maryland Communities for a Lifetime,” indicates current statewide interest in shifting LTSS spending to increase the availability of community-based services (Maryland Statewide Empowerment Zones for Seniors Commission, 2009). To be most effective, the legislation needs funding to carry out its mandate.
* To age successfully in a community setting, it is necessary to have strong coordination of an array of services (MetLife, 2010). However, coordinating care requires time, energy, and knowledge about health and long-term services. Elders with multiple health care problems may need numerous services such as help with cooking, cleaning, bathing, shopping, bill paying, medication management, home maintenance, transportation, medical care, and social support -- to name a few. While families put forth significant effort to provide needed services for their aged relatives, they often do so under stressful conditions. As we saw with Mrs. Green, Mr. Jimenez, and Mrs. Abbot, their families are devoted even with competing demands -- children at home and full-time jobs.
* To add to this problem, there is a nationwide shortage of geriatric professionals and direct- care workers (Institute for the Future of Aging Services, 2008; IOM, 2008). With an aging population, and more elders requiring community-based services, caregiver shortages are likely to become even greater (National Council on Disability, 2004).
* The physical and psychological stress of caregiving has been well documented(CDC, 2008; Feinberg et al, 2011), and caregiving has been associated with high levels of depression and anxiety as well as poor physical health. To sustain existing caregivers (both paid workers and unpaid family caregivers), we need to pay attention to their stressful circumstances and provide evidence-based supports.

Aging in Community Settings in Maryland

While there have been significant n**a**tional and Maryland state efforts to expand options to help elders stay in their communities as they age, clearly, there are many goals yet to be achieved in this arena. Maryland has participated or is currently participating in several grant programs designed to shift the balance of LTSS spending away from nursing homes toward community services including Real Choice Systems Change, Money Follows the Person, Community Living Program, Community Innovations in Aging in Place, and Veterans-Directed HCBS. Maryland has been active in the Village Movement and has NORCs in two metropolitan areas. In addition, the Montgomery County Council recently endorsed the County Commission on Aging Senior Agenda, which calls for a “Community for a Lifetime.” This comprehensive plan includes action steps in transportation, housing, socialization and leisure, health and wellness, communications, employment, security, and safety (Montgomery County, 2012). Despite these efforts, Maryland lags behind most other states in rebalancing outcomes. The interest indicated by the Maryland Communities for a Lifetime Act, as well as financing incentives from the ACA, present opportunities to make great strides in creating more opportunities for older Marylanders with disabilities to age with dignity in community settings.

**Discussion**

This brief overview of literature about “communities for a lifetime” reveals varying levels of knowledge about different aspects of this broad topic. We have learned a great deal about home and community-based services (HCBS) over the past 30 years (Doty, 2010, Kane, 2012), as well as participant-directed HCBS models (Doty, Mahoney, & Sciegaj, 2010, Doty, et al, 2012). As states strive to meet a national goal of re-balancing the focus of long-term services and supports (LTSS) from institutional to community settings, there are many opportunities to adapt these lessons. As LTSS are at the heart of “communities for a lifetime,” this body of literature with evidenced-based practices provides a strong foundation.

We’ve seen recent global, national, and state efforts to develop “age-friendly communities,” including initiatives sponsored by the World Health Organization (WHO, 2007a), the Administration on Aging (2010), and AARP (2012 a,b). However, there is a great deal yet to learn. The WHO initiative, based on extensive, international research, has developed checklists and guidelines to help other communities establish age-friendly cities. Project findings from the AoA initiative are forthcoming, and the AARP program was just announced in April of 2012. The “village movement” has quickly grown throughout the country in the past decade, and researchers are at an early stage of understanding the varying characteristics and structures of this consumer-driven approach to providing a wide variety of community-based LTSS (Scharlach, Graham, & Lehning, 2011; Poor, Baldwin, & Willet, 2012). There is much to learn about villages, including lessons about sustainability and adapting the model to diverse communities in various settings.

To truly understand varying approaches to developing “age-friendly communities,” it is necessary to look within and across numerous disciplines involved in developing services for a diverse, aging population. As previously mentioned, successful age-friendly communities need to draw on knowledge from a variety of disciplines required to help families such as the Greens, Jimenez’, and Abbotts. To meet the complex needs of aging individuals and their families, we need to develop innovative solutions based on multi-disciplinary teams bringing their complementary areas of expertise together. This team approach might include professionals from the fields of gerontology, public health, health care, social work, public policy, urban planning, housing, transportation, and engineering, to name a few. For example, professionals from the fields of gerontology, public health, health care, and social work might see a natural partnership between hospitals and villages as hospitals re-organize their priorities to avoid ACA financial penalties for frequent re-admissions within thirty days of a patient stay. As hospitals target populations most likely to have frequent re-admissions (Wilson, et al, 2012), and seek ways to decrease re-admissions among elders, they may see villages as a valuable source of help for elders transitioning to home after a hospital stay. This type of partnership could result in better quality care for elders when they make the often difficult transition home after a hospital stay. The following section offers recommendations to build on this multi-disciplinary team approach.

**Recommendations**

Developing age-friendly communities to help elders stay active despite disabilities is a complex goal requiring coordination of many resources. There are multiple levels/types of services, such as: (1) prevention (health, social, built environment); (2) chronic disease/disability management; (3) environmental modifications and technologies; and (4) supportive care. As a starting point, the following recommendations aim to expand existing resources.

* Develop a “Maryland Communities for a Lifetime” website so existing resources are accessible in one location: There are a growing number of resources to help communities begin and/or expand their efforts to develop age-friendly communities, and Maryland communities need easy access to them. For example, the Maryland Communities for a Lifetime legislation calls for identification of “best practices” for age-friendly communities. For example, this website could include the detailed WHO age-friendly cities guidebook and checklists (WHO 2007a, 2007b) as they are “best practices” developed from extensive global research conducted in 33 cities. The 2011 AARP/National Conference of State Legislatures publication, “A State Survey of Livability Policies and Practices,” could also guide communities.
* Establish a statewide or regional coalition to support communities in their efforts to develop/expand age-friendly communities (e.g., Westchester County Center for Aging in Place, Metropolitan Atlanta Lifelong Communities): Building on the successful, 2012 three-state Innovations in Aging Conference sponsored by the Maryland Department of Aging, it would be productive to establish a coalition of state, county, and local agencies working toward the same goals. The coalition could include agencies representing the broad array of services needed for age-friendly communities (e.g. health care, HCBS programs, housing, transportation, civic engagement, etc.) During a well-attended session on Communities for a Lifetime, Aging Network attendees were eager to learn from one another about shared goals. A forum for peer-to-peer learning could be an efficient means of helping communities make progress.
* Sponsor a statewide or regional symposium focused on Communities for a Lifetime: A symposium could address the following goals: 1) Collect “lessons learned” from Maryland’s previously mentioned programs that would contribute to building age-friendly cities. There is a wealth of experience among the Maryland agency staff who implemented or are currently operating these programs, and it is important to capture this information. 2) Learn about current research and experience from state and national experts. 3) Begin developing funding partnerships to support future activities by including funders whose priorities are aligned with this topic.
* Explore a partnership with the University of Maryland, Center on Aging and School of Public Health to help implement Maryland Communities for a Lifetime: Communities for a Lifetime need to be informed by applied research, and a state-university partnership would help Maryland implement this legislation with information from cutting edge research. The complexities of developing communities for a lifetime require a multi-disciplinary collaboration of researchers focused on improving services for older Marylanders -- like the Green, Jimenez, and Abbott families -- so they can age with dignity and necessary support in their own homes.

While there have been efforts within individual disciplines to address specific needs of the elderly (MetLife, 2010, McDonald & Janes, 2007, Lawler, 2002), their complex and diverse problems require an approach that benefits from thinking across disciplines found throughout a university setting. Through an emphasis on applied research, best practices, and policy, a university partnership could address necessary services such as community-based health care and assistance with daily living activities, health care and health promotion, transportation, housing, socialization, and assistive devices that help elders age in place. Using a problem-focused research approach, this multi-disciplinary collaboration could also identify and address the barriers and challenges to successful age-friendly communities.

A state-university partnership could help fulfill the renewed and expanded mission of a land-grant university -- translation of research to practice to help Marylanders. It could also provide an opportunity to work across campuses with health professional schools such as Medicine, Nursing, Dentistry, and Social Work – implementing the new Alliance between the University of Maryland campuses at College Park and Baltimore. A university partnership is in place in California and Oregon, where university researchers are conducting applied research and evaluation to better understand the Village Movement (Scharlach, et al, 2011) and evaluate an AARP age-friendly city grantee in Portland, Oregon (2012b). This type of partnership could help Maryland become a nationally recognized leader in solutions to aging in a community setting.

**Conclusion**

Many synergistic trends lead to the conclusion that this is the right time for Maryland to make communities for a lifetime a state priority. In addition to SB 822 Maryland Communities for a Lifetime, which evolved from current demographic and economic imperatives, this priority area is consistent with state and national policies. Maryland has an opportunity to shift its focus on institutional LTSS to community-based services, and reach or exceed the national goal to re-balance public spending in this direction. The many existing lessons and evidenced-based research about HCBS programs and participant-directed HCBS can inform programs and policies developed to meet this goal. In addition, financial incentives and disincentives within the 2010 Affordable Care Act (ACA) are encouraging states to develop and/or expand their community-based LTSS. For example, as hospitals are re-organizing their priorities to decrease their rates of re-admissions within 30 days of discharge, they will rely heavily on high quality, coordinated post-hospital services. The varied services of communities for a lifetime – including assistance with hospital to home transitions, transportation to medical appointments and other needs, and personal care services, to name a few – can help hospitals and other health organizations meet the challenge of providing excellent services to elders and their families in their own communities. The recommendations in this policy brief focus on a multi-disciplinary approach to addressing the diverse needs of people aging in their communities, and are intended to guide the State in this critical priority area.

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